EXECUTIVE SUMMARY

This report reviews the first cycle of Community Health Needs Assessments (CHNA) and Implementation Strategies (IS) completed by North Carolina nonprofit hospitals as required by the Affordable Care Act. It was conducted at the request of the NC Community Health Improvement Collaborative (NC-CHIC), which is in the process of identifying best practices and lessons-learned from this first round of CHNA activities as part of a continuous quality improvement process.

We systematically collected all available CHNAs and Implementation Strategies completed by the 94 501(c)(3) NCHA-member hospitals. We then reviewed each document to identify how the CHNA activity was organized, how the “community” was geographically defined, and what identified health needs were selected as priorities in the Implementation Strategy.

Overall, North Carolina’s hospitals did an excellent job creating or contributing to a CHNA. It appears that only one nonprofit hospital out of the 94 does not have a report available online. A large majority of hospitals, 86 of the 94, posted their CHNA report on their own website.

Implementation Strategies were obtained for 72 of the hospitals that completed CHNA reports. Of these, 22 were combined with the hospital’s CHNA report.

After compiling the statewide data, a sample of 30 hospitals from the pool of 72 available that completed both a CHNA and IS were selected for an in-depth review. This review showed that, overall, the hospitals did an impressive job of incorporating community engagement into the CHNA process.

With respect to the priority health needs addressed in the Implementation Strategies for these 30 hospitals, the distribution among standard categories was: Clinical Care = 64; Health Behaviors = 37; Clinical Care and Health Behaviors = 7; Social and Economic = 5; Physical Environment = 0.

The qualitative review of the CHNA collaborative approaches indicate that a rich diversity of collaborative local CHNA arrangements have evolved in North Carolina. It is quite common for nonprofit hospitals to partner with local health departments and other community stakeholders on CHNAs. Examples of some of these different arrangements are contained in Section IV of the report.
From the preliminary analysis of the data and conversations with multiple stakeholders, there are three key messages to improve this CHNA process in the future.

1. Need for expanding the jurisdictional alignment of CHNA coverage areas.

   It is important for the “community” assessed in the CHNA to realistically reflect the hospital patient catchment areas. From a state perspective, it is also important to extend CHNA coverage to the “empty spots” on the map which tend to be medically underserved areas.

   A number of plans and ideas described in the report have been identified by various stakeholders to expand existing coverage areas in the next CHNA cycle.

2. Need to shift the priority focus of the Implementation Strategies from a concentration in the Clinical Care category, toward the other three categories of Health Behaviors, Social and Economic Factors, and the Physical Environment.

   The findings from a national sample reviewed in an April 2014 report issued by the Public Health Institute showed a skewing of the priority content focus of ISs toward clinical care. The 30 hospital NC sample shows that this same skewing toward clinical care is also present in the NC cohort.

   Efforts should be made to continue to direct more priority content focus “upstream” toward the more preventive components in Health Behaviors, Social and Economic Factors, and the Physical Environment.

3. Need for alignment of the hospital Community Benefits expenditures with the CHNA/IS process.

   The Community Benefits alignment question was discussed with many stakeholders, and no one was aware of any linkages at any NC nonprofit hospital between these two systems. Nevertheless, most parties agreed that such an alignment of the Community Benefit expenditures with the CHNA/IS process made sense and was ultimately something that needed to be done.

   Other practical comments and suggestion are included in the report, together with appendices containing relevant maps and further data from the 30 sample analysis.

SECTION I. INTRODUCTION

This project is a review of the North Carolina nonprofit hospital Community Health Needs Assessments (CHNA) and Implementation Strategies (IS). This review is part of an initiative of the NC Community Health Improvement Collaborative (NC-CHIC) to identify best practices and lessons-learned from the first round of activities completed under this new federal requirement of the Affordable Care Act.

NC-CHIC is comprised of interested participants from the NC hospital and community health leadership, and its regular meetings are hosted by the North Carolina Hospital Association (NCHA) at its headquarters in Cary, NC. This report was prepared for presentation and discussion at the NC-CHIC meeting on this topic scheduled for Tuesday, September 23, 2014.

The short time window for this project is due in part to NCHA and NC-CHIC wanting to quickly identify best practices and communicate that information to NC hospitals and community partners in order to make the next cycle of the CHNA/IS collaboration a more meaningful and effective process.

