Flex Monitoring Team

University of Minnesota
University of North Carolina at Chapel Hill
University of Southern Maine

# Coordinating CHNAs to Improve Rural Health Equity

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February 17, 2021

# Outline

- Context: Hospitals, public health, and Federally Qualified Health Centers (FQHCs) conduct community health needs assessments (CHNAs) to support their missions. These efforts are often disconnected and focus on organizational rather than community needs.
- Goal: Explore opportunities to coordinate CHNAs to address the social determinants of health (SDOH), leverage resources, and enhance rural health equity.
- Review hospital strategies to improve health equity

# Defining Health Equity

- Robert Wood Johnson's definition (2017):
  - Health equity - everyone has a fair and just opportunity to be as healthy as possible.
  - Key - removing obstacles to health (e.g., poverty, discrimination, and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care).
  - Health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.
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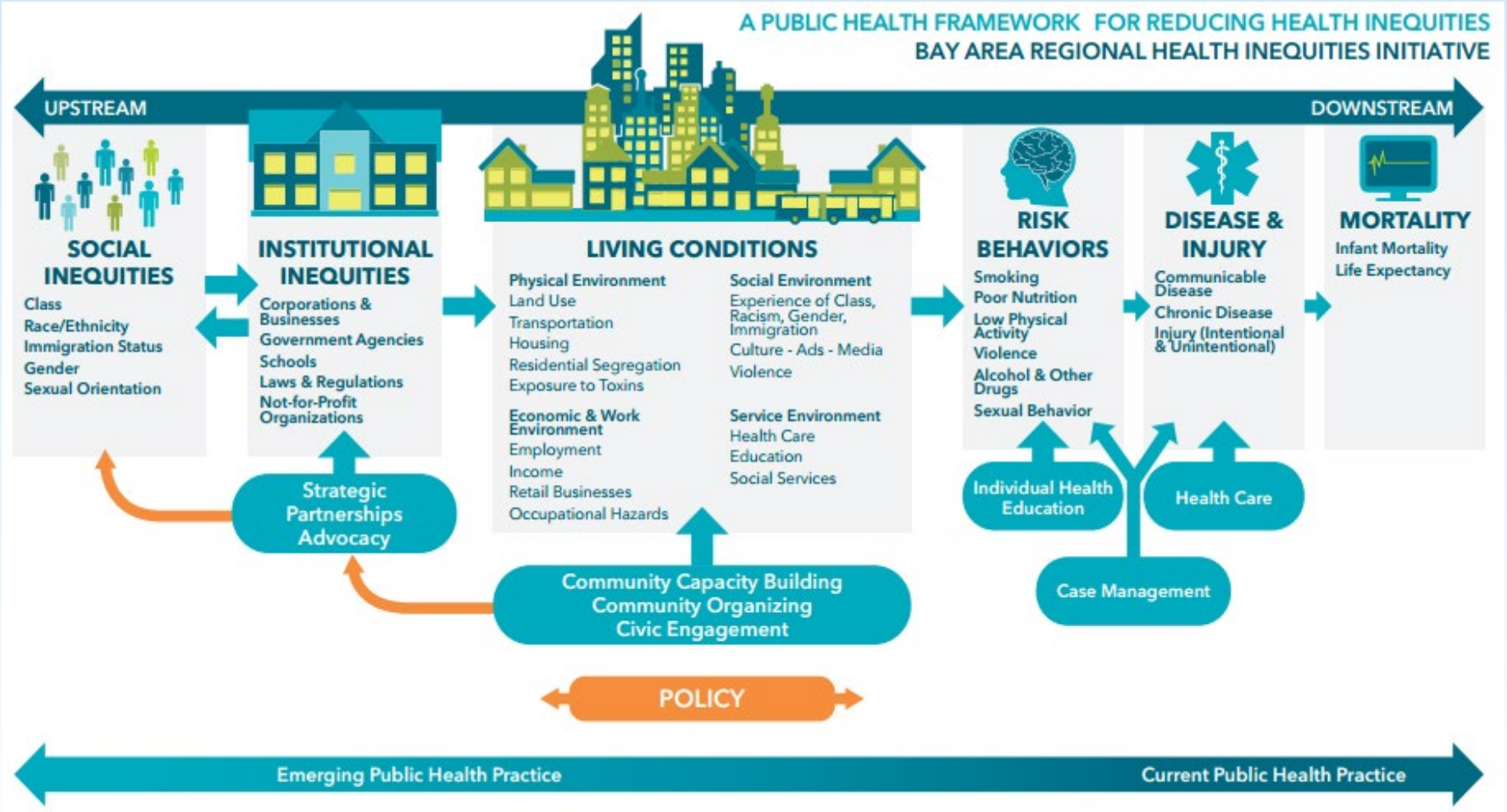
# Key Concepts

- Health equity requires improving access to conditions and resources that influence health care
- Social and economic determinants of health are often proxies for health inequalities in the community
- Health equity and health disparities are closely related
  - Health equity is an ethical and human rights value
  - Health disparities are differences in health or in the key determinants of health that adversely affect marginalized or excluded groups
- Health equity is a process (reducing disparities) and an outcome (eliminating disparities)

