Community Health Needs Assessment and Implementation

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Population Health Colloquium
Preconference Session – Understanding and Preparing for Community Health Needs Assessment
March 23, 2015

Health Systems and Community Health Improvement – Real and Potential Synergies

- Participants in this session will be able to:
  - Describe the historical perspectives (*confluence of movements*) related to current population health improvement efforts
  - Describe the significance of the Patient Protection and Affordable Care Act and requirements to assess and evaluate community health needs
  - Describe processes involved in conducting the CHNA

Healthy Communities Movement

- Sparked by the WHO, Ottawa Charter in 1986 and National Civic League/ US Public Health Service in 1988

- Based on a broad definition of health that includes housing, education, peace, food, a stable eco-system, sustainable resources, income, social justice and equity (Ottawa Charter, 1986)

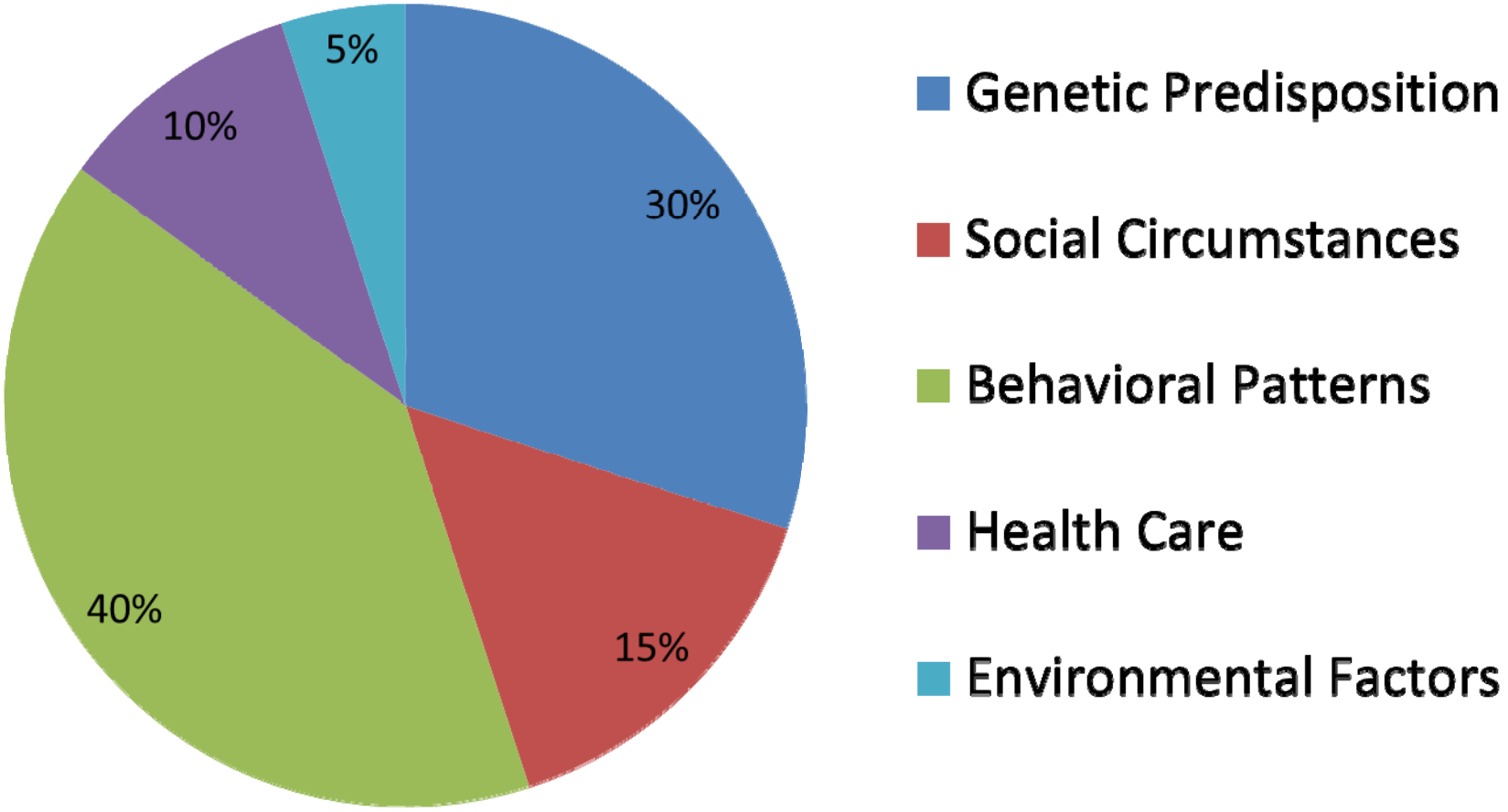
- Movement acknowledges importance of societal and cultural contexts in achieving healthy communities

Healthy Communities Movement

- “A healthy city is one that is continually creating and improving those physical and social environments and strengthening those community resources which enable people to mutually support each other in performing all the functions of life and achieving their potential.”

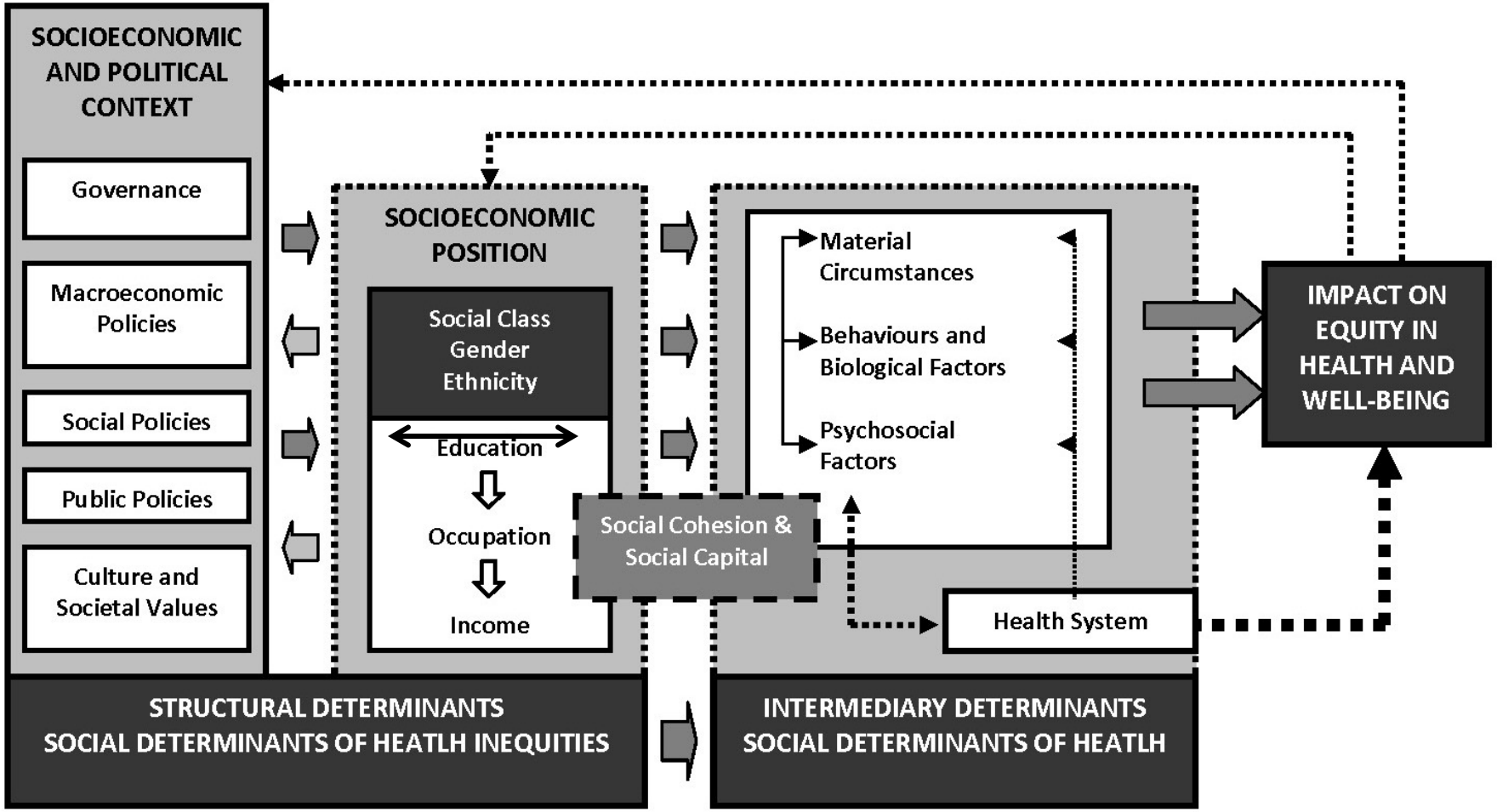
Hancock and Duhl, 1986

Determinants of health and their contribution to premature death



PDPH May 2014 CHNA
Adapted from: McGinnis et al. 2002

World Health Organization
Social Determinants of Health Framework

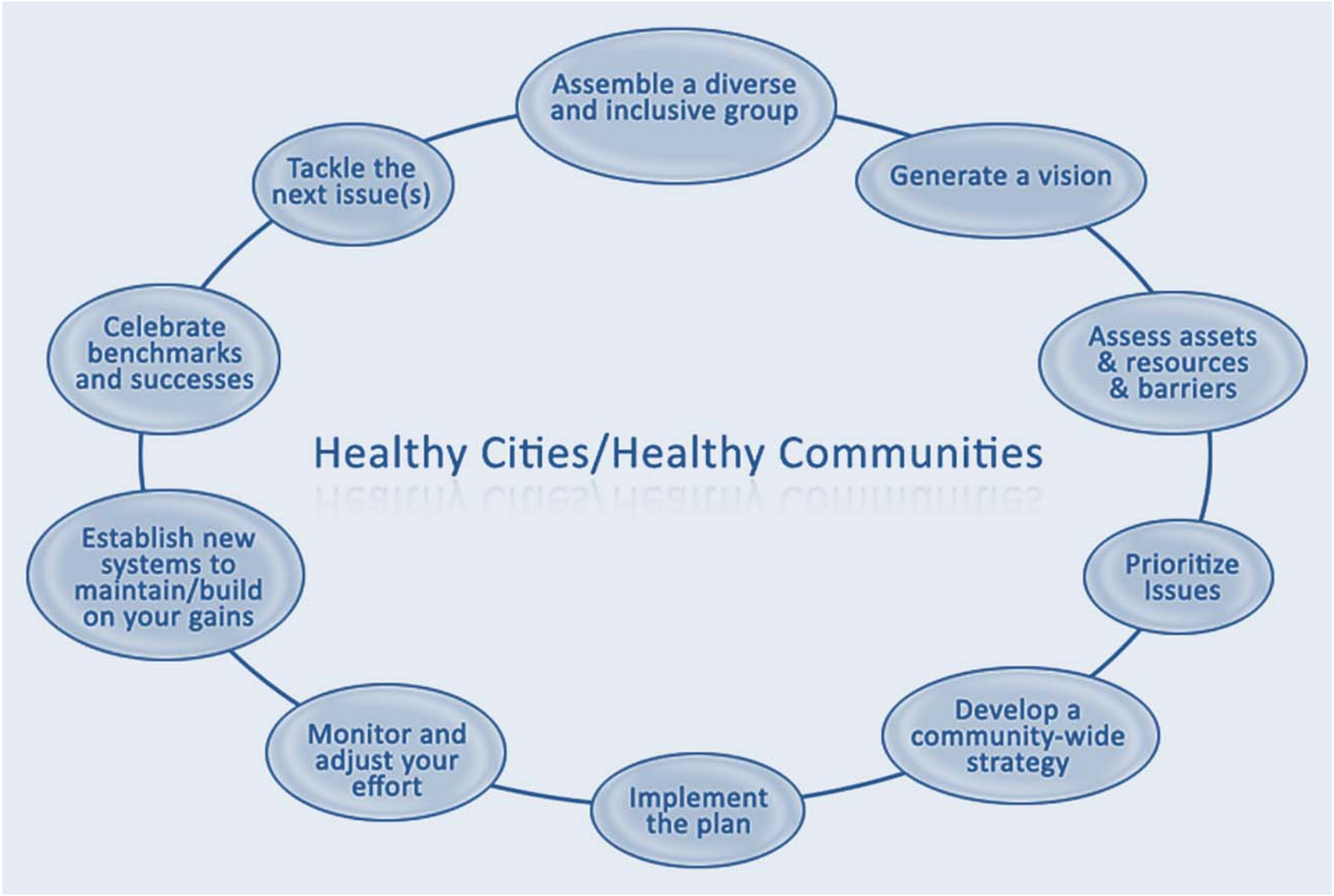


"Healthy Communities"

