

UNDERSTANDING A COMMUNITY

A community consists of individuals, families, groups, social networks, and an array of public and private institutions. For a healthcare executive to manage healthcare in a community, an understanding of the residents, institutions, and stakeholders within that community is essential.

Characterizing a Community

A community can be described in terms of the characteristics of its residents, as well as by an array of factors within the environment, ranging from physical characteristics (e.g., air quality, walkability) to policies and regulations (e.g., nonsmoking ordinances). The Ecological Model of Health suggests several major categories of factors to be considered when describing a community and its health status (McElroy et al. 1988).

The first step is to define “the community.” Each community is unique and thus has its own definition. A “community” might be defined by geography (e.g., all residents within a given set of zip codes), by age (e.g., a senior living community), religion (e.g., people attending a particular church), or ethnicity (e.g., people of Hispanic descent).

The residents of a community can be described by a variety of demographic, economic, social, and other inherent or acquired characteristics. Various data sets provide information about communities in the United States, and many offer information about health behaviors and health status in particular. When existing data are not sufficient to address a given issue, organizations can gather additional data themselves. To obtain a comprehensive picture of overall community health, general community demographic and economic data may be combined with patient data from healthcare providers; enrollee data from insurers; data about environmental factors; and primary data collected through surveys, interviews, or focus groups.

Benchmarks and standards are available for many health behaviors and conditions, and they can serve as the basis for community-level goals, as well as goals for individual patients. The US Department of Health and Human Services (2019), for

instance, maintains a set of targets for priority health conditions in its Healthy People series (www.healthypeople.gov), which is updated each decade. Similarly, the County Health Rankings & Roadmaps (2019) offers a data bank (www.countyhealthrankings.org) through which a county can compare its standing across a number of measures with other counties in its state, or throughout the nation.

Given the number of data sets available—and their growing sophistication—we have a wealth of evidence with which to evaluate the health status of communities and the interventions that affect them. Case 1 of this book focuses on describing the residents of a community, with a particular emphasis on using data, finding relevant data sets, and identifying benchmarks and standards.

Community Health Systems

Community assets are the organizational, physical, financial, political, and social resources that contribute to the health and well-being of a community. Among the most important of these assets is the community's health system, which consists of health organizations and providers, together with related services and organizations. Many of the cases in this book involve identifying the component entities of a community's health system, analyzing the relationships among them, and evaluating the power structure.

Health organizations include hospitals, community clinics, home care agencies, nursing homes, day care centers, dialysis centers, physical therapy clinics, mobile labs, pharmacies, and hearing aid and optical retailers, among many others. Providers include individual physician practices, medical groups, therapists, dentists, nurses, and practitioners working either independently or for formal organizations. Payers include government systems (e.g., Medicare, Medicaid) and private insurers. Support services range from transportation systems for older people to school clinics to water treatment plants. The ways these myriad elements operate vary from one community to another and for specific subsets of the population.

Relationships among these entities vary as well. Some organizations might work well together and exchange client referrals; others might be totally unaware that a particular service even exists in the community. Direct and indirect services may be integrated into a comprehensive continuum of care, or they may function entirely independently. Community-wide information systems, such as 211, may link information about clients even when the service agency staffs do not know one another.

The power structure may differ from one community to another, even if two communities have the same list of organizations. A number of scholars have sought to examine the nature of power. The bases of power proposed by French and Raven (1959)—reward, coercion, legitimate, expert, and referent—can be useful in analyzing relationships among organizations and understanding the public's perception of the organizations serving the community.

Community Asset Mapping

Community asset mapping (CAM) is the process of identifying and characterizing the assets of a community that serve a particular target audience, are based in a defined geographic area, or relate to specific programs of an organization. The purposes of CAM include the following: to enable organizations to determine which entities offer complementary services to their own clients, to identify organizations that might be potential partners, to find organizations with whom data sharing might enhance the quality or efficiency of client care, to recognize gaps in service, and to be alert for potential competitors.

