Elevating Community Health Needs Assessments:

A Strategic Imperative to Advance Health Equity

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Health care providers have a responsibility to ensure that every patient receives equitable care with cultural humility, which includes a commitment to self-reflection and learning, reducing power imbalances and improving institutional accountability. At CHRISTUS Health, we recognize the importance of integrating a health equity lens into our daily routine. To achieve health equity, it is essential to consider the patient's environment, lived experiences, support and resources at every step of the process. And in our work for healthy and equitable communities, we've expanded and refined our data analysis and strategic responses.

ENSURING HEALTH EQUITY THROUGH PARTNERSHIP ENGAGEMENT

To fulfill our mission and build a culture that ensures health equity, CHRISTUS Health adopted three strategies:

1. Promote a culture of diversity and inclusion: Representation matters. We must ensure we represent the communities we serve in every area of our organization.

2. Ensure health care that is equitable for all: We must create a culture of racial equity. Our plan includes implementing our experts' ideas to alleviate the social determinants of health that lead to the comorbidities in communities of color and contribute to early mortality.

3. Improve the impact of community benefit investments: We must expand our community benefit footprint throughout the system to ensure that the organization is aligned with the opportunities outlined in its community health needs assessments (CHNA) and community health improvement plans (CHIPs).

To achieve our goals, we must engage all associates and embrace our community partners. We intentionally partner with diverse stakeholders in decisions that address their needs and improve connection. Our impact has to be known internally throughout the system to ensure equitable patient outcomes and externally through our communications with patients and the public.

As a health system consisting of multiple hospitals in Texas, Arkansas, Louisiana and New Mexico — and health care ministries in Mexico, Chile and Colombia — CHRISTUS understands that health equity is central to our diversity and inclusion and community health programs. We are working with staff and information technology infrastructure to ensure that the stratification of patient data, quality data, process measures, patient satisfaction and performance continues to develop.

To accomplish this, we began internally by

stratifying emergency department use by race, ethnicity and payer mix (Medicare, Medicaid, uninsured and insured).

We looked closely at anonymous data related to high users of our emergency department, and determined that hypertension should be an area of focus related to vulnerable community members. In response, we created goals around communities identified as most vulnerable, and by providing them with the navigation needed to access care resources for treating hypertension, we were able to reduce emergency department visits.

INTERPRETING INSIGHTS AND IDENTIFYING COMMUNITIES OF FOCUS

At the beginning of a CHNA process, we listen to community voices via focus groups, key interviews and a systemwide community survey. This survey also includes our employees who reside in the communities where they work and are a valuable resource for identifying community needs.

In addition to CHRISTUS Health employees, we consulted with community partners on questions to be asked that would be helpful across organizations. We analyzed data from external sources and patient records to comprehensively understand the situation.

To analyze this data and feedback, we used Metopio, a software and data company focused on population and place-based analytics. This partnership was instrumental in accessing and analyzing hyperlocal data to identify common health disparities across populations and service areas. Our approach was unique as we integrated community voices through statistical methods alongside a large volume of quantitative data points.

For example, we created a community learning collaborative with more than 50 area partners to develop and distribute a community survey. By prioritizing community involvement at the beginning, we surveyed more of the vulnerable population than in prior assessments. Together, we identified a community of focus in each service area and worked with them to determine priorities. Across the system, food security and addressing heart disease emerged as priorities. We continued to involve the community in our efforts to build trust and identify and customize programs to address these needs in a way that respected each area's unique characteristics.

With the creation of our organization's communities of focus, we avoid using the word "target" when referring to people and instead focus on community health strategies. Studies show that people's average life expectancies vary according to the ZIP code where they reside,[1] revealing social and economic disparities across our service areas. To identify the communities of focus, we concentrated on six criteria: primary service area, community data, social vulnerability, economic hardship, area deprivation index and life expectancy. By analyzing population data from Metopio, including patient visits and economic conditions, we identified ZIP codes of focus within our larger service area. This process allowed us to create the CHRISTUS Community Needs Index.

STRATEGIC IMPLEMENTATION OF CHNAS

With our communities of focus now defined at CHRISTUS Health, we have applied this concept to several strategies. One of those relates to our community benefit programs, where we select clinical indicators that directly impact our specific population and engage with community-based organizations and other local resources to respond to the priority health needs identified. Another partnered strategy focuses on programs that identify and provide improved outcomes.

Our CHNAs are not meant to sit on the shelves. As a member of a health care anchor network that aims to support communities in our service areas, we recruit and build a diverse health care workforce that includes hiring from communities of focus. This means that when we look for new talent, we intentionally recruit from communities in these ZIP codes to build employment opportunities and to help break down barriers that have created systemic poverty in those communities.