- **Healthy Communities**: community wide initiatives to improve quality of life
- **Livable Communities**: improving quality of life through thoughtful physical and architectural design features
- **Sustainable Communities**: inter-relationships of economic, environmental and social equity factors
- **Whole Communities**: Interfaith efforts to improve healthy
- ***Communities Movement***

Healthy Communities Movement

- Creates a compelling vision based on shared values.
- Embraces a broad definition of health and well-being.
- Addresses quality of life for everyone.
- Engages diverse citizen participation and be citizen-driven.
- Has multi-sectoral membership and widespread community ownership.
- Acknowledges the social determinants of health and the interrelationship of health with other issues (housing, education, peace, equity, social justice).
- Addresses issues through collaborative problem-solving.
- Focuses on systems change.
- Builds capacity using local assets and resources.
- Measures and benchmark progress and outcomes.



Community Toolbox - http://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/healthy-cities-healthy-communities/main

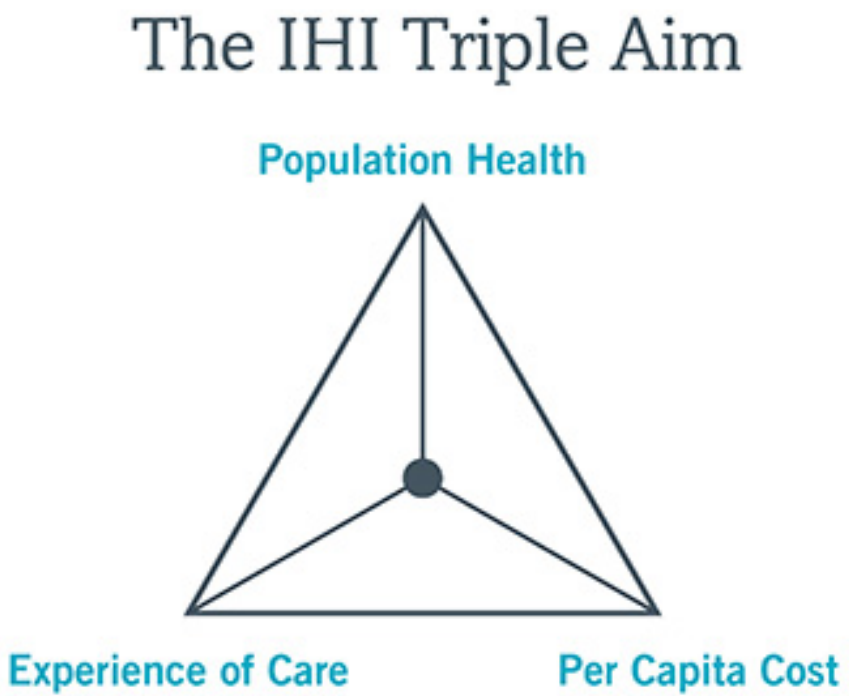
HEALTHY COMMUNITIES
PREVENTING CHRONIC DISEASE BY ACTIVATING GRASSROOTS CHANGE

CDC's Healthy Communities Program (HCP) works through local, state, territory, and national partnerships to prevent chronic diseases and reduce health gaps.

HCP helps to increase the skills and commitment of community leaders and stakeholders to develop and promote lasting strategies that help people make healthy choices where they live, learn, work, and play.
http://www.cdc.gov/chronicdisease/resources/publications/AAG/healthy_communities.htm

Institute for Healthcare Improvement: Triple Aim

- Achieving the Triple Aim means addressing population health – CHNAs and implementation plans are designed to help do that

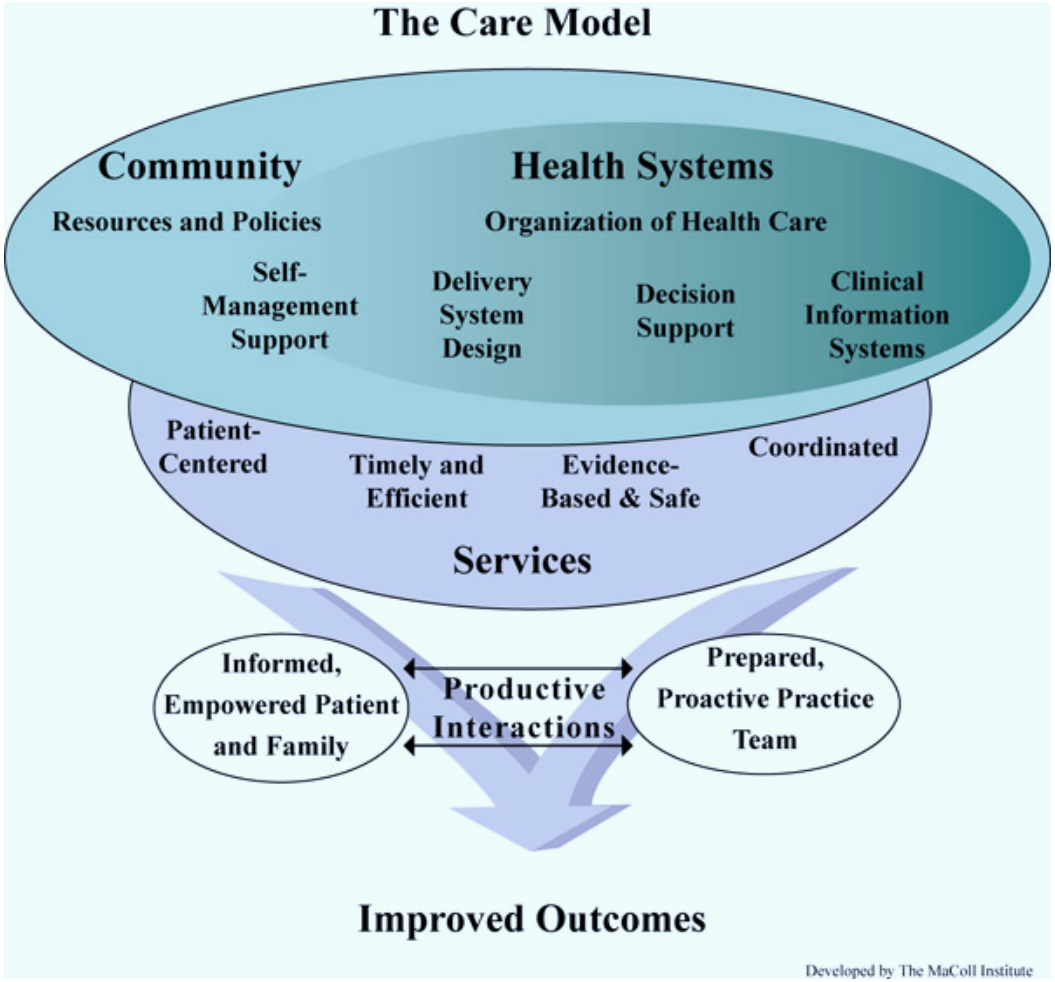


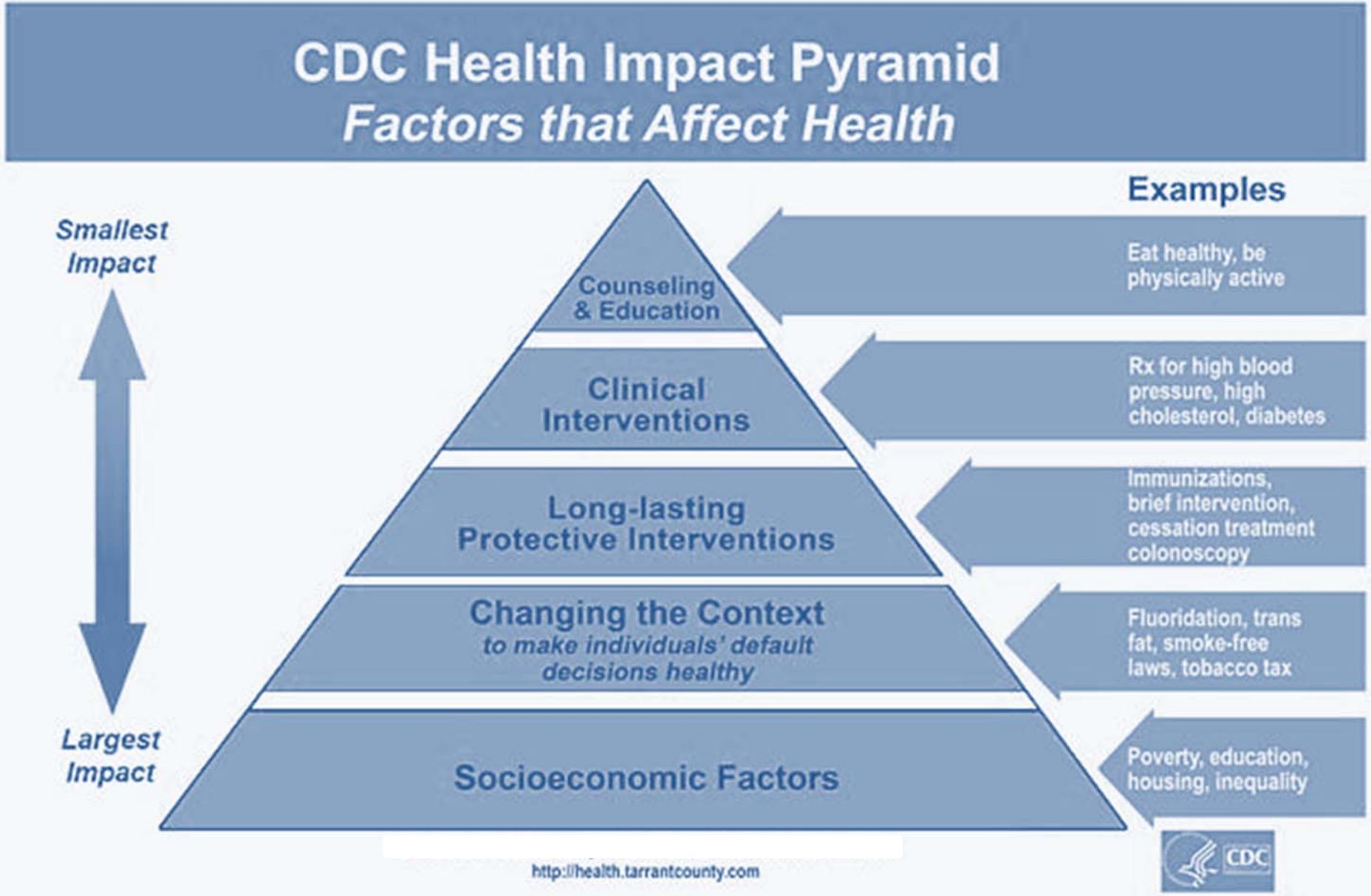
Patient Centered Medical Home

- **Whole person orientation-** care for all stages of life and illness including preventive services.
- **Coordinated/integrated care-**
  - the right care at the right time in a culturally and linguistically appropriate manner.
  - Improved access; improved communications (with patients and among the providers) through use of information technologies.

