



Nonprofit Hospital Community Health Needs Assessments in Georgia

Georgia Watch Health Access Program

BETH STEPHENS, J.D.
HEALTH ACCESS PROGRAM DIRECTOR



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EXECUTIVE SUMMARY

Nonprofit Hospital Community Health Needs Assessments in Georgia

Project Description: Nonprofit hospitals classified by the Internal Revenue Service (IRS) as 501(c)(3) charitable organizations have long been obligated to provide community benefits as a condition of their tax-exempt status. A new requirement in the 2010 Patient Protection and Affordable Care Act (ACA) mandates that all nonprofit hospitals conduct a Community Health Needs Assessment (CHNA) every three years with input from community members and public health. Nonprofit hospitals must then develop an Implementation Strategy to address the significant health needs identified in their communities. Many hospitals published their first CHNAs in 2012 and 2013. With a grant from the Healthcare Georgia Foundation, Georgia Watch examined reports from this first round of CHNAs and Implementation Strategies. This research and advocacy project had several goals:

- Assess Georgia nonprofit hospital compliance with the new ACA requirements;
- Educate community members about the CHNA process and help them understand how to assess their hospitals' CHNAs and Implementation Strategies, giving them tools to evaluate their hospitals' community benefit programming with more than just financial data;
- Give recommendations that can help hospitals ensure their community benefit programs are meeting community needs, particularly for vulnerable populations;
- Encourage hospitals to engage in meaningful ways with community-based organizations and local public health departments in the next round of CHNAs.

Methodology: Georgia Watch then conducted a comprehensive review of 38 CHNAs and 29 corresponding Implementation Strategies from Georgia nonprofit hospitals. Georgia Watch developed an evaluation tool to assess hospital performance on five major components of the new CHNA requirements: 1) defining community; 2) collecting secondary data on community health; 3) gathering community input and primary data; 4) prioritizing community health needs; and 5) implementing strategies to address identified community health needs. In addition to evaluating individual CHNAs and Implementation Strategies, Georgia Watch conducted one-on-one interviews with hospital leadership, private consultants, and individuals from academic institutions and public health who assisted hospitals in completing their CHNAs. Georgia Watch also —

sent an online survey out to representatives from various community organizations to gather their thoughts about the community input process for their respective hospitals. Georgia Watch received a total of 58 survey responses from community members. Georgia Watch also visited the websites of the 82 non-specialty, acute care 501(c)(3) nonprofit hospital facilities in Georgia to find out whether they made their CHNAs, Implementation Strategies or other community benefit reports publicly available on their websites.

Findings: Georgia Watch found that the majority of the 82 non-specialty, acute care nonprofit hospitals published their CHNAs online and made them easily accessible to the public. The in-depth analysis of 38 CHNAs and 29 corresponding Implementation Strategies showed great variation in hospital processes and reporting. When defining community, only 28 (74%) of the hospitals clearly articulated how they defined their communities, despite the IRS requirement that they do so. Most of the reviewed hospitals gathered data for their CHNAs from a variety of local, state and national data sources, with only one hospital listing exclusively national data sources. These data sources were used by hospitals to evaluate an array of social determinants of health, as well as to identify vulnerable populations. The most frequently reported social determinants of health were education level, income, and healthy food access. Only thirteen hospitals (34%) collected data on environmental health indicators, including public safety, transportation, parks, pollution, and water quality. Twenty-five hospitals (66%) used internal hospital utilization data, such as admissions and discharges, to either define their communities or assess the health needs of their communities in their CHNAs.

Georgia Watch took a close look at how hospitals gathered input from community members to assess how responsive hospitals are being in their community benefit planning to the needs of their communities. Hospitals gathered input through community surveys, interviews, community meetings or focus groups. Some hospitals used several of these methods for gathering input. All 38 hospitals gathered input from their community, but only seven (18%) explicitly and intentionally gathered input from members of vulnerable populations. Thirty-one hospitals collected input from county or regional health departments in their service areas. Only twelve hospitals incorporated community members into their CHNA project leadership teams. Community members' perceptions about their hospitals' community input processes were reflected in the community participant survey, in which 50 (93%) of respondents felt the input they provided during the CHNA process was valued by the hospital. The majority of these respondents also thought the CHNA accurately reflected the needs of their communities. However, only 40 of the 58 survey respondents (69%) believed that needs of vulnerable populations in the community were being adequately addressed through

communities. However, only 40 of the 58 survey respondents (69%) believed that needs of vulnerable populations in the community were being adequately addressed through the hospital's community benefit programs.

The IRS requires nonprofit hospitals to prioritize the community health needs identified through the data collection process and develop Implementation Strategies to address those needs. Seven of the 38 hospital CHNAs (18%) reviewed failed to describe how they prioritized community needs with any amount of detail, despite the IRS requirement that they do so. Only eleven of the 31 hospitals that articulated how they prioritized community health needs clearly incorporated community representatives into their needs prioritization process. Thirty-seven hospitals prioritized a total of 245 community health needs, with the most common category being chronic diseases, such as heart disease, cancer, obesity, and diabetes. Most hospitals identified in their Implementation Strategies partnerships with other organizations to address priority health needs; only a few hospitals did not articulate planned collaboration in sufficient detail to understand specific collaborative programs or initiatives. Only sixteen out of 29 hospitals (55%) included an anticipated impact or method of measuring the impact of their programs in their Implementation Strategies.

Recommendations: After analyzing and comparing Georgia nonprofit hospital CHNAs and Implementation Strategies, Georgia Watch made recommendations for hospitals to consider when conducting future CHNAs. Georgia Watch's recommendations include:

- When defining community, hospitals should identify and focus on vulnerable populations, even if they are not the hospitals' traditional service-seeking patients, and they should examine their emergency room utilization data to better understand the needs of the vulnerable community members they serve.
- Georgia Watch encourages hospitals to gather input from members of vulnerable populations when assessing community health needs and incorporate community members into their prioritization and implementation processes.
- Hospitals should also engage in partnerships with local health departments and community-based organizations, as collaboration and coordination are keys to improving community health.

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Introduction & Impetus for the Project

The rationale for providing nonprofit hospitals with tax exemptions is based on the assumption that, as charitable organizations, they contribute to society by providing certain health benefits to their communities, such as financial assistance to indigent patients, health screenings, and community education campaigns – all of which are collectively known as “community benefits.” The Patient Protection and Affordable Care Act (ACA) of 2010 contains important provisions related to nonprofit hospitals and community benefits. Specifically, one of these provisions requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years with input from community organizations and to develop an Implementation Strategy for addressing significant health needs in the community served by the hospital. These assessments can be an important tool in hospitals’ efforts to expand access to affordable, quality care in their communities, and improve population health.

Throughout 2014, the Health Access Program at Georgia Watch reviewed the Community Health Needs Assessments (CHNAs) and corresponding Implementation Strategies written by nonprofit hospitals across Georgia. With a generous grant from the Healthcare Georgia Foundationⁱ, Georgia Watch was able to collect and analyze data from 38 CHNAs and 29 Implementation Strategies to assess compliance with new federal requirements, show trends, and identify strengths and weaknesses.

Through this research and reporting, Georgia Watch aims to assess hospital compliance with these new, important ACA regulations and identify best practices. The hope is that this work will encourage nonprofit hospitals to focus their community benefit programs on vulnerable populations within their service areas and work with community partners to engage in meaningful activities that can make a significant impact on the health of their communities. This project is an extension of the work started in 2007 by the Hospital Accountability Project at Georgia Watch, which analyzed issues of healthcare affordability, socioeconomic barriers to quality care, and evaluation of the indigent and charity care policies at for-profit and nonprofit hospitals in Georgia.

In preparation for this report, Georgia Watch reviewed available literature discussing best practices for nonprofit hospital CHNAs from the Catholic Health Association of the United States, the Hilltop Institute, the Public Health Institute, the Centers for Disease Control and Prevention (CDC), the Robert Wood Johnson Foundation, the Health Research and Educational Trust (HRET), the American Hospital Association, Kaiser Permanente, and the

ⁱ Created in 1999 as an independent private foundation, the Healthcare Georgia Foundation’s mission is to advance the health of all Georgians and to expand access to affordable, quality healthcare for underserved individuals and communities.

Network for Public Health Law. In 2014, two reports reviewing CHNAs were published that informed the methodology for evaluating the CHNAs and Implementation Strategies included in this study. The first is a comprehensive report published by the Public Health Institute in April 2014 focusing on fifty-one nonprofit hospitals from across the country titled *Supporting Alignment and Accountability in Community Health Improvement: The Development and Piloting of a Regional Data-Sharing System* (“PHI report”).¹ The second, published in September 2014 by the Network for Public Health Law, is titled, *Review of North Carolina Hospitals’ Community Health Needs Assessments and Implementation Strategies*.² Both of these reports assess hospital compliance with new ACA requirements, identify best practices and make recommendations for hospitals and policymakers to improve the CHNA process.

New Federal Requirements for Nonprofit Hospitals

It has long been the case that nonprofit hospitals qualify for tax exemption in exchange for the requirement that they invest in the health of the communities they serve. Community benefit obligations for nonprofit hospitals established as 501(c)(3) charitable organizations have existed for decades and evolved from exclusively the provision of charity care (free or reduced cost care traditionally provided to low-income uninsured patients) to include such activities as education, research and programs that improve community health.³ In recent years the federal government has grown increasingly interested in imposing standards that require 501(c)(3) nonprofit hospitals to justify their tax-exempt status. In 2002 alone, it was estimated that nonprofit hospitals saved a total of \$12.6 billion that would have otherwise been owed in federal, state, and local taxes.⁴ In 2008, the Internal Revenue Service (IRS) introduced Schedule H, a tax form that nonprofit hospital facilities and systems must file along with their Form 990 tax filings.⁵ This tax form, which has undergone several iterations since its 2008 introduction, provides guidance on how hospitals should define and report community benefit spending in relation to other costs they incur. The passage of the ACA in 2010 brought further changes to the Schedule H form and increased transparency and IRS oversight for any hospital claiming tax-exemption as a 501(c)(3) charitable organization.

As a result of the Patient Protection and Affordable Care Act (ACA), nonprofit hospitals must now:

- develop written financial assistance policies;
- limit what they charge certain low-income patients for services;
- observe fair billing and debt collection practices; and
- conduct Community Health Needs Assessments and update their Implementation Strategies every three years.

With the exception of the Community Health Needs Assessment, these requirements went into effect in 2011. The Secretary of the Treasury is charged with enforcing these new provisions and has authority to issue further guidance and regulations as needed to make sure they are appropriately implemented.

The Community Health Needs Assessment (CHNA) and Implementation Strategy

In an effort to ensure that nonprofit hospitals fulfill their charitable purpose, the ACA established a formal Community Health Needs Assessment (CHNA) process. The CHNA process aims to improve the relationship between health needs in communities and community benefit investments made by nonprofit hospitals as a condition of their tax exemption. CHNAs do this by requiring that hospitals take into account input from members of the community who represent the interests of those the hospital serves—including individuals who have special knowledge of or expertise in public health—in their CHNA processes and by requiring that hospitals make their CHNAs widely available to the public. Each hospital had to complete its first CHNA by the last day of its first taxable year beginning after March 23, 2012. Although some nonprofit hospitals had a history of conducting needs assessments prior to the ACA requirement, many hospitals published their first CHNAs in 2012 and 2013. Nonprofit hospitals must conduct subsequent CHNAs every three years. CHNAs must be made widely available to the public electronically on a hospital's website, and paper copies must be available upon request at no cost.

In addition to the CHNA, hospitals must also write and adopt a formal Implementation Strategy. The Implementation Strategy outlines how the hospital's community benefit programs will address health needs identified and prioritized through the CHNA process. The Implementation Strategy need not be made available on a hospital's website. However, it must be filed along with the hospital's annual IRS Form 990 and Schedule H tax filings.

IRS Guidelines for CHNAs and Implementation Strategies

The IRS provided guidance to nonprofit hospitals on the CHNA and Implementation Strategy requirements of the ACA through a series of proposed rules, and requested comments on these rules from any interested parties. On July 25, 2011, the IRS issued its first guidance on nonprofit hospital CHNAs, titled 2011 Notice and Request for Comments Regarding the Community Health Needs Assessment Requirements for Tax-exempt Hospitals (“2011 Notice”).⁶ This 2011 Notice outlined the minimum requirements for CHNAs and Implementation Strategies and could be relied on by any nonprofit hospital conducting a CHNA prior to October 5, 2013.⁷ Because all CHNAs reviewed for this project were published in either 2012 or 2013, this analysis focuses on the requirements in the 2011 Notice, which governed the first CHNA process for most nonprofit hospitals. (See 2011 IRS Notice Requirements checklist in Appendix A.)

In response to comments received following the 2011 Notice, the IRS issued new proposed rules in 2013⁸, and again requested comments from interested parties. Taking into account the comments received, the final regulations were released on December 29, 2014 (“final regulations”) and are effective for the first taxable year beginning after December 29, 2015.⁹ The final regulations provide more detail and guidance than the 2011 Notice and will be relied on by many nonprofit hospitals that are conducting their next round of CHNAs. See Georgia Watch’s report titled *An evolution of the IRS Regulations Governing Nonprofit Hospitals’ Community Health Needs Assessments* at georgiawatch.org.

I. Georgia Nonprofit 501(c)(3) Hospitals and CHNA Compliance

There are over 180 hospitals in Georgia, including for-profit and nonprofit facilities. There are 107 nonprofit acute care, non-specialty hospital facilities in Georgia. Of those 107 hospitals, twenty-five (23%) are operated by hospital authorities.ⁱⁱ Some authority-operated hospitals have obtained 501(c)(3) charitable organization status from the IRS. Others have chosen to remain quasi-government facilities and therefore do not have to fulfill the same federal legal requirements as 501(c)(3) facilities.

This project examines 501(c)(3) acute care hospital facilities that must serve all populations. Georgia Watch excluded specialty hospitals from examination in this report. While many specialty hospitals are 501(c)(3) facilities that also have an obligation to conduct CHNAs and design Implementation Strategies, they are likely to focus their efforts on the specific vulnerable populations, like children or individuals with disabilities, they serve.

