COMMUNITY HEALTH
NEEDS ASSESSMENT AND IMPROVEMENT PLANNING

Theresa Green, MBA, PhD Candidate
- Director of Community Health Policy and Education, Center for Community Health
- Faculty, Public Health Sciences Department
Starting with FY 2012, Affordable Care Act

- Apply to 501(c)(3) hospitals
- Requirements are mandatory and tax exemption depends on compliance (fees for noncompliance)
- Reported in Schedule H (Form 990)
- New 501(r) Requirements
  - Community Needs Assessment
  - Financial Assistance Policy
  - Limits on Charges
  - Collections
“During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)?”
Requirements of the CHNA

a) Definition of community
b) Demographics of the community
c) Existing facilities and resources available to respond
d) How data was obtained
e) Health needs
f) Primary and chronic disease needs – health issues of uninsured, low-income and minority
g) Process for identifying and prioritizing needs and services
h) Process for consulting with community’s interests
i) Information gaps
More…

3. Did the hospital take input from representatives of the community, including those with **special knowledge of public health**? How and who?

4. Was the CHNA conducted with other hospital facilities?

5. Did the hospital make the CHNA widely available to the public? (website, upon request, other)
Beyond the CHNA to CHIP…

6 If the hospital facility addressed needs identified in its most recently conducted CHNA, indicate how (check all that apply to date):
   a  Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA
   b  Execution of the implementation strategy
   c  Participation in the development of a community-wide plan
   d  Participation in the execution of a community-wide plan
   e  Inclusion of a community benefit section in operational plans
   f  Adoption of a budget for provision of services that address the needs identified in the CHNA
   g  Prioritization of health needs in its community
   h  Prioritization of services that the hospital facility will undertake to meet health needs in its community
   i  Other (describe in Part VI)

7 Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If “No,” explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs.

“If the hospital addressed needs identified in its most recently conducted CHNA, indicate how”
Partnership for CHNA/CHIP

- System-level public health
- Effects on community health
- Outcome focused
- Evidence base
- Scientific measurement
History of Community Benefits Reporting

- NY Commissioner asked for collaboration in community health assessment and planning and to document those efforts in a hospital’s Community Service Plan (CSP).
- Been reporting for 12 years, now tied to State Prevention Agenda
- New York Local Health Departments (LHDs) instructed to participate in this process and report independently
- Hospital Community Service 3-year Plans were due in 2009 and updates were due in 2010, 2011, and 2012
New York State
2012 Community Service Plan

For Health Systems
serving Monroe County, Including:

Lakeside Health System
Rochester General Health System
Unity Health System
University of Rochester Medical Center – Highland Hospital
University of Rochester Medical Center – Strong Memorial Hospital

With collaboration from
Finger Lakes Health System Agency
Monroe County Department of Public Health
University of Rochester Medical Center – Center for Community Health
Representation, meeting since June 2012

<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE</th>
<th>AFFILIATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Al Bradley</td>
<td>Senior Project Manager, High Blood Pressure Initiatives</td>
<td>Finger Lakes Health Systems Agency</td>
</tr>
<tr>
<td>Wade Norwood</td>
<td>Director of Community Engagement</td>
<td>Finger Lakes Health Systems Agency</td>
</tr>
<tr>
<td>Andrea DeMeo</td>
<td>Executive Director &amp; COO – Center for Community Health</td>
<td>University of Rochester Medical Center</td>
</tr>
<tr>
<td>Theresa Green</td>
<td>Director of Community Health Policy &amp; Education – Center for Community Health</td>
<td>University of Rochester Medical Center</td>
</tr>
<tr>
<td>Anne Kern</td>
<td>Public Health Program Coordinator</td>
<td>Monroe County Department of Public Health</td>
</tr>
<tr>
<td>Byron Kennedy</td>
<td>Deputy Director, physician</td>
<td>Monroe County Department of Public Health</td>
</tr>
<tr>
<td>Barbara Ficarra</td>
<td>Director of Public Relations</td>
<td>Highland Hospital</td>
</tr>
<tr>
<td>Shawn E. Fisher</td>
<td>Administrative Director of Nursing &amp; Director of Surgical Services</td>
<td>Lakeside Health</td>
</tr>
<tr>
<td>Barbara McManus</td>
<td>Director, Marketing &amp; Public Relations</td>
<td>Rochester General Health System</td>
</tr>
<tr>
<td>Kathy Parrinello</td>
<td>Associate VP and COO</td>
<td>Strong Memorial Hospital</td>
</tr>
<tr>
<td>Stewart Putnam</td>
<td>President, Health Care Services Division</td>
<td>Unity Health System</td>
</tr>
<tr>
<td>Wendy Wilts</td>
<td>Senior Vice President Clinical Service Lines</td>
<td>Unity Health System</td>
</tr>
</tbody>
</table>
CHNA – Data

