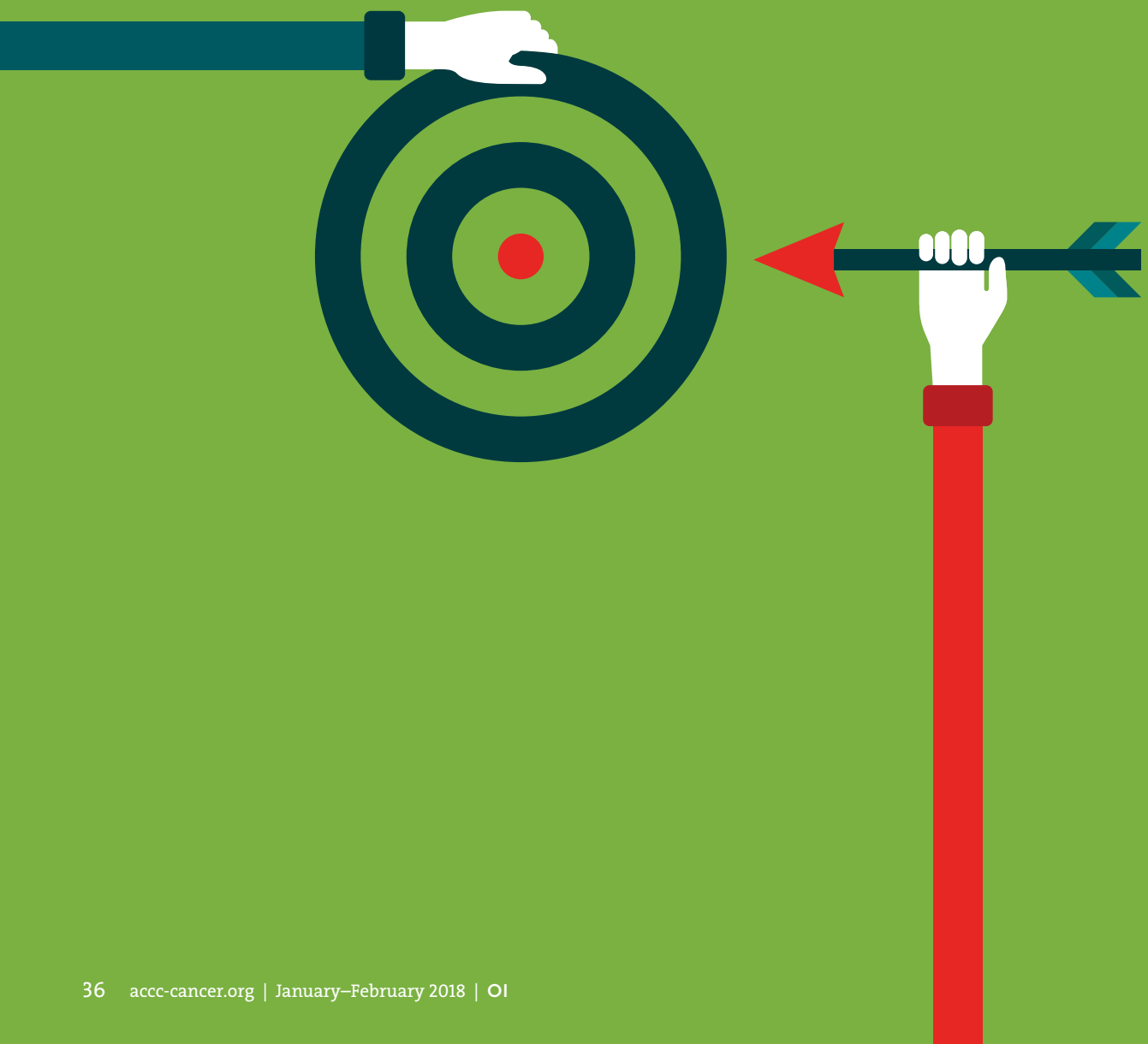
Hitting the Mark



BY KATHLEEN KATCHUR, MPH; RAJIKA E. REED, PHD, MPH, MED; AND BONNIE COYLE, MD, MS

Aligning Your Cancer Community Needs Assessment with Your Network Community Health Needs Assessment to Achieve Measurable Goals

As a nonprofit health institution, St. Luke's University Health Network must conduct a Community Health Needs Assessment (CHNA) every three years, as mandated by the 2010 Affordable Care Act. This CHNA is used to identify priority health areas and to formulate strategic implementation plans for addressing identified health needs. In 2016, St. Luke's University Health Network conducted both the network CHNA and a cancer center community needs assessment (CNA) concurrently, using analogous processes. Both needs assessments were conducted by our Department of Community Health and Preventive Medicine, which has expertise in public health, evaluation, and assessment. Our 2016 network CHNA process included a network-wide CHNA as well as CHNAs for each of our seven campuses, allowing us to identify the specific needs of our unique campus service area's populations.