Patient Centered Medical Home

- **Patients actively participate in decision-making** and feedback is sought to assure patient expectations are being met.
- **Appropriate reimbursement for non-physician staff** who help coordinate care and improve communications and quality of care





Source: Frieden, T. A Framework for Public Heath Action: The Health Impact Pyramid. Am J Public Health. 2010; April; 100(4): 590–595.

Healthy People 2020 organizes the social determinants of health around five key domains:

Economic Stability – Poverty, Employment, Food Security, Housing Stability

Education - High School Graduation, Enrollment in Higher Education, Language and Literacy, Early Childhood Education and Development

Health and Health Care - Access to Health Care, Access to Primary Care, Health Literacy

Neighborhood and Built Environment - Access to Healthy Foods, Quality of Housing, Crime and Violence, Environmental Conditions

Social and Community Context - Social Cohesion, Civic Participation, Perceptions of Discrimination and Equity, Incarceration/Institutionalization

Community Centered Health Home

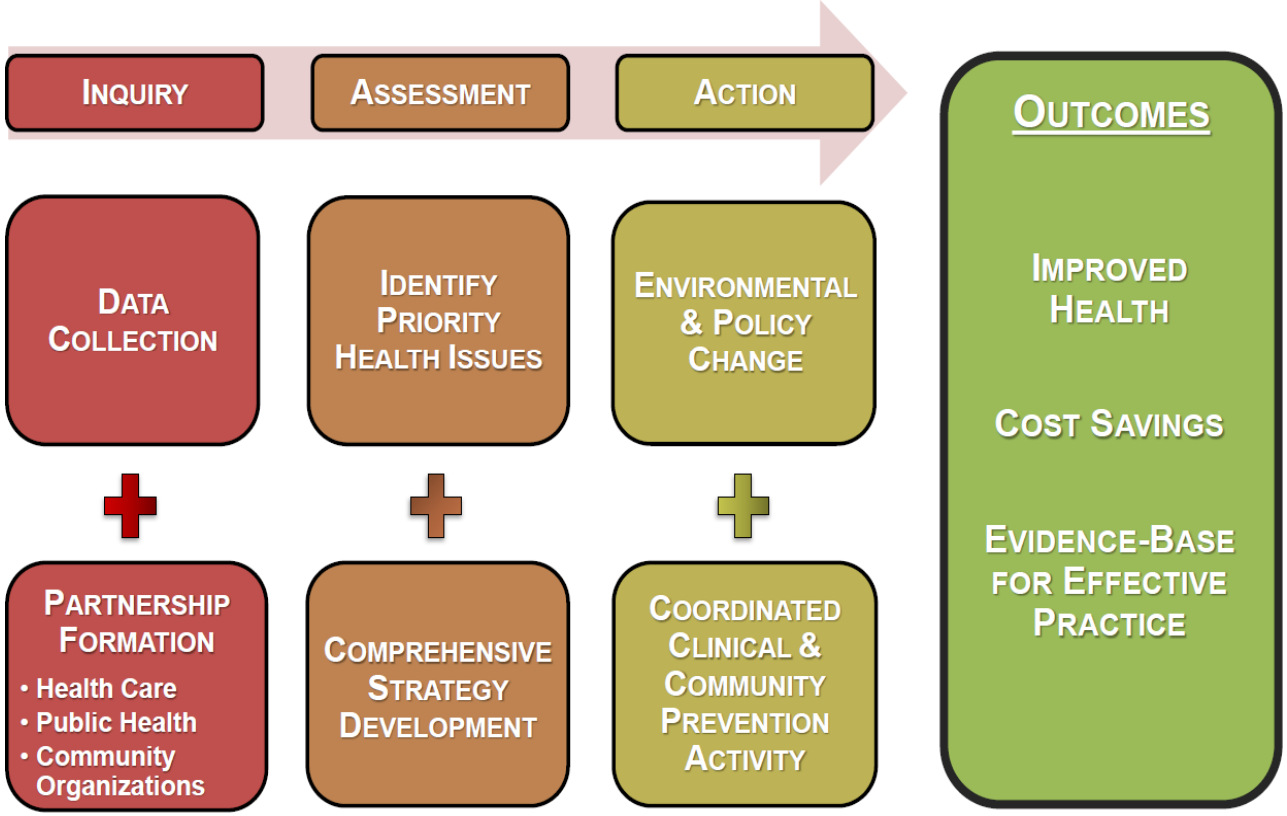
- *The defining attribute of the CCHH is active involvement in community advocacy and systems change. A CCHH not only acknowledges that factors outside the health care system affect patient health outcomes, but actively participates in improving them.*
  - Prevention Institute

Community Centered Health Homes:

An evolving approach to health

The Prevention Institute
www.preventioninstitute.org

Clinical/Community Population Health Intervention Model



http://www.preventioninstitute.org/tools/strategy-tools.html

The “Health in All Policies” approach

“An innovative strategy that introduces improved population health outcomes and closing the health gap as goals to be shared across all parts of government. HiAP seeks to address complex health challenges through an integrated policy response across sectors.”

Kickbusch Ilona, Adelaide Revisited: From Healthy Public Policy to Health in All Policies. *Health Promotion International 2008* 23(1):1-4

HiAP is in the National Prevention Strategy and Healthy People 2020

Health in All Policies

- Takes into account the health and health systems implications of decisions
  - Seeks synergies, and avoids harmful health impacts to improve population health and health equity
  - HiAP - founded on health-related rights and obligations.
  - Emphasizes the consequences of public policies on health determinants
  - Aims to improve the accountability of policy-makers

WHO, 2013, IOM Roundtable on Population Health Improvement, 2013

Health in All Policies

- Health in All Policies: **A systematic approach to public policies across various sectors of society**
- Goal: ensure that decision makers are informed about the health, equity, and sustainability consequences of various policy options
- Premise:
  - good health is fundamental for a strong economy and vibrant society
  - health outcomes are dependent on the social determinants of health
  - health is often shaped by decisions outside of the health sector (e.g. agricultural, transport, occupational and tax policies)
  - incorporating health and health equity requires intersectoral collaboration

Health in All Policies Framework – What is a Healthy Community?

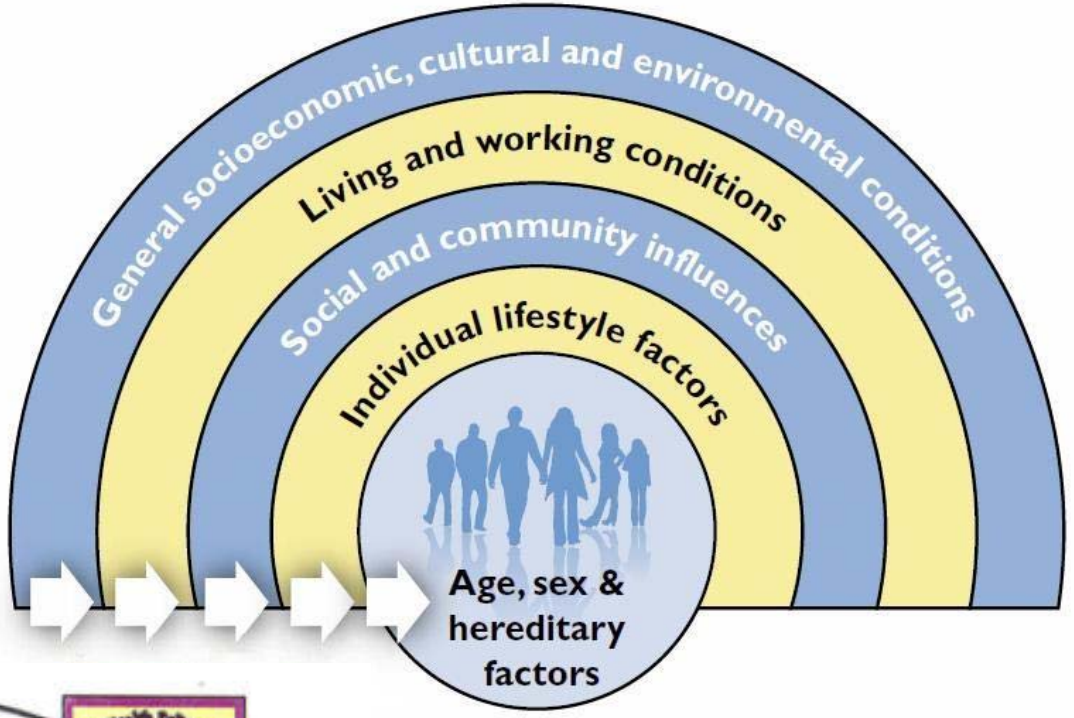
Meets basic needs of all

- Safe, sustainable, accessible, and affordable **transportation** options
- Affordable, accessible, and **nutritious foods and safe, drinkable water**
- **Clean air and smoke-free environments**
- Affordable, high-quality, socially integrated, and location-efficient **housing**
- Affordable, accessible, and **high-quality health care**

Health in All Policies Framework – What is a Healthy Community?

- Complete and **livable communities** including high-quality schools, parks and recreational
- **Facilities, child care, libraries, financial services**, and other daily needs
- Access to affordable and safe **opportunities for physical activity**
- Able to **adapt to changing environments**, resilient, and prepared for emergencies
- **Opportunities for engagement** with arts, music, and culture

California Health in All Policies Task Force, 2010



Health Determinants Model

Current State: Similar but Nonaligned Community Health Improvement Frameworks

Public Health Accreditation, HRSA 330 Grants, United Way, & Other Community Assessments

Community Health Assessment Tools (MAPP, Community Tool Box, etc.)

Philanthropy, Federal/State grant making (CDC/CTGs, HUD, etc.)

