Testimony on Community Health Needs Assessments- Submitted to the

North Dakota Health Care Reform Review Committee

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Introduction and Background on CRH:

Good morning Chairman Keiser and members of the committee. My name is Brad Gibbens and I am the Deputy Director of the Center for Rural Health at the UND School of Medicine and Health Sciences, and an Assistant Professor with the School's Masters in Public Health program. I have worked in rural health for over 28 years concentrating in the areas of community development/community engagement by providing assistance to rural health organizations and communities in the form of organizational and community assessment, strategic planning, network development, program evaluation, grant and program development, facilitation, and other forms of assistance. I also work in our health services research center conducting qualitative research studies and policy analysis.

The Center for Rural Health is one of the most experienced State Offices of Rural Health in the country. Being created in 1980, there are only 4 states with offices predating North Dakota. Over the years we have assisted every rural hospital in North Dakota, along with a number of primary care clinics, public health units, ambulance services, long term care centers, faith-based organizations, economic development, and other rural-based organizations. Rural health covers a wide range of organizational structures and health delivery entities; however, it always, from the perspective of our office, involves and needs to benefit the community. We place a heavy premium on working with rural communities to develop stronger, more sustainable health organizations; building local skills and capacity; fostering collaboration between health organizations; and, strengthening the ties between health organizations and community members. As part of our focus on rural health we also emphasize our efforts to improve health conditions for Native Americans. In addition to our community focused work, we are also home to 6 national programs that concentrate on information dissemination, health services research, and Native American health. We have over 50 employees.

Overview of the Community Health Needs Assessment (CHNA) Requirement:

My focus today is to discuss the Community Health Needs Assessment (CHNA) requirement under the Affordable Care Act (ACA). The ACA requires that all non-profit hospitals conduct a CHNA every three years. The hospitals must file a report of the findings from the needs assessment and post this on their webpage. Following the assessment the hospital must develop an implementation strategy that outlines how they will address some of their community health issues. In other words, they have to identify significant needs, prioritize those needs, and identify measures and resources to address those needs. The hospital can use its own process and judgment to determine significant needs which could include such factors as 1) burden, scope, or urgency of the need; 2) estimated feasibility and effectiveness of possible interventions; 3) health disparities; and 4) importance the community places on addressing the need; but again, the hospital "may use any criteria it deems appropriate." With the exception of one, all the non-profit hospitals in North Dakota have completed their assessments and established implementation strategies.

The CHNA process is important not only as an element within the broader scope of health reform helping providers to factor into their decision making input from the public in an effort to improve system responsiveness, but just as importantly because it helps to facilitate open dialogue between the general public and health care providers. Significant health reform goals are to foster more collaboration, restructure delivery systems and payment methodologies, and improve data sources for both quality improvement and cost functions. A strong emphasis is placed on the ideas of improved prevention and linking provider payments to improved outcomes. This impacts health providers, health facilities, and health plans directly, but it is imperative as we contemplate and gradually implement health reform that we find ways to include patients, clients, families, and the general public in this discussion. Hospitals are also now required to conduct patient satisfaction surveys called HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) as another way to gain public input on hospital performance. We as patients and citizens need to be more responsible for our individual health status and for the overall health of our communities. As part of this we need to share our perspective on the care we receive. Fostering more discussion and dialogue between the public and the local health system regarding community health needs is a legitimate step to nurture collaborative care systems, educate and inform the public, and to increase understanding. It is meant to be inclusive of a broad array of opinions. It is an important process to encourage people to be more involved with their providers and with their neighbors to talk about overall health needs. Granted we need national health goals; however, it should start at the community level.

CRH CHNA Process and Approach

The Center for Rural Health conducted CHNA with 21 of North Dakota's 36 Critical Access Hospitals (58% of the CAHs). We used a mixed methods approach involving both primary data and secondary data. For each of the CHNA our staff conducted two visits to the community to facilitate community discussions in the form of a focus group. The first community meeting was used to explain the CHNA process, review basic demographic information, and to examine county characteristics in comparison to state averages and the second meeting served to facilitate a ranking or prioritization of the identified community needs. In addition to identifying community health needs, by conducting the face-to-face interviews, community surveys, and focus groups, we sought community input on 1) awareness and use of local health services, 2) suggestions for improving local/area collaboration, 3) barriers to local care, and 4) reasons why people use local health facilities and reasons for seeking care outside of the community.