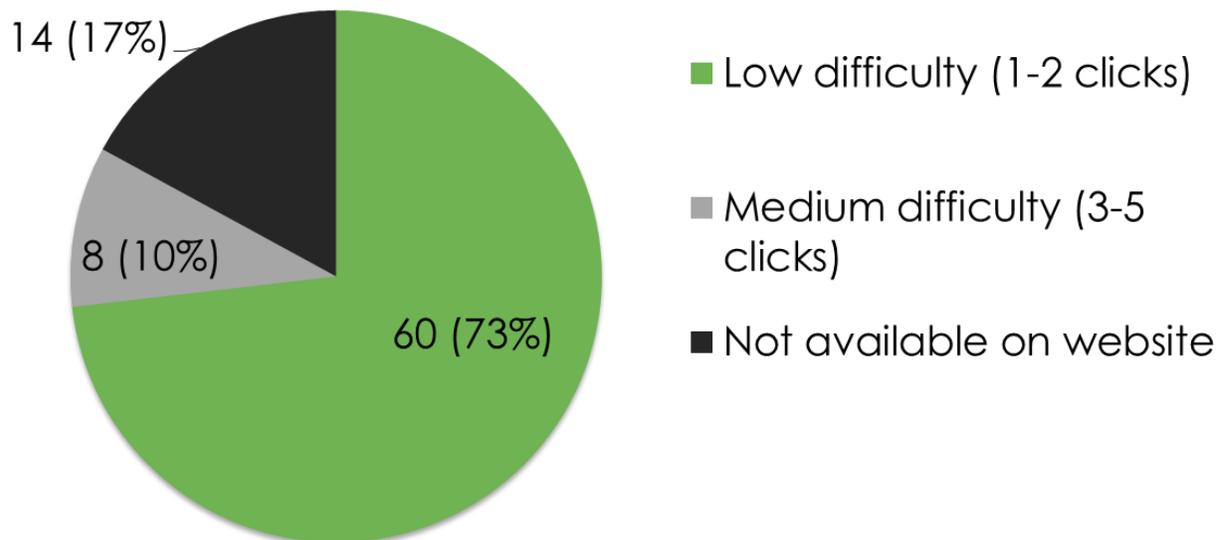
Georgia Watch visited the websites of the 82 identified 501(c)(3) non-specialty, acute care hospital facilities in Georgia to see whether they made their CHNAs widely available on their websites, as the IRS requires.¹⁰ Georgia Watch also looked at whether the hospitals posted their Implementation Strategies and/or issued separate community benefit reports or annual reports that provide the public with details about hospital community benefit programming and spending (*results shown in the table below*).

Number of identified 501(c)(3) non-specialty, acute care hospital facilities in Georgia	82
Number of 501(c)(3) facilities with available CHNAs on their websites	68 (83%)
Number of 501(c)(3) facilities with available Implementation Strategies on their websites	45 (55%)
Number of 501(c)(3) facilities with additional community benefit reports available online	39 (48%)

ⁱⁱ Many hospitals in Georgia are owned by a county hospital authority. Established by an act of the state legislature in 1969, county hospital authorities act as a transfer account for funds between the state and the hospitals. If the hospital takes on debt for construction or other ventures, the hospital authority can issue bonds or other financing to pay for that debt. The authority has the right to approve management and contracts and is the only entity that can legally provide the intergovernmental transfer for Indigent Care Trust Fund (ICTF) and Disproportionate Share (DSH) funds, as well as similar governmental funds. Hospital authorities also hold the lease for a hospital system's or facility's property and oversee property and infrastructure decisions. By Georgia law, county hospital authorities may engage a 501(c)(3) nonprofit entity to manage the hospital on its behalf, but the authority maintains ownership and all liabilities.

Georgia Watch assessed the level of CHNA accessibility by visiting the hospitals' websites and searching for their CHNAs. We used the following scale: low difficulty (meaning it took 1-2 clicks to reach the CHNA from the hospital's home page); medium difficulty (3-5 clicks); and high difficulty (5 clicks or more).¹¹ The results are below in Figure 1. No hospitals with CHNAs available on their websites required more than 5 clicks to reach the CHNA. Georgia Watch found that, when looking for the CHNA on a hospital's website, it was often located on pages with titles such as "community benefit," "community health outreach," or "publications."

Figure 1
Level of difficulty accessing CHNAs online (n=82)



II. CHNA and Implementation Strategy Review Project

A. Methodology

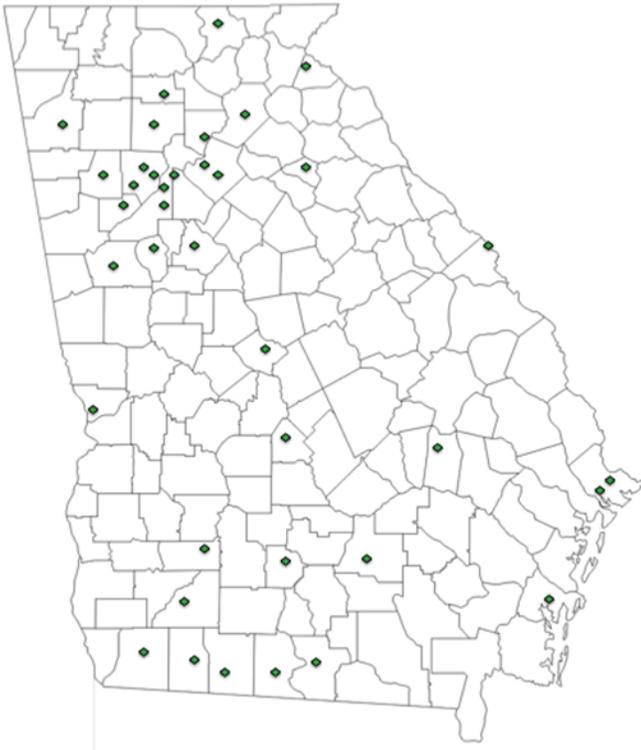
i. Sample

Georgia Watch initially identified 39 hospitals as the sample size for this CHNA and Implementation Strategy review project. These 39 hospitals were chosen based on their geographic locations in the state to represent a diversity of rural and urban facilities from north, south and central Georgia. Eleven of these 39 hospitals (28%) are located in rural areas, and twenty (51%) are safety net facilities. These 39 hospitals represent 19 different health systems. In some cases, we read all of the CHNAs from an entire healthcare system. We did this mostly for systems in our sample size from metropolitan Atlanta to gain an understanding of how hospital communities and planning might overlap in this region. Georgia Watch discovered through the course of this project that six of the 39 hospitals from our original sample size (15%) are owned and operated by hospital authorities. Four of those five do not appear to file IRS Form 990s and therefore may not be 501(c)(3) organizations subject to the same requirements for conducting CHNAs. Six of these 39 hospitals (15%) were part of a state funded project to assist rural hospitals in Georgia with their first CHNAs ("rural hospital project"). The rural hospital project was coordinated by the State Office of Rural Health, and the CHNAs were conducted with the expert assistance of Georgia Southern University's Jiann-Ping Hsu College of Public Health.

ⁱⁱⁱ Six hospitals from sample size owned and operated by hospital authorities: Southeast Georgia Health System, South Georgia Medical Center, Tift Regional Medical Center, Stephens County Hospital, Washington County Regional Medical Center, and Memorial Hospital and Manor.

^{iv} South Georgia Medical Center, Tift Regional Medical Center, Washington County Regional Medical Center, and Memorial Hospital and Manor

Geographic locations for the hospitals and hospital systems reviewed by Georgia Watch



Of the 39 hospitals identified for the project in early 2014, three (8%), Washington County Regional Medical Center, Southeast Georgia Health System and Tift Regional Medical Center, did not have CHNAs available on their websites at that time. These three hospitals are owned and operated by hospital authorities. Washington Regional does not appear to file an IRS Form 990 and therefore may not be a 501(c)(3) facility. Tift Regional confirmed that they are not a 501-(c)(3) facility and do not file an IRS Form 990. Nevertheless, Tift Regional and Southeast Georgia Health System participated in our project, provided us with their CHNAs, and have since made their CHNAs available on their websites. Washington County Regional

Medical Center conducted a CHNA as part of the rural hospital project, but that CHNA remains unavailable on the hospital's website, reducing the final sample size to 38 hospital CHNAs (see Appendix B for the full list of hospital CHNAs reviewed).

Of the 38 hospitals with available CHNAs, 29 (76%) also made their Implementation Strategies widely available online, and Georgia Watch reviewed those as well. The IRS does not require that Implementation Strategies be made publicly available. However, they must be filed annually with a hospital's IRS Form 990.

ii. Hospital Participation and Interviews

Georgia Watch sent initial letters to all 39 hospitals initially identified for the project, inviting them to participate by contributing hospital data and information. Eighteen hospitals and health systems responded to the initial letter and agreed to participate. Georgia Watch attempted to gather recent IRS Form 990 filings from participating hospitals and engage their leadership in one-on-one interviews. In the end, Georgia Watch interviewed leadership from ten healthcare systems, representing 18 hospitals (46%) from our sample. Georgia Watch also interviewed two private consultants and three individuals from academic institutions and public health who assisted healthcare systems with their CHNAs.

iii. Criteria for Analyzing the CHNAs and Implementation Strategies

Georgia Watch wanted to evaluate compliance with the 2011 IRS Notice requirements for CHNAs because these requirements governed all CHNAs conducted prior to October 5, 2013. Georgia Watch also wanted to examine to what extent hospital community benefit programs reflected the needs of vulnerable populations within a hospital's defined community. To do this, Georgia Watch reviewed the IRS requirements, as well as recent studies and literature on CHNA best practices. Using this information, Georgia Watch created two evaluation tools to extract data from the content of the CHNAs. Georgia Watch created a comprehensive spreadsheet for gathering quantitative data from CHNAs and Implementation Strategies. Georgia Watch also created a questionnaire for gathering both quantitative and qualitative data.

Data was gathered in the following categories:

- **Defining Community** – How did the hospital define its community for the purpose of conducting its needs assessment?
- **Secondary Data on Community Health** – What data did hospitals examine to determine community health needs?
- **Primary Data and Community Input** – How did the hospital gather community input for determining community health needs, and were vulnerable populations adequately represented in that process?
- **Prioritizing Community Health Needs** – How did the hospital prioritize the community health needs it chose to address? Was the hospital transparent in that process? Did the hospital involve the community or were the decisions made internally?
- **Implementation** – Was the hospital transparent, thoughtful, and deliberate in its effort to address identified and prioritized community health needs in its Implementation Strategy?

iv. Community Participant Surveys

Following the CHNA and Implementation Strategy analysis, an online survey was sent out to various individuals from community organizations to assess how they felt about their hospital's process for gathering community input during the CHNA. Individuals surveyed were identified by either being explicitly named in a hospital's CHNA with listed contact information, or by only having their organization named as providing input. For the CHNAs that provided only organization names, Georgia Watch found contact information for a representative of the organization. Contact information was gathered for about 10 individuals per geographic location in order to get a better survey representation for the hospitals analyzed. In addition to sending the survey out to individual community members, Georgia Watch sent the survey link to hospital executives that were interviewed by Georgia Watch to forward on to the participants that provided input for their CHNA. 58 individuals from a variety of organizations and regions responded to the survey.

B. Findings

i. Defining Community

The first step in the CHNA process is a critical one: defining community. How a hospital defines its community will shape the entire needs assessment and implementation process. Georgia Watch reviewed the 38 hospital CHNAs from the sample size to determine:

- Did the hospital explain how it determined its defined community?
- What definition for community did the hospital choose?
- Did the hospital make an effort to identify the sub-county geographic locations of vulnerable populations within its service area?

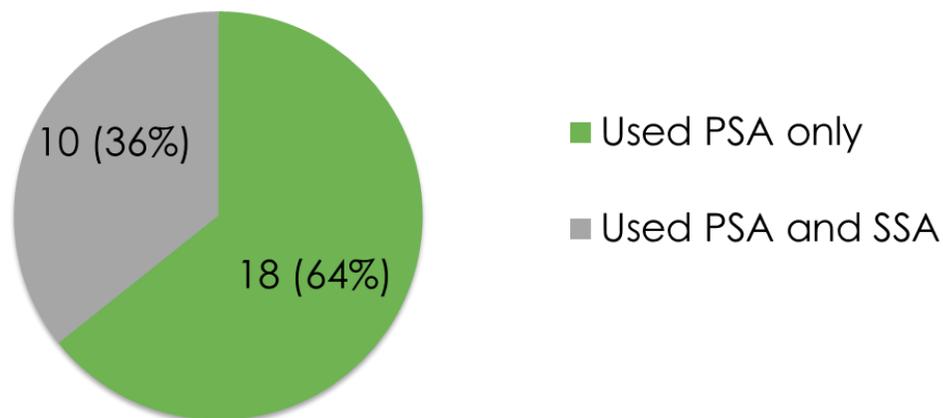
The 2011 IRS Notice required that hospitals describe the community served and how the hospital reached this conclusion. Ten of the 38 nonprofit hospital CHNAs reviewed by Georgia Watch (26%) failed to articulate how or why they came up with the community definition they used in their needs assessment. In addition to meeting mandatory IRS guidelines, hospitals that exemplify transparency in their processes will explain how and why they chose the parameters of their community definitions in their CHNAs.

Of hospital CHNAs reviewed by Georgia Watch that articulated how they came up with their community definitions, all used a service area definition for community based on the locations from where the hospitals draw their patient populations. Some hospitals, such as Phoebe Putney Memorial, Coffee Regional, and the 6 rural hospitals examined that were part of the rural hospital project, used hospital utilization data to identify which zip codes contained the largest concentrations of the hospitals' patients.

Of the 28 hospitals (74%) that articulated how they came up with their defined community, most used their primary service area and did not include their secondary service area. Results are displayed below in Figure 2. Out of 38 CHNAs reviewed, fifteen hospitals (39%) conducted a CHNA for only one county in their primary service area; the other hospital CHNAs reviewed defined their communities as encompassing more than one county. As an example, St. Joseph's/Candler and Memorial University Medical Center (which conducted a joint CHNA), identified only one county, Chatham County, in their primary service area and used that one county for their CHNA community definition; they did not articulate why.

IRS regulation language alludes to the expectation that hospitals will generally use geographic boundaries (city, county, or region) to define their communities. Only two hospital CHNAs reviewed, Northside Atlanta and Coffee Regional, chose to define their service areas outside of officially recognized city or county geographic boundaries using patient utilization zip code data. To the extent possible, these hospitals also used data for these sub-county geographic areas to assess the specific needs of their communities.

