The Collaboration of Not-for-Profit Hospitals and Public Health Departments to Perform Community Needs Assessments that Meet PPACA Requirements

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The Patient Protection and Affordable Care Act (PPACA) has created the need for not-for-profit hospitals and public health entities to work together to implement community health needs assessments. Because of philosophical differences, historically the ability for these stakeholders to work together has been difficult. However, with PPACA requirements tied to not-for-profit hospitals maintaining their tax-exempt status, hospitals recognize the importance of the endeavor. Community health needs assessments may prove to be a successful process for both entities to showcase their unique strengths that will enable them to identify community-perceived health needs and to develop mechanisms to address these needs.

INTRODUCTION

The Patient Protection and Affordable Care Act (PPACA), signed in 2010 but still under a cloud of uncertainty, has the potential of providing public health and not-for-profit hospitals a mechanism to analyze health needs of the community and to develop programs that can change a community's health status (American Public Health Association, 2012). With specific mandates/regulations in-place, the more than 5,800 not-for-profit hospitals (Appleby, 2010) must get out of their comfort zone and work within the community to identify issues that truly impact quality of life. Not-for-profit health organizations had become a PPACA target because the Government Accountability Office (GAO) had found that charitable care, a mechanism for determining tax-exemption, had not been fulfilled by the not-for-profit hospitals/organizations in an amount that should qualify them for tax exemption status (Marietta, 2010; Walker, 2005; Commins, 2012). To ensure not-for-profits include input from the community as they develop appropriate health initiatives, PPACA has tied its mandates to the Internal Revenue Services' requirements for maintaining "charitable" status (Walker, 2005; Grassley, 2010). Equally important, PPACA requires that public health be an integral component of the community needs assessment (Marietta, 2010).

PATIENT PROTECTION AND AFFORDABLE CARE ACT AND NOT-FOR-PROFIT HOSPITALS

Because of the ever escalating cost of health care in the United States, President Obama signed the Patient Protection and Affordable Care Act (PPACA) as a way to address accountability, quality, and access to healthcare. Parts of the bill already have been argued before the Supreme Court, yet the overall bill remains a mystery to most people in the United States. It also remains puzzling to those organizations and agencies who will be heavily involved in the implementation of the regulations. One of these groups is the not-for-profit hospital that offers charitable care.

Not-for-profit hospitals came under the Government Accountability Office's (GAO) scrutiny over 10 years ago when the hospitals were viewed as not providing charitable care in an amount that should qualify them for tax-exempt status. Since those initial concerns, many state watchdog groups had uncovered collection practices, charging mechanisms, and eligibility procedures that were questionable and could certainly create an atmosphere where uninsured and/or poor patients perceived a hostile environment at the hospital.

PPACA contains specific regulations regarding what not-for-profit hospitals must do in order to maintain their special tax status. The PPACA has tied these regulations to Internal Revenue Service (IRS) requirements, thus providing an existing mechanism by which to force not-for-profit hospitals to address charity patients within the community.

In addition to the fiduciary responsibility of the not-for-profits to return care to their communities as a way to be viewed as "charitable," PPACA has created an environment that will force the medical establishments to work with and through communities to identify ways to address health issues. The bill has a focus on health promotion and disease prevention. PPACA is also designed to reorient the financial incentives that drive provider activities toward the improvement of health outcomes, which necessitates ongoing awareness of the health needs of the community. PPACA explicitly requires a community assessment and further requires that public health personnel be involved in the planning, implementing, and analyzing of such needs assessments.

