How Your Community Health Needs Assessment Can Drive Physician Recruitment and Compensation Arrangements

In 2011, the Community Health Needs Assessment (CHNA) for tax-exempt hospitals as part of the Patient Protection and Affordable Care Act (ACA) became an IRS requirement. The CHNA must be updated every three years. So, while the final regulations weren't published until 2014, most hospitals have been through at least two iterations of CHNA development.

The regulations require input from members of the community served who are knowledgeable about and represent the interests of the community served. A key interpretation of this concept is that input must be obtained from at least one state, local, tribal, or regional governmental public health department and/or members of the medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations.

In working with our client hospitals, we see this element of input as critical not only to developing a comprehensive CHNA but also as part of a comprehensive planning document. However, we prefer to take the actual assessment a few steps further and to report on a number of measurable community health indicators. Consider the review of certain critical community-need health indicators that were recently identified by a Stroudwater client hospital:

- Primary care: A high percentage of Medicare patients with no annual exam; a high percentage of adults with hypertension not taking their medications; and a low percentage of patients 65+ who have not received pneumonia vaccine.
- Obstetrics: A high incidence of teen pregnancy, high incidence of low birth weights.
- Mental health: A high rate of opioid use; high admission rates for DRGs related to substance abuse; a lack of access to mental health care providers.

While the CHNA criteria for identifying these factors was documented, therefore meeting the criteria of identifying "need," the next step in the process should be identifying how to *meet* that community need. The regulations also require:

- Prioritized description of all of the community health needs identified through the CHNA, including the process and criteria used in prioritizing that need
- Description of the existing healthcare facilities and other resources within the community available to meet the community health needs identified through the CHNA
- A description of how a hospital plans to address a community health need (in this situation, the recruitment of physicians and other providers)

These elements of the CHNA are often underplayed or overlooked, but in our experience offer excellent opportunities for overall organizational planning. This is particularly true when documenting provider need which is critical in developing recruitment and compensation arrangements that meet fair market value.

Consider the three areas of community need identified above. With specific documentation of the need in primary care, obstetrics, and mental health, there is specific justification for recruitment of primary care providers; consideration of the recruitment or development of coverage relationships with ob/gyn providers; and the recruitment of a psychiatrist, PhD psychologist, or licensed social workers.

Nationally, there is a documented shortage of all three of these specialties. In this particular community there is a definitive need for primary care, ob/gyn and psychiatry based on physician-to-population ratios alone. However, offering justification for their recruitment based on criteria other than the basic physician-to-population ratio helps to build a much stronger case for offering competitive compensation arrangements. Physician and other provider compensation, including signing bonuses and payment of student loans, is becoming increasingly competitive. Compensation, however, must meet the tests of reasonableness and fair market value under Stark and IRS regulations.

Utilizing the CHNA—which documents disease incidence and prevalence, lack of access to specific providers, high utilization of the emergency department, and an aging population—facilitates the physician need planning process. These and other health indicators of the community all provide more validity for developing competitive compensation that can meet the requirements for fair market value and reasonableness.

Going through the process of performing a CHNA every three years may feel like a "check the box" activity. However, by incorporating the findings of the CHNA into the institution's provider recruitment and retention plan, the document can serve to justify competitive arrangements that meet the additional Stark and IRS requirements. Other areas of strategic planning beyond physician compensation should be integrated in the CHNA use process as well—including how the overall need can fit into an accountable care organization (ACO) strategy, what partnerships are needed in the community beyond traditional healthcare resources, and facility planning to incorporate recruited physicians and other ambulatory services that may impact the overall need.

For more information about how Stroudwater can facilitate the development of a comprehensive approach to the CHNA requirement and the recruitment and retention planning process, contact Mike Fleischman or Opal Greenway.