Figure 2
Number of hospitals with articulated community definitions that used Primary Service Area (PSA) or Secondary Service Area (SSA) (n=28)



Georgia hospitals that made an effort to identify the sub-county geographic locations of vulnerable populations within their service areas took a requisite first step in ensuring that those populations will be able to access the hospitals' community benefits and services. Of the 16 hospital CHNAs reviewed from healthcare systems located within metropolitan Atlanta, only Grady Memorial and Northside Hospital identified sub-county geographic concentrations and provided readable maps to show where specific vulnerable populations, such as those who are low income, are unemployed, or have little education, live within the hospitals' service areas.

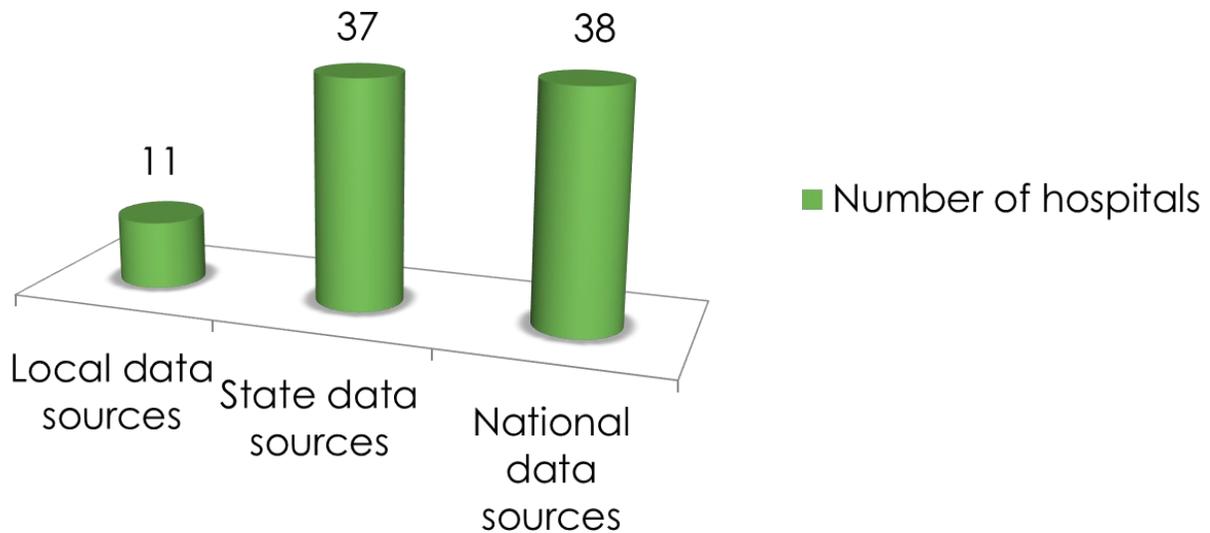
ii. Secondary Data on Community Health

The 2011 IRS Notice required hospitals to document a description of the sources and dates of the data used in the CHNA and the analytical methods applied to identify community needs. All 38 CHNAs reviewed by Georgia Watch identified data sources used, as the IRS requires. However, the type of secondary data used by hospitals to assess community needs is also telling. Therefore, Georgia Watch reviewed the 38 non-profit hospital CHNAs in the sample size to determine the following:

- How many hospitals used national, state and/or local data to determine community needs?
- How many hospitals used internal hospital utilization data to determine service area and/or community needs?
- How many hospitals collected data on specifically identified vulnerable populations within their service area?
- How many hospitals collected data on social determinants of health for their defined communities?

Most hospital CHNAs reviewed by Georgia Watch used a variety of data (federal, state and local) to identify the health needs of their community members. The number of hospitals that used each category of data source is shown below in Figure 3.

Figure 3
Number of hospitals that used national, state, or local data sources to determine community needs (n=38)



a. Common Hospital Data Sources

OASIS (Online Analytical Statistical Information System)

The Online Analytical Statistical Information System (OASIS) is a database used to access the Georgia Department of Public Health's Data Warehouse. The online system creates tables, maps, and charts of state public health data for morbidity/mortality, maternal and child health, infant mortality, population characteristics, behavioral surveys (BRFSS and Youth Risk Behavior), and motor vehicle crashes. OASIS also provides data on vital statistics (births, deaths, pregnancies, etc.) and emergency room use and hospital discharges. Data can be selected by state, county, census tract, and county commission district. Of the 38 CHNAs reviewed, 34 (89%) used OASIS data.

Healthy Communities Institute

The Healthy Communities Institute aids hospitals in the CHNA process by providing a web information system that is embedded into a hospital's individual website and displays dashboards of indicators. A regional comparison indicator or an average comparison indicator displays the statuses of outcomes within the hospital's targeted local area. Indicators can also be viewed over a time period to understand the trend of an outcome. Data is available by census tract and zip code. Of the 38 CHNAs reviewed, 6 (16%) used Healthy Communities Institute data. This is a paid service, which may present an obstacle for its use by some hospitals and communities.

County Health Rankings

The County Health Rankings is a program developed by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute that annually measures various health factors and outcomes for almost every county in the United States. The data compares a selected county's values with the state average and the Top U.S. Performers for each measure. Health outcomes include measures for length of life and quality of life, while health factors consist of measures for health behaviors, clinical care, social and economic factors, and physical environment. Of the 38 CHNAs reviewed, 25 (66%) used County Health Rankings data.

U.S. Census Bureau Data

The U.S. Census Bureau collects data regarding demographics and the economy for the entire country. In addition to the population and housing census and a variety of other surveys, the bureau conducts the American Community Survey (ACS), which has data profiles on social, economic, housing, and demographic characteristics for a single geographic area (by city or county). Census data is available on the national, regional, state, county, city, and zip code level, as well as others. Of the 38 CHNAs reviewed, 29 (76%) used US Census Bureau Data.

Healthy People 2020

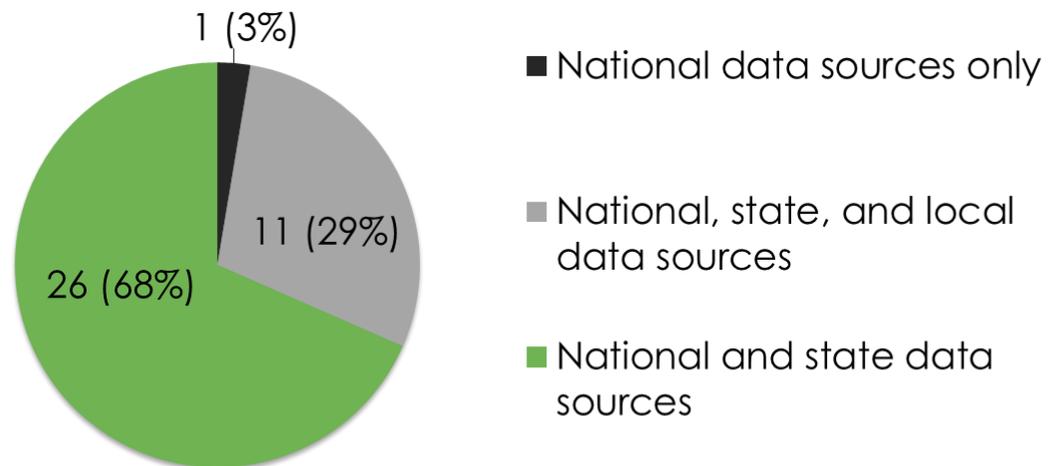
Healthy People 2020 is an initiative by the U.S. Department of Health and Human Services that collects data from national censuses of events, nationally representative sample surveys, and other data sources to "monitor and improve the health of all Americans over the decade." The data is related to the Healthy People 2020 objectives, which give the baseline status and the desired target. Data is searchable for a wide variety of topic areas or data sources and is available on the national level. State level data is expected to be made available this year. Of the 38 CHNAs reviewed, 13 (34%) used Healthy People 2020 data.

CDC Data

The CDC collects and maintains a multitude of data, but two main datasets are the National Vital Statistics System (NVSS) and the Behavioral Risk Factor Surveillance System (BRFSS). The NVSS is collected by the National Center for Health Statistics to gather national data regarding births, deaths, marriages, divorces, and fetal deaths. The BRFSS is a telephone survey conducted in each state to gather data regarding health related risk behaviors, chronic health conditions, and preventative services. Of the 38 CHNAs reviewed, 17 (45%) used data from the CDC.

Figure 4 shows the distribution of hospitals that explicitly used national, state and/or local data to determine community health needs.

Figure 4
Distribution of hospitals that used national, state, and/or local data sources to determine community needs (n=38)



b. Hospital Utilization Data

Twenty-five hospitals (66%) used internal hospital utilization data, such as admissions and discharges, to either define their communities or assess the health needs of their communities in their CHNAs.

The way that data is displayed in a CHNA is also important and determines whether that CHNA is readable and useful for other community members. Hospitals that visualized data in simple charts and graphs succeeded in making the information about community demographics and health outcome statistics more understandable for the general public. Most hospitals used visual tools, like charts and graphs, to display data findings. For example, Northside's CHNAs identified the geographic locations within its hospitals' service area counties of medically underserved areas with helpful maps.

A look at the data also revealed which hospitals focused on vulnerable populations and which hospitals looked at data for various social determinants of health within their defined communities. The 2011 IRS Notice only required that hospitals not exclude vulnerable populations (defined as medically underserved, low-income, or minority populations) in their needs assessments. However, which vulnerable populations and health indicators were specifically considered by hospitals in their examination of community health needs were indicative of the quality of the CHNAs.

Figure 5 shows the number of hospitals that examined data for various vulnerable population groups, such as seniors, medically underserved, uninsured, Medicaid and food stamps recipients, etc. Figure 6 shows the number of hospitals that collected data in various social determinants of health categories, such as education level, housing adequacy, income levels, etc.

Figure 5
Number of hospitals that collected data on specifically identified priority population by category (n=38)

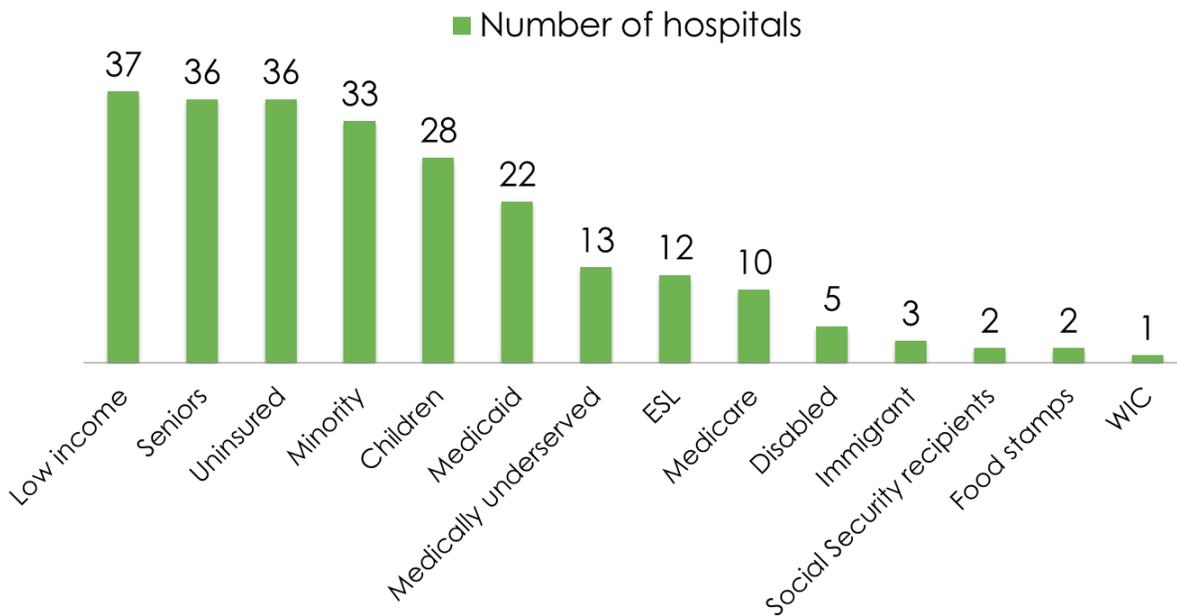
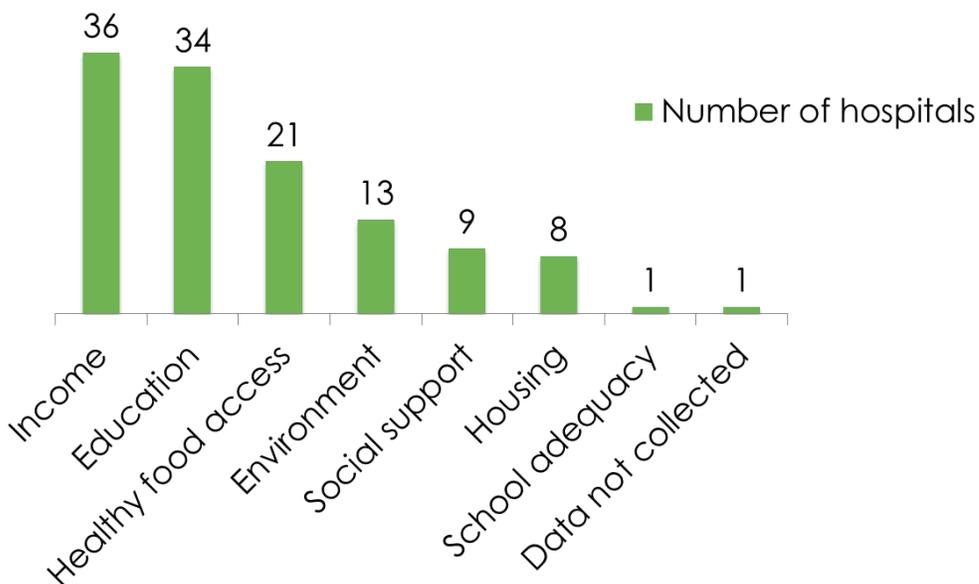


Figure 6
Number of hospitals that collected data in each social determinants of health category (n=38)



Based on our findings, very few hospitals collected data on social determinants of health factors outside of education level, income, and healthy food access. Thirteen (34%) collected data on environmental health indicators, including public safety, transportation, parks, pollution, water quality, etc. Only Doctors Hospital in Columbus, GA did not collect any data on the social determinants of health in its community. If a hospital chose not to collect the secondary data in a particular area, it failed to even initially consider the issue as a potential health need in its community.

iii. Primary Data and Community Input

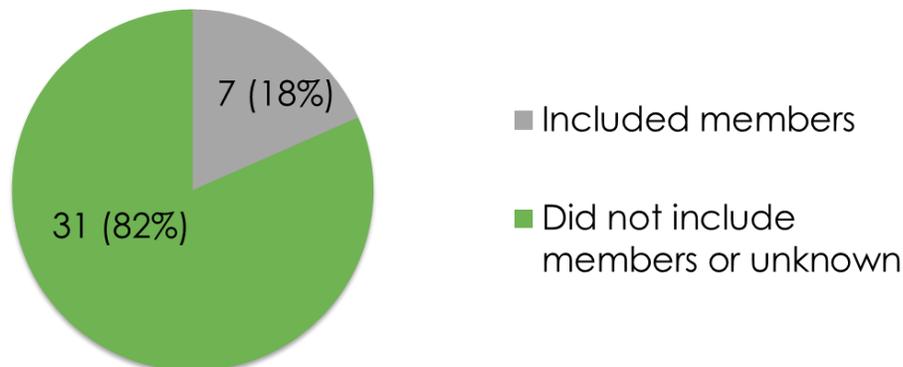
The 2011 IRS Notice required that hospitals gather input from members of their communities in their CHNA processes. In order to have adequately gathered input, the 2011 Notice required that each hospital, at a minimum, collect input from persons with specialized knowledge of or expertise in public health, such as federal, tribal, regional, state, or local health departments with data or information relevant to the health needs of the community served. Hospitals also had to gather input from leaders, representatives, or members of medically underserved, low-income, and minority populations, as well as populations with chronic disease needs, in the communities they serve. There was no requirement for how this information had to be gathered. Georgia Watch reviewed the 38 hospitals CHNAs to determine the following:

- Did the hospital specifically identify which community members or groups provided input during the CHNA process?
- Did the hospital make an effort to gather input directly from members of vulnerable populations, either through interviews, focus groups, surveys or community meetings?
- Did the hospital include community members in its CHNA project leadership team?
- Did the hospital collect input from a local health department?