We also work with our quality and safety partners, nursing leadership, clinical analytics and population health to ensure our CHNAs are used across these departments. Using quality measures to build from the CHNA's foundation and to elevate the work of the CHIPs allows us to address health equity regulatory requirements by partnering with these departments to align community and clinical priorities.

PRIORITIZING COMMUNITY NEEDS

CHRISTUS Health benefits greatly from having one assessment process for evaluation that

covers the whole system. CHRISTUS' health system board requested that we identify a couple of areas for the whole system to prioritize, but it was difficult to do so when we had different processes at each ministry. The systemwide Community Benefit Advisory Council played a vital role in solidifying the process. It comprises each ministry's mission leader, community benefit staff and departmental leaders from strategy, human resources, finance, marketing and communications. Through this council, we identified heart disease and food insecurity as the top two areas of need to address for the entire system.

Today, each local ministry still has its own priorities, but this has been a great step forward. Per board direction, we are now moving forward with determining the metrics we will use to measure success, with progress updates reported to the board every six months. The system's community benefit team receives monthly reports around community benefit from our ministries, mission leaders and their teams. Our health priorities around heart disease and food insecurity are key. We look at indicators in two categories: population-level and program-level indicators.

For population-level indicators, we focus on the CDC's Healthy People 2030 initiative[2] — the 10-year plan to address the nation's most critical health priorities and challenges — that focuses on heart disease mortality and food insecurity. For program-level indicators, we are finalizing these with our stakeholders to ensure we are keying in on what that means for all our ministries. Furthermore, we are building on this infrastructure to ensure that we are prepared to also address health equity regulatory requirements.

TRACKING PROGRESS

In addition to using Metopio in our work to analyze community data, we also use a framework called results-based accountability. Results-based accountability is a framework that can help improve the quality of health care and program delivery by ensuring that outcome and impact objectives are met through continual analysis of performance measures and feedback.

We have just completed training on this framework with our mission integration leaders and community benefit staff. Through this training, our aim is to ensure that we differentiate between population indicators, such as diabetes rates across the entire community, county or state and program outcomes. While it may take time to see progress in the population indicators, we are creating strategies and programs that can help us achieve these objectives by working with our board, partners, community-based organizations, public health departments, federally qualified health centers, local government and the faith community.

To track our progress, we are using tools such as Clear Impact — an online performance reporting and data collection software that helps us to track results-based accountability — with our system-funded community-based organizations. With Metopio, we get information that helps us see the whole picture as it relates to CHRISTUS Health. Additionally, we are tracking our progress using Community Benefit Inventory for Social Accountability, a reporting software that collects statistical and narrative information.

By using these tools, we can develop a dashboard that will help us make informed decisions. This allows us to identify root causes and develop a health equity strategy to address social determinants of health around heart disease and food insecurity.

SUSTAINABILITY AND FUNDING

To secure funding for our community health programs, it is important to integrate them into our organization's overall strategy. This can be achieved through a dedicated goal or leadership incentive program to ensure long-term sustainability.

While each ministry has its own investments in community health, we have aligned our system's grant programs and resources with the priorities identified in our CHNAs. Instead of awarding grants based on individual applications, we are now investing in areas that align with the CHIPs. This approach demonstrates our commitment to local hospitals and communities, while also addressing their identified needs and sharing resources and power. We have a system fund — the CHRISTUS Community Impact Fund — that is now only available through invitation, based on our identified priorities such as heart disease and food insecurity. Each invited community organization receives a portion of this fund for funding and resources. There are currently more than 40 programs funded across the system.

CONTINUING OUR WORK IN HEALTH EQUITY

Our vision for success involves vibrant and engaged communities with strong partnerships in which CHRISTUS Health is on equal footing with all stakeholders. We believe in amplifying the voices of historically marginalized communities and having leaders who understand the lived experiences of all communities. Health equity will be integrated into every aspect of the care continuum, from community outreach to discharge planning. We challenge the health care industry to prioritize health equity and community investments to achieve whole-person care.

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NOTES

1. Garth Graham, "Why Your ZIP Code Matters More than Your Genetic Code: Promoting Healthy Outcomes from Mother to Child," *Breastfeeding Medicine* 11, no. 8 (October 2016): 396-7, https://doi.org/10.1089/bfm.2016.0113.
2. "About Healthy People," Office of Disease Prevention and Health Promotion, https://health.gov/our-work/national-health-initiatives/healthy-people/about-healthy-people.

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