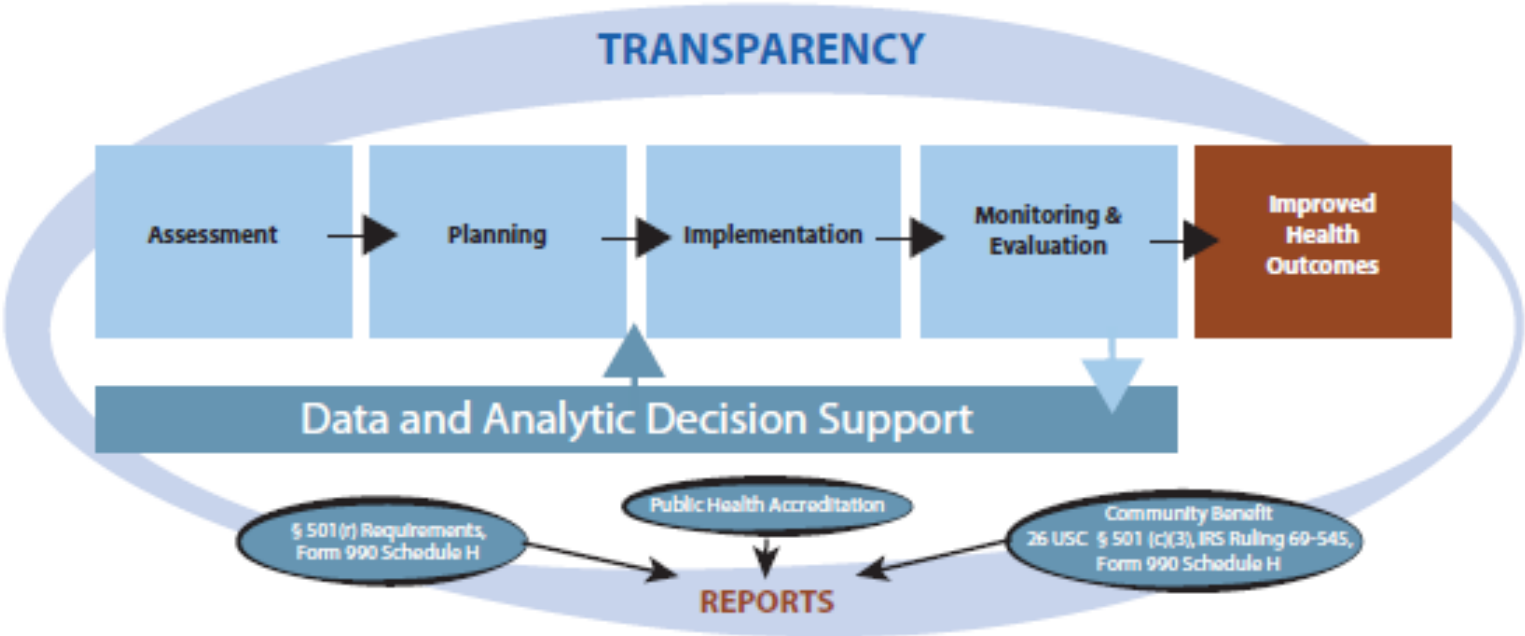
Catholic Health Assoc. Guide
ACHI (AHA) Toolkit
Private Vendors

IRS Hospital Community Benefit Compliance, State & Local Activities

501(r) Requirements, Form 990 Schedule H

26 USC 501(c)(3), IRS Ruling 69-545, and Form 990 Schedule H

Desired State: A Unified Community Health Improvement Framework Supporting Multiple Stakeholders

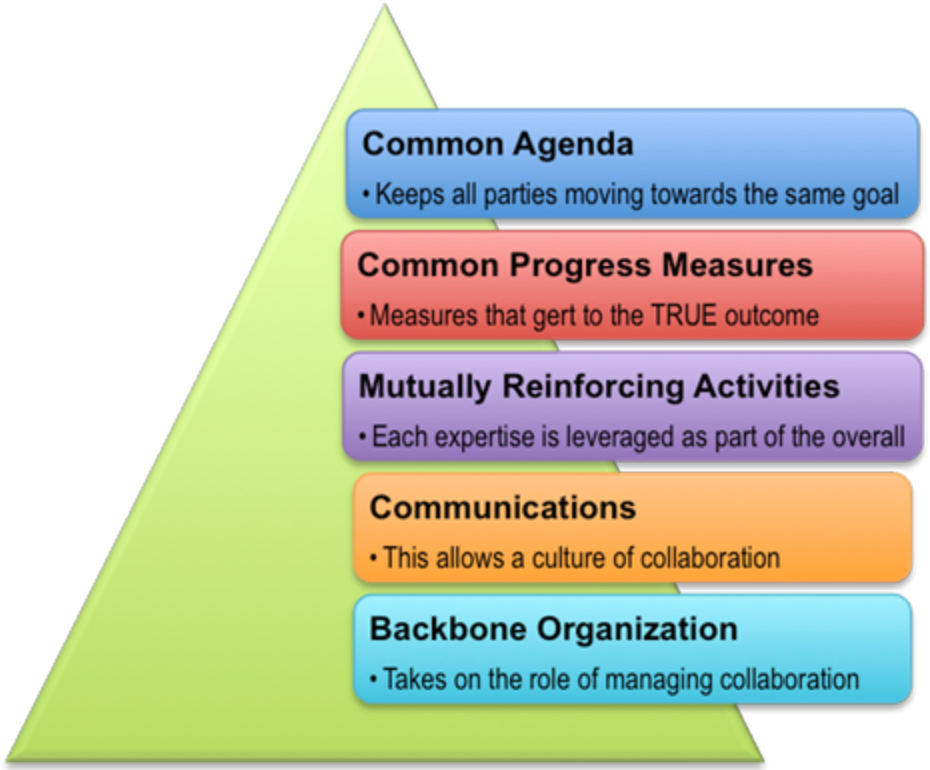


Community Engagement and Assuring Shared Ownership

Key Issues to Address to Promote Alignment between Accreditation, NP Hospital CB, and Other Community-Oriented Processes

- Arranging Assessments that Span Jurisdictions
- Using Small Area Analysis to Identify Communities with Health Disparities
- Collecting and Using Information on Social Determinants of Health
- Collecting Information on Community Assets
- Using Explicit Criteria and Processes to Set Priorities (use of evidence to guide decision-making)
- Assuring Shared Investment and Commitments of Diverse Stakeholders
- Collaborating Across Sectors to Implement Comprehensive Strategies
- Participatory Monitoring and Evaluation of Community Health Improvement Efforts

Collective Impact



http://www.collaborationforimpact.com/collective-impact/

Accountable Care Communities

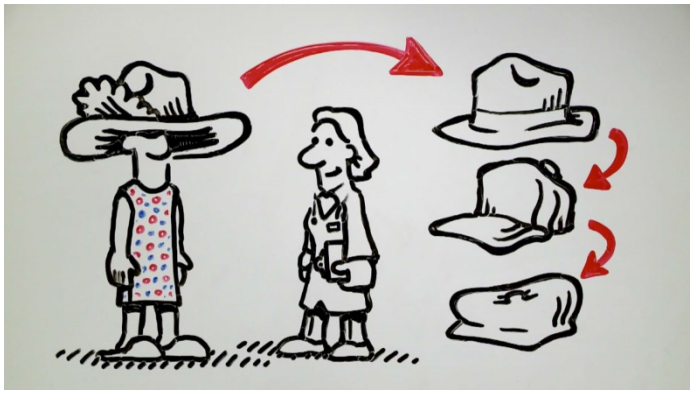
Source: http://www.faegrebdc.com/webfiles/accwhitepaper12012v5final.pdf

Accountable Health Communities

Institute for Clinical Systems Improvement

https://www.icsi.org/health_initiatives/accountable_health

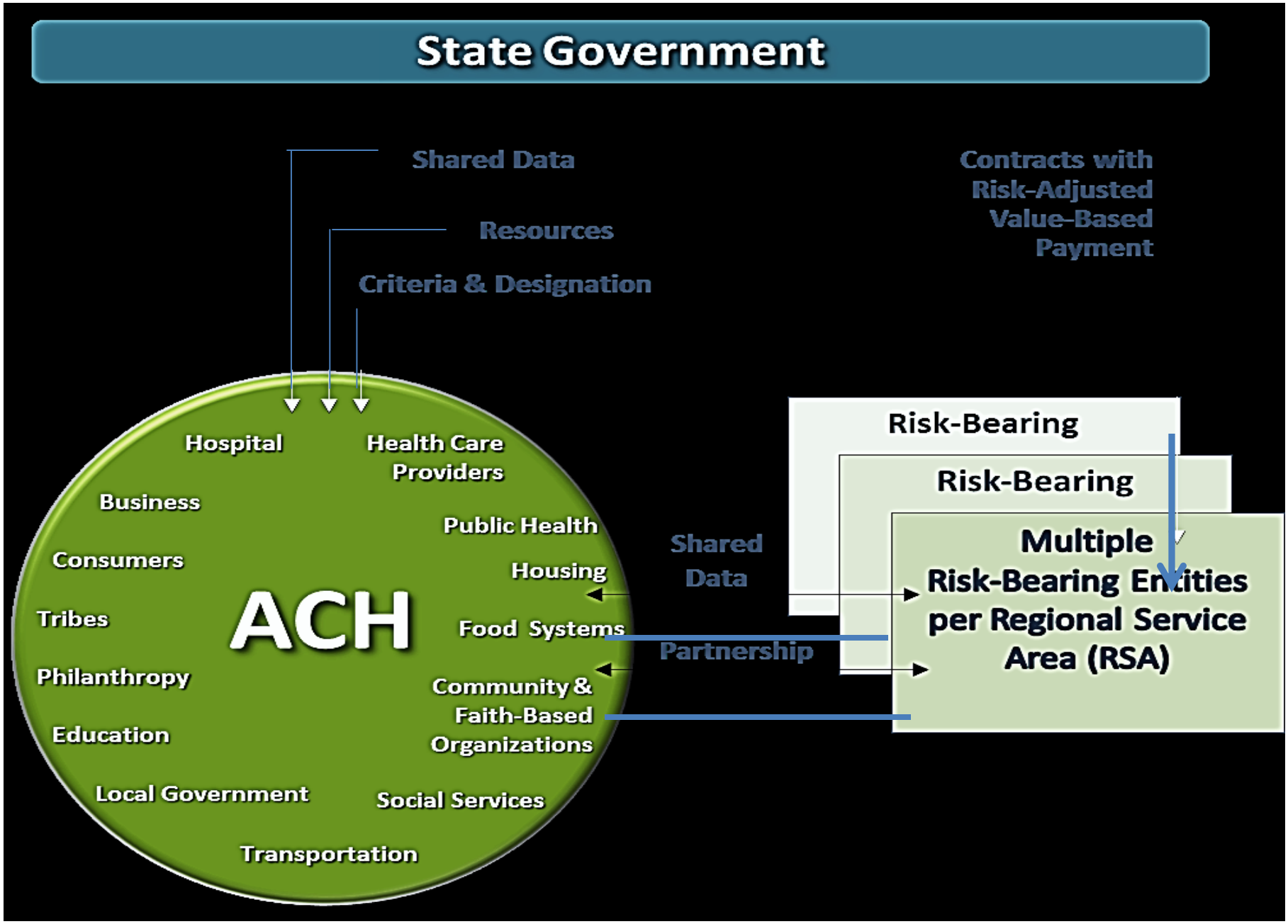
This series of communications and resources — including white papers, videos, a table of examples and related tools — invites clinicians, clinical staff and administrators to connect with community partners and resources for effective problem-solving in health care.