Hospitals that exemplified transparency in their processes provided a list of community members and/or organizations that provided input on their CHNA processes. Thirty of the 38 CHNAs reviewed (79%) did include a list of community input providers in their CHNAs. The level of detail in those lists ranged from providing names and contact information for the individuals that provided input to simply naming the organizations or types of individuals consulted.

All 38 hospital CHNAs reviewed by Georgia Watch gathered input from their communities in various ways (focus groups, interviews, surveys). Only seven of the 38 hospitals (18%) explicitly and intentionally incorporated input that came directly from members of vulnerable populations, either through interviews, focus groups, or meetings. See this finding displayed in Figure 7 below. This number does not include hospitals that may have inadvertently gathered input from vulnerable population members through surveys or community-wide meetings. Large hospital systems, like WellStar, that have the resources to collaborate with consulting firms in their processes, were able to conduct extensive interviews and numerous focus groups, in addition to surveying community members.

Figure 7
Number of hospitals that included "members" of vulnerable populations when gathering community input (n=38)



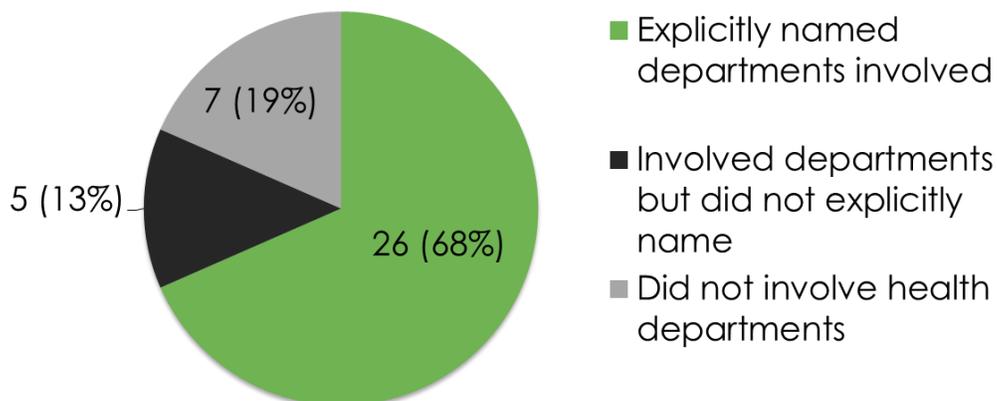
The number of interviews conducted by hospitals varied widely. Eleven hospitals (29%) did not conduct one-on-one interviews as part of their input gathering process. Of the 27 hospitals that did conduct interviews, 22 shared the number of interviews conducted.

Twenty-seven hospitals (71%) used surveys to gather community input, but the usefulness of those surveys varied. Factors that contribute to survey usefulness include: the method of distribution for the survey, whether the survey is available in languages other than English, whether the survey is available only online or also in print, the demographics of the respondents, and the level of detail in the questions asked. Tift Regional ("Tift"), for example, distributed an online link to their survey and also made self-addressed paper copies available. Tift had a high response rate with 1,328 surveys completed. By capturing and reporting demographic information for the survey, hospital decision-makers and community members can know that the respondents were mostly white, female, insured, long-term residents of Tift County.

In its CHNA, Tift acknowledges that this information, while useful to some extent, does not paint an accurate picture of the needs of vulnerable populations in the hospital's eight-county defined community. Tift, however, should be commended for its transparency. Rather than simply saying they surveyed community members, Tift provided detail on the number and demographics of the respondents and publicized the questions and responses from its survey participants.

The IRS also requires that hospitals consult with at least one state, local, tribal or regional governmental public health department. Figure 8 below shows the distribution of hospitals that involved public health departments in their CHNA processes. Thirty-one of the 38 Georgia hospital CNHAs analyzed (82%) gathered input from at least one county health (or regional) department in their service area. Gwinnett Medical Center conducted a joint needs assessment with its local health department and engages with the health department on an ongoing basis to implement programs that improve access to care and lower emergency room utilization.

Figure 8
Number of hospitals that involved public health departments in CHNA process (n=38)



a. CHNA Leadership

Hospitals that demonstrated exemplary incorporation of community input in their CHNA processes included community members in their CHNA project leadership teams. Of the 38 hospitals reviewed, 26 (68%) articulated who was part of the CHNA project leadership. Sixteen of those 26 hospitals had a team responsible for project leadership, while the other 10 listed an individual as being the lead. Twelve hospitals incorporated community members into their CHNA project leadership.

b. Community Participant Survey

In March 2015, Georgia Watch sent a survey to community members identified as participants in the 38 hospital CHNAs reviewed. (See copy of community participant survey tool in Appendix C.) Of the 58 respondents to the community survey sent by Georgia Watch, 54 stated that they had indeed provided input during a hospital's CHNA process. Of those 54, fifty (93%) said that the input they provided during the CHNA process was valued by the hospital. Only 41 of the total 58 respondents (71%) had read the CHNA report and/or the Implementation Strategies that resulted from the hospital's needs assessment process, and 32 of those 41 felt as though the needs of their community were accurately reflected in the hospital's report.

Most of the respondents (54), thought their hospital obtained community input through a meaningful and productive method. In terms of the hospital's current community benefit programs, 40 of the 58 survey respondents (69%) believed that needs of vulnerable populations in the community were being adequately addressed through the hospital's community benefit programs. These questions and responses are displayed in the table below and Figures 9 and 10.

Number of respondents that provided input during a hospital's CHNA process	54
Number of respondents that felt hospital's method for obtaining community input was meaningful and productive	54
Number of respondents that provided input and felt it was valued by the hospital	50
Number of respondents that read the CHNA report and/or Implementation Strategy	41
Number of respondents that felt the needs of the community were accurately reflected in the CHNA	32
Number of respondents that thought hospital's current community benefit programs adequately address important needs of vulnerable populations in the community	40

Figure 9
Survey Question: Did you feel that the needs of the community were accurately reflected in the hospital's resulting CHNA? (n=58)

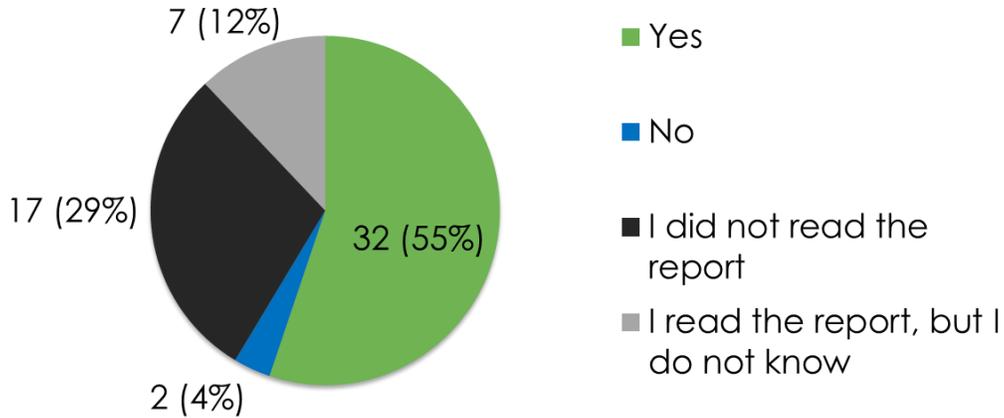
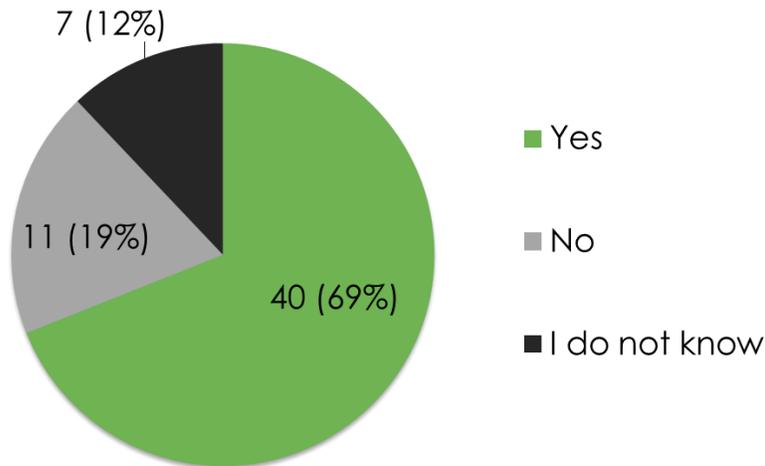


Figure 10
Survey Question: Do you think the hospital's current community benefit programs adequately address important needs of vulnerable populations in your community? (n=58)



Survey data gathered may show more positive responses because Georgia Watch's community participant survey was distributed to community members identified in the 30 CHNAs where participants were listed. In addition, it was distributed to community participants by hospitals interviewed by Georgia Watch. These hospitals were more transparent than others in the original sample size of 39 hospitals and also may have performed better in conducting their CHNAs.

iv. Prioritizing Community Needs

The 2011 IRS Notice required hospital CHNAs to contain a description of the prioritized community health needs and the prioritization methods used. The IRS does not require that community members be an integral part of the need prioritization process. Consequently, hospitals that incorporated community members into their CHNA leadership teams and into their prioritization processes exhibited best practices in transparency and community engagement. Engaging community members and other stakeholder organizations in the needs prioritization process ensures that hospitals are using their resources to meet the needs most important to community members. When analyzing the 38 CHNAs, Georgia Watch asked:

- Did the hospital describe how it prioritized the community health needs and identify who was involved in the prioritization process?
- Were community representatives involved in the hospital's prioritization process?
- What needs were considered priority health needs by the hospital?

Seven of the 38 hospital CHNAs (18%) reviewed failed to describe how they prioritized community needs with any amount of detail. Eleven of the 31 hospitals (35%) that articulated how they prioritized community health needs clearly incorporated community representatives into their needs prioritization process. Seventeen of those 31 hospitals (55%) explicitly prioritized needs with internal representatives.

From interviews with hospital leadership, Georgia Watch found that some hospitals considered the activity of prioritizing community needs in order to determine which were most important for the focus of hospital Implementation Strategies to be an exclusively internal, administrative decision. These hospitals did not engage community members in their prioritization processes.

Georgia Watch also catalogued and categorized the prioritized health needs in the 38 CHNAs reviewed. Some hospitals only prioritized three or four needs, while others prioritized ten or more. No hospital CHNAs reviewed prioritized more than 13 community health needs, and only two hospitals prioritized as few as two needs. When gathering data on prioritized health needs, Georgia Watch created five broad need categories:

1. Access – This category encompasses the community's need for improved access to primary or specialty care, or dental or mental health services. This access problem could be the result of the inability of community members to afford insurance or a doctor's appointment, lack of transportation to appointments, lack of provider availability, or language access issues.

2. Chronic Disease – This category encompasses chronic conditions such as heart disease, cancer, obesity, and diabetes.

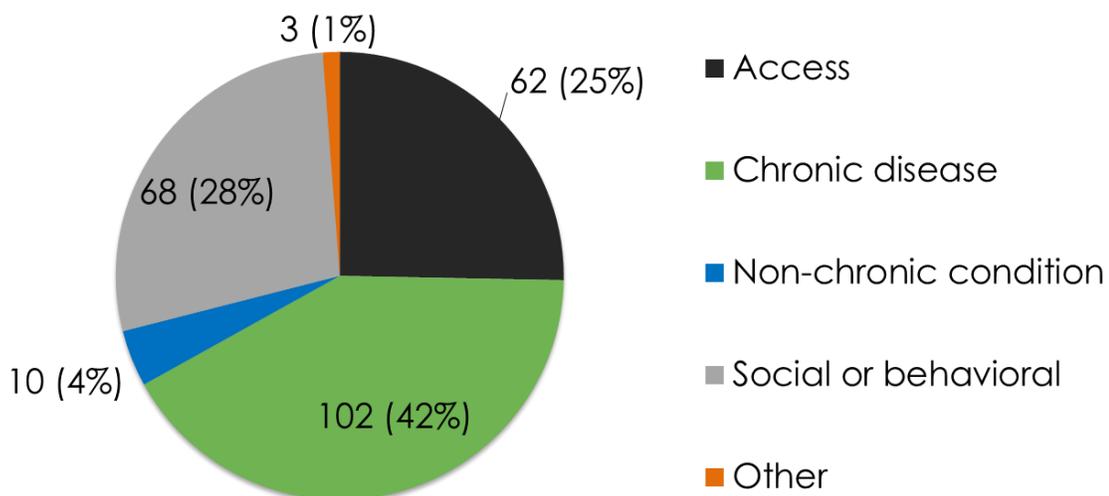
3. Non-chronic Condition – This category encompasses communicable or infectious diseases, like STDs, or discrete health conditions, such as maternal or infant health.

