

# **Report of Critical Access Hospitals (CAH) Community Needs Assessments**

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## **Introduction**

To assist the Iowa FLEX program staff with future program activities, this report reviews the community health needs assessment information (CHNAs) from counties throughout Iowa. The CHNAs were conducted by critical access hospitals and local public health departments.

In 2010, the Patient Protection and Affordable Care Act (ACA) required all hospitals operating under 501.c.3 status to conduct community health needs assessments and produce implementation strategies as a means to better connect community needs with health services. Under ACA, CHNAs are to be completed at least every three years. To better understand the needs of Iowa's rural hospitals and counties, the Iowa Department of Health Medicare Rural Hospital Flexibility Program (IDPH FLEX) work with The University of Iowa School of Social Work, National Resource Center for Family Centered Practice (NRC) and The Center for Evaluation and Research (TCER) to conduct a comprehensive review of CHNAs from Iowa's non-profit hospitals and health departments and report on local health needs from these reports.

## **Methods**

The initial procedure employed involved a request for the most recent community health needs assessment sent by email during FY 2016 by IDPH FLEX (i.e., Iowa Department of Public Health, State Office of Rural Health). The request was sent to public health contacts in each of the 99 counties in the state. The response rate was also very low (five responded). An extensive internet search was then conducted in an attempt to locate CHNAs. While many counties complete their CHNAs on a different schedule than hospitals, many were located because they post their CHNA reports on their website. To increase the number of CHNAs located, follow-up

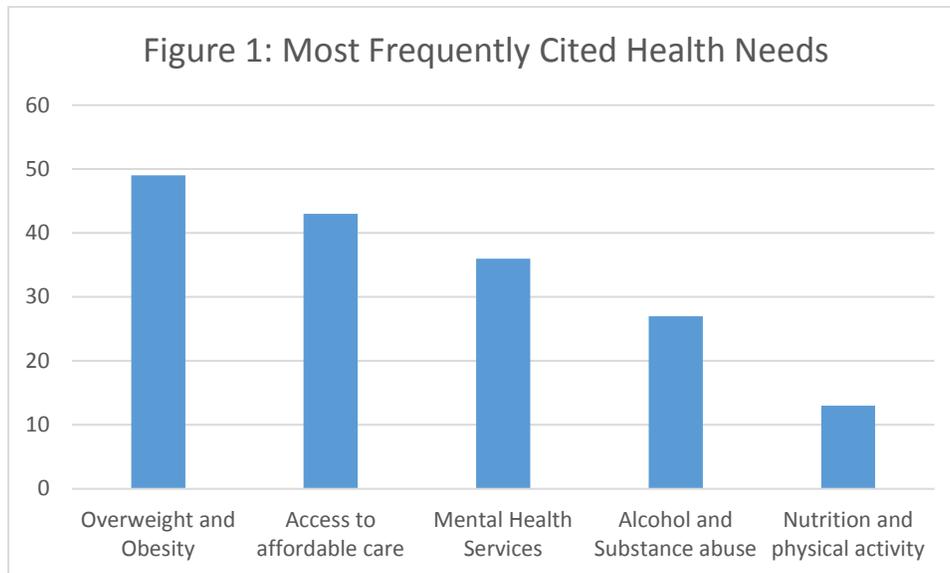
calls were also made to any hospital or county for whom a CHNA could not be located through the search. As a result, 73 CHNAs from hospitals and counties across Iowa were obtained and reviewed. In some counties, the local public health department and the critical access hospital worked together to develop their CHNA and in other counties, the critical access hospital and local public health system completed two CHNAs. In counties where two CHNAs were located, the hospital CHNA was used for consistency because public health CHNAs tend to focus on broader issues in the county than do hospitals.

## **Results**

The analysis included 73 community health needs assessments (52 hospital CHNAs and 22 county CHNAs which included 25 CAHs due to three county CHNAs including more than one hospital in the report). Hospitals and counties had a wide range of formats with CHNAs ranging from three pages to over 200 pages.

In order to determine the overall rankings, the needs identified in each CHNA were coded and grouped for analysis. Priority health needs were grouped into categories based on common content of the health needs described. This approach necessary because health needs described in CHNAs did not have a common lexicon and single health priorities were not always identified. Health needs or issues were coded as “non-priority” if the health issue was ranked lower than fifth in a list or if it was explicitly stated that the issue was not a priority in the CHNA. Where CHNAs did not provide a ranking of health needs information from Health Improvement Plans (HIP) were reviewed, and in the absence of an HIP the order of appearance in the material available was used.