MEDICAL VERSUS PUBLIC HEALTH MODELS

One issue that has frequently proven to be the nemesis of the medical community and the public health community working together is their general philosophies. Historically, there has been what sociologists would call a boundary issue between medicine and public health. The issue involves the division of labor, conflicting skills and theories, and the balance of authority between the two related fields (Brandt & Gardner, 2000). Focus, ethical basis, emphasis, intervention strategies, and payments have different perspectives for medical and public health models (Mechanic, 1976; Turnock, 1997; Schneider, 2011). Thus, when medical and public health personnel discuss issues, the viewpoints seem disjointed, and it is not until commonalities can be established do the two entities have the ability to communicate effectively. It is only after finding common ground that both camps can appreciate what each can provide in a true collaborative effort. As Das and Teng (2000) stated, "Firms cannot work together very well if they are too different in organizational cultures, managerial practices, strategic orientations, and technological systems" (pp. 51-52).

Medical knowledge has advanced tremendously during the past decades, resulting in medical school curriculum that has become so crowded that the social importance of preventive medicine and public health is seldom emphasized. This gap in curriculum creates a blind spot that physicians carry throughout their professional career and results in misunderstandings between practicing physicians and the public health community (Brandt & Gardner, 2000). The medical model, because of the training provided to the medical personnel, focuses on the sick and the role the provider plays in healing the individual. The emphasis is on healing and thus implies a paternalistic status of the provider. The sick individual comes to the provider; the provider determines the illness; the provider instructs the patient how to recover; and the patient follows the orders. If a patient does not recover, the provider first examines where the patient has

gone awry – has the patient taken the medicine as prescribed; did the patient follow all orders as had been directed; where did the patient not follow the provider's guidance. Interventions are developed around and for the sick role, with few activities and time being spent on prevention. Even funding does not prioritize preventing illness. For example, the average health expenditure per capita in the United States in 2010 for people younger than 65 was $4,255 (Health Care Cost Institute, 2012). However, according to the American Public Health Association "only 3 cents of each dollar spent on health care in the U.S. (total public and private) go toward prevention" (2012, ¶4).

As opposed to the medical model, the public health model has borrowed much of its philosophy from social science disciplines, and its emphasis is placed on preventing disease through community health efforts. The health of a community thus becomes the primary focus, and public health recognizes that the most cost-effective way to have a healthy community is to prevent disease from occurring by promoting healthy life choices. Because many, if not most, public health activities are prevention-oriented, effectiveness for efforts is less visible and thus less money is allocated by federal and/or state governments for public health. For example, in 1988, the United States spent approximately $18 billion on primary and secondary prevention activities (Turnock, 2007), which was 3.4 percent of the national health expenditure. In 2004, the amount of funds spent on primary and secondary prevention activities increased to $159.8 billion, but the percent of the national health expenditure for prevention increased less than 1 percent (from 7.8 percent in 1996 to 8.6 percent in 2004) (Turnock, 2007). If secondary prevention activities were excluded, the percent would further drop to a low of 4.2 percent (Turnock, 2007). This percent would further decrease to 2.8 percent should only public health expenditures be considered (Miller, Roehrig, Hughes-Cromwick, & Lake, 2008).

NEED FOR PARTNERSHIP

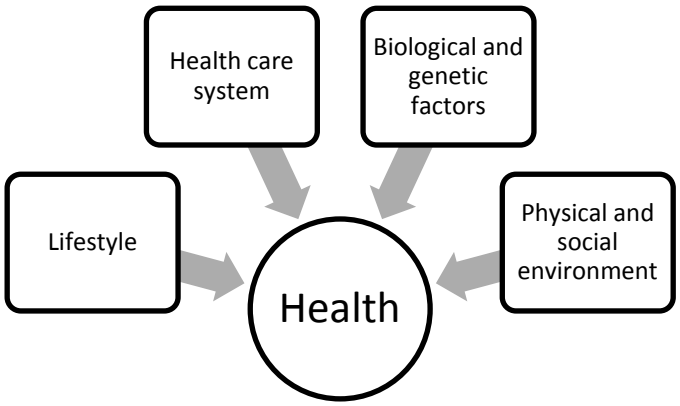
Recognizing the vast difference between theoretical concepts of medicine and public health, the development of a joint community needs assessment may prove challenging for these two entities. Although the PPACA regulations were to initiate in March 2012, many not-for-profit hospitals chose not to adhere to the regulations, hoping that PPACA would be overturned. On the other hand, some hospitals started needs assessments, with varying degrees of success. A main concern of many of the hospitals that began the process was the requirement of community involvement in the needs assessment process.