4. Social or Behavioral – These are health needs related to social conditions or individual behavior, such as seeking preventative care, exercising, or engaging in general good health practices.

5. Other – This category includes items such as improving hospital image, which arguably are not health needs.

No hospitals prioritized health needs related to physical environment, such as improving housing or building parks. The results of Georgia Watch's findings on hospitals' distribution of prioritized health needs are visualized below in Figure 11. Surprisingly, no CHNAs reviewed by Georgia Watch prioritized HIV/AIDS as a critical health need. Only Grady Health System articulates in its Implementation Strategy that it will address this health need for the hospital's community in metropolitan Atlanta's Fulton and DeKalb Counties. According to Grady's Implementation Strategy, the average prevalence rate for HIV in Fulton and DeKalb Counties is 1,119 per 100,000 population. This rate is significantly higher than the prevalence rates in Georgia (443 per 100,000) and the U.S. (309 per 100,000). Georgia Watch reviewed the CHNAs of four other major health systems serving the metro Atlanta area: WellStar, Piedmont, Northside and Gwinnett Medical Center. None of these other health systems prioritized HIV/AIDS as a critical health need.

Figure 11: Distribution of types of needs identified in prioritized list of needs (n=245)



*Grady Hospital was excluded from this calculation as their priority community health needs were articulated in their Implementation Strategy, rather than in the CHNA.

v. Implementation

The 2011 IRS Notice required that each hospital organization produce an Implementation Strategy that identified what needs each hospital facility would address. The 2011 IRS Notice also required that hospitals identify what needs they would not address and why. Implementation Strategies had to be facility-specific, but collaboration with other organizations, such as hospitals and public health departments was permitted. If the hospital collaborated with other hospitals or organizations in producing its Implementation Strategy, the collaborating hospitals or organizations had to be identified in the report. Finally, the 2011 IRS Notice required that the Implementation Strategy be adopted by the hospital's governing body in the same taxable year that the CHNA was conducted.

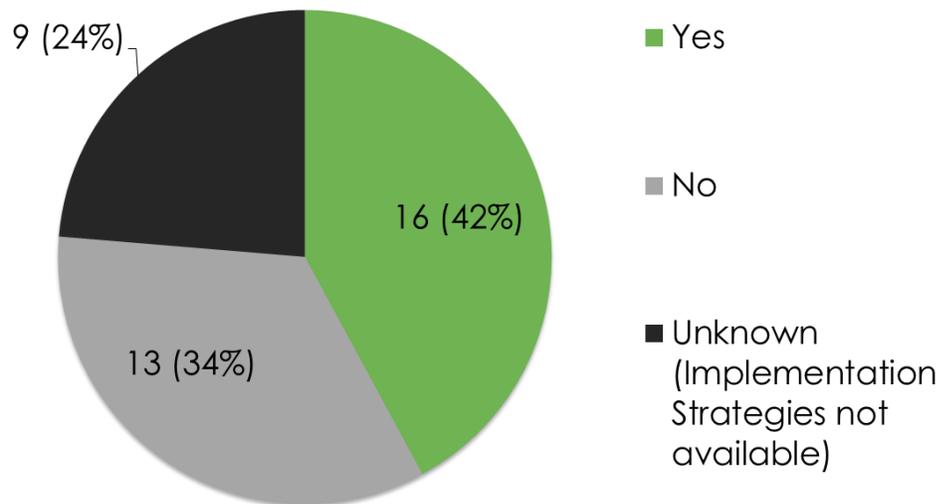
Although there is a requirement that hospital CHNAs be widely available to the public, there is no such requirement for Implementation Strategies. Implementation Strategies must be filed along with nonprofit hospitals' annual tax filings, but they need not be available on a hospital's website. Hospitals exemplifying excellence in community engagement and transparency have gone the extra mile to publicize their Implementation Strategies on their websites along with their CHNAs. Of the 38 hospitals with available CHNAs, 29 (76%) also made their Implementation Strategies widely available online.

In reviewing the 29 Implementation Strategies found online and assessing their quality, Georgia Watch looked for the following information:

- Did the hospital articulate measurable goals and objectives for the described strategies?
- Did the hospital discuss planned collaboration with community organizations or partners to address the health needs identified and prioritized?

As with any project, measurable goals and objectives should be established to ensure that programs or activities are making a positive difference. As a basic starting point for measuring the feasibility and quality of hospitals' Implementation Strategies, Georgia Watch chose to examine whether hospitals included a description of anticipated impact and/or a method of measuring the impact of their community benefit activities and programs in their published Implementation Strategies. These results are displayed below in Figure 12.

Figure 12: Did hospital include anticipated impact or method of measuring impact? (n=38)



In order to measure the success of a hospital's initiatives to address community needs, metrics must be put in place to evaluate success. Some hospitals chose to measure success using community health indicators and evaluating whether they “moved the needle” on improving community health in key areas from one CHNA to the next or through an ongoing measurement system. Gwinnett Medical Center uses community indicators on its website to continually monitor progress in key areas. Archbold will be evaluating success based on community health indicators in next CHNA, using RWJF 2015 Community Health Rankings data. Some hospitals, like Union General and Tift Regional, will also measure success based on hospital output: how many activities they will conduct and how many community members they will reach.

Hospitals that did not include anticipated impact or method of measuring impact in their published Implementation Strategies may still have detailed internal means of measuring and monitoring progress toward articulated goals. For example, Georgia Watch learned from interviewing Piedmont Healthcare that the system has extensive evaluation metrics and project management tracking tools for each collaborative community program. Piedmont has more than forty scope documents for each individual project that are provided to each community partner. There is shared accountability, tracking, and data gathering to assess performance. Without publicizing this information, the public cannot know how the hospital is assessing its success, and the opportunity for public accountability diminishes. However, this must be balanced with the burden and feasibility of making these complex tracking documents public.

Whether a hospital plans to collaborate with community partners reveals whether the hospital is an engaged and cooperative member of its community. It also demonstrates how seriously the hospital is attempting to make a positive impact in its community. Hospitals have expertise in providing healthcare, but hospitals with visionary and committed philosophies of improving community health will engage community members and other community providers, including public health departments, in their endeavors, recognizing that they are important allies in reaching and impacting the community's most needy members. Georgia Watch was pleased to see that most hospitals planned collaboration with other community organizations in their Implementation Strategies. Only a few hospitals did not articulate planned collaboration in sufficient detail to understand specific collaborative programs or initiatives.

C. Analysis

Nonprofit hospitals will be publishing their next round of CHNAs this year and next. Georgia Watch hopes that the findings and analysis in this report provide hospitals with ideas to improve their CHNA processes, particularly the methods by which they involve and gather input from vulnerable community members. Ideally, community members and organizations that serve vulnerable populations will have input throughout the CHNA process, including in the prioritization and implementation phases.

Evaluating hospitals' process performance in this first round of CHNAs presented a challenge because the 2011 IRS Notice requirements were rather vague in places, leaving room for interpretation. This may have contributed to Georgia Watch's finding a tremendous amount of variation in the CHNAs reviewed. The page length of the CHNAs ranged from 7 pages to over 200. Some were very robust, with others lacking in key areas. The IRS issued final rules at the end of 2014 that will govern many hospitals' next CHNA process. This discussion highlights some of the significant changes in the final rules and articulates how Georgia hospitals can improve during this upcoming process.

Throughout this project, Georgia Watch was sensitive to the fact that hospitals and health systems have varying strengths, expertise, and capacities to engage in a robust CHNA process. In particular, rural hospitals in Georgia, many on the brink of financial collapse, benefited during this first round of CHNAs from the help of the State Office of Rural Health and Georgia Southern University as part of a state-funded rural hospital CHNA project. However, this state funding is no longer available to rural hospitals who must now conduct their next CHNAs. This will likely make compliance with the IRS requirements very difficult for some nonprofit, rural Georgia hospitals.

i. Defining Community

The final IRS regulations, like the 2011 Notice, underscore that the focus should be the community that “needs the care of the hospital, not simply current patients.”¹² However, even in the final regulations, the IRS only requires that hospitals, when defining their communities, **not exclude** medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital facility draws its patients. Without a requirement that hospitals specifically identify and focus their efforts on geographic areas with high concentrations of poverty or limited healthcare access, many hospitals will choose to define their communities based on where the majority of their existing patient population lives. Using a service area definition for community and defining that service area based on the make-up of the hospital’s voluntary service-seeking patient population may have the effect of excluding medically underserved geographic areas that cannot easily access hospital services. As the Public Health Institute (PHI) points out, “the exclusive use of hospital service area methods to set CHNA geographic parameters can potentially result in the exclusion of low-income communities, particularly in larger metropolitan areas with multiple hospitals. More commonly, it contributes to a disproportionate allocation of charitable responsibilities among hospitals.”¹³

Without a requirement that hospitals specifically identify and focus their efforts on geographic areas with high concentrations of poverty or limited healthcare access, many hospitals will choose to define their communities based on where the majority of their existing patient population lives.

Georgia Watch found that most hospital CHNAs reviewed used the geographic boundaries of counties within their service areas to define their communities, and many did not gather data for sub-county geographic areas. As the PHI report points out, “service utilization patterns, as well as concentrations of poverty, often do not fit neatly into geopolitical jurisdictional boundaries.”¹⁴ The few Georgia hospitals that made an effort to identify the sub-county geographic locations of vulnerable populations within their service areas took a requisite first step to ensure that those populations would be able to access the hospital’s community benefits and services.

The Catholic Health Association advises hospitals that, “[t]hose who live in poverty and at the margins of our society have a moral priority for services. While assessments will

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look at the health needs of the overall community, low-income and other disadvantaged people deserve special attention and priority.”¹⁵ Community Commons is a publicly accessible website where hospitals (and other community groups) can assess the vulnerable populations footprint (VPF) in their defined service areas. This tool helps to identify sub-county geographic areas with high concentrations of health disparities. It is also a platform for creating maps and reports and engaging in collaborative efforts with community partners. This tool can help hospitals understand where their vulnerable populations live and where to best direct their community benefit efforts. Georgia Watch hopes to see more nonprofit hospitals, particularly those serving metropolitan areas, define their communities in ways that intentionally and thoughtfully include sub-county geographic concentrations of the most vulnerable people living in hospitals’ service areas. This would encourage shared responsibility for providing care to the most needy, particularly in communities with large healthcare markets where hospital service areas often overlap.

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ii. Secondary Data on Community Health

Emergency room data can offer hospitals a glimpse at where their most needy patients live because ERs are often the primary healthcare access point for uninsured populations that have difficulty accessing preventative primary care services. As PHI points out, “[e]mergency room utilization by payer source, particularly if there is a focus on preventable admissions, offers more insights into where there may be concentrations of unmet health needs.”¹⁶ Twenty-five (66%) of the 38 CHNA reports reviewed by Georgia Watch stated that they used internal hospital utilization data, such as admissions and discharges, to either define their communities or assess the health needs of their communities in their CHNAs, but none articulated that they used emergency room utilization data to target the efforts of their programs to address unmet health needs. All hospitals that seek to serve the neediest members of their communities should look at their emergency room utilization data to understand how they can better meet the needs of the most vulnerable patients in their service areas.

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These new community assessment and reporting requirements for nonprofit hospitals are designed to incentivize investments in programs that improve population health by targeting more upstream determinants, such as jobs and housing, and fostering healthy, safe environments. As healthcare legal scholar Sara Rosenbaum points out, these final regulations arrive at “an important moment in U.S. health policy, when health care access for historically excluded populations and improvements in population health both are receiving a high level of focus.”¹⁷ The final regulations outline that the health needs of a community may include, for example, the need to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence the health of the community. This review of Georgia CHNAs revealed that very few hospitals collected data on social determinants of health factors outside of education level, income, and healthy food access. This means that few hospitals initially thought to focus their community benefit efforts on these upstream factors that significantly impact population health. No hospitals prioritized health needs related to physical environment, such as improving housing or building parks. One reason for this may be that, without Medicaid expansion, the provision of charity care and financial assistance to low-income, uninsured individuals continues to be a critical (and expensive) community benefit provided by Georgia nonprofit hospitals, leaving few remaining resources that hospitals can devote to more innovative programs.

iii. Primary Data and Community Input

All 38 hospital CHNAs reviewed by Georgia Watch incorporated community input. Some hospitals used independent consulting firms to gather this input. A few hospitals interviewed by Georgia Watch expressed that they felt community members were more forthcoming about their personal health needs and perceptions of the hospital in focus groups not led by hospital employees. Only seven (18%) of the 38 hospital CHNAs reviewed for this project explained that they intentionally incorporated input directly from members of vulnerable populations. Georgia Watch hopes, in this next round of CHNAs, to see more hospitals intentionally gather input directly from members of vulnerable populations, not just community organization leaders. Hospitals with fewer resources that cannot contract with third parties to organize and facilitate focus groups may be able to rely on local advocacy groups, community-based organizations or public health departments to identify vulnerable population members as CHNA

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participants. Hospitals may also ask these organizations to facilitate focus groups, conduct interviews or share surveys, as their capacity permits.

Georgia Watch would like to see a requirement that hospitals explicitly identify individuals that provide community input for their CHNAs. However, as the final regulations are written, hospitals may be able to avoid the community input requirement altogether. In the final regulations, hospitals are merely required to solicit input from community sources, including vulnerable population groups. In the event a hospital facility solicits, but cannot obtain, input from a source, the facility's CHNA report must merely describe their efforts to solicit input from such source. Because all hospital CHNAs reviewed for this project showed the ability to obtain community input in some way, Georgia Watch expects to see all nonprofit hospitals in Georgia succeed in gathering community input during this next round of CHNAs. However, true community engagement involves incorporating community members into CHNA leadership and engaging their input throughout the CHNA process, including in the prioritization and implementation phases.

