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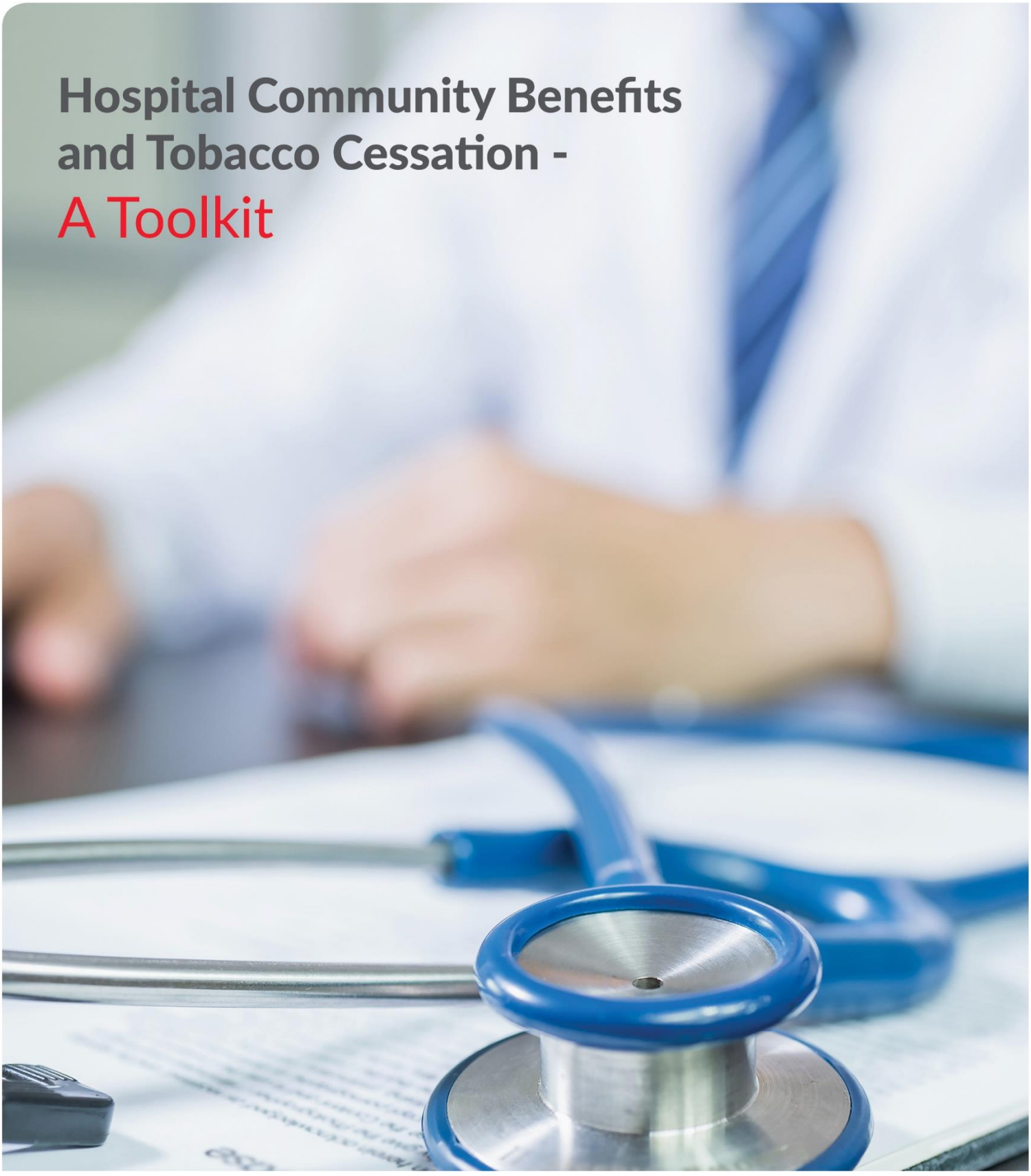
# Hospital Community Benefits and Tobacco Cessation - A Toolkit



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# Hospital Community Benefit and Tobacco Cessation Toolkit

***Summary***

This document provides state and local public health professionals with the tools and guidance they need to be informed and active participants in hospital Community Health Needs Assessments (CHNAs). The document provides background on three topics to help public health professionals approach CHNAs:

1. Why public health professionals should care about hospital CHNAs
2. How to make the case for including tobacco – regardless of what conditions or needs a hospital prioritizes for its post-CHNA implementation plan
3. How to determine which hospitals in your state have completed a CHNA – and if tobacco was identified as a high impact driver in the community or prioritized for the CHNA implementation plan

In addition, it provides supporting resources, including:

- An overview of resources available to public health professionals for working with hospitals on tobacco cessation
- A background document that provides a statutory and plain English overview of what a CHNA is and must include
- A glossary defining acronyms

**Why Public Health Professionals Should Care about Hospital Community Health Needs Assessment** Community Health planning is addressed by the public sector at the state and local level and by the private sector at the state, local, or hybrid level. These different approaches are outlined in the table below. State Health Assessments (SHAs) and State Health Improvement Plans (SHIPs) are under the purview of the state health departments. Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs) are conducted by local public health departments at a local, typically county, level. Community Health Needs Assessments (CHNA) are the responsibility of hospitals. A CHNA may be a geographic hybrid in that it must address the service area of the hospital. If the hospital is a stand-alone hospital, its CHNA is likely to be local; if it is part of a regional or statewide system, its CHNA is likely to cover a larger geographic area.

This guidance is written for state health departments under the assumption they will coordinate and collaborate with local health departments as appropriate.

Community health planning requirements for hospitals and health departments share a common goal: to collaborate and prioritize their communities' most significant health needs and implement strategies to address those needs. Hospitals and health departments can work together to address community health needs.

Hospital requirements are driven by the Affordable Care Act (ACA), which stipulates that to be recognized as a 501(c)(3) organization and maintain federal tax-exempt status, hospitals are required to conduct a CHNA and adopt a CHNA implementation strategy every three years. The IRS regulations make it clear that hospitals *must* work with either state or local health departments (LHDs). Hospitals may coordinate their CHNA process with a government public health department if it has the same "community" definition as the hospital. The ACA CHNA requirement coincided with the launch of the national voluntary public health department accreditation process by the Public Health Accreditation Board (PHAB). The completion of a CHA and CHIP are prerequisites for LHD accreditation applications and must be completed to demonstrate fulfillment of public health accreditation standards. Community health assessment and CHNAs collect the same kind of data.[1]

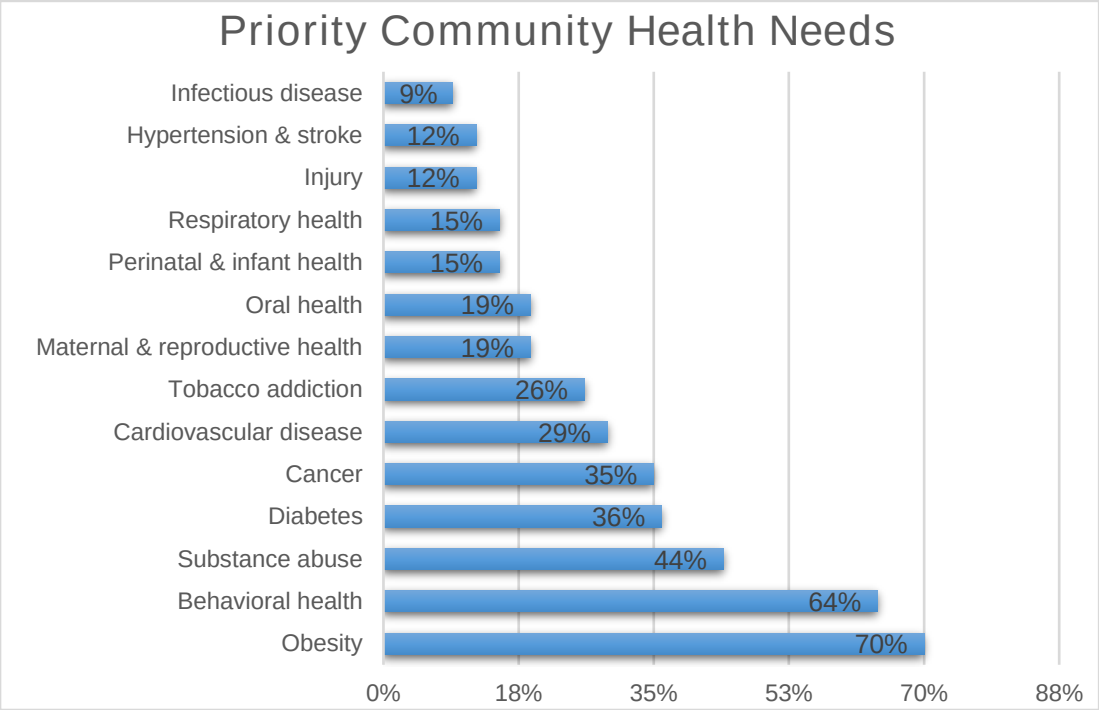
Although collaboration is permitted, public health departments must conduct CHAs every five years (if pursuing/maintaining accreditation), but the IRS requires a hospital CHNA every three years. While the different timing requirements make it difficult to use the same community health planning process, the requirement for public health input provides an important opportunity for public health agencies to:

- Build relationships with local hospitals
- Educate hospitals about overlapping areas of interest
- Leverage hospital resources to support public health initiatives
- Pool resources to conduct comprehensive community health assessments that benefit multiple stakeholders and the community-at-large

| | State | Local |
|---|---|---|
| **State Health Department** | • State Health Assessment (SHA)<br>• State Health Improvement Plan (SHIP) | |
| **Local Health Department** | | • Community Health Assessment (CHAs)<br>• Community Health Improvement Plan (CHIPs) |
| **Hospital** | • Community Health Needs Assessment (CHNA): State, regional, local | |

**How to Make the Case for Tobacco**

According to a 2014 review of over 300 hospital CHNAs[2], tobacco is the 7th most frequently prioritized community health need, providing an obvious opportunity for public health agencies to work with hospitals that prioritize tobacco addiction. Although conditions such as substance abuse and diabetes are prioritized more frequently by hospitals, employers, and even public health, tobacco prevention and cessation can still be important interventions, even if tobacco use is not explicitly prioritized. Of the top 14 conditions prioritized (see graph below), almost all of them are directly impacted by tobacco use.




This provides public health agencies with a tremendous opportunity to educate hospitals about the insidious impact of tobacco use in their priority efforts and to seek a place for tobacco cessation in the CHNA implementation plan.

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**Talking Points Linking Tobacco to Priority Community Health Needs**

What follows are high level talking points on the role of tobacco use in each of the priority community health needs that are impacted by tobacco. The goal is not to convince hospitals to change their priorities to include tobacco use, but to provide public health agencies with the ability to articulate why efforts to address most priority conditions will be more successful if tobacco cessation is included as a component.

The priority community health needs (e.g. behavioral health, substance abuse) are listed based on the importance of the condition relative to the American Lung Association's work, taking into account the order in which hospitals prioritized them in the 2014 review. The hospitals in your community will not necessarily select the same priorities or in the same rank order.

- The **bullet points** address the contribution of tobacco to the condition.

➢ The **arrow** is data regarding the positive impact of tobacco cessation on the primary condition.

<u>Behavioral health (Ranked 2nd across CHNAs)</u>

- Approximately 50 percent of people with mental illness and addictions smoke compared to 23 percent of the general population. While this group smokes half of all cigarettes produced, they are only half as likely as other smokers to quit.[3]
- Psychiatric disorders are more common among smokers than in the general population. The prevalence of depression among current smokers was consistently twice as high as among former and never smokers.[4]

➢ Smoking cessation is associated with reduced depression, anxiety, and stress and improved positive mood and quality of life compared with continuing to smoke. [5]

- The effect size seems as large for those with psychiatric disorders as those without.

➢ The effect of quitting tobacco is equal to or greater than anti-depressant treatment.[6]

➢ Nicotine suppresses the impact of psychiatric medication so doses can generally be reduced when lesser amounts of nicotine are present.[7]

<u>Substance abuse (Ranked 3rd across CHNAs)</u>

- Smoking-related diseases are a leading cause of death among individuals with substance abuse problems.[8]
- Tobacco dependence treatment does not interfere with patients' recovery from the abuse of other substances.[9]
- Opioids
  - According to the National Institute on Drug Abuse, more than two-thirds of people who abuse drugs also smoke cigarettes, and among smokers the craving for nicotine appears to increase the craving for illicit drugs.[10]

  - Cigarette smoking has also been determined to be a risk factor for prescription opioid abuse among chronic pain patients.[11]
  - Seventy-four to 97 percent of methadone-maintained individuals also smoke.[12]

- ➢ Nicotine smoking may extend the duration of heroin reinforcement.[13]
- ➢ Individuals who treat their addiction to tobacco and other substances at the same time are 25 percent more likely to sustain their recovery, compared to individuals who do not address tobacco while in recovery from other drugs.[14]
- ➢ Participation in a smoking cessation intervention provided during substance abuse treatment was associated with a 25 percent greater likelihood of long-term abstinence from alcohol and other drugs.[15][16]
- ➢ *Smoking cessation and alcohol abstinence: What do the data tell us?* (PDF Download Available).

