WNCHEALTHYIMPACT

At-Risk & Vulnerable Populations

Process & Product Guidance for Hospitals & Local Health Departments

[document is for information only – not official legal, compliance, or tax advice]

I. Related CH(N)A Requirements

A. Local Health Department:

Benchmark 1: *A local health department shall conduct and disseminate results of regular community health assessments. (pg 9 – HDSAI[1])*

Activity 1.1: The local health department shall conduct a comprehensive community health assessment (at least) every 48 months. The community health assessment must fulfill each of the following requirements: [2]

- Provide evidence of community collaboration in planning and conducting the assessment.
- Reflect the demographic profile of the population.
- Describe socioeconomic, educational and environmental factors that affect health.
- Assemble and analyze secondary data (collected by someone other than the health department) to describe the health status of the community.
- Collect and analyze primary data (collected by the health department) to describe the health status of the community.
- Compile and analyze trend data to describe changes in community health status and in factors affecting health.
- Use scientific methods for collecting and analyzing data.
- **Identify population groups at risk for health problems.**
- Identify existing and needed health resources.
- Compare selected local data with data from other jurisdictions (e.g., local to state, local to local).
- Identify leading community health problems.

Though there are not universally accepted definitions of the three groups, here are some basic definitions from the Health Department Accreditation Self-Assessment Instrument:

- ***Underserved populations*** relate to those who do not access health care either because there is a lack of services or providers available or because of limitations of income, literacy or understanding on how to access services.

- ***At-risk populations*** are the members of a particular group who are likely to, or have the potential to, get a specified health condition. This could be from either engaging in behavior (such as pregnant women who smoke) that could cause a specified health condition or having an indicator or precursor (high blood pressure) that could lead to a specified health condition.

- A ***vulnerable population*** is one that may be more susceptible than the general population to risk factors that lead to poor health outcomes. Vulnerable populations, a type of at-risk population,

[1] http://nciph.sph.unc.edu/accred/health_depts/materials/HDSAIInterpretation10-1-2014.pdf
Health Department Self-Assessment Instrument Interpretation

[2] Additional LHD requirements related to “at-risk” groups – see Benchmark 10, Activity 10.2 and Benchmark 19, Activity 19.1 – related to behavior change activities and preventive services.

can be classified by such factors as race/ethnicity, socio-economic status, cultural factors and age groups.

B. IRS Requirements for 501c3 hospitals:

- ***Report content/Data.*** Form 990 – Schedule H (2014): Part V – Section B – Community Health Needs Assessment. Line 3, f. (check "yes" if the CHNA report includes) – "primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups."

- ***Input to consider.*** "in assessing the health needs of its community, a hospital facility must take into account input received from, at a minimum, the following three sources:
  (1) At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community;
  (2) Members of medically underserved, low-income, and minority populations in the community, **or** individuals or organizations serving or representing the interests of such populations; and
  (3) Written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy."

- ..."***medically underserved***" populations are defined as "populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or underinsured or due to geographic, language, financial, or other barriers."[3]

  - NOTE: *Integrating additional local data (if available) may be helpful in illuminating/understanding these specific needs within your community given the stratification limitations within the regional dataset.*

II. WNC Healthy Impact Core Dataset

A. Core secondary (existing) data –

- The following metrics within the WNC Healthy Impact secondary dataset have publicly available data that is stratified by **sex, race/ethnicity and/or age group** and can be used to identify population groups at risk for specific health problems.