SECTION II. METHODOLOGY

All hospitals with a 501(c)(3) tax-exempt status are required, under the Affordable Care Act, to conduct CHNAs and ISs every three years. The CHNA is required to be made “widely available” to the public and the IS is required, at a minimum, to be submitted with the hospital’s tax return. Data were collected on how the CHNA activity was organized, the availability of CHNAs and Implementation Strategies, how the “community” was geographically defined, and what identified health needs were selected for priority in the Implementation Strategy.
Since CHNA's are required by law to be made publicly available, most of the data were collected from hospital websites. However, if the CHNA or IS was not readily available on the internet, calls were placed directly to the hospital and/or collaborating partners to procure the reports and understand the collaborative process used to develop them.

This data collection and analysis was conducted by Karen Wade as part of the MSPH internship requirement at the Gillings School of Global Public Health at UNC Chapel Hill. Supervision and coordination was provided by Gene Matthews, JD of the North Carolina Institute for Public Health at Gillings and Director of the Southeast Region of the Network for Public Health Law.

SECTION III. QUANTITATIVE REVIEW AND ANALYSIS OF THE NC HOSPITAL CHNA AND IMPLEMENTATION STRATEGIES

CHNAs Appear Online

Of the 133 North Carolina Hospital Association members, 94 are non-profit 501(c)(3) hospitals. Overall, North Carolina's hospitals did an excellent job creating or contributing to a Community Health Needs Assessment. It appears that only one nonprofit hospital does not have a report available online. A large majority of hospitals, 85 of the 94, posted their CHNA report on their own website, which is required by the IRS regulations. Some of these reports were concise, while others were several hundred pages in length.

Table 1: Distribution of CHNA Data in the State of North Carolina

<table>
<thead>
<tr>
<th>Variables</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of 501(c)(3) facilities</td>
<td>94</td>
</tr>
<tr>
<td>Number of Non 501(c)(3)'s that also completed a CHNA and IS</td>
<td>1</td>
</tr>
<tr>
<td>Number of CHNA’s Not Located</td>
<td>1</td>
</tr>
<tr>
<td>Number of Implementation Strategies Not located</td>
<td>22</td>
</tr>
<tr>
<td>Number of CHNA’s Not on Hospital Website</td>
<td>8</td>
</tr>
<tr>
<td>Number of IS’s Not on Hospital Website</td>
<td>14</td>
</tr>
<tr>
<td>Number of Combined CHNA/IS</td>
<td>22</td>
</tr>
</tbody>
</table>

Implementation Strategies

With respect to the Implementation Strategies, 72 IS reports were ultimately obtained, although 14 were not available on the hospital's website. Twenty-two hospital Implementation Strategies (out of 94 CHNA reports) were unable to be located even after attempts were made to reach out to hospital staff. Some other hospitals (22) combined their IS plan with their CHNA report into one document, which at first glance may appear only to be a CHNA.

This rate of available CHNAs and Implementation Strategies is significantly higher than the rates reported in the national sample conducted by the Public Health Institute of Oakland, CA (PHI) in its April 2014 report Supporting Alignment and Accountability in Community Health Improvement: The Development and Piloting of a Regional Data-Sharing System. 
http://nnphi.org/CMSuploads/SupportingAlignmentAndAccountabilityInCommunityHealthImprovement.pdf
Analysis of a Sample of 30 NC Hospital CHNAs and Implementation Strategies

After compiling the statewide data, 30 hospital Community Health Needs Assessments and Implementation Strategies were chosen for an in-depth review. These reports were selected from the pool of 72 hospitals that completed both components. The sample includes reports selected from all areas of the state, from large and small jurisdictions, and from a variety of health systems.

Only 5 of the 30 sampled hospitals defined their "community" to include two or more counties. While the majority of hospitals did not provide a clear methodology for their community definition, the most common choice for those that did was to select the largest county of origin for discharges.

Community Engagement

Overwhelmingly, the hospitals did an impressive job of incorporating community engagement into the process. Only five hospitals did not either clearly describe their procedure for engagement or relied only on previously-collected needs data compiled by other community sources, such as local health department Community Health Assessments (CHA). However, neither of these two distinctions necessarily means that community opinion or feedback was not factored into their reports.

It was discovered from discussions with stakeholders that some hospitals who simply displayed their county's CHA (required for LHD accreditation purposes) may also have been very actively involved (along with other community partners) in the development of that earlier CHA for the benefit of the LHD.