Cancer[17] (Ranked 5th across CHNAs)

- Smoking accounts for about 30 percent of all cancer deaths in the United States.[18]
- Smoking accounts for about 80 percent of all lung cancer deaths.[19]
- Smoking is a risk factor for at least a dozen other cancers, including stomach, pancreas, liver, colon, bladder, cervix, kidney, larynx, mouth, pharynx, esophagus, and myeloid leukemia.[20]

- ➢ Patients with cancer who have recently quit smoking have an approximately two-fold increase in the five-year overall likelihood of survival from cancer.[21]
- ➢ Researchers have found that treating cancer patients with comorbid smoking, depression, and/or alcohol use had higher cessation rates compared with usual care.[22]

Heart disease: Cardiovascular disease, hypertension and stroke (Ranked 6th across CHNAs)

- Smoking causes stroke and coronary heart disease[23], which are among the leading causes of death in the United States (heart #1, stroke #4).[24]
- Even people who smoke fewer than five cigarettes a day can have early signs of cardiovascular disease.[25]
- Smoking increases the risk for coronary heart disease AND stroke by two to four times.[26]
- Increased blood pressure or hypertension is caused when smoking damages blood vessels and can make them thicken and grow narrower. This can also cause clots to form.[27]

➢ Quitting smoking can lower your risk of heart disease as much as, or more than, common medicines used to lower heart disease risk, including aspirin, statins, beta blockers, and ACE inhibitors.[28].

Respiratory (Ranked 11th across CHNAs)

- Lung diseases caused by smoking include COPD, emphysema, and chronic bronchitis.[29]
- COPD is the third leading cause of death in the United States.[30]
- Tobacco smoke (inhaled or second hand) can trigger an asthma attack or make the attack worse.[31]

➢ Smoking cessation is the only proven way of modifying the progression of COPD.[32]

Diabetes (Ranked 4th across CHNAs)

- Smoking is a cause of Type 2 diabetes mellitus and can make it harder to control. The risk of developing diabetes is 30-40 percent higher for active smokers than nonsmokers.[33]
- Smoking increases the risk of complications once diagnosed with diabetes, including heart and kidney disease, poor blood flow to legs and feet, blindness and nerve damage.[34]

➢ For smokers with diabetes, quitting smoking will benefit health immediately. People with diabetes who quit have better control of their blood sugar levels.[35]

Maternal and Child Health: Reproductive, perinatal and infant[36]: (Ranked 8th and 10th across CHNAs)

- Smoking can make it harder for a woman to become pregnant. It can also affect her baby's health before and after birth. Smoking increases risks for[37]:
    - Preterm (early) delivery
    - Low birth weight
    - Stillbirth (death of the baby before birth)
    - Ectopic pregnancy
    - Orofacial clefts in infants
    - Sudden Infant Death Syndrome (known as SIDS or crib death)
- Smoking can also affect men's sperm, which can reduce fertility and increase risks for birth defects and miscarriage.[38]

➢ Tobacco dependence interventions for pregnant women are especially cost-effective because they result in fewer low birth weight babies and perinatal deaths, fewer physical,

cognitive and behavioral problems during infancy and childhood and yield important health benefits for the mother.[39]

- ➢ Interventions promoting breast feeding to incentivize continued smoking abstinence may be effective prior to weaning. Those promoting breast feeding longer than six months and partner smoking cessation may increase rates of long-term smoking abstinence lasting longer than two years post-delivery.[40]

Oral health[41] Ranked 9th across CHNAs)

- Tobacco users brush and floss much less frequently than non-users and report more oral health problems.[42]
- Current smokers (16%) were twice as likely as former smokers (8%) and four times as likely as never smokers (4%) to have poor oral health status.[43]
- Smoking affects the health of your teeth and gums and can cause tooth loss.[44]

Obesity Ranked 1st across CHNAs)

- The most compelling reason to include tobacco cessation in efforts to address obesity is that smoking is conducive to greater accumulation of visceral fat and greater insulin resistance. As noted above, smoking increases the risk of metabolic syndrome and type 2 diabetes.[45]