Funded by the Robert Wood Johnson Foundation, the series is designed to support conversations that identify problems and opportunities, develop a shared vision for connections with community partners, and build practical next steps.

Going Beyond Clinical Walls: Hats Matter

https://www.youtube.com/watch?v=EWid8o79lXU&feature=youtu.be

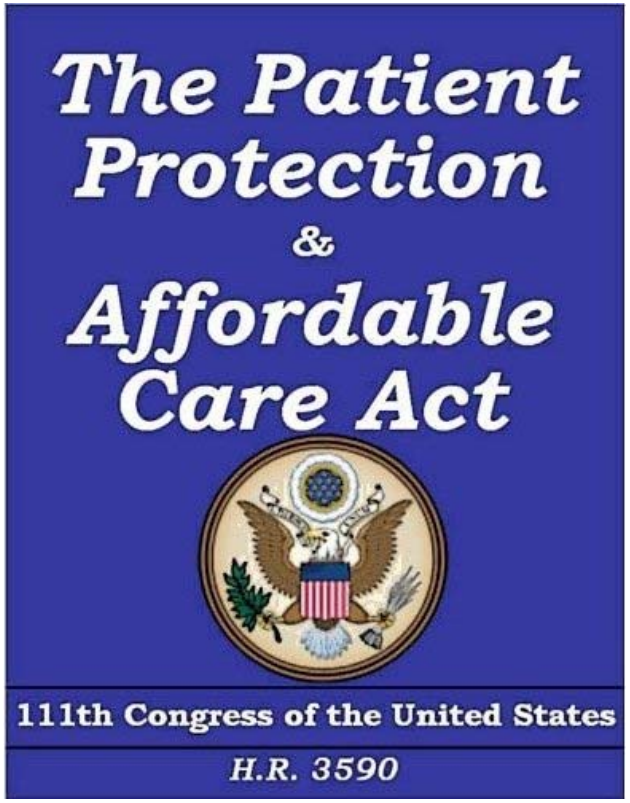


Proposed Role of Accountable Communities of Health (ACH) in Washington State –
http://crhn.org/pages/wp-content/uploads/2014/08/ACH-Intent-and-Goals_CMMI-Responses.pdf

New Federal Mandate:
The Patient Protection and Affordable Care Act

Two broad areas of policy change:

1. Insurance or payer reform
2. System or delivery reform



"Big F…Deal"

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

ACA: Greater Focus on Prevention and Public Health

- Prevention and Public Health Fund (PPHF)
- Community Transformation Grants
- Accountable Care Organizations (ACO)
- Patient-Centered Medical Homes (PCMH).
- Patient-Centered Outcomes Research Institute (PCORI) established to specifically address the mandates for improvement of quality and efficiency

Shared National Health Priorities

Community Transformation Grant Priorities	National Prevention Strategy Strategic Directions and Priorities	Healthy People 2020 Leading Health Indicators Priorities
Tobacco-free living	Tobacco Free Living	Tobacco Environmental Quality (i.e. childhood exposure to second-hand smoke)
Healthy Eating and Active Living	Healthy Eating and Active Living	Physical Activity and Nutrition
Clinical and other preventive services to prevent and control high blood pressure and high cholesterol	Clinical and Community Preventive Services	Access to Health Services/ Clinical Preventive Services
Social and emotional wellness	Mental and Emotional Well-Being	Mental Health

Making Healthy Living Easier, Community Transformation Grants Program Fact Sheet, http://www.cdc.gov/communitytransformation/pdf/ctg-factsheet.pdf

National Prevention Council, National Prevention Strategy, Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011., http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf

HHS Healthy People 2020 Leading Health Indicators, http://www.healthypeople.gov/2020/LHI/default.aspx

New Federal Mandate

Patient Protection and Affordable Care Act of 2010,

Section 9007 contains requirements that non-profit hospitals must meet to maintain its 501(c)3 charitable organization status.

- Completion of a **community health needs assessment (CHNA) every three years** ***by an individual with special knowledge or expertise in public health***.
- Development of **community benefit implementation plan that addresses identified needs**
- Formal **adoption** of the community benefit strategic and implementation plan **by the hospital's governing body**
- **Publication** of the CHNA findings and community benefit plan so that it is widely available **to the public**.
- **Demonstration of effectiveness** of community benefit efforts

Community Benefits

Past, Current and Future State

TIMELINE

Rise of Community Benefits

Charity care first regulated at the federal level in 1946. Initial tax-exempt status was based on a hospital's volume of charity care

Lack of clear qualitative standards or effective enforcement led to widespread noncompliance, and need to clarify regulations

Because insurance coverage started to increase in late 1960s, new IRS ruling required nonprofit hospitals to provide "Community Benefits," instead of only charity care, to retain their tax-exempt status

Need for Federal Regulation

In early 2000s, there was much scrutiny around adequacy of nonprofit hospitals' Community Benefit activities

In 2008, Congress proposed that each hospital maintain and publicize its charity care program and report the percentage of total dollars to charity care

990 Form was revised to better capture this information

Current State of Community Benefits

In 2010, the ACA mandated that nonprofit hospitals conduct a Community Health Needs Assessment (CHNA) at least once every three years and publically report outcomes to maintain tax-exempt status

No clear federal direction on how to conduct CHNA

Develop and implement action plan to address community health needs

Need to fill out revised Form 990 and entire Schedule H

Future State of Community Benefits

Implementation plan will need to define metrics and demonstrate measurable outcomes (i.e., population health improvements), not just dollars

Future collaboration recommended with nearby hospitals on conducting regional CHNAs and strategically implementing action plans to have a broader and more meaningful impact on the community

What is Community Benefit?

- **Community benefits should meet an identified community need and meet at least one of the following community benefit objectives:**
  - Improve access to healthcare
  - Improve community health
  - Advance knowledge through education or research
  - Relieve a government burden

- **Community Benefits include providing:**
  - free or low-cost medical care (charity care)
  - care to low-income Medicaid beneficiaries
  - services designed to improve community health and access to care

When should CHNA be Conducted?

- During the current tax year or in either of the two immediately preceding taxable years, beginning March 23, 2012
- Considered “conducted” in the taxable year that the written assessment report is made publicly available
- Most recent CHNA must remain widely available for two subsequent CHNA reporting cycles.

Components of the Written CHNA

Source: AHA Regulatory Advisory Jan. 22, 2015
Final "Section 501(r)" regulations for Charitable Hospitals

- *Defining the Community Served*: Description of the community served by the hospital and how it was determined.

- *Assessing the Community Health Needs*: Description of the process and methods used to conduct the assessment, including a description of the sources and dates of the data and other information used in the assessment and the analytical methods applied to identify community health needs.

Components of the Written CHNA

- *Input Representing the Broad Interests of the Community*: Description of how the hospital took into account input from persons who represent the broad interests of the community.
- *Documenting the CHNA*: A prioritized description of all of the community health needs identified through the CHNA, including a description of the process and criteria used in prioritizing such needs, resources to address needs, and evaluation of actions taken to address needs in previous CHNA.
- *Adopting the CHNA*
- *Making the CHNA Widely Available*

How is *Community* Defined?

- By geographic location (city, county, metropolitan region)
- By target populations served (e.g., children, women, aged)
- By a hospital's principal function (e.g., specialty area or disease)
- May not be defined in a way that excludes certain populations served by the hospital (for example, low-income persons, and minority groups)

Documenting the CHNA –
The assessment must include and describe:

- Definition of community and how determined

- Process/methods used to conduct CHNA
  - Description of data and other information used
  - Methods for collecting and analyzing
  - Documentation of who hospital collaborated/ contracted with in conducting CHNA

Documenting the CHNA –
The assessment must include and describe:

- Process for consulting with persons representing community's interests
  - local health department and members of medically underserved, low-income and minority populations or organizations serving/representing their interests
- Significant health needs and other social needs of community at large and for uninsured persons, low-income persons, and minority groups
- Process for identifying and prioritizing needs
- Existing facilities and resources available to respond to needs

Adopting the CHNA

- The CHNA must be adopted by the governing body of the hospital, or a committee or other party authorized by the governing body to act on its behalf

Making CHNA Widely Available

- Use of the internet meets this requirement provided paper copy is available for public inspection without charge at hospital facility.
  - Current and 2 previous CHNAs must be available on internet
  - The complete version of the CHNA must be conspicuously posted and available without requiring individuals to provide personal identifiable information to access.

IRS CHNA Regulations Update:

A new definition of a “Hospital Facility.” A hospital organization must conduct a CHNA and adopt an implementation strategy for each facility its operates.

The regulations amend the original definition to state that multiple hospital buildings operated under a single state license “are” (rather than “may be”) considered a single hospital facility.

IRS CHNA Regulations Update:

IRS changes allow multiple hospital facilities to complete one CHNA, and one implementation plan, for a community

- Each hospital collaborating must be clearly identified, hospitals must define their community to be the same, and the CHNA must be adopted by an authorized body for each collaborating hospital. Although hospital organizations can collaborate when conducting CHNAs and developing implementation strategies, each facility must have a separately documented CHNA and implementation strategy.
- Collaboration can lead to funding opportunities
- Collaboration can lead to opportunity to leverage partnership assets and reduce duplicative efforts

The Implementation Strategy

Includes a written plan that prioritizes and addresses each of the significant community health needs identified through the hospital CHNA process

- The **Content of the Strategy** must include:
  - How the hospital plans to meet the health need, or
  - Why the hospital does not intend to meet an identified health need
  - A description of the programs, anticipated impact , and resources the hospital intends to commit
  - A description of planned collaborations to address needs

The Implementation Strategy

Joint Strategy

- Hospitals that collaborated on the CHNA may create joint a Implementation Strategy
  - Must clearly identify that it applies to each hospital
  - Particular hospitals roles and responsibilities must be clearly delineated including programs and resources it plans to commit
  - A summary tool must be included to make it easy for readers to locate those portions of the strategy that relate to each hospital facility

The Implementation Strategy

Adoption

- Must be adopted by the hospital's governing body

- Instead of requiring that the implementation strategy be adopted in the same taxable year in wihich the CHNA is completed, the final rule extends timeframe for adoption of implementation plan by four-and -a -half months (to match the due date without extensions, of the hospital's Form 990)

Other Provisions:

IRS Notice 2011-52

IRS Form 990 Schedule H

Hospital must include on its IRS Form 990:

- Most recently adopted implementation strategy (or include URL address for website where strategy is made publically available)

- Update of implementation of the strategy

Financial consequences of not adhering to ACA regulations

- Failure to comply will result in a $50,000 excise tax penalty that will be applied to each hospital facility in the organization that fails to satisfy the requirements.
- Potential loss of tax-exempted status

– Includes exemption from paying federal and state income taxes, state and local sales tax, and local property tax