Analysis of Priority Health Needs Selected In the Implementation Strategies

Priorities identified in the Implementation Strategies of the sample were initially divided into the four categories as described by the Community Health Rankings (CHR) and used in the April 2014 national report by Public Health Institute of Oakland, CA. The four CHR categories used by PHI are: Clinical Care, Health Behaviors, Social and Economic, and Physical Environment.

Health needs such as obesity, tobacco use, and sexual activity fell under Health Behaviors. Topics relating to access and quality of care were placed under the Clinical Care category. We also added a fifth category, Dual: Clinical Care and Health Behaviors. The reason for this insertion is that some of the health needs (diabetes for example) combined both categories of Clinical Care and Health Behaviors.

Table 2: Number of Priority Health Needs by Category in NC Sample of 30 Hospitals

<table>
<thead>
<tr>
<th>Clinical Care</th>
<th>Health Behaviors</th>
<th>Dual: Clinical Care and Health Behaviors</th>
<th>Social and Economic</th>
<th>Physical Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>64</td>
<td>37</td>
<td>7</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

This NC priority distribution, above, is consistent with the concentration in the Clinical Care category as observed and reported in the national sample from PHI in April 2014, shown below:

Comparison Percentages from the PHI National Sample – April 2014

<table>
<thead>
<tr>
<th>Clinical Care</th>
<th>Health Behaviors</th>
<th>Social and Economic</th>
<th>Physical Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>73%</td>
<td>19%</td>
<td>8%</td>
<td>0%</td>
</tr>
</tbody>
</table>

SECTION IV. QUALITATIVE REVIEW OF CHNA COLLABORATIVE APPROACHES IN NC

A common approach in NC is for nonprofit hospitals to partner with local health departments and other community stakeholders in developing CHNAs. Part of this trend flows out of earlier state requirements existing for over a decade that LHDs conduct community health assessments as part of the LHD mandatory accreditation certification program.
In NC there are 100 counties (See Figure 1) and 94 nonprofit 501(c)(3) hospitals, so it is not surprising that the current federal CHNA process led to discussions with hospital administrators, local health officials, nonprofit community organizations, and academic centers. In the course of this project, conversations took place with two dozen leaders actively involved as stakeholders and collaborators in CHNA programs.

It is clear that there is a rich diversity of collaborative local CHNA arrangements that have evolved in this state. It sometimes appears as though an ongoing natural experiment is taking place regarding the different structure and composition of these collaborative approaches.

Described below are a number of different collaborative arrangements present in the CHNA documents. They include a number of various “organizational backbones” that facilitate multi-party collaborations. A comprehensive summary of all the different arrangements that exist in NC would be beyond the scope of this report, so these are presented as examples of some of the distinctly different collaborations that exist.

**Wake County/WakeMed/Rex/Duke Raleigh:**

(This is a good example of a local health department providing the organizational backbone for a collaboration among several different health systems in a single county.)

Wake County serves as a good example of multiple, competing health systems coming together to collaborate on one report with Wake County Human Services, Public Health taking the lead. Wake County is home to WakeMed Health and Hospitals, Rex Healthcare, and Duke Raleigh Hospital. In addition to actively participating in working groups, each organization contributed to the financial cost of the assessment, including support from the United Way and Wake Health Services FQHC. These organizations also collaborated on an After Action Review Report developed to examine what was successful during the CHNA process and what areas needed improvement. Additionally, stakeholders continue meeting to discuss the process and track the implementation progress. Key successes included the collaboration between members and well-organized meetings. One recommendation from a stakeholder was to provide more time in the next cycle to conduct the assessment.

This Wake collaboration demonstrates a partnership of health systems combining both resources and expertise. As a result of the new IRS regulations, the health systems were more actively engaged in the assessing and making plans to address community needs. This can spur great synergy within the process, however it can have potential drawbacks. One such drawback is that it limits the scope of the hospitals “community served” definition to only individuals living within the county lines.

Large hospitals like WakeMed and Rex see patients from multiple counties and not accounting for that can restrict the ability to take a regional approach to population health. Conversely, a well-developed county-specific plan could become a sub-section of a more comprehensive regional plan that can evolve from this beginning.

**Lexington Medical Center/Davidson County:**

(This is an example of a hospital collaborating with other area partners but still developing its own report that accurately reflects its patient catchment area.)