Stratified data available in the Secondary Data Workbook:

- Population (Census 2010) – stratified by sex, race/ethnicity, and age group
- Birth rate trend – stratified by race/ethnicity
- Growth in elderly population – stratified by age group
- Veteran population – stratified by sex and age group
- Registered voters trend – stratified by race/ethnicity
- High School graduation rates – stratified by sex, race/ethnicity, economically disadvantaged and limited English proficiency
- Pregnancy and abortion trends for ages 15-44 and ages 15-19 – stratified by race/ethnicity

[3] Paragraph Citation 79 FR 78963 https://www.federalregister.gov/articles/2014/12/31/2014-30525/additional-requirements-for-charitable-hospitals-community-health-needs-assessments-for-charitable#h-33

- Low and very low birth weight births – stratified by race/ethnicity
- Infant mortality – stratified by race/ethnicity
- Life expectancy at birth – stratified by sex and race
- Mortality rates for the 16 leading causes of death (age-adjusted) – stratified by race/ethnicity
- Unintentional falls mortality – stratified by age group
- Gonorrhea cases and rates – stratified by race/ethnicity
- Health insurance coverage (Census SAHIE estimates) – stratified by age group

Secondary Data Workbook measures where **stratified data is available**, from the original source **but it is not currently reported in the WNC Healthy Impact Secondary Data Workbook:**

- Poverty – source for this metric, Census ACS estimates (S1701) includes stratification by sex and race/ethnicity
- Sexual assault and domestic violence – source includes stratification by sex, race/ethnicity and age group
- Pregnancies receiving prenatal care in the first trimester, months 1-3 – stratifications by the age of the mother are available from the source
- Unintentional falls mortality – stratifications by race and sex are available from the source
- Health insurance coverage (Census SAHIE estimates) –stratifications by race/ethnicity, sex and income are available from the source

B. Maps in core dataset

- The core data set will include census tract level maps that correspond to a small subset of the secondary data set.
- The maps provided will aid in the identification of vulnerable populations and of trends in community health over the space or geography of a county. The maps are a supplement to the secondary dataset.
- In the same way that some of the secondary data is stratified by race/ethnicity, age, etc., the maps stratify this information over space or geography. The maps can be used to gain a better understanding of subsets of a county.