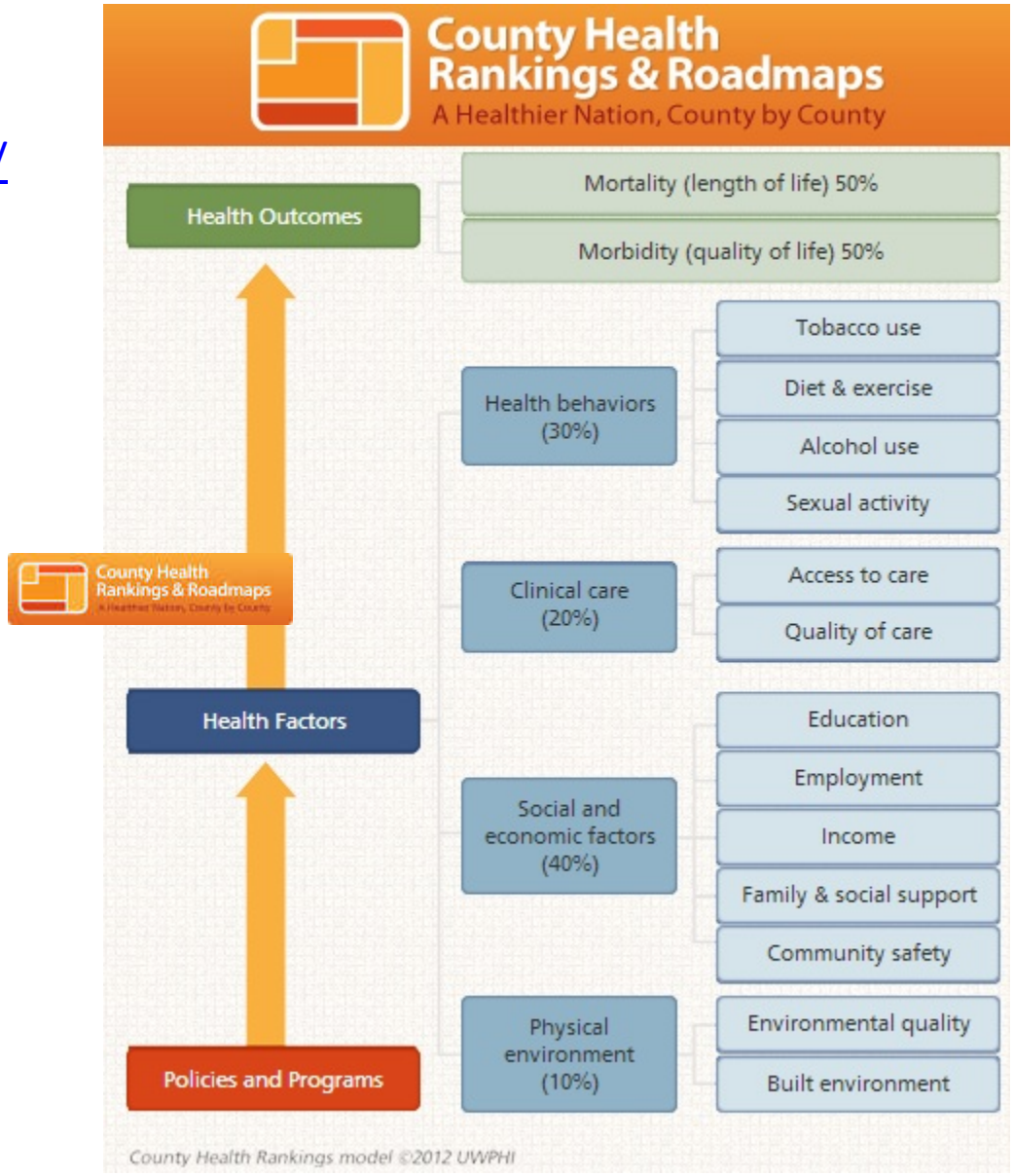
– Congressional Budget Office estimated that nonprofit hospitals received $12.6 billion in annual tax exemptions, on top of the $32 billion in federal, state and local subsidies the hospital industry as a whole receives each year

  - 2007 Case Study: Property owned by nonprofit hospitals in Boston is worth $2.4 billion. Found that the 8 largest hospitals in Boston would have had to pay the city nearly $65 million in property taxes if they had not been exempt

SOURCE: Congress of the United States Congressional Budget Office: Nonprofit Hospitals and the Provision of Community Benefits. December 2006. http://www.cbo.gov/sites/default/files/12-06-nonprofit.pdf

http://www.countyhealthrankings.org/

This online database provides communities with information to help select and implement evidence-informed policies, programs, and system changes that will improve the variety of factors that affect health. The website includes a short video tutorial on how to use the database



Community Health Assessment aNd Group Evaluation (CHANGE):

Building a Foundation of Knowledge to Prioritize Community Needs

Purpose of the CHANGE Tool

- Identify community strengths and areas for improvement.
- Encourages collaboration across sectors Identify and understand the status of community health needs.
- Define improvement areas to guide the community towards population-based strategies that create a healthier environment (e.g., increased physical activity, improved nutrition, reduced tobacco use and exposure, and chronic disease management).
- Assist with prioritizing community needs and consider appropriate allocation of available resources.
- Tracking progress

http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/change.htm

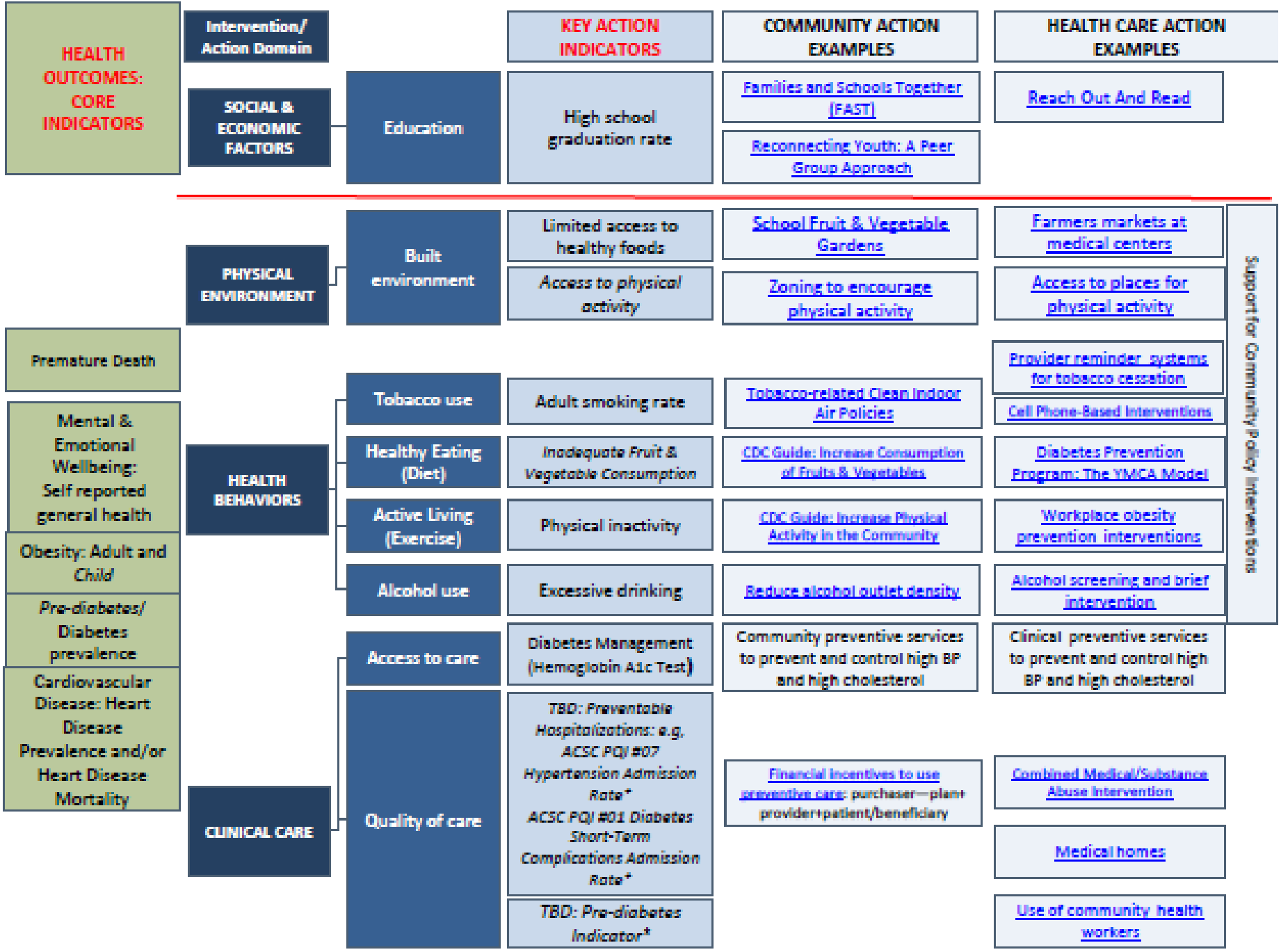
Community Commons

http://www.communitycommons.org/chna/

Community Health Needs Assessment

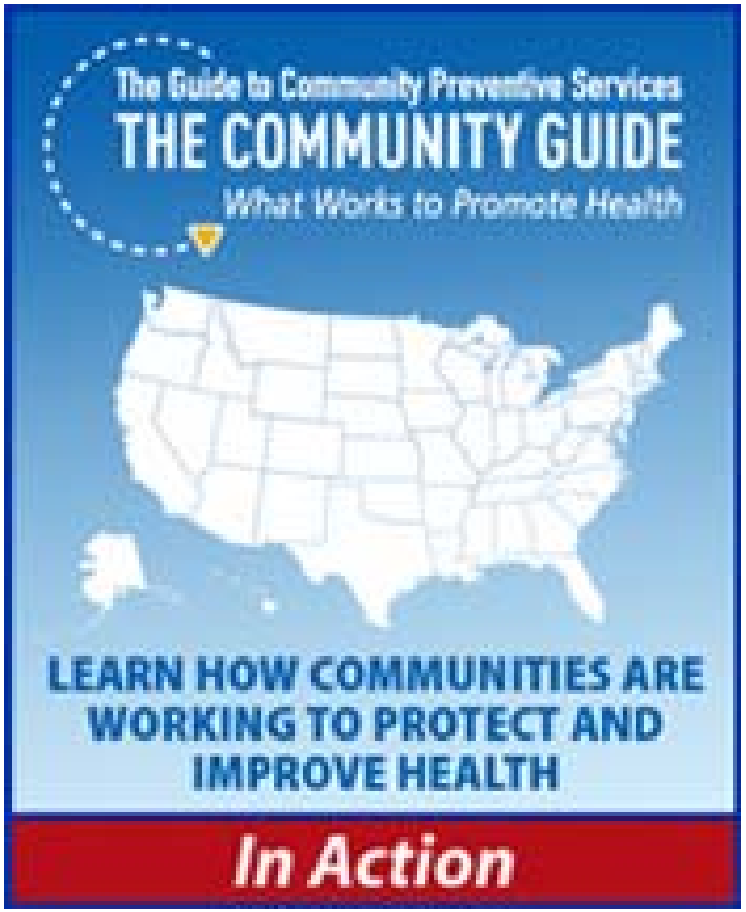
The CHNA toolkit is a free web-based platform designed by a collaborative body in response to the IRS requirement outlined in the Affordable Care Act. This tool was built to assist hospitals and organizations seeking to better understand the needs and assets of their communities as well as collaborate to make measurable improvements in community health and well-being.