In addition to the 21 CHNA's conducted by the CRH, there were 18 hospitals that either contracted with a consultant group or did them themselves. Combined that represents 39 CHNA's for 41 hospitals. There were two CHNA's at the time of our analysis that were not completed. We were able to obtain the data from the 18 hospitals and combine them with the 21 assessments we did for an aggregate data base. I want to stress the data represents both urban and rural hospitals.

Attached to this testimony is a Fact Sheet "North Dakota's Significant Health Needs as Identified by Community Health Needs Assessments", (December, 2013, Center for Rural Health). The document identifies 21 themes or subjects and the number of CHNA where this was identified as a prevalent, persistent, and substantial need or issue. The top ten are as follows:

- Health care workforce shortages 28 CHNA
- Obesity and physical inactivity 16
- Mental health 15
- Chronic disease management 12
- Higher costs of health care for consumers 11
- Financial viability of the hospital 10
- Aging population services 9
- Excessive drinking 7
- Uninsured adults 6
- Maintaining EMS 6
- Emphasis on wellness/education/prevention 6
- Access to needed equipment/facility update 6

As you can see they cover a wide range of subjects. The health care workforce shortage does not surprise us. The Center and the medical school view this as a priority. I know you have heard Dr. Wynne speak to this issue. However, it takes on even more importance when we can empirically show that North Dakotans, living in rural areas and urban communities, singled this out as the number one issue. There were 28 out of 39 CHNA's (almost ¾) where this was a significant issue.

I want to offer some brief comments on some of the other issues. As has been previously stated, a significant focus within health reform is health improvement which includes ideas such as disease prevention, disease management, wellness, care coordination, development of patient centered medical homes, individual responsibility, and similar concepts. Physicians and nurses understand the need to significantly improve health status; health organizations and health systems understand; health plans and businesses understand. However, having the general public of North Dakota place subjects such as obesity/physical inactivity, mental health, chronic disease management in the top five identified needs, and excessive drinking and an emphasis on wellness in the top ten really indicates to me that the public also views these as very important subjects. They see them as issues and problems that need to be addressed not only for the benefit of the individual, but also for the benefit of the overall community. These are community health issues. By health providers and community members coming together and forming a consensus on community needs, then we can take the necessary steps to improve health.

I wish to take a minute and focus on mental health. This is not the first empirical measure our office has taken regarding mental health access. There are two others I wish to share. The first is input from hospital administrators. In 2005, 2009, and in 2011 we surveyed the rural hospital administrators on a number of factors including 21 common issues facing rural hospitals. Access to mental health services was seen as a problem in all three surveys. In 2011, 79 percent of the administrators saw it as a problem, moderate problem, or severe problem. In isolating the severe problem scores, it ranked 3rd out of 21 items with 45 percent of the hospital administrators rating it a severe problem. The second empirical study is a series of rural community interviews we are doing looking at facilitators and barriers to rural physician recruitment and retention. We have interviewed rural physicians, hospital CEOs, and others in 16 rural communities. Mental health has emerged as a barrier in two ways. First, if physicians believe there are a limited number of mental health professionals in the area that is a barrier. Second, if they feel that they as primary care physicians will be the principal provider of mental health services, then that is a barrier. Thus, there appears to be a shared perspective emerging from both the general public and from the provider community that mental health access is an issue in North Dakota.

My final area to share with you is what we do to assist hospitals in addressing community health needs once they have been identified. At the Center for Rural Health we administer the Medicare Rural Hospital Flexibility Program (Flex for short), which is a federal rural health program that is essentially a companion program to the Critical Access Hospital (CAH) designation. We do this in collaboration with the North Dakota Department of Health, North Dakota Hospital Association, North Dakota EMS Association, and the North Dakota Healthcare Review, Inc. All rural hospitals in North Dakota with the exception of the two IHS hospitals are CAHs. Flex is a program to provide technical assistance to CAHs to help them maintain viability and access to essential health services. One of the key TA elements is we can provide small grants to rural hospitals generally in the area of $5,000 to $20,000. In 2013 we provided $155,000 to 12 CAHs for CHNA strategic implementation grants. These were small grants ($6,892 to $15,000) to provide them with some financial resources to address some of their community health needs. Six of the CAHs sought resources to address health care workforce, three to address obesity and physical inactivity, one to address Chronic Disease Management/wellness, one to address access to needed equipment/facility update, and one to address the higher costs of health care for consumers.

In conclusion the CHNA requirement can be viewed as an important process to help non-profit hospitals connect more with their community members. It is an opportunity for citizens to help develop a realistic agenda to improve health in their community. It helps in providing a road map for improved community health.

Thank you.

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