

Assessing & Addressing Community Health Needs

2015 EDITION II

CHA advances the Catholic health ministry of the United States in caring for people and communities. Comprised of more than 600 hospitals and 1,400 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation. Every day, one in six patients in the U.S. is cared for in a Catholic hospital.

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ASSESSING & ADDRESSING COMMUNITY HEALTH NEEDS

2015 EDITION II

Developed in cooperation with VHA and the Healthy Communities Institute



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FOREWORD

Responding to the health needs of our communities, especially to the most vulnerable among us, is central to the mission of Catholic and other not-for-profit health care organizations. To do so, we need to have an understanding of community health needs and use a deliberate approach for addressing those needs.

The importance of assessing community health needs and developing an implementation strategy to address selected needs was reinforced by the Patient Protection and Affordable Care Act (Affordable Care Act), enacted March 23, 2010. The law added new requirements for tax-exempt hospitals to conduct community health needs assessments and to adopt implementation strategies to meet the community health needs identified through the assessments.

Assessing community health needs and developing community benefit plans have been issues of concern to the Catholic Health Association (CHA) for over 25 years. Both issues were featured in the CHA's 1989 *Social Accountability Budget* and further described in CHA's 2008 *A Guide to Planning and Reporting Community Benefit*, developed in collaboration with VHA.

This resource draws on our previous work, the experience of community benefit professionals and expertise from the field of public health to describe how hospitals can assess community health needs and work with partners to develop effective strategies for improving health in our communities.

It is our hope that this publication will help hospitals identify the most pressing needs of their communities, develop and broaden relationships with community partners and dedicate resources where they are most needed.



Sr. Carol Keehan, DC
President and Chief Executive Officer

ABOUT US

THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

The Catholic Health Association of the United States (CHA), founded in 1915, supports the Catholic health ministry's commitment to improve the health of communities and provide quality and compassionate health care.

CHA is recognized nationally as a leader in community benefit planning and reporting. In collaboration with member hospitals, health systems and others, CHA developed the first uniform standards for community benefit reporting by not-for-profit health care organizations. These standards were used by the Internal Revenue Service to develop the Form 990, Schedule H for Hospitals.

www.chausa.org

VHA

Founded in 1977, VHA serves nearly 1,400 not-for-profit hospitals and more than 30,000 non-acute care providers nationwide. As a member-owned health care alliance, VHA has long supported and protected the value of not-for-profit hospitals.

VHA members work together and with VHA to drive maximum savings in the supply chain arena, set new levels of clinical performance, identify and implement best practices to improve operational efficiency and clinical outcomes, and improve the health status of the communities they serve. In the early 1990s, VHA introduced its voluntary community benefit standards followed by a series of resources and tools for effectively implementing an organization-wide community benefit strategy.

www.vha.com

HEALTHY COMMUNITIES INSTITUTE

The Healthy Communities Institute's mission is to help public and private community stakeholders in counties, regions and states improve the health and environmental sustainability of their communities through the use of the Healthy Communities Network. The Healthy Communities Institute provides innovative web-based solutions for hospitals conducting community health needs assessments and planning evidenced-based community benefit programs.

Tools are available that are specifically designed to support hospital organizations conducting community health needs assessments, and to help them plan evidence-based community benefit programs.

www.healthycommunitiesinstitute.com

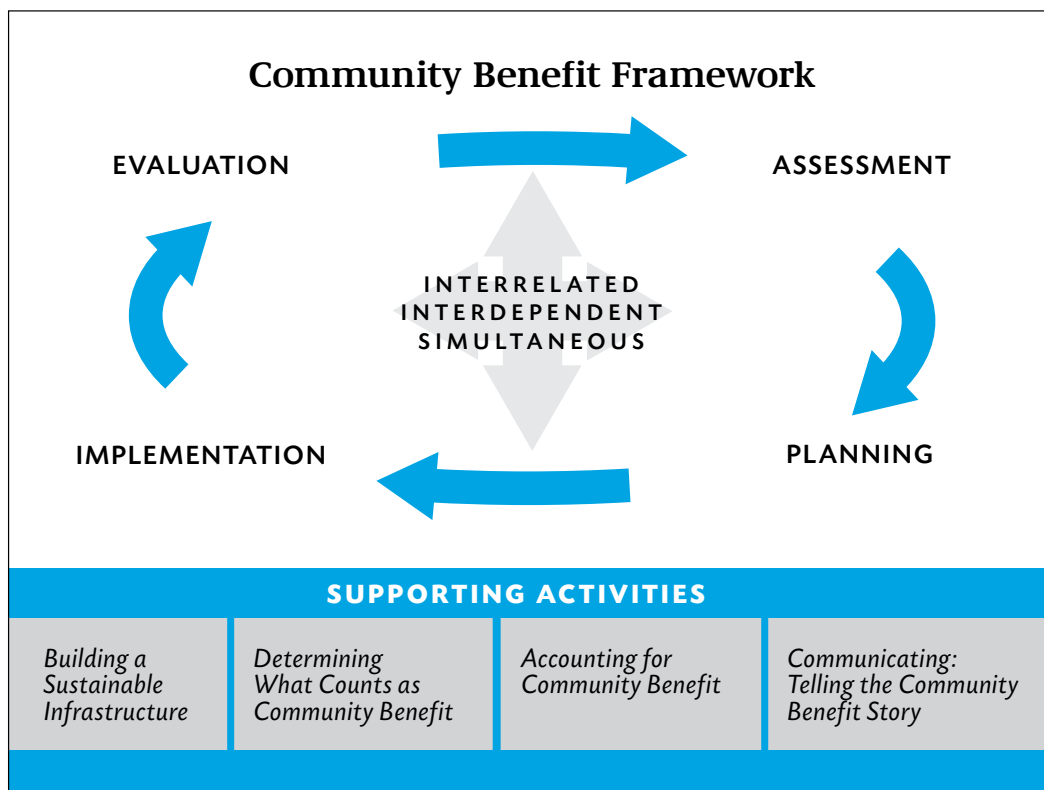
ABOUT THE BOOK

This book is designed to help tax-exempt hospitals assess the health needs of their communities and develop implementation strategies to address prioritized needs.