- Monroe County Adult Health Survey (AHS)
  - Countywide random digit dial telephone survey for 18+ year olds
    - 1800 responses collected
    - ½ in City zip codes
    - 140 Latino, 1400 white, 225 African American
- Local information such as the Blood Pressure Registry
- State Prevention Agenda indicators
Process Check

Logistical issues:
1. The needs assessment, Board approval and community dissemination must occur in the same fiscal year.
2. 4 hospital systems were involved with two different fiscal years.
3. In November 2012, we learned that the first fiscal year for reporting ended in June 2013.

Practical issues:
1. Hospitals wanted to do relevant work, but did not want to add to the workload.
2. No budget.
3. Preconceived bend towards worksite wellness and HTN.
<table>
<thead>
<tr>
<th>County and # of Deaths</th>
<th>#1 Cause of Death and # of Deaths</th>
<th>#2 Cause of Death and # of Deaths</th>
<th>#3 Cause of Death and # of Deaths</th>
<th>#4 Cause of Death and # of Deaths</th>
<th>#5 Cause of Death and # of Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age-adjusted Death Rate</td>
<td>Age-adjusted Death Rate</td>
<td>Age-adjusted Death Rate</td>
<td>Age-adjusted Death Rate</td>
<td>Age-adjusted Death Rate</td>
</tr>
<tr>
<td>Monroe</td>
<td>Cancer</td>
<td>Heart Disease</td>
<td>Stroke</td>
<td>Chronic Lower Respiratory Diseases (CLRD)</td>
<td>Pneumonia and Influenza</td>
</tr>
<tr>
<td></td>
<td>1,492</td>
<td>1,434</td>
<td>326</td>
<td>267</td>
<td>185</td>
</tr>
<tr>
<td>Total: 6,168</td>
<td>176 per 100,000</td>
<td>157 per 100,000</td>
<td>36 per 100,000</td>
<td>30 per 100,000</td>
<td>20 per 100,000</td>
</tr>
<tr>
<td>Ontario</td>
<td>Cancer</td>
<td>Heart Disease</td>
<td>Stroke</td>
<td>Chronic Lower Respiratory Diseases (CLRD)</td>
<td>Unintentional Injury</td>
</tr>
<tr>
<td></td>
<td>231</td>
<td>226</td>
<td>52</td>
<td>51</td>
<td>31</td>
</tr>
<tr>
<td>Total: 949</td>
<td>175 per 100,000</td>
<td>169 per 100,000</td>
<td>39 per 100,000</td>
<td>39 per 100,000</td>
<td>25 per 100,000</td>
</tr>
<tr>
<td>Orleans</td>
<td>Heart Disease</td>
<td>Cancer</td>
<td>Chronic Lower Respiratory Diseases (CLRD)</td>
<td>Stroke</td>
<td>Unintentional Injury</td>
</tr>
<tr>
<td></td>
<td>127</td>
<td>97</td>
<td>24</td>
<td>19</td>
<td>11</td>
</tr>
<tr>
<td>Total: 408</td>
<td>256 per 100,000</td>
<td>194 per 100,000</td>
<td>50 per 100,000</td>
<td>39 per 100,000*</td>
<td>25 per 100,000*</td>
</tr>
<tr>
<td>Wayne</td>
<td>Cancer</td>
<td>Heart Disease</td>
<td>Chronic Lower Respiratory Diseases (CLRD)</td>
<td>Stroke</td>
<td>Liver Disease</td>
</tr>
<tr>
<td></td>
<td>193</td>
<td>184</td>
<td>59</td>
<td>35</td>
<td>32</td>
</tr>
<tr>
<td>Total: 780</td>
<td>182 per 100,000</td>
<td>175 per 100,000</td>
<td>59 per 100,000</td>
<td>33 per 100,000</td>
<td>31 per 100,000</td>
</tr>
</tbody>
</table>
Cancer and Heart Disease: Number of Deaths
Monroe County, 1994-2010