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iv. Prioritizing Community Needs

From interviews with hospital leadership, Georgia Watch found that hospitals that did not engage community members in their prioritization processes considered the process of prioritizing community needs in order to determine which were most important for the focus of Implementation Strategies to be an exclusively internal hospital decision. As the Public Health Institute (PHI) report explains, “[a]mong hospitals, the predominant view may be that this is a process of determining how to spend their own resources, and thus decisions should be limited to internal leaders.”¹⁸ Only eleven (29%) of the 38 hospital CHNAs reviewed by Georgia Watch incorporated community members in their prioritization processes. In the final rules, the criteria a hospital can use to prioritize the significant health needs it identifies includes (but is not limited to) the burden, scope, severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; or the importance the community places on addressing the need. Georgia Watch hopes that, in this next round of CHNAs, more hospitals incorporate community members or leaders into their prioritization processes to ensure that they are using their resources to meet the needs most important to their communities.

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From reading the Implementation Strategies and interviewing hospital leadership, Georgia Watch found that some hospitals were not altering their community benefit programming and spending, even though they may have recently conducted a community needs assessment for the first time. According to PHI, “[t]he new priority setting requirements must be viewed in the context of the pre-existence of an array of hospital community benefit services and activities that have been in place, in some cases for many years. Otherwise objective processes may be influenced by a desire to preserve as much of the existing slate of program activities as feasible.”¹⁹ This idea was reflected in the one-on-one interviews Georgia Watch conducted with hospital administration representatives, during which several stated that the new CHNA requirements did not alter their community benefit strategies in any meaningful way. Instead, the CHNA process only reinforced to them that their hospitals were already providing the programs and benefits their communities need. Hospitals should take into account the findings from their CHNAs to update their service offerings and foci; this should include creating and improving partnerships with community stakeholders to meet community health needs not being addressed directly by the hospital. The CHNA should not simply be used to reinforce the continuance of existing community benefit programs.

Hospitals should take into account the findings from their CHNAs to update their service offerings and foci; this should include creating and improving partnerships with community stakeholders to meet community health needs not being addressed directly by the hospital.

v. Implementation

The IRS does not require that nonprofit hospitals make their Implementation Strategies widely available to the public; this a significant weakness in the final rule. Georgia Watch found that, of the 38 hospitals with available CHNAs, 29 also made their Implementation Strategies publicly available; nine did not. These nine hospitals may have strategic reasons for not publicizing their Implementation Strategies. They may engage with partner hospitals or health systems on initiatives and therefore feel a

shared sense of ownership and responsibility for Implementation Strategies. They may feel they lack the authority to share Implementation Strategies publicly without the permission of partner hospitals or organizations. Perhaps they do not publicize the Implementation Strategies because they do not want to invite public scrutiny of their community benefit initiatives. They may wish to shield themselves from accountability for implementing their community benefit strategies and measuring their impact. Perhaps they simply fail to see the value in transparency. Without an IRS requirement that hospitals share their Implementation Strategies publicly, some hospitals will choose not to do so, whether out of convenience or some other motive.

While it may seem simple to locate the Implementation Strategy as an attachment to the hospital's IRS Form 990, this task is not as easy as it seems. Hospital IRS Form 990s can be accessed by creating an account at [Guidestar.org](https://www.guidestar.org). However, there is a delay between filing of the IRS Form 990s and publication of those forms on Guidestar. It is also necessary to know what tax-filing year one is searching to find. Hospitals' fiscal years do not typically align with a calendar year. Also, some healthcare systems will file a Form 990 for the entire system, making it difficult to break out the data and paperwork for the individual hospital facilities.

In developing their strategies to address prioritized community needs, it is a best practice for hospitals to partner with community stakeholders in the planning and implementation of community benefit activities.²⁰ One of the guiding community benefit principles, according to the Catholic Health Association, is that “[h]ealth care facilities should actively involve community members, organizations and agencies in their community benefit programs.”²¹ Georgia Watch was pleased to discover that most of the hospitals from our sample size engaged in partnerships with local health departments, charitable clinics, FQHCs, YMCAs, United Ways, schools, Community Service Boards, police departments and other community groups to reach vulnerable and needy populations with their services and programs.

Georgia Watch found it nearly impossible to glean from published CHNAs and Implementation Strategies alone whether hospital community benefit activities were meaningful. Some CHNAs and Implementation Strategies look scarce on paper, but it is clear from financial data and community perception that the hospitals are investing heavily in community benefit and engaging in innovative collaborations. Ideally, community members should be able to examine whether a hospital's Implementation Strategy aligns with community benefit spending reported in the hospital's IRS Form 990 Schedule H. However, there is often not clear alignment in these categories. Of the Implementation Strategies reviewed for this project, only WellStar grouped their community benefit activities into the Schedule H categories, which include: community health improvement services, health professions education, subsidized health services,

research, cash and in-kind donations, and community building activities. Community building activities include projects that contribute to upstream factors leading to improved population health, such as housing, economic development, environmental improvement, coalition building, advocacy, workforce development, and leadership training for community members.

Different approaches to community benefit programming, spending and reporting also make it difficult to extract valuable and comparable information about hospital efforts to address community needs from the CHNAs and Implementation Strategies.

Some hospitals told Georgia Watch in interviews that certain programs articulated in a facility's Implementation Strategy may not be reportable as community benefit spending in the IRS Form 990 Schedule H. Other hospitals told Georgia Watch that they view community benefit spending as something that should be directly correlated to the community health needs identified through the CHNA process and the Implementation Strategies developed. These differing philosophies for community benefit spending and reporting often make it necessary to review additional community benefit reports hospitals may publish to gain a full picture of their community benefit spending and programming. Of the 82 non-specialty, acute care hospital facilities identified by Georgia Watch, only 39 (48%) published separate community benefit reports or annual reports outlining community benefit spending on their websites. These different approaches to community benefit programming, spending and reporting also make it difficult to extract valuable and comparable information about hospital efforts to address community needs from the CHNAs and Implementation Strategies.

Partnering with public health departments can provide hospitals with some of the expertise needed to implement evidenced-based strategies to improve public health and monitor the progress of those strategic efforts.

In this report, Georgia Watch also chose to look at whether hospitals included measurements in their Implementation Strategies as a means to evaluate the impact of their community benefit programming. Georgia Watch found that only 16 (42%) out of 38 hospital CHNAs reviewed did include such metrics or methods. The findings from the PHI report analyzing 51 hospital Implementation Strategies from across the nation also indicated a "clear need for assistance in the development of metrics and monitoring strategies" for program activities in hospitals' Implementation Strategies.²² PHI pointed

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out that most hospitals lack the internal staffing and expertise to effectively evaluate community benefit program activities. PHI encouraged hospitals to partner with external stakeholders who can provide assistance in this area.²³ In particular, Georgia's smaller rural hospitals struggle to find the capacity and skills necessary on staff to effectively evaluate their community benefit efforts. Partnering with public health departments can provide hospitals with some of the expertise needed to implement evidence-based strategies to improve public health and monitor the progress of those strategic efforts.

In the end, responsibility for successful implementation must lie with an individual or a designated group within the hospital's leadership. If nobody is designated to monitor program implementation and measure success, hospitals risk operating community benefit programs that offer little or no value to community members. The final IRS rules require that hospitals have an ongoing feedback mechanism to gather input from community members between CHNAs. Community groups should be actively engaged in providing this feedback to hospitals to improve the next round of CHNAs. If a hospital is not actively soliciting feedback, Georgia Watch encourages community members or organizations to send written communications to the hospital's leadership providing constructive feedback and/or requesting to provide input in the next CHNA

Responsibility for successful implementation must lie with an individual or a designated group within the hospital's leadership.

In these next CHNAs, the final rules require hospitals to provide an evaluation of the impact of any actions that were taken since the hospital finished conducting its immediately preceding CHNA to address the significant health needs identified in the prior CHNA(s). In these next CHNA reports, Georgia Watch will be looking to see what progress hospitals have made and what feedback hospitals have received from community members about their community benefit programming and CHNA processes. The findings from this report can serve as a benchmark by which to evaluate future nonprofit hospital CHNAs in Georgia.

Recommendations

In the end, Georgia Watch developed this guidance for nonprofit hospitals now embarking on their second round of CHNAs:

- When defining community, hospitals should identify and focus on vulnerable populations, even if they are not the hospitals' traditional service-seeking patients. This is one way to ensure that unmet healthcare access needs are being addressed with available community resources. Hospitals sharing geographic service areas should work together to address community health needs to ensure shared responsibility for providing care to the community's most vulnerable.
- When gathering data, hospitals should examine data from a variety of sources and should collect data on a wide variety of social determinants of health in their communities. Hospitals should also look at their own utilization data to give a clear picture of the health of the communities they serve.
- In community benefit programming, hospitals are encouraged to go beyond providing charity care and existing fee-for-service hospital services. Hospitals should look at upstream social determinants of health and begin to implement strategies that keep communities healthy. As examples, hospitals can invest in programs that improve low-income housing, create green space and deliver healthy food options to impoverished neighborhoods. Hospitals should be exploring and creating new programs – not just continuing existing ones – to address needs identified through the CHNA.
- When gathering community input, hospitals should take advantage of the important opportunity this requirement presents for engaging in a meaningful way with community stakeholders. Hospitals should make an effort to gather input directly from members of vulnerable populations. CHNAs should be responsive to the community, with specific attention to populations in need.
- In Implementation Strategies, hospitals should be specific about their plans and make someone within the hospital accountable for measuring the success of their programs. Hospitals should directly relate strategies to the prioritized needs and set measurable goals. If possible, hospitals should engage community members in the prioritization process and make Implementation Strategies available on their websites.

Nonprofit Hospital Community Health Needs Assessments in Georgia

- Collaboration and community partnerships are key to improving community health. Hospitals should engage with their local health departments to understand their community needs and create evidenced-based approaches for implementing strategies that will impact community health in significant ways. Hospitals should identify those community organizations which are already working to meet specific needs and partner with them to fully address those needs.
- Nonprofit hospitals should pay careful attention to following the IRS guidelines. While the 2011 IRS Notice gave general requirements for hospitals in conducting CHNAs, the final regulations, published at the end of 2014, are much more detailed and deserve thoughtful attention. See Georgia Watch's report titled *An evolution of the IRS Regulations Governing Nonprofit Hospitals' Community Health Needs Assessments* at georgiawatch.org.

End Notes

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³Rosenbaum S, Byrnes M, Hurt N. Community benefit and the ACA: a brief history and update. http://www.nchh.org/Portals/0/Contents/HCF_CBACA%20overview.pdf.

⁴Congressional Budget Office. Nonprofit hospitals and the provision of community benefits. <http://www.cbo.gov/publication/18256>. Published December 2006.

⁵IRS. Instructions for Schedule H (2008). <http://www.irs.gov/pub/irs-prior/i990sh--2008.pdf>. See also Davis C. Nonprofit hospitals and community benefit. National Health Law Program; July 2011.

⁶Notice and Request for Comments Regarding the Community Health Needs Assessment Requirement for Tax-Exempt Hospitals, Notice 2011-52 (proposed July 25, 2011) (to be codified at 26 C.F.R. pts. 1, 53).

⁷I.R.B. 2013-21, May 20, 2013.

⁸Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. 66 (proposed Apr. 5, 2013) (to be codified at 26 C.F.R. pts. 1, 53).

⁹26 C.F.R. pts. 1, 53, 602 (2014).

¹⁰Concept source: Wade K, Matthews G. Review of North Carolina hospitals' community health needs assessments and implementation strategies. Network for Public Health Law. https://www.networkforphl.org/_asset/r1gg6w/Network-NC-CHNA-Report.pdf. Published September 19, 2014.

¹¹Concept source: Public Health Institute. Supporting alignment and accountability in community health improvement: the development and piloting of a regional data-sharing system. <http://nnphi.org/CMSuploads/SupportingAlignmentAndAccountabilityInCommunityHealthImprovement.pdf>. Published April 2014.

Nonprofit Hospital Community Health Needs Assessments in Georgia

¹²Rosenbaum S. Additional requirements for charitable hospitals: final rules on community health needs assessments and financial assistance. Health Affairs Blog. http://healthaffairs.org/blog/2015/01/23/additional-requirements-for-charitable-hospitals-final-rules-on-community-health-needs-assessments-and-financial-assistance/#_ftn30. Updated January 23, 2015.

¹³Public Health Institute. Supporting alignment and accountability in community health improvement: the development and piloting of a regional data-sharing system. <http://nnphi.org/CMSuploads/SupportingAlignmentAndAccountabilityInCommunityHealthImprovement.pdf>. Published April 2014.

¹⁴Ibid

¹⁵Catholic Health Association of the United States. Assessing & addressing community health needs. https://www.chausa.org/docs/default-source/general-files/cb_assessingaddressing-pdf.pdf?sfvrsn=4. Updated June 2013.

¹⁶Public Health Institute. Supporting alignment and accountability in community health improvement: the development and piloting of a regional data-sharing system. <http://nnphi.org/CMSuploads/SupportingAlignmentAndAccountabilityInCommunityHealthImprovement.pdf>. Published April 2014.

¹⁷Rosenbaum S. Additional requirements for charitable hospitals: final rules on community health needs assessments and financial assistance. Health Affairs Blog. http://healthaffairs.org/blog/2015/01/23/additional-requirements-for-charitable-hospitals-final-rules-on-community-health-needs-assessments-and-financial-assistance/#_ftn30. Updated January 23, 2015.

¹⁸Public Health Institute. Supporting alignment and accountability in community health improvement: the development and piloting of a regional data-sharing system. <http://nnphi.org/CMSuploads/SupportingAlignmentAndAccountabilityInCommunityHealthImprovement.pdf>. Published April 2014.

¹⁹Ibid

²⁰IRS regulations; Public Health Institute. Supporting alignment and accountability in community health improvement: the development and piloting of a regional data-sharing system. <http://nnphi.org/CMSuploads/SupportingAlignmentAndAccountabilityInCommunityHealthImprovement.pdf>. Published April 2014.

²¹Catholic Health Association of the United States. Assessing & addressing community health needs. https://www.chausa.org/docs/default-source/general-files/cb_assessingaddressing-pdf.pdf?sfvrsn=4. Updated June 2013.

²²Public Health Institute. Supporting alignment and accountability in community health improvement: the development and piloting of a regional data-sharing system. <http://nnphi.org/CMSuploads/SupportingAlignmentAndAccountabilityInCommunityHealthImprovement.pdf>. Published April 2014.