ASSESSMENT AND PLANNING – CORE COMMUNITY BENEFIT PROGRAMMING ACTIVITIES

The ultimate goal of not-for-profit health care organizations is to improve the health of the communities they serve. One way these organizations achieve this goal is through community benefit programs and activities that promote health and healing as a response to identified community needs.

Assessing community health needs and developing an implementation strategy to address prioritized needs are critical steps in developing community benefit programs as shown in the community benefit framework below. While this book focuses on assessment and planning all, the key components of the framework are described in CHA’s *A Guide for Planning and Reporting Community Benefit* (www.chausa.org/communitybenefitguide)



WHAT IS COMMUNITY BENEFIT?

Community benefits are programs or activities that promote health and healing in response to identified community needs and meet at least one of these community benefit objectives:

- ▶ Improve access to health care services.
- ▶ Enhance the health of the community.
- ▶ Advance medical or health care knowledge.
- ▶ Relieve or reduce the burden of government or other community efforts.

WHO SHOULD USE THIS BOOK?

This resource was developed especially for the hospital staff responsible for conducting or overseeing community health needs assessments and planning community benefit programs.

Others with an interest in community health may find this book useful as well. These could include staff within the organization such as administrators, clinicians, population health management leaders and strategic planners, and community partners such as policy makers, consumer advocates, public officials and representatives of community groups.

HOW TO USE THIS BOOK

- ▶ All readers should review the Introduction, which outlines why this resource was developed, guiding principles for assessment and planning and definitions of a community health needs assessment and implementation strategy.
- ▶ If you are new to community benefit, we recommend starting with another resource, CHA's *A Guide for Planning and Reporting Community Benefit*, paying special attention to the sections on getting started and building a sustainable infrastructure.
- ▶ If you are new to community health assessment and/or program planning, review Section II - Key Concepts. This will give you an overview of the task ahead and a preview of important considerations as you and your team move forward.

- ▶ If you need guidance on how to involve the community, go to the Build (on) Community Relationships in Section V. Community involvement can take your assessment and plans to a new level with greater potential for improving community health.
- ▶ If you already have processes in place to assess community health needs and develop an implementation strategy, you may find new approaches and tools to enhance these processes in Sections III and IV.
- ▶ If you would like a quick overview of the elements in a community health assessment and an implementation strategy, go to Appendix A.

RELATED ONLINE RESOURCES

This information is supplemented by resources, tools and sample materials on the CHA website at www.chausa.org/guideresources under the Planning for Community Benefit heading.

Please note: The guidance in this resource should not be considered legal or tax advice. Health care organizations should consult the most recent guidance from their state and the Internal Revenue Service (IRS) regarding required reporting of community health needs assessment and community benefit planning information.

NEW TO THIS EDITION

This Fall 2015 edition of *Assessing & Addressing Community Health Needs* has been updated to align with final regulations issued by the Internal Revenue Service in December 2014 (“Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return; Final Rule,” 79 FR 78953 [December 31, 2014], pp. 78953-79016). The final rules discuss community health needs assessments, implementation strategies and establishing hospital financial assistance and billing and collection policies. These regulations implement new requirements for charitable hospitals imposed by Section 501(r), added to the Internal Revenue Code by the Affordable Care Act (ACA).

While the final rules are mostly consistent with earlier guidance issued by the IRS in April 2013 (“Community Health Needs Assessments for Charitable Hospitals,” 78 FR 20523 [April 2, 2013], pp. 20523-20544) they do contain important modifications and clarifications in the following areas:

- ▶ Expands examples of health needs to include preventing illness and addressing the social determinants of health.
- ▶ Gives hospitals flexibility if they are unable to obtain required community input.

- ▶ Adds requirement to use community input in setting priorities as well as in the assessment process.
- ▶ Requires that CHNA documentation must include evaluation of impact of any actions that were taken to address significant health needs since the previous assessment. The requirement that implementation strategies include a plan to evaluate planned actions was deleted from the final rule but the strategy still must include anticipated impact of planned actions.

To view a complete summary of the final rule and a checklist for compliance, visit the CHA website at www.chausa.org/communitybenefit.

Introduction



I

SECTION I

INTRODUCTION

Mission-driven, tax-exempt health care organizations have a long tradition of working to improve community health through community benefit activities. Now, as hospitals align and integrate community health improvement goals with other strategic priorities, community benefit leaders recognize that they need a systematic approach to assessing community needs and planning community benefit programs to help ensure that their efforts will impact the health of the communities they serve.

Federal law requiring health care organizations to assess the health needs of their communities and adopt implementation strategies to address these needs also drives the need for more structured assessment and planning processes.

This book was developed to meet these two major needs of mission-driven, tax-exempt health care organizations: first, to continually improve the effectiveness of their community benefit programs; and secondly, to address legal requirements. It also looks at ways to work more effectively with community members and public health experts in both assessment and planning for community health improvement.

FEDERAL AND STATE REQUIREMENTS

Federal law and laws in many states require tax-exempt hospitals to conduct periodic community health needs assessments and adopt plans to meet assessed needs.

In order to comply with federal tax-exemption requirements in the Affordable Care Act, a tax-exempt hospital facility must:

- ▶ Conduct a community health needs assessment every three years. The assessment must
 - Take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.
 - Be made widely available to the public.
- ▶ Adopt an implementation strategy to meet the community health needs identified through the assessment.
- ▶ Report how it is addressing the needs identified in the community health needs assessment and a description of needs that are not being addressed with the reasons why such needs are not being addressed.

In addition to these new federal requirements, many states require tax-exempt hospitals to conduct community needs assessments and develop community benefit plans, in varying degrees of specifications.

Check the Compliance/Public Policy section of CHA's community benefit website (www.chausa.org/communitybenefit) for federal regulations and a description of state requirements.

WHAT IS A COMMUNITY HEALTH NEEDS ASSESSMENT AND AN IMPLEMENTATION STRATEGY?