Lexington Medical Center (LMC), part of Wake Forest Baptist Health, collaborated with Thomasville Medical Center, part of Novant Health, on their Community Health Needs Assessment. The partnership between the two health systems was already established through the respective Forsyth County hospitals of Novant and Wake Forest Baptist. LMC characterized the relationship as collaborative and open, such as the health systems sharing CHNA formatting and presentations. Additionally, Lexington Medical included a dashboard tool on their website to allow users to easily see what data they are collecting and health indicators they are tracking that is publicly available.

While their collaborative effort also included the Davidson County Health Department, both Lexington Medical Center and Thomasville generated their own individual reports. These separate reports represent an extra step not taken by all hospitals that collaborated closely with their local health departments. Many hospitals submitted the county’s Community Health Assessment as their report.

LMC’s concise 28 page report addresses all the IRS requirements while clearly mapping out the hospital’s unique IS responsibilities in a dual hospital jurisdiction. The role of the hospital can become convoluted when the hospitals and health departments only generate
one, often lengthy, document. Executing this additional step demonstrates a level of commitment to the process of improving population health more so than simply meeting the IRS’s requirements. Both hospitals’ reports are limited to a countywide community definition, which can be a restricting in terms of regional population health improvement. With the case of Lexington Medical, close to 90% of patients reside within Davidson County. In this particular example, the community definition appears to be more accurate than the larger participating hospitals in Wake County’s assessment.

**Alamance Regional Medical Center/Alamance County:**

*(In this example a local non-profit organization provides the organizational backbone for the ongoing CHNA process.)*

Alamance County presents a case of a strong partnership with multiple stakeholders. Along with the hospital and health department, United Way and Healthy Alamance were active participants in the assessment.

Healthy Alamance is a local public health non-profit organization affiliated with Alamance County Health Department and Alamance Regional Medical Center. It provides a forum for community leaders and residents to come together to identify health needs and mobilize resources to address crucial issues in order to improve the quality of life in Alamance County. It also serves as the Healthy Carolinians coalition for Alamance County.

This is a good example under “collective impact theory” of a local non-profit 501(c)(3) organization providing the “organizational backbone” that enables the ongoing collaboration of multiple parties in this CHNA/IS process. Alamance Regional Medical Center provides funding for Healthy Alamance staff and is actively engaged in collaboration. Tasks for the assessment were divided among the partners, which resulted in a comprehensive report. Additionally, Elon University conducted a survey free of charge, highlighting the benefit of local university engagement.

**Vidant Medical/Pitt County:**

*(This arrangement illustrates a long-standing collaboration of an academic center with the health system and local health department.)*

Established in 1995, Vidant Medical Center’s (formerly Pitt County Memorial Hospital) Community Health Programs began its work by partnering with the Department of Family Medicine in the Brody School of Medicine at East Carolina University and the Pitt County Public Health Department. With support through a grant from The Duke Endowment, this initiative conducted a county-wide survey of public opinion regarding health-related concerns. That project led to the development of the dynamic grassroots collective, Pitt Partners for Health, and formed the basis for the establishment of priorities for future and ongoing health improvement initiatives.

Collaborative partnerships and strong stakeholder collaboration continue to be a theme throughout the identified best practices, providing the foundation for successful community health improvement initiatives in Pitt County. Pitt Partners for Health still exists today and serves as the county’s only community health improvement partnership representing local health and human services agencies, churches, non-profits, and grassroots members from the community. Vidant Medical Center serves as the administrative agency for Pitt Partners for Health and has provided financial support for the Community Health Needs Assessments.

In the next CHNA cycle, the Vidant Medical Center CHNA Administrator plans to convene an internal hospital advisory council to review the CHNA and provide expertise with regard to a community wide implementation plan. Time constraints initially prohibited the establishment of an internal hospital group for the first CHNA. The CHNA Administrator worked with individual hospital departments that had typically provided outreach to the community to develop plans that were in alignment with the CHNA. The establishment of the internal hospital advisory council would provide for a more cohesive and efficient method of implementation planning.

Once the second CHNA cycle is completed, hospital, county, and Brody School of Medicine leadership would like to begin discussions regarding a regional community health needs assessment process that would enhance the community health improvement planning process and provide a comprehensive view of the most compelling health needs impacting the citizens of eastern North Carolina.

**New Hanover Regional Medical Center/New Hanover County:**

*(This is an arrangement in which a single hospital system partners with 3 county health departments and plans are well underway to extend this collaboration to 2 additional counties and an academic center.)*
New Hanover Regional Medical Center created a CHNA that covers a three county area. Their program included Pender and Brunswick counties in addition to New Hanover where the hospital is located. This approach differed from the many CHNAs that were limited to one county.