The steps in CAM as it pertains to a specific subset of the population are as follows:

1. Identify the target population being served.
2. Analyze the health and related needs of the target population.
3. Catalog the local organizations that serve this population.
4. Characterize these organizations according to the following:
 - Geographic location
 - Referral patterns/networks
 - Capacity and staff availability
 - Cost of services and payment sources accepted
 - Quality measures
 - Communication mechanisms
 - Potential for collaboration or competition

Information about community assets can come from all types of stakeholders: patients and their families, healthcare staff, physicians, community foundations, board members, local chamber of commerce members, local healthcare professionals associations, and others. Surveys of representatives from each group, or key informant interviews with a select number of individuals, can provide a wealth of information.

Case 2 includes CAM as an important step in the process of developing a new clinic for seniors. CAM can be similarly useful in other situations where an organization seeks to improve quality of care for its clients, improve efficiency of its business operations, or develop a strategic plan for the future.

Community Benefit

The term *community benefit* refers to the idea that a nonprofit hospital must contribute to its community, presumably in an amount equivalent to what the hospital would have paid in taxes.

The Internal Revenue Service (IRS) articulated the idea of a “community benefit standard” to help judge hospitals’ contributions in a 1969 ruling. In 2007, after almost 40 years of informal interpretation, the IRS added to Form 990 a Schedule H, which requires nonprofit hospitals to report various ways in which they contribute to the community they serve (IRS 2018). Compliance requirements were specified further in 2010 as part of the Affordable Care Act (ACA), and Schedule H was expanded accordingly.

Nonprofit hospitals wishing to maintain exemption from federal income tax must, among other tasks, define the community they serve, conduct a community health needs assessment every three years, identify other local organizations that respond to the community’s needs, prepare a community health improvement plan, and be transparent with their community and patients about their financial aid policies. Activities pertaining to social determinants of health may be counted as community benefit contributions under certain circumstances, with detailed data provided.

Many of the cases in this book involve hospital initiatives related to the community. In some instances, the rationale for an activity is to fulfill the hospital’s financial obligation to its community to maintain its tax-exempt status. But in other instances, the hospital becomes engaged with its community for other reasons, whether a sense of moral obligation, a desire to improve the overall well-being of the population, or a financial motive associated with the transition to value-based payment.

One excellent source of information about community benefit is the Catholic Health Association, an established leader in documenting healthcare organizations’ contributions to their communities. The organization offers a variety of resources at www.chausa.org/communitybenefit/community-benefit.

Community Health Needs Assessment

A community health needs assessment (CHNA) has become a requirement for nonprofit community hospitals, Federally Qualified Health Centers, certain entities providing mental health services, Area Agencies on Aging, and sundry other organizations that receive funding from federal, state, or local government sources. Private accrediting agencies, such as the Public Health Accreditation Board, also require the organizations they accredit to conduct periodic needs assessments.

A comprehensive CHNA can involve all the elements of characterizing the community, identifying the components of the community health system, and mapping community assets, with all of these steps contributing toward a community health improvement plan aligned with the goals and mission of the leading organization.

Many communities had been conducting needs assessments prior to the release of the IRS CHNA requirements, but the types and quality of activities varied widely. Today, the CHNA requirements offer organizations an opportunity to do more than just meet minimum requirements; they offer a focus upon which to build collaborations with other organizations in the community, to become more data driven and evidence

based, and to move beyond preparing reports to actually take actions that improve the health of the community (Deryk Van Brunt, Healthy Communities Institute, personal communication, 2018).

Case 3 describes the CHNA process in detail, examining how a health organization identifies potential health partner organizations in its community, compiles the essential primary and secondary data, and analyzes data to pinpoint the priorities of the community for subsequent interventions.

Community Health Improvement Plan

The term *community health improvement plan* (CHIP) can be broadly applied in a generic sense, or it can represent a specific, formal response by nonprofit hospitals to community benefit requirements. A CHIP serves as a guide to help organizations improve the health of the community's residents. A CHIP can be created in a variety of ways; no single process or template has been firmly established by the government or other sources. The IRS requires nonprofit hospitals to submit an implementation strategy but does not provide details about content or format.

Several cases in this book refer to a CHIP. Case 3, for instance, describes a process linking the CHNA and the CHIP for nonprofit hospitals in ways that meet IRS requirements. Case 6 asks the reader to be creative in developing a CHIP for a multiple-county collaborative.

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