CHA worked with several leading public health experts and community benefit professionals to develop the following definitions:

*A **community health needs assessment** is a systematic process involving the community to identify and analyze community health needs and assets in order to prioritize these needs, and to plan and act upon significant unmet community health needs.*

*An **implementation strategy** is the hospital's plan for addressing community health needs, including significant health needs identified in the community health needs assessment. The implementation strategy is also known as the hospital's overall community benefit plan.*

GUIDING PRINCIPLES

CHA's *A Guide for Planning and Reporting Community Benefit* details a set of core beliefs that underpin community benefit programs. These core beliefs also guide the assessment and planning processes:

- ▶ *Those who live in poverty and at the margins of our society have a moral priority for services.* While assessments will look at the health needs of the overall community, low-income and other disadvantaged people deserve special attention and priority. Their needs should be a top priority and implementation strategies should include interventions to address these needs.
- ▶ *Not-for-profit health care has a responsibility to work toward improved health in the communities they serve.* While assessment and planning are key steps in the overall process to improve community health, they are not ends in themselves. Assessment results and the implementation strategy must be put into action and these actions should be evaluated and refined, as needed, to ensure that the community and community partners are achieving their ultimate goal – improved community health.
- ▶ *Health care facilities should actively involve community members, organizations and agencies in their community benefit programs.* Collaboration among providers and community partners expands the community's capacity to address health needs through a shared vision, shared resources and skills, and creates a foundation for coordinated efforts to improve community health.
- ▶ *Health care organizations must demonstrate the value of their community service.* Government (at all levels), community members, funders and others committed to improving community health want to know that tax-exempt hospitals are aware of the major needs of the community and that their community benefit planning takes into account these needs.
- ▶ *Community benefit programs must be integrated into the organization's overall planning.* The results of the assessment and the community benefit plan should be integrated with the strategic and operational plans of the organization. This will ensure that the organization allocates the necessary resources to carry out these processes effectively.
- ▶ *Leadership commitment is required for successful community benefit programs.* As leaders of charitable organizations, hospital board members, chief executive officers and senior managers should view access to health care and improved community health as important concerns of their organizations. Leadership commitment helps ensure that assessment and planning processes are viewed as organizational priorities and the results are used to implement programs that will improve community health.

NOTES

Key Concepts



II

SECTION II

KEY CONCEPTS

This section covers aspects of assessment and implementation strategies to consider before you start these activities. Addressing these “key concepts” in your initial planning will increase the effectiveness of your efforts.

COLLABORATE WITH OTHERS

Conducting a community health needs assessment and developing an implementation strategy are good opportunities to initiate or strengthen relationships within the communities you serve. Engaging the community will not only improve your assessment and implementation strategies, it can lead to successful collaborations for addressing community health needs.

Productive and meaningful community engagement throughout the process can also lead others in the community to take ownership of needs that cannot be addressed by the hospital.

Federal law regarding community health needs assessments requires hospitals to take into account input from persons who represent the broad interests of the community served by the organization, including experts in public health. This is another reason to ensure that securing community input is effectively incorporated into your assessment and planning efforts.

See Section V, Build (on) Community Relationships, for more information on potential partners and how to engage community members throughout the process. Also see Section III, Step 1.2, Plan for Community Engagement, on specific ways to involve the community in the assessment process and Section IV, Steps 1, Plan and Prepare for the Implementation Strategy and 2, Develop Goals and Objectives and Identify Indicators for Addressing Community Health Needs, for ways to include the community in the implementation strategy development process.

MAKING THE CASE FOR COLLABORATION

Collaborating across the community allows the hospital to 1) leverage existing assets in the community creating the opportunity for broader impact; 2) avoid unnecessary duplication of programs or services thereby maximizing the use of scarce resource; and 3) help build the capacity of community members to engage in civic dialog and collaborative problem solving, positioning the community to build upon and sustain health improvement activities.

DEFINE YOUR COMMUNITY

How community is defined serves as the foundation on which subsequent assessment and implementation strategy decisions are made.

In defining your community you should consider your hospital's:

- ▶ Primary service area.
- ▶ Secondary service area.
- ▶ Patient categories (e.g., general population, children-only or rehabilitation-only).

Also consider areas and populations that are beyond the hospital's traditional service boundaries:

- ▶ Areas and populations served by your hospital's community benefit programs.
- ▶ Opportunity areas – neighborhoods and other geographic areas having at-risk populations.

If the assessment is being conducted with other organizations such as other hospitals, public agencies and community groups, it is important to agree on the definition of the community to be assessed.

See Section III, Step 2.2, Determine the Scope of the Needs Assessment, for more detail on how to define the community to be assessed.

BUILD UPON EXISTING ASSESSMENTS AND INTERNAL INFORMATION

Use prior assessments

An existing health needs assessment of your community can serve as a starting point for your efforts.

In addition to your organization's previous community health needs assessment find out if your local or state health department, or a local organization such as the United Way, have developed an assessment that included community health information.

If there is an existing assessment, ask questions to determine how you can best use the data:

- ▶ Is the information valid and well-documented with regard to data sources and collection methods?
- ▶ What time period does the data used in the assessment or report cover? Even outdated information can help you identify historical health needs and trends.

See Section III, Step 3, for more guidance about how to review existing assessments.

Use internal information

As part of their strategic planning efforts, most hospitals collect a wide range of information about the communities they serve. This can include information about unmet community health needs. Therefore, staff from the strategic planning department should be part of the internal assessment team that will carry out the assessment. They can identify what information the hospital has already collected that can also be used in the community health needs assessment.

USE PUBLIC HEALTH DATA

The best sources for reliable, statistically valid and comparable health data are federal and other public health agencies. Whenever possible, use this data as the basis of your assessment efforts.

Visit the website of Partners in Information Access for the Public Health Workforce (http://phpartners.org/health_stats.html), a collaboration of U.S. government agencies, public health organizations and health sciences libraries for links to many federal, state and local agencies that publish health statistics.

BECOME EXPERT AT FINDING SOUND, PUBLISHED DATA

Hospitals should be good data finders and users, not data generators. Hospitals and those working with them on community health needs assessment should focus their time and resources on validating and supplementing public health data findings through targeted surveys and interviews and forums with community members and other key informants.

Julie Trocchio, Catholic Health Association

See Section III, Step 3, for more information on public health data.