²³Ibid

Appendix A:

2011 IRS Notice Requirements Checklist

The following checklist of basic requirements was derived from the 2011 Notice and applies to the CHNAs completed during this initial round of needs assessments:

Community Health Needs Assessment Requirements:

- If the hospital is part of a health system, did the health system conduct and publish separate CHNAs for all hospital facilities that it operates?
- Did the hospital contract with one or more third parties in conducting the CHNA? If yes, does the CHNA report disclose the identity and qualifications of those parties?
- Does the CHNA describe the community served?
- Does the CHNA contain a description of how the hospital determined the community served?
- Does the CHNA contain a description of the analytical methods and process applied in identifying the community needs?
- Does the CHNA include a description of the sources and dates of the data and other information in the assessment?
- Does the CHNA describe information gaps that impact the ability to assess the health needs of community?
- Was there input from the community?
- Does the CHNA describe the collaborative efforts and partnerships in the assessment?
- Does the report identify at least one person from each collaborative organization by name title and affiliation and provide a brief description of that person's specialized knowledge?
- Does the report contain a description of when and how the hospital organization consulted with persons who represent the broad interests of the community served by the hospital (whether through meetings, focus groups, interviews, surveys, written correspondence, etc.)?

<input type="checkbox"/>	Were any individuals with special knowledge or expertise in public health consulted? Were they identified by name, title and affiliation?
<input type="checkbox"/>	Did the CHNA take into account input from federal, tribal, regional, state, local or other health departments or agencies?
<input type="checkbox"/>	Were any community “leaders” or “representatives” identified in the report?
<input type="checkbox"/>	Does the CHNA contain a prioritized description of the community health needs? Is there a description of the prioritization methods used for needs identified?
<input type="checkbox"/>	Does the report describe other resources and healthcare facilities in the community which are addressing or capable of addressing needs identified in the assessment?
<input type="checkbox"/>	Did the hospital make the CHNA widely available? Is it available in its entirety online? Can it be easily downloaded? In what year was the report made widely available?
<input type="checkbox"/>	Does the report specifically identify vulnerable populations in the community served (low-income persons, the medically underserved, minority groups, those with chronic diseases)?

Implementation Strategy Requirements

<input type="checkbox"/>	Did the hospital also produce an implementation strategy for each hospital facility that identifies what needs the hospital(s) will address or will not address and why?
<input type="checkbox"/>	If the hospital organization owns numerous facilities, did it separately document the implementation strategy for each facility?
<input type="checkbox"/>	Did the hospital identify other organizations that collaborated on the implementation strategy?
<input type="checkbox"/>	Was the implementation strategy adopted by the hospital's governing body (or by a committee or individual authorized by the governing body) in the same taxable year that the CHNA was conducted?

Appendix B:

38 Nonprofit Hospital CHNAs Reviewed

1. Archbold – Archbold Memorial Hospital (Thomas County)
2. Archbold – Brooks County Hospital (Brooks County)
3. Archbold – Grady General Hospital (Grady County)
4. Archbold – Mitchell County Hospital (Mitchell County)
5. Athens Regional Health System
6. Coffee Regional Medical Center
7. Doctors Hospital - Columbus Regional Healthcare System
8. Floyd Medical Center
9. Grady Memorial Hospital
10. Gwinnett Medical Center - Duluth
11. Gwinnett Medical Center – Lawrenceville
12. Meadows Regional Medical Center
13. Medical Center of Central Georgia (now called Medical Center, Navicent Health)
14. Memorial Hospital and Manor
15. Memorial University Medical Center
16. Northeast Georgia Medical Center
17. Northside Hospital Atlanta
18. Northside Hospital Cherokee
19. Northside Hospital Forsyth
20. Phoebe Putney Memorial Hospital
21. Piedmont Atlanta
22. Piedmont Henry
23. Piedmont Fayette
24. Piedmont Mountainside
25. Piedmont Newnan
26. South Georgia Medical Center
27. Southeast Georgia Health System
28. St. Joseph's/Candler
29. Stephens County Hospital
30. Taylor Regional Hospital
31. Tift Regional Medical Center
32. Union General Hospital
33. University Hospital
34. WellStar Cobb Hospital
35. WellStar Douglas Hospital
36. WellStar Kennestone Hospital
37. WellStar Paulding Hospital
38. WellStar Windy Hill Hospital

Appendix C:

Georgia Watch Community Participant Survey

Georgia Watch Community Health Needs Assessment

With a grant from the Healthcare Georgia Foundation, the Health Access Program at Georgia Watch is currently reviewing the Community Health Needs Assessments (CHNAs) and corresponding implementation plans written by non-profit hospitals across the state. We will analyze the data we collect in order to help ensure that CHNAs have a real impact in their communities. This survey is designed to collect data from community members, like you, who participated in a hospital's CHNA process between 2011 and 2013.

YOUR RESPONSES WILL REMAIN ANONYMOUS. Personal, identifying information from respondents will not be released.

Traditionally, non-profit hospitals have been exempt from paying federal, state, and local taxes. The historic rationale for these tax exemptions is the assumption that non-profit hospitals contribute to society by providing certain health benefits to their communities, such as financial assistance to indigent patients, health screenings, and community education campaigns, all of which are collectively known as "community benefits." The Patient Protection and Affordable Care Act (ACA) of 2010 contains important provisions related to non-profit hospitals and community benefits. Specifically, the ACA requires non-profit hospitals to conduct a CHNA every three years, with input from community organizations, and develop an implementation strategy for addressing identified health needs in the community served by the hospital. These assessments can be an important tool in hospitals' efforts to expand access to affordable, quality care in their communities.

Form begins on next page.

Appendix C:

Georgia Watch Community Participant Survey

* Required

Top of Form

Have you (or an organization that you represented) provided input during a hospital's community health needs assessment process? *

Yes

No

What is the name of the hospital(s) to which you gave input during the community health needs assessment process? *

In your opinion, was the hospital's method of obtaining community input for its community health needs assessment meaningful and productive?

Yes

No

Did you feel that your input (or your organization's input) was valued by the hospital?

Yes

No

Did you feel that the needs of the community were accurately reflected in the hospital's resulting community health needs assessment report? *

Yes

No

I read the report, but I do not know.

I did not read the report.

Do you think the hospital's current community benefit programs (free screenings, charity care, education classes, support groups, partnerships with local nonprofit organizations or health departments, etc.) adequately address important needs of vulnerable populations in your community? *

Yes

No

I do not know.

Is there anything additional you would like Georgia Watch to know?

Appendix D: Hospital Best Practices

St. Joseph's/Candler and Memorial University Medical Center

Best practice: point CHNA between two neighboring health systems

St. Joseph's/Candler Health System (SJC) and Memorial University Medical Center (MUMC) are both nonprofit healthcare systems located in Savannah, Georgia in Chatham County. SJC is a faith-based health system operating two historic hospitals in Savannah that are located 7 miles apart. In addition, SJC offers an array of auxiliary healthcare services. SJC is also one of the founding members of the Chatham County Safety Net Planning Council. As they describe on their website, MUMC is a 604-bed academic medical center that serves a 35-county area in southeast Georgia and southern South Carolina.

Despite being competitors, these systems worked together to assess the needs of their community in a joint CHNA process. For reasons unexplained in their CHNAs, they jointly chose to only assess the needs for Chatham County. In conducting the needs assessment together, they collaboratively completed the data assessment, and community surveying processes, but each hospital published individual CHNA reports. The collaborative work of the hospitals included:

- collaborating with the Savannah Chatham County Community Indicators Coalition, United Way of the Coastal Empire and local and county governments to determine their social determinant and health indicators for gathering data using the Healthy Communities Institute web-based data tool;
- collecting primary data through a survey that was available in both English and Spanish;
- reporting the primary and secondary data gathered to other organizations for assistance with the prioritization process, and
- summarizing the findings.

The Healthy Communities Institute web-based data tool used by SJC and MUMC in their CHNAs is available through the Savannah Chatham County Community Indicators Coalition ("Coalition") website. Between 2007 and 2008, the Coalition undertook efforts to identify significant issues of importance to community stakeholders in Chatham County and the City of Savannah. Through late 2009 and into 2010, the project

developed and grew into the Savannah::Chatham Community Indicators project website that hosts the Healthy Communities Institute web-based data tool. SJC and MUMC joined the Coalition in 2012. The Savannah::Chatham Community Indicators project is meant to serve as an informational tool that can be used to monitor progress on matters of importance to the well-being of the Chatham County community.

The Savannah::Chatham Community Indicators report (the 3rd addition was issued in August 2013) provides data on about twenty key indicators describing the well-being of the community that encompass education and youth development, health and wellness, economic independence and regionalism. The indicators are meant to provide information that is meaningful, valid, understandable and applicable. The purpose of reporting the information is to describe emerging trends, inform the citizenry of important issues, and serve as a catalyst for conversation among members of the community leading to action.

The Chatham County community is incredibly collaborative. MUMC and SJC drew on that collaborative spirit and involved community groups who represent underserved and vulnerable populations in their needs prioritization process. The hospitals ultimately appear to have chosen what needs to address in their Implementation Strategies without the participation of community members, but they did work together to choose the needs and decide which hospital would take on what actions to address those needs. Both hospitals made their Implementation Strategies available online and included in them target completion dates and metrics for evaluating progress.

SJC had not conducted a needs assessment prior to this new ACA requirement. However, they had long provided benefits to their community. SJC participated in this CHNA review project, and Adam Walker, the health system's Community Benefit Coordinator, participated in an interview with Georgia Watch by phone on December 5, 2014. MUMC did not participate in this project.

Appendix D: Hospital Best Practices

Gwinnett Medical Center

Best practice: effective collaboration with a county health department

Gwinnett Medical Center (GMC) is a 553-bed, nonprofit healthcare network that provides a wide array of services and facilities to Gwinnett County residents. The two acute care nonprofit hospital facilities in this system are GMC-Duluth and GMC-Lawrenceville. These facilities are approximately eleven miles apart. This 501(c)(3) nonprofit health system leases its hospital property from the Hospital Authority of Gwinnett County. GMC conducted a joint CHNA with the Gwinnett, Newton, Rockdale County Health Departments (GNR Health) for 2012-2013.

It is a national trend and suggested best practice for nonprofit hospitals to conduct joint CHNAs with a county or regional health department that may also need to undertake a needs assessment as part of its Mobilizing for Action through Planning and Partnerships (MAPP) accreditation process. Health department accreditation requires a community needs assessment every 5 years, a community improvement plan and an agency strategic plan. GMC's partnership with GNR Health in conducting its CHNA and also the coordinated efforts in Gwinnett County to implement multi-agency programs that benefit the Gwinnett County community are exemplary.

GMC has a long history of assessing and addressing community needs. The hospital system issued its first community benefit report in 1993. It also began conducting Health Status Reports (HSR) in cooperation with the county health department in 1999. The most recent HSR was published in 2007. The HSR looked at areas of needs in the community and allowed the hospital to show that services provided by the hospital were meeting an identified need. The HSR did not take into account primary data from community members, such as interviews and surveys. This was new requirement of the CHNA. The HSR also did not involve the prioritization of community needs.

In addition to GMC's recent collaborative CHNA effort, Gwinnett County itself has long-standing partnerships for addressing community needs. The Gwinnett Coalition for Health and Human Services is a public/private partnership whose mission is to facilitate collaboration that improves the well-being of the community. Initially begun with funding as a family connection coalition, the Gwinnett Coalition has been identifying needs and resources, setting priorities and planning solutions since 1998. The Gwinnett

Coalition participated in the joint CHNA effort undertaken by GMC and GNR Health by organizing two town hall meetings to gather community input. They also used some of the data gathered for their own planning purposes.

GNR Health, with its direct link to vulnerable populations, provided focus group participants for this needs assessment process. Focus groups were conducted in 2011. Members of vulnerable populations, including homeless individuals, seniors and those with behavioral health needs, were included in focus groups.

GMC and GNR Health participated in this CHNA review project, and Georgia Watch conducted a joint in-person interview with Martha Jordan, GMC's Community Benefit Director, and Connie Russell, District Program Director for GNR Health, on February 5, 2015. During our conversation, several challenges in the CHNA process were articulated by GMC and GNR Health:

- **Coordinating timelines** – Nonprofit hospital CHNAs must be conducted every 3 years, while public health department accreditation requires needs assessments every 5 years. GMC had a June 30, 2013 deadline for its first CHNA, and GNR Health did not need to complete its needs assessment until after that date.
- **Coordinating responsibilities** – With so many people involved and so many different goals, a Swim Lane flow chart had to be created to identify responsibilities and project objectives and keep participants on task.
- **Gathering data and community input that met the needs for both organizations** – CHNAs and public health accreditation needs assessments have different criteria for successful completion, and engaging in a single process that met the needs of all participants was challenging. For example, GNR Health had to provide more detail about health disparities in their needs assessment. Therefore, questions for focus group participants had to be broad.
- **Defining terms** – All three groups did not always have the same vocabulary or definitions for terms. Participants met monthly to create measurements that worked for all groups.

Appendix D: Hospital Best Practices

Gwinnett Medical Center

There are a few ways in which GMC's philosophies differed from those of other hospital systems reviewed for this project. First, GMC chose to prioritize community needs internally with hospital facility leadership. They did not involve the community in their prioritization process. GMC's prioritization process took about 4 months. Second, the strategies outlined in GMC's Implementation Strategy do not necessarily correspond to the community benefit categories that can be reported on the Schedule H. GMC views the Implementation Strategy as encompassing more than may be reported on the community benefit spending line items of the Schedule H, and therefore exact alignment of these documents may not exist. Additionally, GMC acknowledges that it also engages in collaborations that may not be mentioned in the hospital's Implementation Strategy.

GMC leadership takes an active role in understanding and approving the health system's community benefit planning. A Community Benefit Plan has been done at GMC every year since 2006, and it must be approved by the health system board. There is a health system board subcommittee specifically for community benefit. Ms. Jordan regularly educates hospital department leaders and administrators about public health terms and concepts because hospital staff may not have the training or background necessary to understand population health issues.

GMC's second CHNA process is already underway. The health system will publish its next CHNA by June 30, 2016, the hospital system's next three-year deadline.