Historically, hospitals have performed needs assessments, usually based on data generated from hospital records, to identify areas of health/medical issues that the hospital should address. However, PPACA, with an interest on community involvement and inclusion, has created concern among not-for-profit hospitals regarding the most appropriate way to conduct community needs assessments and to capture information from community stakeholders that adequately address health needs (as opposed to medical needs) of the community. Finally, hospitals may be unsure how they can use information collected from community perception of health needs in the development of strategic plans for the hospitals themselves.

THEORETICAL MODEL

The concept of medical and public health professionals working together to address health promotion/disease prevention initially began in the 1970s when Lalonde introduced the concept of health going beyond traditional public health activities and medical care (Glouberman & Millar, 2003). The Lalonde Framework emphasized other factors that impact health (see Figure 1) such as the health care system (access to care), personal behaviors, genetics, and the environment.

FIGURE 1
LALONDA FRAMEWORK



Source:www.sciencedirect.com

Although still a viable theoretical model, the Lalonde Framework has been revised to more accurately reflect the impact of social determinants on health. According to the World Health Organization (WHO), social determinants are "complex, integrated, and overlapping social structures and economic systems that include social and physical environments and health services" (CDC, 2010, p.1). At the community level, social determinants are affected by distribution of money, power, and policy. Social determinants drill into the social fabric of the community and help explain root causes of social ills. Because of the importance that social determinants play in health inequality, the concept has become paramount in the development of *Healthy People 2020* (Centers for Disease Control and Prevention, 2012).

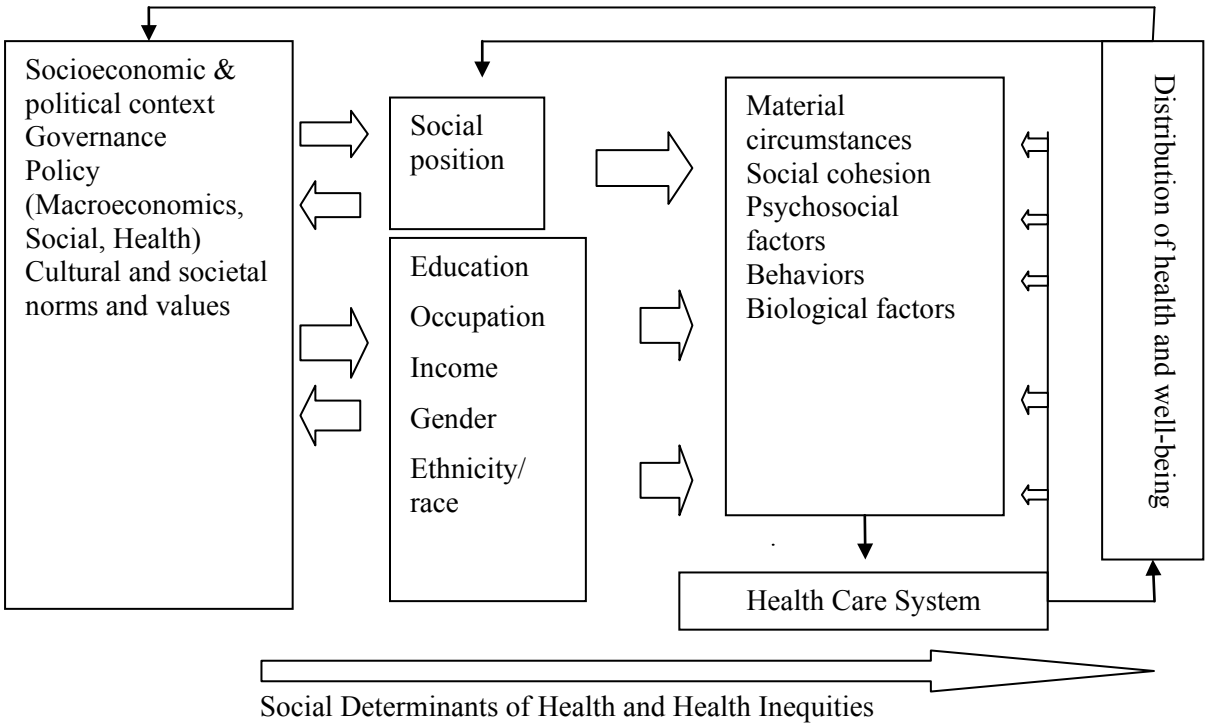
The original Lalonde framework has grown to include more social determinants, and in early 2000, the Canadian Institute for Health Research incorporated the numerous social determinants into four pillars which have become the Population Health Indicators Framework (Glouberman & Millar, 2003) that defines "health" across a continuum, from well-being to death, and places determinants into four categories – health behaviors, living/working conditions, personal resources, and environmental factors. The model further defines health systems in eight levels, all of which impact quality of care. Finally, the framework addresses the integration of the community and health systems, with all four "pillars" being incorporated to reflect health equity. These pillars have been incorporated into the WHO Social Determinants of Health Conceptual Framework (see Figure 2), and this theoretical framework is beneficial in addressing the numerous stakeholders that should be involved in a community health needs assessment.