PLAN TO UPDATE THE ASSESSMENT AND IMPLEMENTATION STRATEGY

As you plan your assessment and develop your implementation strategy, consider how they will be updated to reflect:

- ▶ Changing community needs and priorities.
- ▶ Changes in available resources.
- ▶ Evaluation results of specific programs addressing community health needs.

Make the assessment sustainable over time

Select tools and approaches that allow you to update information and evaluate progress toward community health goals. The value of a community health needs assessment is enhanced when the data and process become part of ongoing strategic or collaborative efforts.

Suggestions to ensure assessment sustainability include:

- ▶ Choose data sources that collect and publish data periodically. This will allow you to track changes over time and examine trends.
- ▶ If you choose to collect your own data, ensure that the data collection can be replicated over time so that progress towards goals can be evaluated.
- ▶ Choose tools that support an ongoing, rather than periodic approach to assessment. Online web-based systems are available that update data on an on going basis, thereby presenting both a snapshot and moving picture of community health.

Make the implementation strategy sustainable over time

Just like your community health needs assessment, the implementation strategy should be dynamic. It will need to be updated as new information becomes available: changes in community needs, changes in resource availability and the effectiveness of the implementation strategy and supporting programs.

- ▶ Set time frames for periodic review of information about the community.
- ▶ Monitor availability of resources required to carry out the implementation strategy.
- ▶ Make evaluation part of the implementation strategy and all supporting community benefit programs. Have in place processes that will ensure that evaluation findings are used to improve the strategy and supporting programs.

For more information on updating your implementation strategy, see Section IV, Step 8.

UNDERSTAND ORGANIZATIONAL IMPACTS OF LEGAL AND REGULATORY REQUIREMENTS

The Introduction to this book describes federal requirements for charitable hospitals to conduct CHNAs and adopt implementation strategies enacted as part of the 2010 Affordable Care Act. Many states also have requirements related to community benefit planning and reporting. It is very important for community benefit, finance and legal staff in hospital organizations to clearly understand these requirements and how they impact their community benefit planning, implementation and reporting processes.

For example, the federal requirements related to CHNAs and implementation strategies require these two documents to be completed and then adopted by an authorized body of the hospital by specific times. Since boards of organizations often meet only a few times a year it is important to consider their meeting schedules in the overall CHNA planning schedule. The federal requirements also lay out certain ways to share the results of the assessment and report on actions taken to address significant health needs identified in the assessment through websites and regulatory filings (e.g., Form 990). To meet these requirements community benefit leaders need to work with others in their organizations (e.g. staff in communications, finance and compliance). Some organizations may need to build these interdepartmental relationships to ensure that sharing of information is coordinated and timely.

For more information on federal and state tax-exemption and community benefit requirements, visit the CHA website at www.chausa.org/communitybenefit and go to the Compliance/Public Policy page.

Conducting a Community Health Needs Assessment



III

SECTION III

CONDUCTING A COMMUNITY HEALTH NEEDS ASSESSMENT

INTRODUCTION

A community health needs assessment is a systematic process involving the community to identify and analyze community health needs and assets in order to prioritize, plan and act upon unmet community health needs. This process results in a product: a summary report.

The process

Steps for health care organizations conducting a community health needs assessment include:

- Step 1:** Plan and prepare for the assessment.
- Step 2:** Define the community.
- Step 3:** Identify data that describes the health and needs of the community.
- Step 4:** Understand and interpret the data.
- Step 5:** Define and validate priorities.
- Step 6:** Document and communicate results.

The product

A summary report of the community health needs assessment should include the following, as required by IRS regulations:

- ▶ Definition of the community served by the hospital and description of how it was determined.
- ▶ Description of the process and method used to conduct the assessment.
- ▶ Description of how hospital took into account input from persons who represent the broad interests of the community.
- ▶ Prioritized description of the significant health needs of the community.
- ▶ Description of the process and criteria used to identify certain needs as significant and to prioritize those significant needs.

ASSESSMENTS CAN BE CATALYSTS FOR CHANGE

Community health status assessment can be among the most powerful community development/community health improvement tools we have available. A well-organized community assessment can be the focal point and catalyst for tremendous community change.

James Burdine, Texas A&M School of Rural Public Health

STEP 1: PLAN AND PREPARE FOR THE ASSESSMENT

In this step you will:

- 1.1 DETERMINE WHO IN THE HOSPITAL WILL PARTICIPATE IN THE NEEDS ASSESSMENT PROCESS.
 - 1.2 PLAN FOR COMMUNITY ENGAGEMENT.
 - 1.3 ENGAGE HOSPITAL BOARD AND EXECUTIVE LEADERSHIP.
 - 1.4 DETERMINE HOW THE COMMUNITY HEALTH NEEDS ASSESSMENT WILL BE CONDUCTED.
 - 1.5 IDENTIFY AND OBTAIN AVAILABLE RESOURCES.
 - 1.6 DEVELOP A PRELIMINARY TIME LINE.
-

Please note: as you work through activities in this step, you will notice that the activities are not necessarily sequential. The activities inform one another and are interrelated.

1.1

DETERMINE WHO IN THE HOSPITAL WILL PARTICIPATE IN THE NEEDS ASSESSMENT PROCESS

Assessment leader

A hospital staff person should be selected to lead the hospital's community health needs assessment efforts. The following are examples of staff who might fill this lead role:

- ▶ Director or staff member of the community benefit department.
- ▶ Assessment expert from the organization's strategic planning office.
- ▶ Other staff member with experience and expertise in community health assessment.

The duties of the staff leader will vary, but potential responsibilities include:

- ▶ Forming an internal team.
- ▶ Identifying and working with community partners.
- ▶ Investigating any existing assessments or current assessment processes.
- ▶ Leading a process to help hospital decide whether to conduct assessment on its own or in collaboration with community partners.
- ▶ Developing a budget of financial and other resources needed for the assessment.
- ▶ Identifying sources for data and expert consultation.
- ▶ Developing a time line for the assessment and making sure that time lines are met.
- ▶ Informing the board and executive leadership about progress, challenges and findings.
- ▶ Developing a plan for setting priorities.
- ▶ Maintaining communications with all people and groups interested in the assessment.