The hospital used the three county community health assessments to determine the top needs for the patients they serve. Additionally, the hospital provided staff to the New Hanover Health Department to help with focus groups. However, the hospital did not engage in their own data collection. They also did not actively collaborate with the health department on the report or the implementation strategy. New Hanover Regional Medical Center’s Director of Government Affairs suggested the need for a common data template used by the LHDs to allow for greater consistency when pooling multi-county data on community needs.

In addition, the New Hanover experience provides an important example of a more comprehensive regional approach that is being developed. This three county region is part of a greater regional consortium, the Southeastern NC Regional Health Collaborative. This new partnership includes Brunswick, Columbus, New Hanover, Onslow, and Pender Counties in conjunction with the University of North Carolina Wilmington. One of the roles of this collaborative is to pull together Community Health Assessments of the member health departments and compile their prioritized health needs. Similar to WNC Healthy Impact, this approach could serve as framework for a regional assessment.

In May of 2014, this New Hanover regional collaborative was awarded a $150,000 planning grant through UNC Wilmington from GlaxoSmithKline to support the goal of improving the region’s health.

**CarolinaEast Health System/ Craven County:**

(This 3 county / one health system arrangement is somewhat similar to New Hanover’s regional approach, with the additional aspect that a joint survey instrument is used for all 3 jurisdictions.)

For their initial CHNA, CarolinaEast Health System utilized three local counties’ CHAs to determine their patients’ needs. This structure is similar to the approach taken by New Hanover Regional Medical Center. An important difference is that the three counties-Craven, Jones, and Pamlico- designed their survey together to allow for a uniform regional approach.

For their newest CHNA, which they are in the process of completing, CarolinaEast is attempting a new process. Their community definition will continue to include the three county region but they will now be more actively involved with the data collection. The hospital has provided both financial and staff support to the process, such as purchasing tablets for the health department staff to use when surveying community members.

**FirstHealth of the Carolinas/Moore County:**

(This shows a long-established coalition organized around a health system that smoothly adapted to the new CHNA/IP requirements and expanded to include adjoining counties.)

FirstHealth began conducting need assessments as a health system in 1999. As seen multiple times throughout the statewide review, FirstHealth had a strong relationship in place with their health department through the Healthy Carolinians program. They, like WNC Healthy Impact, also employ the services of Professional Research Consultants (PRC) to carry out their survey. This was identified as a very important element to the success of their CHNA. By utilizing PRC’s demographic data, FirstHealth and the local health department were able to consolidate their door-to-door surveys to ensure a more efficient process. They were able to limit questions asked and therefore minimize the time needed by community members.

Both demographic and door-to-door data sources served complimenting purposes. One example in particular was the discovery of a prescription drug abuse problem in the community. Only the door-to-door survey provided insight into this growing issue that was not captured in the demographic and secondary health data. Direct communication with citizens was needed to bring this concern to the surface. Following the discovery, FirstHealth launched a task force with local community members. This displays how truly beneficial a collaborative CHNA process can be to identify and address a priority need of a community.

FirstHealth identified critical strategies for success including: being transparent, assigning clear roles to reduce duplication, and actively engaging partners to keep everyone at the table. Additionally, the Sandhills Area, where FirstHealth’s hospitals are located, serves as another successful regional approach involving the counties of Moore, Montgomery, and Richmond. The local health departments have
partnered to develop one survey and sync up their time frame for completion. This also addresses one of the concerns raised by New Hanover Regional Medical Center about establishing consistency between county reports.

Albemarle Regional Health Services/ Albemarle Health District:

(This is a multi-county district health department providing a significant level of clinical health care and serving as the "organizational backbone" across a region for a collaboration of hospitals and rural counties.)

Albemarle Regional Health Services (ARHS) is a seven-county regional Public Health agency in rural, northeastern North Carolina. Also known within the state public health structure as the “Albemarle Health District,” ARHS is the largest “district health department,” consisting of the counties of Pasquotank, Perquimans, Camden, Chowan, Currituck, Bertie, and Gates.

ARHS provides a significant number of clinical services to persons in the 7 county region. In addition, some of the ARHS programs extend to 12 counties in northeast NC, including Hertford, Washington, Tyrrell, Dare, and Hyde.