# A Public Health Framework for Health Equity





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# Evolving Model of Health Equity

| Phase 1 | Phase 2 (Where we are now) | Phase 3 |
|---|---|---|
| Align program and services with the needs/location of insured populations<br>Proprietary model<br>Random acts of kindness | Focus on identifying gaps in services<br>Traditional community benefit framework focused on "counting" benefits in dollar value<br>Use of county level data to identify needs<br>Lack of financial incentives<br>Stronger collaboration with community stakeholders<br>Strategy plans largely internally oriented | Focus on health disparities and social determinants<br>Emphasis beyond just clinical services<br>Intersectoral approach to programs<br>Institutional financial incentives aligned<br>Active engagement of vulnerable populations in CHNA and development of strategies<br>Collaboration with all stakeholders |

# Social Determinants of Health

| Economic Stability | Physical Environment | Education | Food | Community and Social Context | Health Care System |
|---|---|---|---|---|---|
| Employment<br>Income<br>Expenses<br>Medical bills<br>Support | Housing<br>Transportation<br>Safety<br>Parks<br>Playground<br>Walkability | Literacy<br>Language<br>Early childhood education<br>Vocational training<br>Higher education | Hunger<br>Access to healthy options | Social integration<br>Support systems<br>Community engagement<br>Discrimination | Health coverage<br>Provider availability<br>Provider linguistic and cultural competency<br>Quality of care |
| Health Outcomes: Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations, Quality of Life | | | | | |

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# Disparities in Access and Health Outcomes

| Barriers to Access & Social Determinants of Health | Leading Health Issues |
|---|---|
| • Housing<br>• Poverty, income, and employment<br>• Transportation<br>• Food access<br>• Race/ethnicity, culture, and language Access<br>• Health literacy/education<br>• Safety and violence | • Mental health/substance use<br>• Chronic/complex disease<br>  ○ Heart disease, diabetes, asthma/COPD, hypertension, cancer<br>• Health Risk Factors<br>  ○ Obesity, fitness/nutrition, tobacco use, alcohol and other substances |

# Potential At-Risk Populations

- Individuals/families with low incomes/limited resources
- Racial/ethnic minorities
- American Indians/Alaska Natives
- Immigrants and refugees
- Older adults
- Disabled adults
- Children, youth, and adolescents
- Women
- LGBTQ individuals
- Veterans

# Concerns

- CHNAs increasingly use the language of health disparities, SDOH, and health equity, but relatively few implement strategies to explicitly improve health equity
- Some question whether hospitals are the right vehicles for community health improvement and advancing population-level health equity
- Tax exempt/public hospitals have community obligations but their community benefit activities may not make substantive contributions to community health improvement
- Rural hospitals bear some costs of health inequality

# Health Equity Lens for CHNAs

- Disadvantaged stakeholders involved?
- Understandable, transparent, and inclusive?
- Consider differences in prevalence/severity of health problems in disadvantaged populations?
- Increase funding of topics relevant to disadvantaged groups?
- Increase engagement of disadvantaged groups or practitioners who work with disadvantaged groups ?
- Change policies, clinical practice, or programs in favor of disadvantaged groups?
- Increase feedback from disadvantaged groups or practitioners who work with disadvantaged groups?

# CHNA Changes to Advance Health Equity

- Hospitals must view themselves as part of the larger community health ecosystem
- Engage community organizations that are part of that ecosystem to work in partnership to improve community health
- Look outside the hospital walls to engage new partners, consider the breadth of community health needs, and prioritize those needs
- Place community engagement at the core of the CHNA process by including vulnerable populations and key stakeholders

# CHNA Changes to Advance Health Equity (cont'd)

- Include underserved and vulnerable populations, and communities of color in the data collection process by including those people, not just those who typically try to speak on their behalf
- To encourage CHNA participation, be inclusive in constructing data collection methods
  - Surveys should be available in the languages spoken in the community with translators to provide assistance
  - Focus groups, interviews, and community meetings should be led by individuals or organizations trusted by participants
  - Culturally competent measures are central to enhancing the ability of individuals to speak freely about personal/ community health issues

# CHNA Changes to Advance Health Equity (final)

- Examine health indicators for at-risk populations
  - By zip code, race/ethnicity, age, sex, or income to shed light on disparities in health and identify strategies to address top health concerns
- Create strategies to address the needs identified through CHNAs
  - For both traditionally underserved individuals (e.g., low-income, minority, or geographically isolated communities) and privately insured patients served by hospitals

# Coordinate CHNA Efforts

- Linking CHNAs, population health, community benefit, and health equity can bring accountability and transparency to the process
- Coordinate across community stakeholders to maximize information and minimize cost
- Challenges: Requires a broader focus; may be more time consuming and labor intensive; collaboration can be messy
- Benefits: greater involvement and acceptance by community, participants can share costs

# Closing Thoughts

- Ground CHNAs in thorough community engagement
- Community voice complements quantitative data on health disparities
- Vulnerable population can be hard to engage but their input is essential to improving health equity
- Use CHNA to engage all residents in a conversation about structural and historical barriers to health and identify strategies to overcome them
- Improving health equity and reducing health disparities requires a combined community effort

# Thank you!

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This work was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under cooperative agreement grant #5U27-RH01080. The information, conclusions, and opinions expressed in this presentation are those of the authors and no endorsement by FORHP, HRSA, or HHS is intended or should be inferred.

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