Internal assessment team

One of the first tasks of the assessment leader may be to establish an internal team. Identify hospital staff members with expertise, interest and availability to contribute to the assessment process.

The internal team should have a diverse set of knowledge and skills including experience with assessments, familiarity with the health needs of the community and knowledge of hospital and community resources. If possible, it is recommended that the internal team include individuals with expertise in public health and statistical analysis.

The team may include staff and managers from the following departments:

- ▶ Community benefit.
- ▶ Mission.
- ▶ Strategic planning.
- ▶ Population health management.
- ▶ Communications.
- ▶ Admissions.
- ▶ Finance.
- ▶ Emergency.
- ▶ Community relations.
- ▶ Social services and discharge planning.
- ▶ Clinical areas.

RECRUIT DOERS AND INFLUENCERS

Select a combination of doers and influencers. Doers are people who will be willing to roll up their sleeves and do the physical work needed to see that the [assessment] is planned and implemented properly. Influencers are those who, with a single phone call or signature on a form, will enlist other people to participate or will help provide the resources to facilitate the [assessment].

Make sure the [staff team] is large enough to accomplish the work, but small enough to be able to make decisions and reach consensus. If necessary, subcommittees can be formed to handle specific tasks.

Source: McKenzie, Neiger, and Smeltzer (2005). Planning, Implementing, and Evaluating Health Promotion Programs: A Primer. 4th edition.

The role of the internal team is to support the hospital's community health needs assessment efforts, including:

- ▶ Reviewing and advising on budgets and time lines.
- ▶ Reviewing existing assessments and/or reports.
- ▶ Monitoring and advising on data collection and analysis.
- ▶ Establishing and maintaining community partnerships and/or relationships.
- ▶ Participating in setting priorities.
- ▶ Being a champion for the assessment process.

1.2

PLAN FOR COMMUNITY ENGAGEMENT

Involve members of the community from the beginning of the community health needs assessment process. See Section V, Build on Community Relationships, for examples of community members and organizations a hospital can work with to conduct an assessment.

Possible ways members of the community can become involved include:

- ▶ Join the advisory committee membership.
- ▶ Help to define the community for the needs assessment.

- ▶ Participate in focus groups and community forums.
- ▶ Help with priority setting or validation.

Assessment advisory committee

Most hospitals will use an advisory committee in the needs assessment process. If the hospital has an existing community benefit advisory committee, consider using this group as a starting point.

The assessment advisory committee should include community stakeholders and representatives of organizations knowledgeable and interested in community health issues. Include representative(s) from the local health department. If two or more organizations are partners in the assessment, include representatives from each partner organization. The advisory committee can collaborate with the internal assessment team to address the roles and responsibilities highlighted earlier in this step.

If your hospital is considering joining a community coalition or partnership that will conduct the assessment, find out how your organization can ensure that the effort will include community representatives, including public health experts, that will provide a comprehensive view of the community's needs.

1.3

ENGAGE HOSPITAL BOARD AND EXECUTIVE LEADERSHIP

Involve members of the executive staff and the organization's board from the beginning of the assessment process. Their involvement will show the community that the health assessment is considered a priority for the organization and will lend credibility to the needs assessment process. In addition, their expert advice and approval will be needed in the prioritization process.

Finally, the board and executive leadership can support integration of the assessment findings into the hospital's organizational strategy and other organizational plans. They can also help secure the necessary resources to address identified priorities.

The role of executive leaders may include:

- ▶ Appointing qualified staff to lead the assessment and implementation strategy efforts and giving them the authority to speak to the community on behalf of the organization.
- ▶ Allocating sufficient financial and human resources to the process.
- ▶ Keeping the board informed about the assessment and implementation strategy.

- ▶ Contributing information to the assessment from discussions with community leaders and other providers.
- ▶ Being champions for assessment and the implementation strategy both inside and outside of the organization.
- ▶ Establish relationships with leaders of community organizations and groups who are working to improve community health to promote and strengthen collaborative action.

The role of the board may include:

- ▶ Representing the interests of the community.
- ▶ Contributing information for the assessment based on their knowledge and observations of the community.
- ▶ Approving the CHNA report and implementation strategy.
- ▶ Discussing the findings from the assessment and progress of the implementation strategy.
- ▶ Participating in the setting of priorities among identified community health needs.

BOARD RESPONSIBILITIES

Final regulations require an authorized body of the hospital to adopt the CHNA report and implementation strategy. According to the regulations an authorized body of a hospital facility means “the governing body (that is, the board of directors, board of trustees, or equivalent controlling body) of the hospital organization that operates the hospital facility, or a committee of, or other party authorized by, that governing body to the extent such committee or other party is permitted under state law to act on behalf of the governing body; or the governing body of an entity that is disregarded or treated as a partnership for federal tax purposes that operates the hospital facility or a committee of, or other party authorized by, that governing body to the extent such committee or other party is permitted under state law to act on behalf of the governing body.”

1.4

DETERMINE HOW THE COMMUNITY HEALTH NEEDS ASSESSMENT WILL BE CONDUCTED

There are two options for developing a community health needs assessment: a single organization approach and a multiple organization partnership approach. The main differences between the two are described in the table below.

Ideally, the assessment will be approached as a partnership, and the hospital will be one of several community organizations (including other hospitals) and agencies collaborating to develop a needs assessment. However, this approach may not be feasible for all hospitals. Therefore, each organization should choose the approach consistent with its goals, resources and capabilities.

SINGLE ORGANIZATION APPROACH	MULTIPLE ORGANIZATION PARTNERSHIP APPROACH
Results intended for use primarily by the lead organization.	Results intended for use by multiple organizations.
Single organization establishes goals of assessment, identifies community needs, prioritizes issues and determines appropriate strategy for action.	Multiple organizations establish goals of assessment, identify community needs, prioritize issues and determine appropriate strategy for action.
Assessment may have a narrower focus.	Assessment will likely have a broader focus.
Assessment may be completed in a shorter time frame and at a lower cost.	Assessment processes may be more time-consuming, labor-intensive and expensive.
Single organization is responsible for the majority of the cost.	Multiple organizations can share the cost of the assessment.