CASE STUDY

A case study may be useful to assist not-for-profit hospitals, public health departments, and other community stakeholders to identify key components that should be included in the development of a community needs assessment that meets the requirements of PPACA and that ensures IRS regulations are met. Equally important is the consideration of what unique qualities that the not-for-profits and public health departments "bring to the table" and how these can be melded to form a strong partnership that can formulate a strategy to address health needs of the community. Analyzing the case study should allow the reader to see how a not-for-profit hospital can use existing validated community assessment instruments while working with university personnel trained in public health to analyze community needs. This is an alternative should the community not have a local health department or is not in close proximity to state

or district health departments. The case study should also allow the reader to develop strategies of how public health department personnel should approach not-for-profit hospitals regarding the issue of partnering for this crucial component of the PPACA. Finally, the case study will address the unique situation that health department personnel are afforded in that the mandate requires public health involvement; thus, this proves a time when public health personnel need to be in the forefront of the "best practices" of developing and processing community health needs assessment.

FIGURE 2
WHO SOCIAL DETERMINANTS OF HEALTH CONCEPTUAL MODEL



Source: Centers for Disease control and Prevention, 2010

In 2011, the CEO of a 32-bed rural hospital in central Texas approached an associate professor and an assistant professor within a School of Health Administration about the possibility of facilitating a community health needs assessment that would meet PPACA requirements. The consultants were chosen because both had public health degrees, both had experience in public health – one serving as a county public health administrator and the other having worked on numerous community needs assessments - and this would meet the requirements stipulated in PPACA.

To ensure full board support, both professors met with the hospital's Board of Directors to determine the hospital's definition of a community health needs assessment. The hospital provided previous needs assessments, which served as a template to educate the board and staff as to the need to learn from the community what social determinants impact health. Furthermore, the board, as well as the hospital, had to re-define the term "community." Analysis of the hospital catchment area found the majority of patients came from the entire county, and thus the staff/board had to start thinking beyond the town in which the hospital was located.

After the consultants and Board of Directors more broadly defined the catchment area, the second step was to identify existing valid instruments that could be used to seek community input but also to stay within the time and funding parameters established by the board of directors. The consultants chose the

Community Health Assessment and Group Evaluation (CHANGE) model that had been developed by CDC (US Department of Health and Human Services, 2011). Not only has CHANGE been validated, but it has been used throughout the United States in varying size communities to ascertain focused input from the community.