**Determining if the Hospitals in Your State Have Conducted a CHNA and if Tobacco was Prioritized**

Two states were selected to use as test states to articulate how to identify which hospitals had identified tobacco use as a driver and if a strategy was included in the implementation plans. Oregon was selected because it includes over 60 tax-exempt hospitals, has a high community profile, is a Medicaid expansion state, and a recent report indicated that more than 70 percent of LHDs have collaborated with a non-profit hospital on a CHNA. Nevada was selected because fewer than 40 percent of LHDs have collaborated on a CHNA, is a Medicaid expansion state, has fewer hospitals (37) and a greater mix of for-profit and non-for-profit, has a statewide community health planning requirement in even-numbered years, and has several counties pursuing accreditation by the Public Health Accreditation Board (PHAB). The results below provide some guidelines that may be helpful for searches. We also provide a time estimate for both states.

The first four steps below will provide a public health professional with information about which hospitals have identified tobacco as a driver and which of those prioritized tobacco in the subsequent implementation plan. Step five describes three different outcomes in terms of next steps. Step six simply provides an estimate of the time it took to generate this information for our two trial states. This will help inform resource allocation decisions to obtain the information necessary to pursue working with hospitals and their CHNAs.

1. Every hospital in your state that is a 501(c)(3) federal tax-exempt organization is required to conduct a CHNA and adopt an implementation strategy.
    a. To find a list of tax exempt hospitals, you can search the state hospital association's website. Many state hospital associations publish a guide to the state's hospitals. Searching "Oregon hospital association" led us to their website, which in turn helped us find the Oregon Hospital Guide.
    b. You can also use the federal Medicare hospital compare site to identify all hospitals in your state https://www.medicare.gov/hospitalcompare/search.html.
    c. A general search of "hospitals in [state] or "nonprofit hospitals in [state]" also produces assorted lists.
    d. Create a spreadsheet and use that to track whether tobacco use was identified as a driver and if tobacco was prioritized in the implementation plan.
2. Do a web-based search for each hospital's CHNA.
    a. Perhaps the easiest approach is to do a global search such as "Nevada hospital community health needs assessment." Because the CHNAs and implementation plans must be posted, this typically provides a link to most of the state's hospitals' CHNAs. Your spreadsheet can help identify gaps.
    b. If you are not finding the CHNA using a global search, use IRS Form 990 Schedule H to find the hospital's CHNA and Implementation Plan

- The IRS requires all tax-exempt hospitals to file a Form 990 Schedule H that provides information regarding the CHNA and its implementation plan (see IRS Reporting Requirements in CHNA Background for more detail).
- Two sites the provide access to hospital 990s are:
    - http://www.communitybenefitinsight.org/?page=search.home
    - https://projects.propublica.org/nonprofits/

c. Be aware that some multi-hospital systems will do a CHNA for each hospital while others will do an integrated CHNA for the whole system.

3. Save the pdf CHNA plans as well as CHNA implementation strategies.
    a. Sometimes these are included in a single document and other times they are separate document.
4. Search the documents for the key word "tobacco." In reviewing content, look for two distinct components:
    a. If tobacco use is identified as a driver of poor health – typically found in the CHNA
    b. If a tobacco cessation strategy is included in the implementation plan
5. There are three possible outcomes
    a. Tobacco use as a driver, tobacco prevention or cessation as a strategy: This is the best possible outcome since it indicates that the hospital has prioritized tobacco control in its implementation plan. Review the document and consider how your agency may contribute to the hospital's strategy. This may mean suggesting alternative strategies to ensure ongoing success. Make sure to find out when the next CHNA will be conducted to ensure tobacco remains a priority.
    b. Tobacco use as a driver, no tobacco strategy: In this case, it is likely that the hospital will be receptive to identifying ways to integrate tobacco control but primarily in the context of the areas already prioritized. Review the document and identify what strategies were selected and for what conditions. It is likely that most of the conditions prioritized will have a tobacco component. Review the strategies and identify ways that a tobacco cessation component could accelerate progress. This provides an opportunity to reach out to the hospital to contribute to their efforts. If a CHNA will be redone soon (every three years), contact the hospital to find out who will be leading the work and suggest ways that your agency can contribute.
    c. Tobacco use not identified as a driver: If tobacco use is not viewed as a driver of poor health in the community, there will be no tobacco component in the

implementation plan. While more challenging, the process of linking tobacco to the drivers and strategies selected will identify mechanisms by which the public health agency can suggest adding tobacco. The goal is not to have the hospital change its mind about its priorities but rather to suggest ways to leverage available tobacco control resources to contribute to their selected priorities.