To effectively conduct and implement these network and campus CHNAs, campus CHNA liaisons—most of whom work within the Department of Community Health and Preventive Medicine—serve as a connection between the community, the campus, and the network. The liaison positions were funded by each campus and report to the Department of Community Health and Preventive Medicine and the president of each campus. This liaison model has served as the basis of a similar process with our cancer center. A staff member from the Department of Community Health and Preventive Medicine serves as the cancer CNA liaison and the community outreach coordinator for the Cancer Committee. This direct connection to the network CHNA team allows our cancer center to employ similar evidence-based and best practices processes in conducting and implementing the cancer center CNA, as well as establishing measurable implementation goals.

> To effectively gauge the true needs of the community, an extensive amount of primary and secondary data must be collected and analyzed when conducting a needs assessment.

The Needs Assessments

The network CHNA must identify priority health disparities among residents within the community served by the health institution. Additionally, the report must state every health priority addressed by community stakeholders, hospital professionals, or public health experts. View our network CHNA online at slhn.org/Conditions-Services/Community-Health/Community-Health-Needs-Assessment. Table 1, page 38, depicts the similarities between both needs assessments.

Table 1. CNA Alignment to CHNA

	Network CHNA	Cancer Center CNA
What	Identifies crucial health disparities faced among residents within the community served States every health priority addressed by community stakeholders, hospital professionals, or public health experts	Community and local patient population Health disparities Barriers to care (patient, provider, or health system centered) Resources available to overcome barriers Gaps in availability of resources to overcome barriers
Who	All nonprofit health institutions	All cancer centers seeking CoC accreditation
Why	Section 501(c)(3) of the Internal Revenue Code, as mandated by the Affordable Care Act, enacted March 23, 2010	CoC standard 3.1 (Patient Navigation), also applies to standard 1.8 (Prevention, Screening, and Outreach)

According to the 2016 Commission on Cancer (CoC) Cancer Program Standards, Standard 3.1[1]:

"The cancer committee must conduct a Community Needs Assessment (CNA) at least once every three years during the three-year accreditation cycle. The Cancer Committee defines the scope, selects appropriate tools to perform the CNA, and is involved in the assessment and evaluation of results. Local, county, or state cancer-related information may be utilized in obtaining data. Further, the Cancer Committee may work with outreach and/or marketing departments, as well as community-based organizations outside of the facility to accomplish a robust CNA."

The CNA must define/identify the following:

- The cancer program's community and local patient population
- Health disparities (numerous factors can contribute to disparities in cancer incidence and death such as race, ethnicity, gender, underserved groups, and socioeconomic status)
- Barriers to care, which may include patient-centered, provider-centered, or health system–centered barriers
- Resources available to overcome barriers on-site or by formal referral
- Gaps in the availability of resources to overcome barriers.

In CoC CNA processes, barriers are broken down into three groups: patient centered, provider centered, and system centered. Examples of patient-centered barriers to cancer screening may include lack of awareness or education on screening, fear of screening procedure or procedure results, or personal beliefs about screening. Examples of provider-centered barriers to cancer screening may include provider beliefs about preferred screening methods, lack of knowledge of who should be screened, or discomfort in discussing screening options. Examples of system-centered barriers to cancer screening may include screenings not covered by health insurance, lack of transportation, or difficulty in scheduling appointments.

To effectively gauge the true needs of the community, an extensive amount of primary and secondary data must be collected and analyzed when conducting a needs assessment. Our needs assessment processes began with collection and analysis of secondary data sources, followed by collection and analysis of primary data sources.

Secondary Data Sources

For both our network and cancer center needs assessments, Pennsylvania, New Jersey, and U.S. county-level data were collected from sources including the U.S. Census Bureau, Centers for Disease Control and Prevention *Vital Statistics*, Robert Wood Johnson Foundation County Health Rankings, and hospital data, among others. We collected the ZIP codes of patients who receive services at our hospital or cancer center facilities and determined that our service area would be defined as the top 80 percent of these ZIP codes. Having this geographic information allowed us to focus specifically on the counties where most of our patients reside, thus making it more relevant to our patients.

Cancer-specific sources were used for our cancer CNA. The National Cancer Institute's State Cancer Profiles and our St. Luke's University Health Network Cancer Tumor Registry data from calendar years 2012, 2013, and 2014 were used to determine cancer incidence and prevalence in our patient population, as well as to gauge basic demographic characteristics of our cancer population.

Secondary data collection and analysis for our 2016 needs assessments were conducted in the fall of 2014 and winter of 2015.