Appendix D: Hospital Best Practices

Rural Hospital Project

Best practice: state grant funds allow for academic institutional support to rural hospitals

The Department of Community Health provided funding through the State Office of Rural Health to give technical assistance to 18 nonprofit hospitals¹ in rural areas for completing the first round of ACA-mandated Community Health Needs Assessments by 2013. Georgia Southern University (“Georgia Southern”) was contracted to provide technical assistance and expertise. Georgia Watch selected six of these 18 rural hospitals as part of the sample for this CHNA review project.² Of these six hospitals, only Washington County Regional Medical Center did not make its CHNA report available online and did not provide it to Georgia Watch upon request.³ Only Union General Hospital agreed to participate in Georgia Watch’s CHNA review project. Georgia Watch conducted interviews with representatives from Union General Hospital and Georgia Southern.

This rural hospital project represents a state government best practice to provide nonprofit hospitals with the support and education that they need to complete newly required CHNAs and make valuable contributions to improving the health of their communities. Because Georgia’s rural hospitals have struggled financially in recent years, many do not have the extra income needed to hire professionals to conduct CHNAs and develop thoughtful Implementation Strategies with clear goals and performance metrics. Eight rural hospitals in Georgia have closed since 2001, and according to an analysis conducted by the Atlanta Journal Constitution, nearly two-thirds of the remaining 61 rural hospitals have experienced significant losses in the past

¹Appling Hospital, Bacon County Hospital, Clinch Memorial Hospital (SGMC Affiliate), Memorial Hospital & Manor, Jasper Memorial Hospital, Miller County Hospital, Morgan Memorial Hospital, Taylor Regional Hospital, Meadows Regional Medical Center, Chatuge Regional Hospital, Union General Hospital, Washington County Regional Medical Center (CHNA unavailable online), Louis Smith Memorial Hospital (SGMC), Evans Memorial Hospital, Jeff Davis Hospital, Jefferson Hospital, Stephens County Hospital, Monroe County Hospital

²Washington County Regional Medical Center, Meadows Regional Medical Center, Taylor Regional Medical Center, Stephens County Hospital, Union General Hospital and Memorial Hospital and Manor.

³Washington County Regional Medical Center is owned and operated by the county hospital authority and therefore may not be subject to the same CHNA requirements as 501(c)(3) nonprofit hospitals.

Appendix D: Hospital Best Practices

Rural Hospital Project

five years. The AJC points out that dozens of rural hospitals in Georgia are struggling to survive in the face of “declining populations, fewer paying patients and decreasing payments from the government and private insurers.”⁴ Because Georgia has not opted to expand its Medicaid program, it currently has the second highest percentage of uninsured adults according to a recent Gallup-Healthways Well-being Index study.⁵ These facts, coupled with large concentrations of uninsured patients and primary care physician shortages in rural areas, result in large amounts of uncompensated care provided by rural hospitals.

Georgia Southern's CHNAs are among the best that Georgia Watch read out of the 39 CHNAs reviewed. The rural hospital CHNA projects led by Georgia Southern, had four aims:

- 1) to organize core steering groups at each hospital site to provide assessment support and guidance;
- 2) to complete community health assessments (needs identification and assets inventory);
- 3) to prioritize identified community health issues, and
- 4) to educate core steering group members and community members on the principles and practices of health promotion program planning and evaluation.

Although lengthy (most reports were over 100 pages long with over 80 pages of appendices), these rural hospital CHNAs included detailed information about how each hospital's defined community was chosen, which community members were involved in the process, and the methods for prioritizing community needs. Most rural hospitals with websites posted the completed CHNAs, making them widely available. Georgia Southern did not assist these hospitals with their Implementation Strategies. So, the quality and availability of the corresponding Implementation Strategies for these 18 rural hospitals vary.

⁴Williams, Misty, “Failing rural hospitals turn to taxpayers,” The Atlanta Journal Constitution, January 8, 2015, available at: <http://www.myajc.com/news/news/state-regional/failing-rural-hospitals-turn-to-taxpayers/njWp/#4cb56dd2.3789425.735606>.

⁵Witters, Dan, “Arkansas, Kentucky See Most Improvement in Uninsured Rates,” Gallup, February 24, 2015, available at: http://www.gallup.com/poll/181664/arkansas-kentucky-improvement-uninsured-rates.aspx?utm_source=Well-Being&utm_medium=newsfeed&utm_campaign=files.

Defining Community and Reporting Data:

Each CHNA contained a detailed description of how the hospital's community definition was established. Hospital utilization data by patient residential zip code was gathered from each hospital to establish a county-based service area definition. Counties containing zip codes from which the proportions of the hospital's in and/or outpatient stays/visits was greater than 10% of all hospital visits/stays were included in a hospital's identified primary service area. With this information, the community definition was then determined by the hospital's Steering Group. Some hospitals chose to include both primary and secondary service area counties in their community definition. Of the 5 rural hospital CHNAs we read, only Union General Hospital chose to include one county in their defined community.

Georgia Southern used state and national data to identify community health needs. County-level data was not further broken down to identify specific geographic locations of vulnerable populations within the service area. Of the 38 CHNAs reviewed by Georgia Watch, these were the only reports that articulated provider availability in the hospitals' defined communities based on Georgia Board of Physician Workforce data.

Gathering Community Input:

Each hospital was responsible for forming a Steering Group to provide CHNA project oversight at each hospital site. Hospitals were encouraged by Georgia Southern to include members of the community in their Steering Groups, but only 3 out of the 5 rural hospital CHNAs reviewed chose to do so.

Additionally, at the beginning of the project, Community Advisory Committees (CACs), consisting of 15-25 members representing a cross-section of the hospital's defined

⁶Zip code data for Union General Hospital identified Clay, NC and Towns County as additional primary service areas for Union General Hospital. Towns County was excluded from data collection because Chatuge Regional Hospital, which is also owned by Union General, serves Towns County and was also part of the Georgia Southern University rural hospital project.

Appendix D: Hospital Best Practices

Rural Hospital Project

community, were created at each hospital site to inform the CHNA process. Hospitals were specifically encouraged to maintain diversity in their CACs and recruit people or organizations representing traditionally underserved populations within the hospitals' service areas. The CACs helped distribute a minimum of 400 surveys throughout the defined service area for each hospital. Because CAC's distributed surveys to their personal networks, the hospitals had an excellent response rate (80% or higher in most cases). However, this also meant that, unless the personal networks of the CAC members consisted of low-income, vulnerable populations, the community input gathered may not have been reflective of the neediest community members.

Focus group sessions were held for each hospital. Each hospital's CAC members participated in a focus group session facilitated by Georgia Southern, and also recruited the participants for two additional focus group sessions. Focus groups were small, typically ten or fewer people each, and the demographics of participants varied. For example, in the focus groups for Memorial Hospital & Manor, many participants were retirees. Georgia Southern's community input data collection tool templates, including surveys and focus group questions, were made available in the CHNA reports. Georgia Southern also provided summaries of the community input gathered using quotes and example statements from community members, which very few other hospitals from Georgia Watch's sample pool did with this amount of detail.

Need Identification and Prioritization:

Identified issues were prioritized for each hospital site in a very thoughtful, scientific, and organized manner. The method for prioritization was completely transparent. Prioritizing the community needs was a two-part process. First, community members participated in the prioritization process by engaging in a multi-voting activity during an in-person meeting. The prioritization group consisted of CAC members, Steering Group members and focus group participants. Second, Georgia Southern used the Hanlon Method, which calculates a Basic Priority Rating through a series of measurements inputted into an equation, to give each identified priority a value. Community members were given the last opportunity to prioritize the needs before the list was finalized.

Implementation:

Georgia Southern assisted with these 18 rural hospital CHNAs, but did not help hospitals draft Implementation Strategies. Therefore, the quality and availability of Implementation Strategies for these rural hospitals varied. The lack of goals, metrics and assigned responsibilities in many of the Implementation Strategies reflects the limited resources and expertise of hospital staff in establishing goals and effective measurements.

Much was demanded of each participating hospital, and it seems that the organization and process clarity provided by Georgia Southern contributed to each hospital's success. The make-up of the Steering Group and, particularly, the CAC for each hospital had a tremendous effect on the community members represented in the CHNA process. Overall, the organization and transparency of these CHNAs and Georgia Southern's thoughtful and scientific process should be commended and, in many areas, is worthy of replication.

Appendix D: Hospital Best Practices

Grady Memorial Hospital & the Atlanta Regional Collaborative

Best practice: a regional collaborative

Grady Health System operates Grady Memorial Hospital, a 900+ bed hospital with a Level I trauma facility, in downtown Atlanta. Hughes Spalding is owned by Grady Health System and is operated by Children's Healthcare of Atlanta. In addition to the acute care services, Grady operates six primary care centers, the Infectious Disease Program on Ponce de Leon Avenue, emergency medical services and Crestview nursing home. Grady Memorial Hospital is an important teaching hospital staffed with doctors from Emory University and Morehouse School of Medicine. According to the hospital, 25% of all physicians practicing in Georgia received training at Grady. Grady Memorial is also a safety net hospital, supplying the most significant amount of charity care in the Atlanta area. Grady is exemplary in its provision of community benefit with approximately 14% of the hospital's expenses attributed to community benefit. That's twice as high as the 7.5% national average for nonprofit hospitals.

Grady is the only hospital in Georgia that is owned by two counties; DeKalb County shares ownership of the hospital with Fulton County through the Fulton-DeKalb Hospital Authority. Grady is a restructured hospital, meaning the hospital facilities are leased by the Hospital Authority to Grady Health System, a 501(c)(3) organization, which operates them. As a 501(c)(3) hospital, Grady must conduct a CHNA and author an Implementation Strategy.

Grady published its CHNA in 2013. This document is widely available to the public on Grady's website. Grady has strategically chosen not to make its Implementation Strategy publicly available on its website, but Georgia Watch obtained it upon request from the hospital. The IRS regulations do not require that hospitals make their Implementation Strategies widely available. Grady participated in this project, and Georgia Watch interviewed Shannon Sale, Senior Vice President of Planning and Business Development, on October 24, 2014.

Grady has been a leader in much of the work of a regional initiative called "ARCHI," or the Atlanta Regional Collaborative for Health Improvement, and the hospital drew from the needs assessment work of ARCHI to inform their CHNA report. Because ARCHI's

target area is the same as Grady's (Fulton and DeKalb counties), information gathered from interviews and focus groups conducted as part of ARCHI's needs assessment process were also used in Grady's CHNA. ARCHI is an interdisciplinary coalition working to improve the health of Fulton and DeKalb counties through a collaborative approach to community health needs assessment and action. Regional collaborative needs assessment and implementation efforts, like this one, are a model for best practices in conducting CHNAs. Georgia Watch interviewed several ARCHI Steering Committee members in preparation for this report.

The Georgia Health Policy Center, United Way of Greater Atlanta and Atlanta Regional Commission form the triad of ARCHI leadership and provide ongoing project management, data and planning resources, facilitation, and partner building assistance to ARCHI. ARCHI Steering Committee members include, among others, representatives from the Centers for Disease Control and Prevention (CDC), Piedmont Healthcare, St. Joseph's Health System, Kaiser Permanente of Georgia, and The Carter Center. Other ARCHI members include Concerned Black Clergy, Atlanta Community Food Bank, Rite Aid Pharmacy, Emory Healthcare, Fulton and DeKalb County government, and the Georgia Department of Public Health.¹ Major players missing from the ARCHI membership list are Blue Cross Blue Shield of Georgia, the largest insurer in the state, and Northside, one of the largest hospital systems in Atlanta.

ARCHI was created to foster collective thought about how best to improve the health of metropolitan Atlanta and facilitate collaboration in strategies to address identified needs. ARCHI stakeholders convened from July to November 2012 to discuss a transformation of the health and healthcare delivery system in Atlanta.² The meetings culminated in the collective identification of seven key priorities. Three priorities focus on financing the ARCHI goals through: 1) an innovation portfolio to seed early interventions; 2) increased use of contingent global payment; and 3) capturing and reinvesting savings generated. Four priorities focus on the health needs of the region by emphasizing the need for: 1) care coordination; 2) creating pathways to advantage that increase opportunities for students and families; 3) encouraging healthy behaviors;

Appendix D: Hospital Best Practices

Grady Memorial Hospital & the Atlanta Regional Collaborative

and 4) health insurance coverage. While many of these are long-term, more abstract strategies, the documented support for these concepts from numerous important players in the Atlanta healthcare industry is an important first step in a collective effort to improve health outcomes and share responsibility in the region.

The ARCHI Playbook for Action, published in November 2013, was created by ARCHI subcommittee members to begin to operationalize the seven key priorities identified in 2012. This Playbook contains innovative ideas and impressive examples from Atlanta and other parts of the country. ARCHI leaders regularly monitor progress on a 28-year strategic plan to transform the healthcare system in Atlanta. Currently, ARCHI is implementing a pilot project in the Tri-Cities area of College Park, East Point and Hapeville. As part of this project, Grady is modifying its hours and services to accommodate residents who visit its neighborhood clinic. The United Way is providing funds to improve education, income, health and housing stabilization. Piedmont Healthcare will be implementing non-clinical interventions, such as support for community gardens, to promote healthy behaviors.³ Right now, ARCHI is only 2 years into its 28-year plan, and this pilot project is an important beginning to fostering collaborative priority setting and coordinated investment in the Metro Atlanta region.

Of the Atlanta health system CHNAs reviewed by Georgia Watch that identify at least parts of Fulton and DeKalb counties as being within their defined communities (Grady, Piedmont Atlanta, Northside Atlanta, and WellStar), only Grady's CHNA draws from the collective work of ARCHI. Georgia Watch hopes to see increased participation in ARCHI in the near future by regional insurers and nonprofit and for-profit healthcare providers. Georgia Watch also hopes to see more Atlanta-area nonprofit hospitals use the ARCHI collaborative as a vehicle for conducting a coordinated regional CHNA. Without utilization of the ARCHI collaborative needs assessment process by all participating hospitals, Grady may continue to be the hospital that shoulders the brunt of the responsibility to provide care to the neediest residents of Atlanta. A fully realized regional needs assessment is one that, ideally, should be utilized by all participating hospitals.

¹Atlanta Regional Collaborative for Health Improvement (ARCHI) website, “Who We Are,” available at: <http://www.archicollaborative.org/who.html>.

²ARCHI Playbook, November 2013, available at: http://www.archicollaborative.org/archi_playbook.pdf.

³Minyard, Karen and Mary Wilson, The Atlanta Journal Constitution, “Breaking down a health disparity,” Guest Column, Page A12, May 14, 2015.



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55 Marietta Street NW, Suite 903

Atlanta, GA 30303

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