Table adapted from *ACHI Community Health Assessment Toolkit*.

Before deciding on an approach, determine if there are any ongoing or existing needs assessments in the community. Contact your local health department and organizations such as the United Way to determine if a community assessment process is underway or planned.

If an assessment process is ongoing or another organization has planned to conduct a needs assessment, your hospital may be able to join this effort in order to produce a collaborative needs assessment report. For a more detailed discussion of potential partners and criteria for successful partnerships, see Section V and Appendix B.

IRS NOTE ON CONDUCTING THE ASSESSMENT WITH OTHERS

IRS regulations clarify that hospitals can use information collected by another organization or work in collaboration with others as long as each hospital posts its own separate assessment report. The regulations also state that a hospital organization may conduct a CHNA in collaboration with other organizations, including related organizations, other hospital organizations, for-profit and government hospitals, and state and local agencies, such as public health departments. The regulations go on to say that to ensure that each hospital facility meets the requirements separately, each hospital must document its needs assessment in “a separate CHNA report ... however, if a hospital facility is collaborating with other facilities and organizations in conducting its CHNA or if another organization (such as a state or local public health department) has conducted a CHNA for all or part of the hospital facility’s community, portions of the hospital facility’s CHNA report may be substantively identical to portions of a CHNA report of a collaborating hospital facility or the other organization conducting a CHNA, if appropriate under the facts and circumstances.”

The regulations do offer an exception to the general requirement of separate CHNA reports. If a hospital facility collaborates with other hospital facilities in conducting its CHNA, all of the collaborating hospital facilities may produce a joint CHNA report as long as all of the facilities define their community to be the same and conduct a joint CHNA process. In addition, the joint CHNA report must clearly identify each hospital facility to which it applies and an authorized body of each collaborating hospital facility must adopt the joint CHNA report as its own.

COORDINATE ASSESSMENT EFFORTS

Many entities are mandated to do a community health needs assessment – hospitals, state and local health departments and federal grantees. In 2011, a voluntary national accreditation program was launched for Tribal, state, local and territorial public health departments. Public health departments must complete a community health needs assessment and community health improvement plan as part of the accreditation process. As hospitals establish and refine their assessment and planning processes they should work with these other entities to find ways to coordinate their efforts to maximize their efforts for the least amount of expense. Community benefit leaders should also find out if any other department or program within the hospital has community needs assessment requirements.

Using consultants

Assessments conducted by either a single hospital or multiple organizations may use a consultant to assist in the process. Check to see if the local health department or other community agency or organization can provide this assistance. These organizations know the community and may be more helpful than an outside firm. Local universities, colleges or planning organizations might also be able to help.

Potential roles for a consultant include:

- ▶ Guiding and advising on the assessment process.
- ▶ Performing specific tasks, such as gathering available public health data, facilitating focus groups, analyzing and interpreting assessment data and helping to prioritize needs and develop the implementation strategy.
- ▶ Conducting the entire assessment. Before you take this approach, clearly identify how hospital staff and leaders will be involved in the assessment, especially the community engagement process.

Before you hire a consultant:

- ▶ Determine the consultant's expertise in public health and community health needs assessments.
- ▶ Ask for references from previous clients.
- ▶ Consider if the consultant has experience working with hospitals and community groups.

- ▶ Assess the consultant’s familiarity with tax-exemption requirements.
- ▶ Consider if the consultant is familiar with your community.
- ▶ Review reports of other assessments the consultant has conducted.

STAY INVOLVED IN THE PROCESS

If your organization decides to use a consultant, it is important that the hospital’s staff stay closely involved in the process. Community benefit leaders and other key representatives from the facility should be part of all aspects of the assessment process, even if the consultant has primary responsibility for completing the work. Many health care organizations discover that community assessment is about developing relationships and partnerships as much as it is uncovering health needs. The assessment process can be used to develop consensus about problems and priorities and to gain commitment of organizations to work together. In short, the process can be as important as the product, so stay involved.

1.5

IDENTIFY AND OBTAIN AVAILABLE RESOURCES

Before you start a community health needs assessment, get a general idea of the human and financial resources available for the assessment. This can be found both within your organizations and from the community at large. It may be helpful to discuss the following questions about resource availability with the internal assessment team, the board and executive leadership or the assessment advisory committee.

- ▶ Does a *hospital or community infrastructure* currently exist that can be built upon in conducting the assessment and developing the implementation strategy? This could include the hospital’s community benefit steering committee or strategic planning office or a community health coalition.
- ▶ Are there *people within your hospital who have assessment experience and expertise*, such as knowledge of data sources, developing environmental scans, gathering information on attitudes in the community and working with focus groups? Clinicians with advanced degrees in public health, strategic planners and communication specialists are examples of staff that may possess needed skills.

- ▶ Are there hospitals, public agencies or other *organizations already conducting or planning to conduct a community health needs assessment*? If so, can your organization participate and/or get the results? Local health departments, federally qualified health centers and some other organizations are expected to assess community needs – as well as hospitals.
- ▶ Who in the community can help in conducting the assessment? Are there community groups that can provide *in-kind support for the assessment* in the form of data, data analysis or access to community members – particularly those from low-income and disadvantaged populations?

1.6

DEVELOP A PRELIMINARY TIME LINE

Planning and conducting a needs assessment is a multistep process, and, as such, requires a reasonable time line. Hospitals should expect to spend approximately six to 18 months planning and conducting their community health needs assessment.

The time frame will depend on the approach selected for assessment (single organization or multiple organization partnership), the size of the hospital and its community, and the number of partners involved. The availability of financial and human resources may also influence the duration of the process.

IRS NOTE

IRS guidance indicates that a Community Health Needs Assessment (CHNA) should be conducted:

- ▶ Every three years.
- ▶ Considered “conducted” in the taxable year that the written assessment report is made widely available to the public as described in IRS regulations. If a version of the report that is marked as a draft is publicly released for the purposes of obtaining public comment, the report is not considered to be made publicly available and “conducted.”