6. Time Estimate

    a. Oregon has over 60 hospitals and all but two are required to conduct a CHNA. The process of completing steps 1 – 4 took approximately five hours.

    b. Nevada has almost 40 hospitals with a slightly greater mix of for-profit than not-for-profit. The process of completing steps 1 – 4 took approximately two hours.

    c. If you need to search for a hospital's 990 it may take longer. Although the websites provided are helpful, it requires more careful searching to ensure you have the right organization (e.g. not the hospital's foundation that may go by the same name).

These time estimates are important because they underscore that it takes a relatively small investment of time to have a good understanding of which hospitals have identified tobacco use as a driver and which have also included tobacco cessation as a strategy in their implementation plans.

## Glossary of Acronyms

ACA – Affordable Care Act

The Patient Protection and Affordable Care Act, often shortened to the Affordable Care Act (ACA) is a United States federal statute enacted by the 111th United States Congress and signed into law by President Barack Obama on March 23, 2010.

CHA – Community Health Assessment

Community health assessment (CHA) is a systematic examination of the health status indicators for a given population that is used by health departments to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues.

CHIP – Community Health Improvement Plan

A community health improvement plan (or CHIP) is a long-term, systematic effort by health departments to address public health problems based on the results of community health assessment activities and the community health improvement process.

CHNA – Community Health Needs Assessment

Community health needs assessments (CHNA) and implementation strategies are required of tax-exempt hospitals as a result of the Patient Protection and Affordable Care Act.

COPD – Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) is a lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible.

IRS – Internal Revenue Service

The Internal Revenue Service (IRS) is a bureau of the Department of Treasury that is tasked with the enforcement of income tax laws and oversees the collection of federal income taxes.

990 - IRS Form 990 Schedule H
The tax documentation that a tax-exempt hospital must file with its tax return describing the community benefit it provides. It includes a section on CHNA process, product, and implementation plans.

LHD – Local Health Department

A local health department (LHD) is a government agency in the United States on the front lines of public health. Local health departments may be entities of local or state government and often report to a mayor, city council, county board of health or county commission.

PHAB – Public Health Accreditation Board

The Public Health Accreditation Board (PHAB) is a nonprofit organization dedicated to improving and protecting the health of the public by advancing and ultimately transforming the quality and performance of state, local, tribal, and territorial public health departments.

SHA – State Health Assessment

A State Health Assessment (SHA) is a systematic approach to accessing, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health. Similar to a CHA but at a statewide level.

SHIP - State Health Improvement Plan

The State Health Improvement Plan (SHIP) is a systematic plan to address issues identified in the SHA. Based on the SHA, the SHIP describes how the state health department and the communities it serves can work together to improve the health of the population.

SIDS – Sudden Infant Death Syndrome

Sudden infant death syndrome (SIDS) is the unexplained death, usually during sleep, of a seemingly healthy baby less than a year old.

**Recommended Resources**

The Catholic Health Association of the United States has a set of tools and websites to assist hospitals with assessing community health needs and developing implementation strategies. Reading these may assist your agency in determining how to help. Most PDF copies are free to download at several web pages, including:

- https://www.chausa.org/communitybenefit/assessing-and-addressing-community-health-needs
- https://www.chausa.org/communitybenefit/a-guide-for-planning-and-reporting-community-benefit
- https://www.chausa.org/communitybenefit/social-determinants-of-health
- https://www.chausa.org/communitybenefit/resources/resources-overview

The Oklahoma Hospital Association provided documents to address comprehensive tobacco control within hospitals. They will assist you in thinking about the range of projects a hospital can undertake to address tobacco use in the hospital. These include:

- Tobacco-Free Properties Policy: For many hospitals, this is a starting point activity in their efforts to support tobacco cessation in the community. Activities include efforts to support patients, visitors, employees, volunteers, vendors, and contractors.
- Patient Centered Tobacco Cessation/Nicotine Addiction Treatment – Inpatients
- Patient Centered Tobacco Cessation/Nicotine Addiction Treatment – Outpatients
- Employee Cessation Support and Treatment

For additional information, see www.okoha.com/hhpq.