Primary Data Sources

Our primary data came predominantly from two sources: community focus groups and community surveys. We conducted

community focus groups for each of our network campuses in spring 2015. These focus groups included key stakeholders, hospital staff, and public health professionals within each community. They provided us with meaningful insights from people who work extensively within the community. Additionally, St. Luke's University Health Network oncology staff and patient focus groups were conducted in summer 2015 to understand and determine oncology-specific needs.

In addition to our focus groups, we developed and conducted a network-wide community survey to further identify health needs within the community, especially among our vulnerable populations. Community surveying conducted by staff, volunteers, and community partners took place during summer 2015. To effectively reach our vulnerable populations, surveys were conducted in both English and Spanish primarily through the local health bureaus, community organizations, community functions, St. Luke's University Health Network clinics, and medical facility waiting rooms. In these community-based settings, iPads with wireless connectivity were used to administer the survey; however, surveys were also available through email links, social media, Web advertising, and paper copies.

A total of 3,214 respondents accessed the survey; however, when checked for completion, only 2,757 surveys were ultimately used for data analysis. Wireless connectivity posed some issues related to survey completion, especially in rural areas. Furthermore, some respondents took longer to complete the survey or were unfamiliar with how to use an iPad, which posed further challenges. During the last month of survey administration, paper surveys were completed in our rural areas to achieve greater completion rates.

Primary data for our cancer CNA came from two additional sources: key informant interviews and the St. Luke's University Health Network Tumor Registry. During summer 2015, a series of key informant interviews was conducted with St. Luke's University Health Network oncologists, as well as cancer experts within the community. These interviews allowed us to get a better indication of need from within St. Luke's University Health Network, as well as within the community we serve.

St. Luke's Cancer Tumor Registry data from calendar years 2012, 2013, and 2014 were another vital source of primary data for our cancer CNA. Using our tumor registry data, we determined our most commonly diagnosed cancers and cancer staging, as well as important demographic indicators for our oncology population.

Identified Disparities

Our network CHNA community surveys allowed us to see patterns in disparities related to race, ethnicity, insurance, and income. During Cancer Tumor Registry data analysis, we explored relationships between cancer staging and insurance type, which played a key role in identifying health disparities in our community. Additionally, we examined the relationship between self-reported cancer screening and insurance in our community survey responses. Through our needs assessment process, we identified disparities in both cancer screening and cancer staging in our community.

Through our data analysis, we identified that our uninsured and Medicaid populations had much poorer screening rates for both breast and colorectal cancer. Additionally, later stage breast and colorectal cancers were reported among our vulnerable populations. These disparities align with national trends, which also indicate that vulnerable populations have lower rates of cancer screenings and tend to have later stage cancer upon diagnosis.

Identified Priority Areas

The final step in our needs assessment process was to identify health priority areas. Our network CHNA identified these five priority areas:

1. Improving access to care and reducing health disparities
2. Promoting healthy lifestyles and reducing chronic disease
3. Improving mental and behavioral health
4. Improving child and adolescent health
5. Improving elder health.

Our cancer CNA identified these three priority areas:

1. Increasing colon, breast, and lung cancer screening and outreach for all individuals in our service area, especially for vulnerable populations
2. Enhancing current patient navigation services
3. Increasing cancer prevention programs and holistic care offered to patients and our greater community.

Cancer is considered a chronic disease; therefore, all cancer CNA priority areas fall under our network priority area of promoting healthy lifestyles and reducing chronic disease. All cancer initiatives are classified as components of the network strategy to promote healthy lifestyles and reduce chronic disease. Additionally, our focus on vulnerable populations falls under the network priority area of improving access to care and reducing health disparities; therefore, all targeted screening and outreach activities are classified as such. Furthermore, aligning the priority areas allowed us to subsequently align measurement strategies and tools. Measurable objectives for cancer-specific priority areas can then be reported on program and network levels. Having this close alignment of our two sets of priority areas allows our cancer program to have influence on a network level, thus improving our overall cancer screening and outreach capability.

CHNA and CNA Next Steps

Once our network CHNA reports were finalized, and before they were submitted for St. Luke's University Health Network Board approval prior to publication, the next step was to develop and adopt measurable implementation strategies that address identified needs. To develop these strategies, internal teams from each campus, as well as CHNA liaisons and staff from the Department of Community Health and Preventive Medicine, met to discuss findings and strategize how to address the priority areas.

Similarly, after the cancer CNA report was finalized and presented to the St. Luke's University Health Network cancer committee, an internal team made up of oncology service line

There is ample opportunity for collaboration between network CHNAs and cancer CNAs. Conducting both needs assessments simultaneously is highly effective, not only reducing duplication of work but also maintaining the true spirit of the needs assessments—to identify and address health needs within our communities.

staff, administrators, and managers, as well as the liaison and staff from the Department of Community Health and Preventive Medicine, was created to develop, implement, and evaluate navigation, screening, and outreach activities to address the identified needs. This step was crucial in ensuring adoption and implementation of measurable activities developed to address the identified needs and the allocation of both personnel and financial resources.