- **Identify the most vulnerable populations in your community**
  - The Vulnerable Population Footprint tool allows you to locate areas of concern for vulnerable populations and health disparities in your community based on spatial visualization of two key indicators, poverty rate and educational attainment.
- **Run a CHNA report**
  - The CHNA toolkit allows all community members–regardless of training, expertise, and experience–to ask and answer questions about health and quality of life at the local and regional level.
- **Create maps of key indicators for inclusion in your CHNA**



http://www.communitycommons.org/chna/

The Guide to Community Preventive Services
The Community Guide



Systematic reviews are used to answer these questions:

- Which program and policy interventions have been proven effective?
- Are there effective interventions that are right for my community?
- What might effective interventions cost; what is the likely return on investment?

http://www.thecommunityguide.org/

https://www.healthypeople.gov/

Healthy People Tools and Resources

- Evidence-Based Resources database to find interventions and resources to improve the health of your community.
- Track available data related to select Healthy People 2020 objectives at the county level in our County Data Resources database.
- Use the Federal Prevention Initiatives tool to see how Healthy People supports health promotion and disease prevention efforts across the U.S. Department of Health and Human Services (HHS) to create a healthier Nation.
- Find online educational opportunities for health professionals, students, and community leaders working to reach Healthy People 2020 objectives.
- Review program planning tools, including MAP-IT—a guide to mobilize partners, assess community need, create and implement a program plan, and track community progress.

MAP-IT: A Guide To Using Healthy People 2020 in Your Community

Use the MAP-IT framework to help:

- **M**obilize partners.
- **A**ssess the needs of your community.
- **P**lan your approach
- **I**mplement a plan to reach Healthy People 2020 objectives.
- **T**rack your community's progress.

https://www.healthypeople.gov/2020/tools-and-resources/Program-Planning

COMMUNITY TOOL BOX

http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources

Community Benefit At Jefferson

TJUH

Methodist

Jefferson Hospital of Neurosciences

Community Health Needs Assessment Process

Source: ACHI - American Community Health Improvement

CHNA Advisory Leadership

- Inter-professional Internal Leadership Hospital and University

- External Leaders (United Way, Achievability, KPMG and Vanguard)

Community Benefit Principles

- **Reduce health disparities**.
- **Build on Jefferson strengths and resources**
- **Involve two or more of our mission elements**: patient care, education & research
- **Embrace community engagement and partnerships**
- **Sustainability,** economically and programmatically, over time

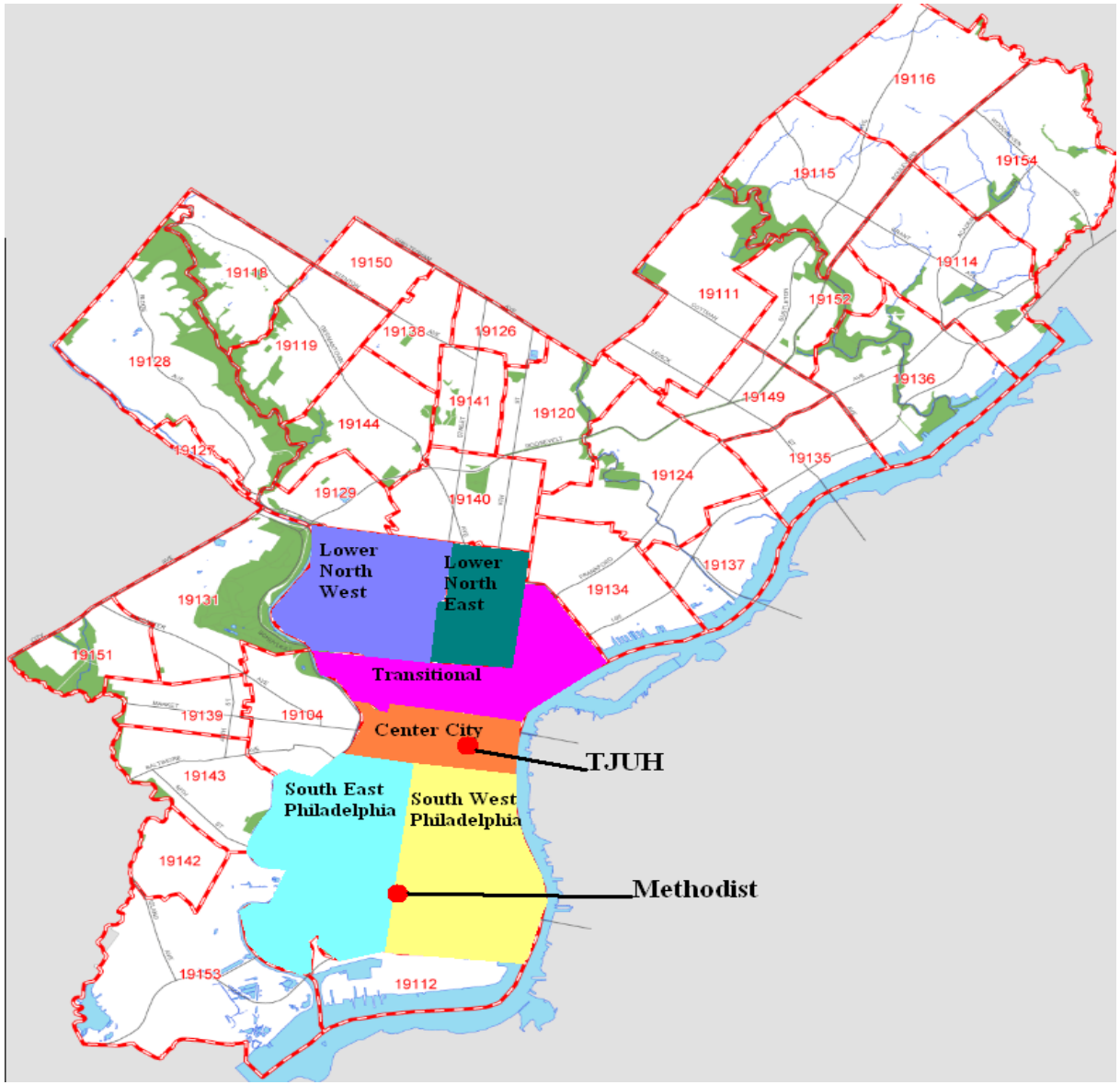
Additional factors in determining a neighborhood focus to maximize effectiveness:

- Are geographically proximate to both TJUH and Methodist.
- Have a density of high-risk patients who demonstrate poor health indicators (health disparities)
- Have a poverty rate >20%
- Have assets and resources that are not harnessed synergistically
- Have individuals and organizations with developed historical relationships with Jefferson staff or have the potential for partnering to address specific health and social issues

Jefferson Community Benefit Area

Nearly 354,000 people

23% of all Philadelphia residents.



Assessment Methods

Secondary Data and Literature Review

- Healthy People 2020
- Reports from Philadelphia Dept. of Public Health, Maternity Care Coalition, Philadelphia Corporation on Aging, Pew State of the City, Philadelphia School District, and others
- Public Health Management Corporation- Household Health Survey (2008 -2012)
- Census 2010 data with updates from Claritas
- County Health Rankings and Roadmap 2013
- Pennsylvania Department of Health State
- Community Need Index
- Community Preventive Services Taskforce Guidelines

Assessment Methods

Primary Data

- **Key Informant Interviews**
  - **More than 65 internal and external interviews** were conducted with individuals representing health care and community based organizations that have knowledge of the health and underlying social conditions that affect health of the people in their neighborhood and broader community.
  - Includes TJU and TJUHs faculty and staff
- **Focus Groups with employees who live in TJUHs CB area**
  - **4 focus groups** were held; **35 employees** participated

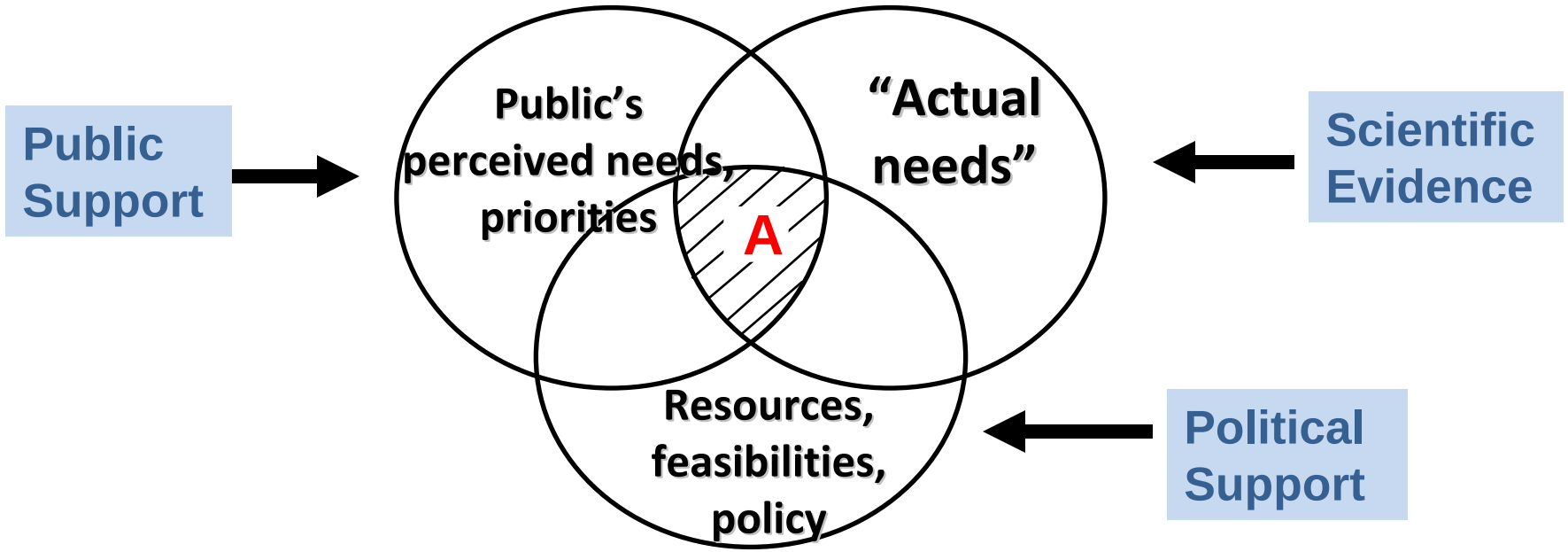
Assessment Content Areas

- **Demographics**
- **Mortality**
- **Morbidity**
- **Health Behaviors**
- **Healthcare access**
  - Health insurance
  - Transportation
  - Literacy
  - Culture and language
- **Social Determinants of Health**
  - Education
  - Income and poverty
  - Access to healthy and affordable food
  - Employment and job training
  - Community safety
  - Built and natural environment
- **Special Populations**
  - Older Adults
  - Immigrants and Refugees
  - Homeless
  - LGBT

Key Findings and Priorities

- Lack internal coordination of outreach activities
- Cultural competence
- Language assistance
- Low health literacy
- Workforce diversity
- Food Security
- Transportation
- Community safety
  - Substance use
  - Interpersonal Violence
  - Built environment
- Access to care
  - Health Insurance
  - ED use
- Chronic disease prevention and treatment
  - Obesity, diabetes, hypertension, stroke, cancer
  - Smoking, diet, exercise
- Maternal and Child Health
- Mental Health Care
- Lack of care coordination across the continuum
- Older Adult health and well-being

Closing the Gaps Between Public's & Practitioners' Perception of Needs, and Scientific & Policy Assessments



A – Community has the greatest potential for mobilization of resources and action

Green & Kreuter, *Health Program Planning,* 4th ed., NY: McGraw-Hill, 2005, Fig 2-3, p. 40.