Because ARHS is a government entity, it does not need to participate in the CHNA/IS requirements under the ACA for non-profit hospitals. However, ARHS and the health systems in the region (including Vidant Chowan, Vidant Bertie, Outer Banks Regional Hospital, and Sentara Albemarle Medical Center in Elizabeth City) have been partners in both the earlier county accreditation requirement for LHD community health assessments (CHA), and the more-recent ACA requirement of non-profit hospital CHNA/ISs. In 2013, ARHS adjusted its CHA cycle to be in synch with the CHNA/IS schedule for the hospitals. There has been significant collaboration among these entities in this ongoing process. The hospitals participated in the state CHA process and then used the needs identified as part of their federal CHNA requirement. The hospitals have provided ARHS with funding to support this ongoing effort.

At times ARHS has also made use of nursing and health administration students from College of Albemarle in Elizabeth City to assist in data collection activities. In 2012 ARHS contracted with UNC’s North Carolina Institute for Public Health for primary data collection. In the next cycle ARHS will be contracting with East Carolina University to provide technical assistance with focus group data collection.

One comment received was that the federal 3 year cycle makes it tight for the stakeholders to complete the needs assessment and then implement the strategies before it is time to start planning the assessment phase all over again.

Western North Carolina Health Network / Healthy Impact:

(WNC Healthy Impact represents the largest single CHNA collaboration in the state, including 16 counties and approximately the same number of hospitals.)

WNC Healthy Impact is a unique partnership between hospitals and health departments that spans a 16 county area and is focused on the entire community health improvement process. This regional approach facilitates extensive collaboration throughout Western North Carolina. The backbone support responsibility is provided by the WNC Health Network alliance of hospitals.

During the assessment phase in 2012, WNC Healthy Impact regionally coordinated data collection and developed support materials to benefit hospital and health department participants. For the 2012 assessment processes, they contracted with a team of data consultants and a survey vendor to support secondary and primary data collection and reporting at the regional and local levels. Results were distributed via county specific templates to help support collaborative CHA and CHNA processes and final product development.

Additionally, WNC Healthy Impact provided support through presentations about requirements, communication tools, creating opportunities for local and regional networking, creating templates, and identifying other resources to support the process. Overall this approach facilitates the opportunity to view population health not only countywide but also with the greater regional perspective. Furthermore, the partnership conserves resources for local health departments and hospitals by conducting one coordinated data collection effort (including secondary data retrieval, surveying, data presentation, and reporting) and building on existing assets and partners at the local level.

In addition to this comprehensive regional approach, there is a continued commitment and support for the full, three-year process of improvement. In addition to working on data and reporting together, WNC has continued to support important dialogue, trainings, tools,
and connectivity, etc. around collaborative action planning, and most recently a focus on evaluation and results. The next collaborative assessment will be in 2015.

SECTION V. LESSONS-LEARNED AND NEXT STEPS

This project has already revealed a rich amount of useful information for stakeholders to consider in improving the CHNA process in North Carolina.

In addition, further analysis of the extensive CHNA/IS database that has been developed for each hospital is certain to reveal additional insights and comparisons. This database can also serve as the baseline data set that can be used in the future to measure and chart the evolution and improvement of the CHNA process in North Carolina.

As discussed in the introduction, the immediate goal of this project has been to quickly identify best practices and lessons-learned from the first round of compliance in North Carolina with the federal CHNA process in order to communicate this information to stakeholders planning the next cycle.

A. Three key messages:

From preliminary analysis of the database and conversations with multiple stakeholders, there appears to be strong agreement regarding three "big picture" next steps to improve the process.

It is possible that with further deliberation the NC-CHIC may want to assemble working groups to focus on one or all of these three key ideas.

1. Need for expanding the jurisdictional alignment of the CHNA coverage areas.

It is important for the “community” assessed in the CHNA to realistically reflect the hospital patient catchment areas. From a state perspective, it is also important to extend CHNA coverage to the “empty spots” on the map which tend to be medically underserved areas.

In the examples described in Section IV, the narrative about the 16 county + 16 hospital regional collaboration of Western North Carolina depicts one effort to comprehensively cover a large area of the state. The 7 county Albemarle Regional Health Services collaboration in the northeastern part of the state is another model of a comprehensive regional approach.