Implementation Strategy

Since implementation plans were developed, regularly scheduled implementation plan meetings have been conducted to ensure consistent communication on implementation activities. Implementation plan teams differ among campuses; some only consist of hospital staff, wheras others include community members as well. These scheduled implementation plan meetings were initially critical in establishing measurable objectives for each of the implementation plan goals. This encouraged collaboration between internal and external partners to address implementation goals. As we transition into the 2019 needs assessment cycle, these internal groups will serve as our initial work groups for the upcoming focus groups and community surveying opportunities. Table 2, below, summarizes how our needs assessments were conducted and implemented through corresponding evidence-based and best practice processes.

Implications

There is ample opportunity for collaboration between network CHNAs and cancer CNAs. Conducting both needs assessments simultaneously is highly effective, not only reducing duplication of work but also maintaining the true spirit of the needs assessments—to identify and address health needs within our communities. For example, through this needs assessment process, we have established network-wide initiatives to improve screening rates, especially among vulnerable populations. We have identified increasing colorectal screening rates as a network priority and have begun using a social–ecological approach to improve screening rates across the network. The social–ecological model is a multilevel approach that examines the effects of personal and environmental factors on health behaviors, spanning levels of influence from the individual level to the policy level. The social–ecological model is used within public health practice because it addresses problems at five different levels, therefore allowing for synergistic effects across levels to achieve the greatest impact.[2]

On an individual level, we are encouraging and educating patients about the importance of self-care. On an interpersonal level, we are working with our employee wellness program to send out birthday reminders encouraging employees who are between the ages of 50 and 75 to talk to their doctor about getting screened. On an organizational level, we are partnering within our network and with outside community agencies to conduct targeted community outreach initiatives. In addition, we have embarked on a network-wide quality improvement project to increase colorectal screening rates in our resident-based family practice and internal medicine clinics. Faculty, residents, medical students, and support staff are actively engaged in developing and conducting patient and provider surveys, conducting literature searches to identify best practices, and implementing system transformation processes to support this screening.

Table 2. Summary of Needs Assessment Processes

	Network CHNA	Cancer Center CNA
When	At least once every 3 years	Every 3 years
How	Analysis of primary and secondary data	Analysis of primary and secondary data
Next Steps	Development and adoption of measurable implementation strategy created to address identified needs	Development, implementation, and evaluation of navigation, prevention, screening, and outreach activities

On a community level, we are conducting a marketing campaign through all St. Luke's University Health Network facilities, using Centers for Disease Control and Prevention public service announcements to encourage people to talk to their doctor about screening, as well as participating in a local race to raise funds for St. Luke's University Health Network cancer screening initiatives. We also engaged in Colorectal Cancer Awareness Month marketing efforts in March. Finally, on a policy level, we have implemented a network-wide colorectal screening protocol, advocated for the use of fecal immunochemical tests as a colonoscopy screening alternative, and signed the National Colorectal Cancer Roundtable's 80% by 2018 pledge. Additionally, we have worked to integrate our needs assessment work into medical education for our medical students, into resident physician education for physicians in internal medicine and family medicine residency programs, and into continuing medical education opportunities for practicing healthcare providers.

By integrating these assessment processes, our cancer program was given the opportunity to have network-level influence by aligning CNA implementation goals to CHNA network implementation goals, as well as providing opportunity for collaboration across the network. OI

Kathleen Katchur, MPH, is an epidemiologist in the Department of Community Health and Preventive Medicine and the community outreach coordinator for St. Luke's Cancer Center, Bethlehem, Pa. Rajika E. Reed, PhD, MPH, MEd, is the network director of Epidemiology and Bonnie Coyle, MD, MS, is chair, Department of Community Health and Preventive Medicine, St. Luke's University Health Network, Bethlehem, Pa.

About St. Luke's University Health Network

St. Luke's University Health Network is a nationally recognized nonprofit health network serving 10 counties in eastern Pennsylvania and western New Jersey. The network is composed of seven hospitals and more than 270 outpatient facilities. Our cancer center is accredited by the American College of Surgeons CoC as an Integrated Network Cancer Program—meaning that we have multiple facilities providing integrated cancer care and comprehensive services. Similar to most integrated network cancer programs, we have a unified cancer committee, standardized registry operations, and coordinated services, locations, and practitioners.

References

1. American College of Surgeons Commission on Cancer. Cancer program standards: ensuring patient-centered care. Available online at: facs.org/quality-programs/cancer/coc/standards. Last accessed October 3, 2017.

2. Centers for Disease Control and Prevention. Social ecological model. Available online at: cdc.gov/cancer/crccp/sem.htm. Last accessed October 23, 2017.