Assessment steps and time lines from the field

These time lines were provided by a health system with hospitals, outpatient centers and eldercare services in the Midwest.

EXAMPLE ONE

A large hospital in a medium size city formed an internal team and hired a consultant to conduct personal interviews with more than 40 individuals including public health experts, low-income clinic providers, food pantry operators, crisis counseling centers and others. The hospital spent approximately \$35,000 to have the consultant come in, conduct interviews, research secondary data reports, analyze data and write a report. From start to finish, it took 11 months.

The major steps included:

- | | |
|---|----------|
| a) Organizing and planning leadership team meeting. | 1 month |
| b) Selecting the consultant and negotiating a written contract. | 1 month |
| c) Developing the scope and purpose and getting organizational buy-in. | 2 months |
| d) Coordinating consultant trips for interviewing community representatives – 2 trips, each lasting three days. | 2 months |
| e) Collecting the primary data and analysis of emergency department data. | 3 months |
| f) Writing reports, preparing the presentation and other group handouts. | 2 months |

Total = 11 months

EXAMPLE TWO	
<p>A hospital in a small town with a major state university, using the hospital system's in-house staff, conducted a similar assessment in seven months with a direct cost of approximately \$5,000. (Staff costs were an in-kind donation, so not included as part of the direct costs.)</p>	
The major steps included:	
a) E-mail exchanges to develop the scope and purpose and get a plan drafted and submitted for hospital leadership team.	1 month
b) Identification of people to interview in the area – coordinated by local hospital team.	1.5 months
c) Collection of secondary data for the area by the health system community benefit leader (going on at same time as step b).	1 month
d) Two visits to the community to interview and collect primary data.	1 month
e) Analyzing data, drafting reports, soliciting comments from hospital team, editing and presenting to the board.	3.5 months
Total = 8 months	

STEP 2: DETERMINE THE PURPOSE AND SCOPE OF THE COMMUNITY HEALTH NEEDS ASSESSMENT

In this step you will:

-
- 2.1 DETERMINE THE PURPOSE OF THE NEEDS ASSESSMENT.
 - 2.2 DEFINE THE COMMUNITY.
 - 2.3 REVISIT RESOURCE NEEDS.
-

2.1

DETERMINE THE PURPOSE OF THE NEEDS ASSESSMENT

The ultimate purpose of the community health needs assessment is to improve community health. This means it is much more than a report that fulfills regulatory requirements.

A community health needs assessment contains information that will be valuable to a variety of individuals and organizations, both inside and outside of the hospital, who are concerned about community health improvement.

Below are examples of additional possible purposes for an assessment and possible users and uses of assessment findings:

PURPOSE OF NEEDS ASSESSMENT	EXPECTED USERS	EXPECTED USE
Support community-based planning.	Community groups, health care organizations, public health officials, policy makers.	Providing community health stakeholders and decision-makers with public health information needed for community-wide planning.
Internal hospital planning.	Board of trustees, executive leadership, community benefit staff, strategic planners, advocacy or government relations staff, communications specialists.	A broad understanding of community health needs and assets is necessary to prioritize and plan community benefit programs, allocate resources, develop policy/advocacy positions and identify and strengthen community relationships that can support community benefit efforts as well as help plan for appropriate services to deliver care to the community.
Secure grants.	Hospital grant writers/foundation staff, foundations, benefactors.	Funders that support the hospital's community benefit efforts may want to focus on certain health issues or populations. Gathering information about these issues or groups should be included in the scope of the assessment.
Meet regulatory requirements.	Policy makers, regulatory agencies, elected officials.	Reporting is required by law or regulation. It should be noted that laws and regulations may dictate some aspects of the needs assessment process, including how data is collected and reported.

Identify all the reasons you are doing the assessment and what information is needed to fulfill each purpose. This will help you determine the scope of the assessment.

If your hospital is conducting the needs assessment as part of a multiple organization partnership, make sure to understand how the partnership's purpose for the needs assessment may coincide with and/or differ from yours. If there are certain elements of your hospital's purpose for conducting a needs assessment that are not being addressed by the partnership effort (for example, information needed for internal community benefit planning), your hospital may need to do additional work to collect and analyze the necessary information.

2.2

DEFINE THE COMMUNITY

The community is the geographic area, priority populations and the range of issues that will be included in the needs assessment. If there was a previous needs assessment conducted, its definition of community may be used to define the community for the current assessment.

Geographic area of the assessment

Here are some geographical areas you may want to include in the assessment, in addition to the organization's primary and secondary service areas:

- ▶ A nearby area federally designated as a medically underserved area (MUA) or health professional shortage area (HPSA). Visit <http://muafind.hrsa.gov> to find MUAs and HPSAs.
- ▶ An underserved area selected because of high need.
- ▶ An underserved area historically served by the organization or its sponsor.
- ▶ Areas selected based on ZIP codes of patients admitted to the hospital's emergency department for ambulatory care-sensitive conditions which indicate a lack of access to primary care. For a list of ambulatory sensitive conditions, visit <http://www.ahrq.gov/downloads/pub/ahrqqi/pqiguide.pdf>.
- ▶ Areas served by the hospital's community benefit programs.
- ▶ Areas identified by assessment partners or advisors.
- ▶ Neighborhoods and other geographic areas:
 - ▷ Having at-risk populations.
 - ▷ With limited access to health care resources/professionals.

- ▶ Impacted by adverse social/economic/environmental factors such as high unemployment, unsafe housing, failing schools or presence of high levels of toxic materials.

IRS NOTE

In defining the community IRS regulations state that the hospital may take into account all of the relevant facts and circumstances, including the geographic area served by the hospital, target population(s) served and principal function. However, a hospital may not define its community to exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital draws its patients (unless such populations are not part of the hospital's target patient population(s) or affected by its principal functions) or otherwise should be included based on the method the hospital uses to define its community. In addition, in determining its patient populations for purposes of defining its community, a hospital must take into account all patients without regard to whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital financial assistance policy. Treas. Reg. § 1.501(r)-3(b)(3).

Priority populations

Although initial data collection should focus on all populations in the geographic area covered the assessment (see above), you may want to collect information on specific, priority populations in this geographic area so they are not overlooked during the assessment process. All hospitals should pay special attention to low-income and vulnerable populations.