A common pattern often observed in this first CHNA cycle was for hospitals to partner with their local county health department, which already had a state-required community health assessment in place. While this partnership jump-started important community collaborations, it also tended to limit the hospital’s initial definition of their community served to only those living within the bounds of the county.

As noted in Section IV, a number of plans and ideas have been identified by various stakeholders to expand existing coverage areas in the next CHNA cycle. Such an expansion may also compliment the development and implementation of Accountable Care Organizations in the future.

The maps in Figures 1, 2, and 3 of the Appendix may be helpful in understanding potential geographical realignments.

2. Need to shift the priority content focus of the Implementation Strategies from the concentration in the Clinical Care category, with more emphasis directed toward the other 3 categories of Health Behaviors, Social and Economic Factors, and the Physical Environment.

The findings from the national sample reviewed in the April 2014 report issued by the Public Health Institute, showed a skewing of the priority content focus toward clinical care. (73% Clinical Care; 19% Health Behaviors; 8% Social and Economic Factors; and 0% Physical Environment.)

The 30 hospital sample described in Section III shows that this same skewing toward clinical care is also present in the NC cohort.

Efforts should be made to continue to direct more priority content focus “upstream” toward the more preventive components in Health Behaviors, Social and Economic Factors, and the Physical Environment.
Evidence-based strategies to address this agenda need to be identified or developed. The inclusion of business community representatives in CHNA coalitions is one such step.

3. Need for alignment of the hospital Community Benefits expenditures with the CHNA/IS process.

One obvious gap in the federal regulatory structure is that there is no requirement that the nonprofit hospital Community Benefit (CB) expenditures be aligned with the priorities in the Implementation Strategies that emerge from the CHNA process.

The scope of this project did not attempt to compare IS elements with reported Community Benefit expenditures at specific hospitals.

On the other hand this CB question was discussed with many stakeholders, and no one was aware of any linkages at any NC nonprofit hospital between these two systems. Nevertheless, most parties agreed that such an alignment of the Community Benefits with the CHNA/IS process made sense and was ultimately something that needed to be done.

B. Other Practical Comments and Suggestions

1. Build in continuous flow for CHA→CHNA→IS→Community Benefit Alignment. Then view this flow as a continuous process that cycles back to the assessment function.

2. Many of these collaborations are “Actor Dependent / Relationship Dependent” so be opportunistic in taking advantage of persons and events.

3. Do not underestimate the basic principle contained in Collective Impact Theory of identifying and supporting an “Organizational Backbone” to sustain the collaboration.

4. Explore how to reach out to local legacy foundations to provide assistance in supporting organizational backbone arrangements. (See Figure 3 for a map of NC legacy hospital foundations.)

5. Have the collaboration develop an After Action Review Report to examine what was successful and what areas needed improvement.

6. After the priorities and roles are identified, stakeholders should continue meeting to discuss the process and track progress in implementation.

7. It helps if a hospital has its own internal CHNA working group to understand and support this process. It helps if such internal group has linkages to the hospital’s Community Benefit program.

8. It is important to have the local business community participating in the process, particularly with respect to workforce, employment, and economic factors.

9. Take advantage of previous partnerships & collaborations, such as Healthy Carolinians; seek out local stakeholders such as United Way; and take advantage of university involvement wherever possible.

10. Start early and be transparent with the data collected.

11. Encourage the LHD to voluntarily get on the same cycle as the hospital, and encourage neighboring counties to utilize the same survey template.
APPENDIX

The authors express their appreciation to Matthew C. Simon, Research Associate with the NC Institute for Public Health for his assistance in creating the maps shown below.

Figure 1. North Carolina Local Health Department Jurisdictions.

Figure 2. Counties referenced in Section IV as examples of collaborative arrangements.
Figure 3. North Carolina Legacy Hospital Foundations and their geographic focus areas. *Note that WestCare Foundation is recently formed and that Sisters of Mercy of NC Foundation services the entire state of NC but focuses primarily on the Asheville and Charlotte metropolitan areas.

This report was prepared by Karen Wade, M.S.P.H. Candidate (2015), Gillings School of Global Public Health, UNC Chapel Hill and Gene W. Matthews, J.D., Director, Network for Public Health Law — Southeastern Region and NC Institute for Public Health Gillings School of Global Public Health UNC Chapel Hill. The Network for Public Health Law provides information and technical assistance on issues related to public health. The legal information and assistance provided in this document does not constitute legal advice or legal representation. For legal advice, readers should consult a lawyer in their state.

SUPPORTERS

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