Source: Vital Records, MCDPH
Ultimate Priority Areas…

Leading Causes of Death* United States, 2000

- Heart Disease
- Cancer
- Stroke
- Chronic lower respiratory disease
- Unintentional injuries
- Diabetes
- Pneumonia/influenza
- Alzheimer’s disease
- Kidney disease

Actual Causes of Death† United States, 2000

- Tobacco
- Poor diet/Physical inactivity
- Alcohol consumption
- Microbial agents (e.g., influenza, pneumonia)
- Toxic agents (e.g., pollutants, asbestos)
- Motor vehicles
- Firearms
- Sexual behavior
- Illicit drug use

# Risk Factors for Monroe County

<table>
<thead>
<tr>
<th>Risk Behaviors, Adults Ages 18+, 2012 (% of population)</th>
<th>Monroe County</th>
<th>City</th>
<th>Suburbs</th>
<th>African American</th>
<th>Latino</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently Smoke</td>
<td>16</td>
<td>25*</td>
<td>13</td>
<td>23**</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>Obese</td>
<td>30</td>
<td>36*</td>
<td>27</td>
<td>38**</td>
<td>41**</td>
<td>27</td>
</tr>
<tr>
<td>No Physical Activity in the Past Month</td>
<td>16</td>
<td>25*</td>
<td>13</td>
<td>30**</td>
<td>26**</td>
<td>13</td>
</tr>
<tr>
<td>Consume 1+ Sodas/Sugar Sweetened Beverages per Day</td>
<td>23</td>
<td>30*</td>
<td>21</td>
<td>46**</td>
<td>23</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: Monroe County Adult Health Survey, 2012
Even though our clinical care score is very high, our health outcomes scores are low – maybe due to socio-economic, behaviors and environmental factors?

Monroe County: Results of the 2013 County Health Rankings for New York (62 counties)

www.countyhealthrankings.org
New York Tracking PH Priority Indicators

## Monroe County “Problem Areas”

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Monroe County</th>
<th>New York State</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Percent of commuters who use alternate transportation</td>
<td>18.2</td>
<td>44.6</td>
<td>49.2</td>
</tr>
<tr>
<td>18. Percentage of population with low-income and low access to a supermarket or large grocery store</td>
<td>6.9</td>
<td>2.5</td>
<td>2.24</td>
</tr>
<tr>
<td>21. Percentage of adults who are obese</td>
<td>31.7</td>
<td>23.1</td>
<td>23.2</td>
</tr>
<tr>
<td>23. Percentage of cigarette smoking among adults</td>
<td>19.6</td>
<td>17.0</td>
<td>15.0</td>
</tr>
<tr>
<td>29. Rate of hospitalizations for short-term complications of diabetes per 10,000 (ages 18+ years)</td>
<td>6.0</td>
<td>5.6</td>
<td>4.9</td>
</tr>
<tr>
<td>36. Gonorrhea case rate per 100,000 women ages 15-44</td>
<td>425.4</td>
<td>203.4</td>
<td>183.1</td>
</tr>
<tr>
<td>37. Gonorrhea case rate per 100,000 men – ages 15-44</td>
<td>360.1</td>
<td>221.7</td>
<td>199.5</td>
</tr>
<tr>
<td>38. Chlamydia case rate per 100,000 woman – age 15-44</td>
<td>2,431.9</td>
<td>1,619.8</td>
<td>1,458</td>
</tr>
<tr>
<td>60. Percentage of unintended pregnancy among live births</td>
<td>32.3</td>
<td>26.7</td>
<td>24.2</td>
</tr>
<tr>
<td>65. Percentage of live births that occur within 24 months of a previous pregnancy</td>
<td>24.4</td>
<td>18.0</td>
<td>17.0</td>
</tr>
<tr>
<td>66. Age-adjusted percentage of adults with poor mental health for 14 days or more in the last month</td>
<td>12.4</td>
<td>10.2</td>
<td>10.1</td>
</tr>
<tr>
<td>68. Age-adjusted suicide death rate per 100,000</td>
<td>7.7</td>
<td>7.1</td>
<td>5.9</td>
</tr>
</tbody>
</table>
CHNA – Community Input

GOAL: to improve the health of the citizens of Monroe County by aligning community resources to focus on selected priorities for action (since 1995)

Health “report cards” are available
- Maternal Child Health Report Card -2011
- Adolescent Health Report Card – 2012
- Adult/Older Adult Health Report Card – 2008 (slated for 2013)
Community Action Priorities for Adult/Older Adult:

- Increase Physical Activity and Nutrition
- Improve Prevention and Management of Chronic Disease
- Improve Mental Health (reduce violence among adults and elder abuse)
## Process for Prioritization

<table>
<thead>
<tr>
<th>IMPORTANCE (How important is this goal?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number affected</td>
</tr>
<tr>
<td>How much disability/illness this will prevent</td>
</tr>
<tr>
<td>Long term impact on health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIKELIHOOD of IMPACTFUL SUCCESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the likelihood that setting this goal will result in substantial health improvements in 3-5 years?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COMMUNITY SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there willingness on the part of community leaders and partner organizations, and residents to address this goal?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOSPITAL SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>How likely are hospital leaders to strongly support this initiative and dedicate resources to its success?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL of CURRENT COMPLEMENTARY ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the level of community plans, activities and resources already directed to address similar goals?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What is the potential to address health disparity</th>
</tr>
</thead>
</table>

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<thead>
<tr>
<th>OVERALL RANK</th>
</tr>
</thead>
</table>

### Prevent Chronic Disease:
1. Reduce obesity
2. Decrease smoking
3. Increase access to prevention and management

### Back Burner
- STD, HIV, unintended and teen pregnancy
- Mental health
Community Health Improvement Plan

• Identify Priority Areas from NY 2013 Prevention Agenda:
  • Prevent Chronic Disease
  • Promote a healthy and safe environment
  • Promote healthy women, infants and children
  • Promote mental health and prevent substance abuse
  • Prevent HIV, STD, Vaccine preventable diseases and HAI

PREVENT CHRONIC DISEASE

http://www.health.ny.gov
Evidence Based Interventions

New York State Prevention Agenda 2013-17

For each priority area, gives

- List of evidence based Interventions
- Interventions by level of Health Impact Pyramid
- Intervention by sector
- Tracking indicators
- Baseline data
# New York State Prevention Agenda - Prevention Agenda 2013-17 - Preventing Chronic Diseases Action Plan

## Appendix 2: Alignment with National and State Key Documents, Objectives and Evidence Base.

<table>
<thead>
<tr>
<th>Key Document, Goal or Objective</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus Area 1: Reduce obesity in children and adults</strong></td>
<td></td>
</tr>
<tr>
<td>CDC Winnable Battle</td>
<td>Centers for Disease Control and Prevention. Winnable Battles.</td>
</tr>
</tbody>
</table>
Focus Area 1: Reduce obesity in children and adults

- Goal 1.1: By December 31, 2017, reduce the percentage of adults ages 18 years and older who are obese by 5% from 30% (Monroe County AHS, 2012) to below 28.5%.
- Goal 1.1a: Expand the role of public and private employers in obesity prevention
  - Objective 1.1.1. By 12-31-17, expand the worksite wellness package at each hospital system by 3 effective interventions, as measured by increase in each hospital systems score on the Monroe County worksite wellness index
  - Objective 1.2.2. By 12-31-17, increase by 10% the percentage of small to medium worksites that offer a comprehensive worksite wellness program for all employees
Focus Area 2: Reduce illness, disability and death related to tobacco use and second hand smoke exposure

- Goal 2.1. By 12-31-17, reduce the percentage of adults ages 18 years and older who currently smoke by 5% from 16% (MCAHS, 2012) to below 15% among all adults. Also, reduce the percentage of adults in the City who currently smoke by 7% from 25% to 23% or less.

- Objective 2.1.1. By 12-31-17, increase the number of unique callers from Monroe County to the NYS Smokers’ Quitline by 20%, from 7,389 (2011) to 8,900 annually. (Data source: NYS Smokers’ Quitline Annual Report)
  - Standardize and support refer to quit at hospitals (especially at discharge) and CMMI clinics
Focus Area 3: Increase access to high quality chronic disease preventive care and management in both clinical and community settings

• Goal 3.1. Promote use of evidence-based care to manage chronic disease.
  • Objective 3.1.1. By 12-31-17, increase the percentage of adults ages 18+ years with hypertension who have controlled their blood pressure (below 140/90) by 10% from 66.7% (2012) for residents in the blood pressure registry to 73.4%
    • Interventions: BP Ambassadors, BPAP, worksite demonstrations, practice improvement consultants
  • Objective 3.1.2. By 12-31-17, all primary care medical homes in the CMMI initiative will be linked to community resources electronically and through care managers.
    • Intervention: CMMI grant and CHW with electronic database
Thank you!

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  Center for Community Heath, URMC
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