Although many hospital CHNA Implementation Plans start with the kind of hospital-centric activities noted above, many also include community-based activities. These are in the direct domain of public health agencies (e.g. outreach to low income populations or high-risk populations), so the state and local public health resources already available in your state will be the most beneficial.

**Background: What is a CHNA?**

The Patient Protection and Affordable Care Act (ACA) added section 501(r) to the Internal Revenue Code which imposes new requirements on 501(c)(3) organizations that operate one or more hospital facilities. Under section 501(r), each hospital facility operated by a 501(c)(3) organization must meet the following four general requirements on a facility-by-facility basis in order for the organization to maintain its 501(c)(3) tax exempt status:[46]

1. Establish written financial assistance and emergency medical care policies
2. Limit amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the hospital's financial assistance policy
3. Make reasonable efforts to determine whether an individual is eligible for financial assistance before engaging in extraordinary collection actions
4. Conduct a CHNA and adopt an implementation strategy at least once every three years

The final regulations[47] (effective December 29, 2014) provide that a hospital facility must define the community it serves and assess the health needs of that community.

- Community served: For the purposes of a CHNA, a hospital facility may define the community it serves geographically or take into account target populations or specialized functions. However, a community cannot be defined in a manner that excludes medically underserved, low-income, or minority populations.
- Assessing community health needs: A hospital facility conducting a CHNA must identify and prioritize the significant health needs of the community it serves. Hospitals have flexibility in determining whether a health need is significant; there are no requirements to use a particular methodology or specific criteria to prioritize significant health needs (only examples of criteria are provided).
- Community input: A hospital facility must consider input from persons who represent the interests of the community served, including those with special knowledge or expertise in public health. The final regulations require that the hospital facility consider, at a minimum, input from the following:
    - ✓ At least one state, local, or regional governmental public health department
    - ✓ Members of medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing their interests
    - ✓ Written comments received regarding the hospital's most recent CHNA and most recently adopted implementation strategy

- Documentation: A hospital facility must document the following in its CHNA report:
  - ✓ Definition of the community served and how the community was defined
  - ✓ Process and methods used to conduct the CHNA
  - ✓ Community input received
  - ✓ Prioritized description of the significant health needs of the community and a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs
  - ✓ A description of resources potentially available to address the significant health needs identified

  A general summary of community input is required (including how and over what time period input was provided), but the report does not need to specifically name individuals who provided input. Every hospital facility must document its CHNA in a separate report. However, the proposed regulations recognize collaboration, and joint CHNA reports may be accepted under appropriate circumstances.
- Make the CHNA report widely available to the public: the CHNA report must be made widely available to the public via a hospital facility's website

**Internal Revenue Service Reporting Requirements: Form 990 Schedule H**

A tax-exempt hospital must file an IRS Form 990 Schedule H to provide information on the activities and policies of, and community benefit provide by its hospital facilities and other non-hospital health care facilities it operated during the tax year. Schedule H was revised after passage of the ACA to gather the information stipulated by the ACA and described above.

The IRS Form 990 Schedule H includes a checklist of the items required in the CHNA and a list of non-hospital facilities website(s) on which the CHNA was published. In Section C it requires further detail, including:

- How the hospital facility took into account input from people who represent the community
- The people with whom the hospital facility consulted.
- A list other hospital facilities or other organizations with whom the CHNA was conducted.
- How the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.

Schedule H also requires the hospital to attach its Implementation Strategy or reference a website where it can be found.

Although the Schedule H was made mandatory in 2009, the IRS has stated that the benefits of Schedule H are intended to be increased transparency, and compliance, and not to create a bright line standard for determining whether a hospital should be tax exempt.

There are two online sources that provide access to hospital 990s:

1. The Community Benefit Insight web site provides data to the public on non-profit hospital community benefit spending. Their tool to search specific hospitals can be found at: http://www.communitybenefitinsight.org/?page=search.home
2. ProPublica maintains a Nonprofit Explorer tool that provides access to summaries of millions of tax returns from tax exempt organizations. It provides IRS data released since 2013 and access to tax filing documents going back as far as 2001 and can be found at: https://projects.propublica.org/nonprofits/
    a. To find the 990s for a specific hospital, enter its name or city in the tool. You can also do a broader search by entering a geographic area (e.g. city, state), the nonprofit category of "health" and organization type 501(c)(3). Unfortunately, this can produce a very long list. For Nevada, this produced 529 organizations that filed a tax return for any fiscal year during the 2012-2017 calendar years.

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For more information, please visit www.lung.org/cessationta.

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