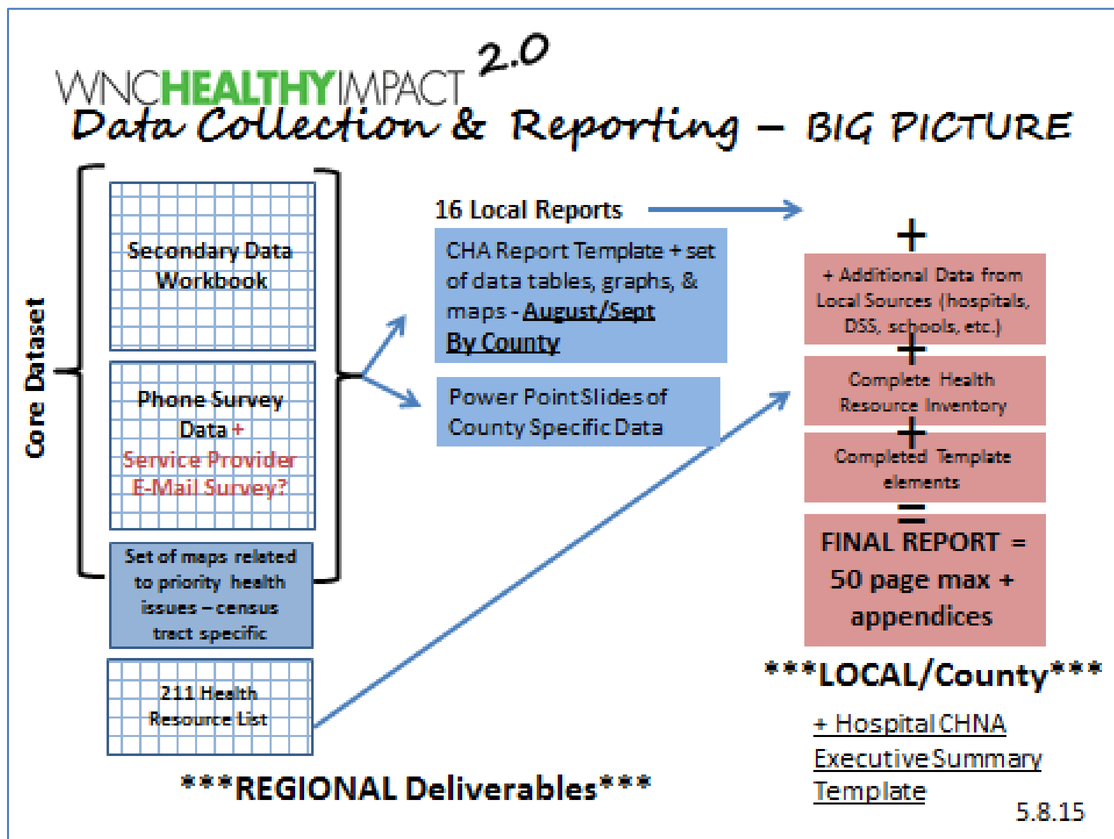
C. Core primary (collected) data

- County-level survey data. Counties can stratify relevant survey questions in some ways to determine who is at-risk or vulnerable for certain health outcomes. All counties can stratify most WNC Healthy Impact survey data by age and gender. It is suggested that there be a minimum of 50 members of a subpopulation (e.g., a specific race/ ethnicity) to obtain accurate estimates; thus, only some counties can stratify data by income, race, and ethnicity, depending on the size of subpopulations of interest. After you receive your local survey data, you can contact heather.gates@wnchn.org if you have a specific stratification request for our team to explore.

  - Regional-level (16 counties) survey data. Regional survey data, which includes 3,300 respondents representative of the 16-county Western North Carolina region, can be stratified at the regional level by age, gender, income, race, ethnicity, and other socio-demographic factors (e.g., health insurance status) to identify disparities. Some counties may choose to consider regional-level survey data that is stratified in their CHA process or product.

- Survey Methodology Note: The telephone survey can be conducted in either English or Spanish based on participant preference.

- Additional Primary Data Possibility: WNC Healthy Impact is currently considering a regional email survey of key informants that would contribute a new perspective on health issues, assets, and needs.



III. Local Options & Resources to Consider

A. Secondary (existing) data –

- Clinical/hospital data is a source that can be used to help supplement the regional core to better understand specific health needs of at-risk and vulnerable populations.
- Additional sources, such as data from the Department of Social Services, and other community partners can also be used to help understand specific health needs.
- See presentation and handouts from the May 22nd Local Data & Process workshop for more information and details.

B. Maps

- Community Commons has specifically created a "Vulnerable Population Footprint" mapping tool that you may find helpful: http://assessment.communitycommons.org/Footprint/ for more about learning to map

with outside agencies please see: http://issuu.com/leahferguson/docs/mappinghealthassets_toolkit_8-27-14.

- See presentation and handouts from the May 22nd Local Data & Process workshop for more information and details.

C. **Primary (Collected) Data** –

- Locally, hospitals, health departments and their partners can use listening sessions, key informant interviews, email or paper surveys, PhotoVoice and other methods to understand the needs of, and gain input from, at-risk/vulnerable populations and/or those representing the interests of specific groups.
- See presentation and handouts from the May 22nd Local Data & Process workshop for more information and details.

IV. Community Engagement

- Community organizations and individuals (including those that represent or include at-risk and vulnerable populations) should be involved in the other elements and phases of the community health improvement process.
- Consider the various phases of the process and how you plan to engage community members and partners in:
  - The CHA Team and/or other steering or advisory groups
  - Data collection, analysis and/or interpretation
  - Priority setting
  - And other steps in the planning, implementation, and evaluation process
- Related resources:
  - **Community Health Improvement Navigator** from the CDC has a section on Engaging the Community http://www.cdc.gov/chinav/tools/engage.html
  - **North Carolina Division of Public Health – CHA resources** http://publichealth.nc.gov/lhd/cha/resources.htm
  - New article from Health Resources in Action (May 2015) on "Embracing Equity in Community Health Improvement: http://www.hria.org/uploads/catalogerfiles/embracing-equity/Embracing_Equity_Report.pdf

For questions or suggestions related to this document, please contact Heather Gates, heather.gates@wnchn.org (828) 418-5034