Weighted Ranking Criteria

Total points	Value	Criteria
	2	Doesn't meet HP 2020 and regional/national priority
	3	Disparity exists compared to rest of Philadelphia
	2	Focus groups and key informants perceive problem to be important
	3	Sub-population is special risk
	1	Problem not being addressed by other agencies
	3	Has great potential to improve health status
	1	Positive visibility
	2	# People affected
	2	Feasibility/resources available
	2	Links to TJUHs strategic plan

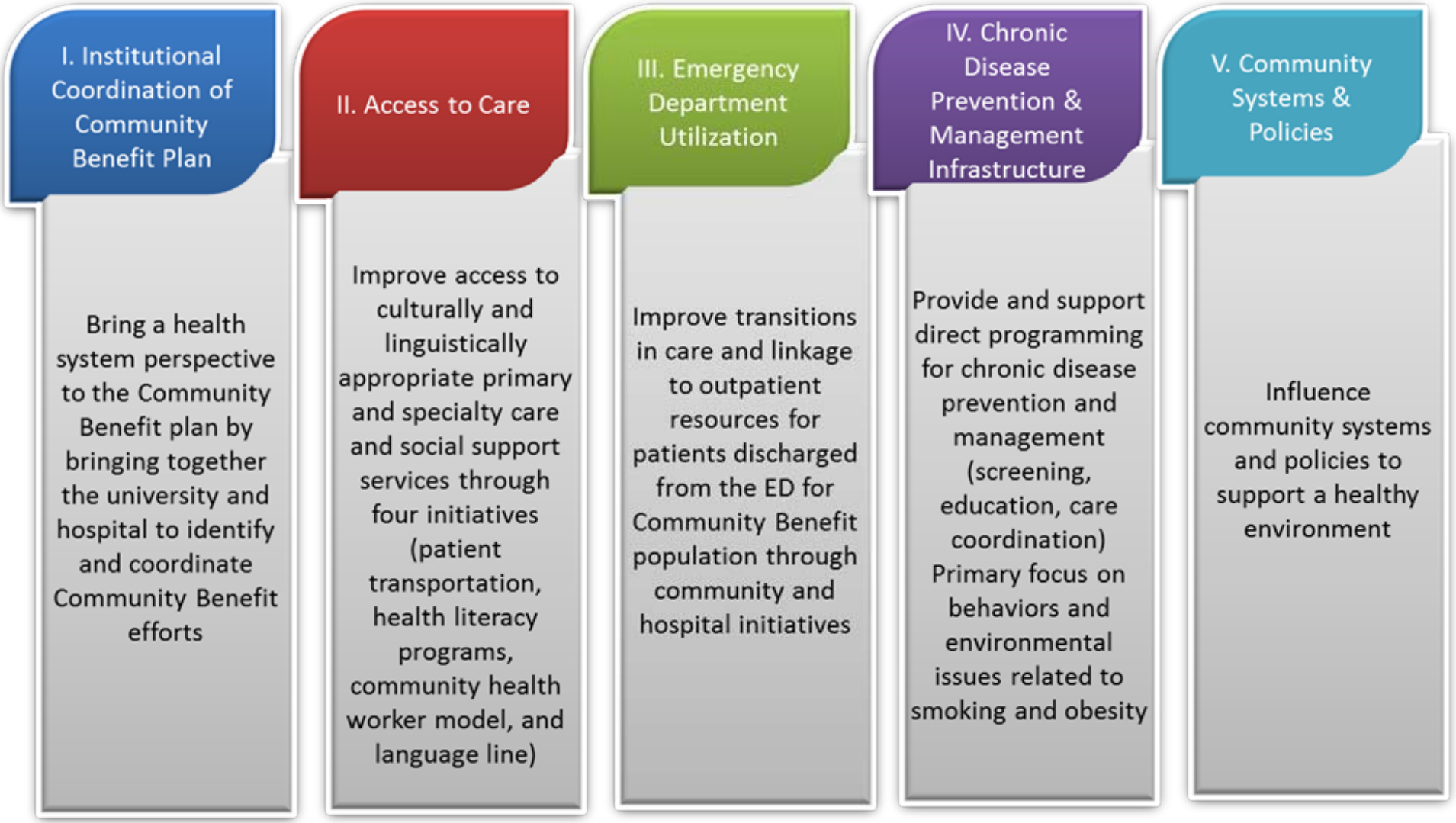
Jefferson's 2012 Community Health Needs Assessment

CHNA Implementation Plan was approved in June 2013 by the Board of Trustees. Five main domain categories with 24 priority health needs were identified. Health needs highlighted in red have been designated with the "most important" priority level.

Findings of Priority Community Health Needs			
5 DOMAINs	**24 PRIORITY HEALTH NEEDS**		
1. Chronic Disease Management	Diabetes	Obesity	Heart Disease
	Hypertension	Stroke	Asthma
2. Access to Care	ED Utilization and Care Coordination	Health Education, Social Services, Regular Source of Care	Language Access, Health Literacy, Cultural Competence
	Health Insurance	Maternal and Child Health	Mental Health Services
	Social and Healthcare Needs of Older Adults		Transportation
	Medication Access		
3. Healthy Lifestyle Behaviors and Community Environments	Smoking Cessation	Physical Activity	Access to Healthy Affordable Food, Nutrition Ed
	Built Environment	Youth Health Behaviors	Community Safety
	Food Security	Alcohol/Substance Abuse	
4. Internal Organizational Structure	Workforce Development and Diversity	Hospital Readmissions	
5. Health screening and early detection	Colon Cancer	Women's Cancer	HIV

Community Benefit Implementation Plan Overview

- Five programs were created to address the main health needs identified in the CHNA
- The community benefit plan will leverage Jefferson's strengths and resources to develop and implement a sustainable population health strategy to address the priority health issues identified in the CHNA through these five programs:



Yellow Highlights indicate frequent overlaps between Institutional Goals and Community Benefits' Priorities

	LOS	JUP New Patient Visits	Admissions	OP Visits	Readmission Rate	HCAHPS Comm. Re: Medication	Ambulatory Care Ease of Scheduling Appt	HCAHPS Pain Mgmt	HCAHPS Comm. w/ Doc	Women and Children Discharges	Discharges	Diabetes Composite Score
Chronic Disease Mgmt: Diabetes	X	X	X	X	X	X	X	X	X		X	X
Chronic Disease Mgmt: Heart Disease	X	X	X	X	X	X	X	X	X		X	X
Chronic Disease Mgmt: Hypertension	X	X	X	X	X	X	X	X	X		X	X
Chronic Disease Mgmt: Stroke	X	X	X	X	X	X	X	X	X		X	
Chronic Disease Mgmt: Asthma	X	X	X	X	X	X	X	X	X		X	
Obesity	X	X	X	X	X	X	X	X	X		X	X
ED Utilization and Care Coordination	X	X		X	X	X	X		X			X
Health Education, Social Services and Regular Source of Care	X	X		X	X	X	X	X	X			X
Language Access, Health Literacy and Cultural Competence	X	X		X	X	X	X		X			X
Smoking Cessation		X		X	X				X			
Workforce Development and Diversity												
Health Insurance		X	X	X	X							
Maternal and Child Health		X	X	X	X	X			X	X		
Access to Healthy Affordable Food and Nutrition Education	X	X			X							X
Physical Activity	X	X			X					X		X
Built Environment					X					X		
Food Security		X			X							X
Hospital Readmissions	X	X		X	X	X	X	X	X			X
Youth Health Behaviors										X		

Collaborations

- Create an Advisory Group with community
- Maintain and expand community relationships by connecting with community groups and coalitions
- Collaborate with community partners on
  - grant/funding opportunities
  - research and evaluation of programs and initiatives

Jefferson Resources:

- Emergency Department
- Employees from target area
- Grant funding
- JNH stroke outreach
- Legislation liaison
- Marketing department
- Nurse Magnet Program
- Pharmacy
- Registered dieticians
- TJU students and residents
- TJUH certified diabetes educators
- TJUH/JHN support groups
- Pastoral Care
- Finance
- Human Resources

Potential Community Partners

Community relationships including:

- Cambodian Association
- Common Market
- Dixon House
- Faith Based Organizations
- Federation of Neighborhood Centers
- Food Trust
- Mamie Nichols Center
- Maternity Care Coalition
- Norris Square Civic Association
- Philadelphia Department of Public Health
- PACDC
- SHARE
- Coalition Against Hunger
- Southeast Asian Mutual Assistance Associations Coalition
- Southeast Philadelphia Coalition
- United Communities of Southeastern Pennsylvania
- Urban Tree Connection
- YMCA
- Schools
- CUSP
- Project HOME
- Nationalities Services Center
- Health Care Improvement Foundation
- PICC
- FPAC
- Welcoming Center

CHNA 2016

HHS Region III and Hospital Association of Pennsylvania Leadership

- Convening stakeholder group (hospitals, HAP/DVHC of HAP, county health departments, community organizations) around CHNA
- Facilitating collaboration with Federal agencies (CDC, HRSA, CMS) to identify CHNA support resources and potential funding sources
- Pursuing partnerships with other Mid-Atlantic institutions
- Efforts provide opportunity for ***Accountable Health Communities*** using a collective impact model to prioritize and align initiatives, increase scale and effectiveness through pooled resources, develop shared measurement and accountability

Lessons Learned

- Integration into strategic planning of clinical enterprise (hospital, university, primary care, etc)
- Need senior leadership champions and buy-in
- Foster engagement across clinical enterprise in linking together Community Benefits and Institutional Goals
  - Need for integration and coordination of programming across clinical enterprise
  - Opportunity to coordinate assessment of program impacts
- Reporting and measurement issues (quarterly reporting and metrics)

CHNA Resources

- http://www.countyhealthrankings.org/
- http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/addressing-determinants
- The CHNA toolkit is a free web-based platform built to assist hospitals and organizations seeking to better understand the needs and assets of their communities as well as collaborate to make measurable improvements in community health and well-being. http://www.communitycommons.org/chna/
- Community Need Index – Dignity Health http://cni.chw-interactive.org/
- The Prevention Institute - http://www.preventioninstitute.org/tools/strategy-tools.html

CHNA Resources

- **Other Tools**
  - CDC Resources

  Implementing the Community Health Needs Assessment Process
  - CHIP Collaborative Handbook

  Community Health Improvement Planning
  - Stakeholder Health

  Transforming Health Through Community Partnership
- **Regulations**
  - Community Health Needs Assessments for Charitable Hospitals

  Summary - Notice of Proposed Rulemaking on CHNA for Charitable Hospitals
  - Proposed IRS Regulations

CHNA Resources

- **Plans and Collaborative Models**
  - Successes and Challenges in Community Health Improvement: Stories from Early Collaborations

  Association of State and Territorial Health Organizations (ASTHO) Issue Brief:
  - New Opportunities for Prevention

  Chicago Hospitals and the Affordable Care Act:
  - Community Health Improvement Plan 2014-2018

  City of Philadelphia
  - The Road to Health

  Health Care Council of the Lehigh Valley
  - Community Health Improvement Plan

  Greater Worcester Region
  - San Francisco Health Improvement Partnership