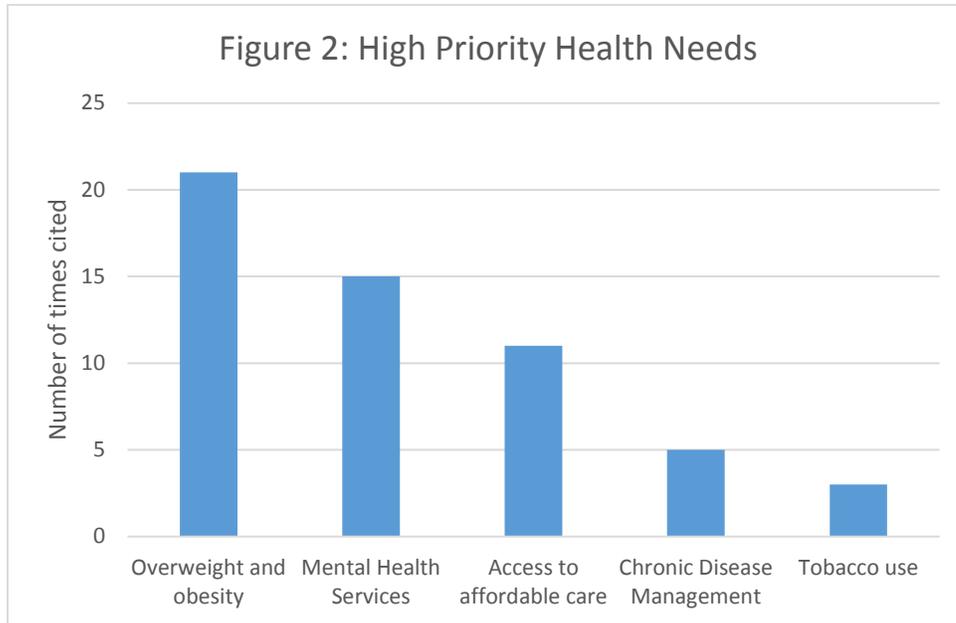
The five most frequently indicated priority health needs CHNAs identified are illustrated in Figure 1, below:



The top five priority health concerns identified were overweight and obesity, access to affordable care, mental health services, alcohol and substance abuse, and nutrition and physical activity. Overweight and obesity appeared as a priority need in 67 percent (n=49) of CHNAs, access to affordable care appeared in 59 percent (n=43), mental health services appeared in 49 percent (n=36), alcohol and substance abuse appeared in 37 percent (n=27), and nutrition in physical activity appeared in 16 percent (n=12). These results are consistent with other reports (e.g., IDPH Bureau of Planning Services, 2016 findings; 2016 county summary reports to IDPH). Based on the information available, it was not clear what hospital capacity, collaboration or activities are currently underway to address the health needs identified in the reports.

In addition to being the most frequently mentioned health needs, overweight and obesity, access to affordable care and mental health services were also most frequently ranked as the top

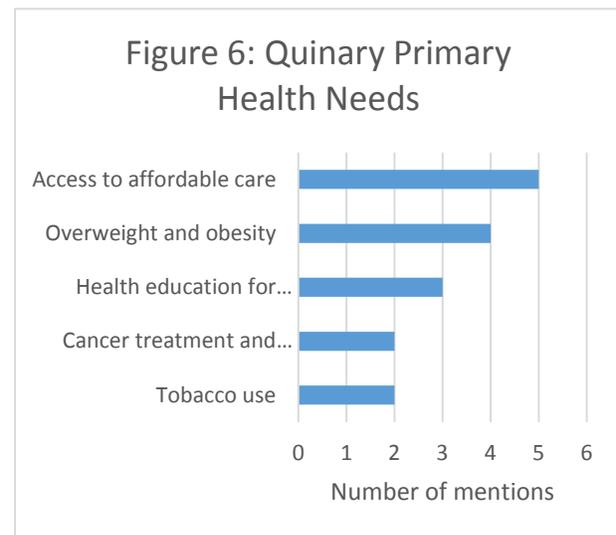
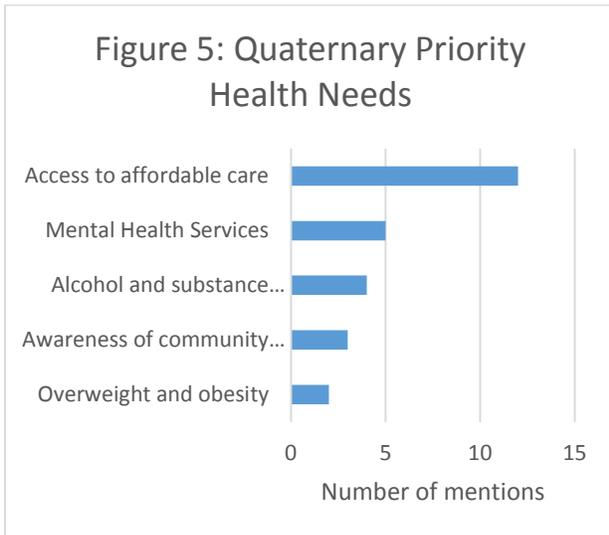
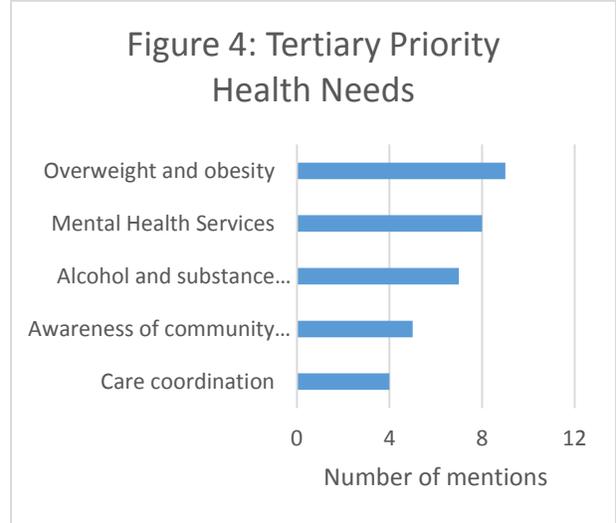
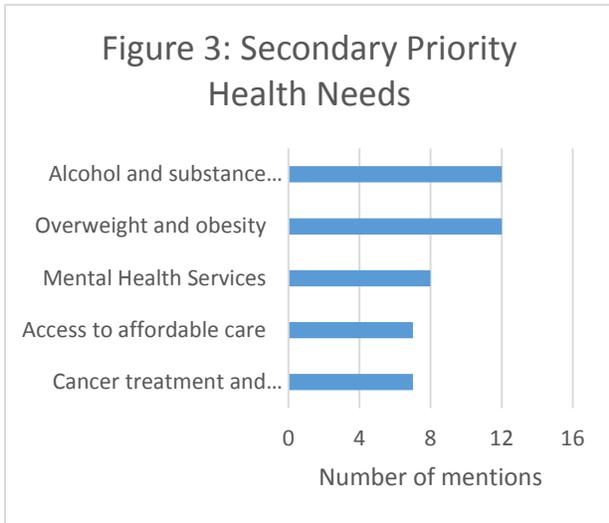
priority health need in CAHs. Figure 2, below, illustrates the rank-order of the highest priority needs CHNAs:



Overweight and obesity was cited as the highest priority health issue in 29 percent (n=21) of CHNAs, mental health services by 21 percent (n=15), access to affordable care by 15 percent (n=11) chronic disease management by 7 percent (n=5), and tobacco use by 4 percent (n=3). Other health issues with more than one mention as the highest priority need included: alcohol and substance abuse, nutrition and physical activity, increasing and maintaining emergency personnel and economic development.

Analysis of health needs mentioned as secondary or lower priority reveals many the same health needs discussed above. Overweight and obesity appeared frequently at every priority level. Access to affordable care, substance abuse and mental health services were also frequently mentioned among priority levels two through five. However, when examining items ranked two through five in CHNAs, some additional needs emerge, for example, cancer treatment, care

coordination, awareness of community resources and health education. Figures 3-6, below, illustrate additional health needs mentioned frequently in CHNAs.



## Findings

Across the CHNAs available throughout the state, three health needs emerged as the most frequently mentioned and highest priorities: reducing rates of overweight and obesity, improving mental health services and increasing access to affordable care. The consistency with which these needs are described indicate that hospitals and others conducting CHNAs are finding and facing similar issues regardless of where in the state they are located. Lower priority needs were also consistently mentioned further suggesting commonality of needs facing many across the state. For those familiar with public health and health services in the state, these are not surprising findings. However, the consistency of these findings over the past few years as well as geographically may be concerning for those with state public health responsibility.

## Recommendations

It is clear that some needs and priorities identified in CHNAs were common across both time and geography. While needs are consistently identified, barriers to addressing these needs and effective interventions are not well-defined or described. As a result, *it will be necessary to determine if more effective interventions to address needs are unique to local areas or if there are other ways in which these common needs can be addressed (e.g., statewide, regionally, sequentially etc.).*

For example, access to mental health services was mentioned frequently; however, reasons for lack of access could not reliably be attributed to a need for more providers, lack of affordability, stigma associated with receiving mental health services, lack of “beds,” a combination of these factors or other local, regional or state factors. *Gathering information about*

*contributing factors and drivers that could affect the needs described will require collecting information from sources other than CHNAs.*

IDPH FLEX or other programs at IDPH may be able to offer CAHs or other non-profit hospitals and county public health agencies with assistance in determining ways in which to address the needs identified in CHNAs. For example, *assistance in identifying drivers that could address the needs in local areas and then connecting areas with similar issues could be an efficient use of technical assistance that could result in collective impact.*

In addition to more information regarding specific barriers facing CAHs in Iowa, *current activities and collaborations underway are not available and are important for planning to assist CAHs in addressing needs identified and the effectiveness of assistance being provided. IDPH FLEX may be uniquely situated to collect this information and facilitate training or educational options (e.g., social determinants of health or ways for hospitals to engage with the community or collaborate with others). To the extent possible, this role in future planning efforts should be considered.*

## **Limitations**

The information available through CHNAs, HIPs and previous needs assessments used for the present analysis were not compared to brief updates submitted to the Bureau of Planning Services by all counties summarizing their most recent CHNAs and HIP work. This comparison could further validate the results. It is also possible that some of the needs are being addressed by the implementation of the Affordable Care Act in Iowa or that some geographical areas of the state have seen positive changes but needs still remain high.