CHANGE involves a team approach to consider assets of the community as well as needs of the community, and five sectors of the population were involved in the focus groups. The marketing director of the local hospital supplied names of persons throughout the county who were from the five sectors, including community-at-large, community institution/organizations, health care sector, school sector, and work site sector. For the case study county, between 5-12 people attended the sessions; there was representation from the three towns/villages located within the central Texas county. Ages of the participants ranged between 25 and 66, an issue since elderly were not involved in the focus groups.

Four focus groups were created in half-day segments for all sectors except health care. In order to encourage health care input, the consultants met the providers at varying times throughout the workday. The consultants met with the physicians at their monthly staff meeting. Hospital staff met in 2-hour segments, and the focus groups included 30-50% of the staff; this was to allow continuity of care while getting input from all levels of staff to ensure the best opportunity to obtain as complete a picture of perceived health needs as possible.

CHANGE was developed by CDC in a "forced" effort. Focus group members were asked their current knowledge of demographics, physical activity, nutrition, tobacco, chronic disease management, and leadership. Each focus group was charged with getting consensus of the extent to which these areas were included in community policy as well as which areas were already implemented within the county. After all focus groups had completed the CHANGE instrument, the consultants analyzed the data for consistency as well as determined sectors that were viewed differently between the focus groups. In addition, each focus group was asked for specific recommendations they would like included in the community health needs assessment

Upon completion of the focus groups, the consultants performed a telephone survey, using random phone numbers generated from the county telephone book. The consultants used the LAN line concept, as they felt an older population would be more likely to have LAN lines within their homes. Surveys occurred in early evening hours (7-8:30 p.m.), Monday through Friday, as well as random times during the weekend. A total of 159 people responded to the survey, which consisted of 8 demographic questions and 18 survey questions. The respondents were also able to provide comments at the close of the survey.

The community health needs assessment yielded a variety of issues that were of concern to the citizens of the county. Many of the issues were not immediately viewed by the board of directors as areas that the hospital should address. Issues such as food deserts, school drop-out rates, increasing minority population were viewed by the community as important in health consideration, but hospital personnel questioned their specific responsibility in these issues. All focus groups identified health education as the top priority, and this was an area where the hospital and its providers could serve in a leadership capacity.

A major recommendation was the need to develop a community health advisory board that would prioritize issues within the county and work collectively to address the problems. Once advisory boards were implemented, the hospital realized how its roles could change as various issues were addressed. However, the hospital recognized the impact that these issues had upon the hospital itself – whether it was the quality of the staff being hired or the number of students who dropped out of school and thus had difficulty in finding employment that offered insurance.

The community health needs assessment was incorporated into the local hospital's 3-year strategic plan. The hospital is active on a local advisory board, having identified an organization whose charge covers bringing stakeholders to the table. Since this county does not have a local health department, the consultants continue to serve in that capacity, although the regional and state health departments are becoming more involved.

CONCLUSION

From a public health standpoint, partnering with a not-for-profit hospital to address community health needs should be a logical approach to addressing community issues. Public health personnel have the latest data on morbidity and mortality; they also have access to county, regional, state information that can put health and wellness into perspective. Public health already is involved in community activities, so its involvement in a needs assessment is an extension of its current focus. Much of the demographics of the county should be in the grasp of the public health department, thus one less thing for the not-for-profit hospital to do. In addition, because of the breadth of public health, not-for-profit hospitals can turn to public health personnel for answers to questions that may not be in the purview of the hospital.

Not-for-profit hospitals/organizations and public health agencies have the opportunity to meld their areas of expertise into an activity that will benefit both organizations as well as the community at large. Because some not-for-profits in the past had abused their IRS tax exempt status by not providing services that were deemed by the community as important, PPACA requires that agencies perform routine community health needs assessments. To ensure the needs assessments focus on the community, PPACA requires that public health be involved in the activity. Once not-for-profit and public health departments identify their common grounds, they can become involved in developing and implementing a community health needs assessment that will benefit both agencies and, more importantly, the community.

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