Potential priority populations include:

- ▶ Low-income seniors.
- ▶ Children.
- ▶ Pregnant women.
- ▶ Immigrants and migrant workers.
- ▶ Members of ethnic or minority groups.
- ▶ Residents of public housing.
- ▶ Uninsured and underinsured persons.
- ▶ Persons with certain disabilities or medical conditions.

ONE HOSPITAL, MANY COMMUNITIES

Some hospitals serve many communities: local, regional and national or even international. They may have different assessment strategies with different health need indicators for each.

For example, a children's hospital that is a regional poison control resource and nationally known pediatric transplant center could have a three-part assessment:

- ▶ Local area (nearby ZIP codes or city) for overall needs of children in the area including causes of illness, injury and death, risk factors and socioeconomic issues.
- ▶ Regional (multistate) for needs related to the public's knowledge of poisonous substances and incidence of accidental poisoning.
- ▶ National for the number and types of pediatric transplants in the U.S., including access and research issues.

IDENTIFY NEEDS

No matter how needs assessment is defined, the concept is the same: identifying the needs of the priority population and determining the degree to which these needs are being met.

Planning, Implementing & Evaluating Health Promotion Programs: A Primer, by McKenzie, Neiger, Smeltzer.

Range of issues

The community health needs assessment will examine health issues for the geographic areas and priority populations covered by the assessment, as well as the social and economic issues that influence health. The definition of community will be affected by the range of issues included in the assessment.

Health issues

Health needs assessments traditionally study data on mortality, morbidity and health risk factors. For a more detailed discussion of health indicators, see Section III - Step 3.4.

Social determinants of health

In order to fully understand the community health problems identified through health status data, it is necessary to also consider possible social and environmental factors that may be contributing to those problems. These are

known as the determinants of health. Understanding all aspects of health needs can help organizations develop programs that target the root causes of health problems and programs that focus on symptoms.

The U.S. Department of Health and Human Services recognizes that individual and population-level health is influenced by the relationships between policymaking, social factors, health services, individual behavior and biology and genetics. For this reason, they have chosen social determinants of health as one of its topics for Healthy People. To learn more about Healthy People visit www.healthypeople.gov.

SOCIAL DETERMINANTS OF HEALTH INDICATOR RESOURCES

- ▶ County Health Rankings & Roadmaps, (<http://www.countyhealthrankings.org/our-approach/health-factors>)
- ▶ NACCHO's *Resources for Social Determinants of Health Indicators*, (<http://www.naccho.org/topics/infrastructure/CHAIP/upload/Final-Resources-on-Social-Determinants-of-Health-112811.pdf>)
- ▶ CDC's *Data Set Directory of Social Determinants of Health at the Local Level*, (http://www.cdc.gov/dhdsp/data_set_directory.htm)
- ▶ Robert Wood Johnson Foundation's *A New Way to Talk about the Social Determinants of Health*, (<http://www.rwjf.org/content/dam/farm/reports/reports/2010/rwjf63023>)

2.3

REVISIT RESOURCE NEEDS

After you have defined the community that will be assessed, you can start to plan the budget for the assessment.

Start by reviewing the resources you obtained in Section III, Step 1.5, Identify and Obtain Available Resources.

Items to consider when planning your budget include:

- ▶ Assessment approach (e.g., purpose, scope, partners, need for consultants or outside expertise).
- ▶ Data collection and analysis resource needs.
- ▶ Need for help with facilitation of collaboration, planning and priority-setting.
- ▶ Report writing and dissemination.
- ▶ Operational expenses, including meeting supplies and communications costs.

As you plan your budget, ask:

- ▶ Can the scope of the assessment be achieved with available resources and within the preliminary time line?
- ▶ If not, will the scope or approach be revised or will additional resources be secured?

YOU MAY NEED TO REVISIT THE BUDGET

After determining your data needs, you may find that you need to collect additional information on specific areas or subpopulations. This may require additional resources.

STEP 3:

IDENTIFY DATA THAT DESCRIBES THE HEALTH AND NEEDS OF THE COMMUNITY

The community health needs assessment process will use data to describe the health needs of your community. Needs can vary from specific adverse health outcomes (e.g., high incidence of asthma) to poor quality of life indicators (e.g., high poverty rates).

To accurately understand and quantify the health and other characteristics of your community, it is necessary to use data that is both reliable and current. Outdated data or data that was not collected properly may inaccurately describe your community.

Today there are excellent data sources for public health information that have been verified by experts. Review available data before collecting new information.

In this step you will:

- 3.1 UNDERSTAND THE DIFFERENT TYPES OF DATA.
 - 3.2 REVIEW AND EVALUATE PRIOR ASSESSMENTS AND REPORTS.
 - 3.3 DESCRIBE COMMUNITY DEMOGRAPHICS.
 - 3.4 SELECT INDICATORS.
 - 3.5 IDENTIFY RELEVANT SECONDARY DATA FOR INDICATORS.
 - 3.6 COLLECT COMMUNITY AND PUBLIC HEALTH INPUT AND FEEDBACK.
-

3.1 UNDERSTAND THE DIFFERENT TYPES OF DATA

There are many different ways to describe data. This section will discuss four main ways to categorize data: qualitative, quantitative, primary and secondary.

Qualitative data is descriptive information. Typically, qualitative data is non-numeric; however, it can be coded into numeric categories for analysis. Qualitative data is considered to be more subjective but describes what is important to the people who provide the information (key informants such as community members, other providers).

An example of qualitative data is the finding of a focus group that asthma is among the top five health priorities for the community.

Quantitative data is numeric information. Quantitative data is considered to be more objective. An example of quantitative data is the number of children in your community with a history of asthma.

Please note: Qualitative data and quantitative data can be either primary or secondary data.

Primary data is new data that is collected or observed directly from first-hand experience. An example of primary data would be data collected from a telephone survey. It also includes information obtained through community forums and interviews.

While primary data has the potential advantage of directly addressing the data needs of your community health needs assessment, it is difficult to be sure of statistically sound results.

Quantitative primary data collection (use of original surveys) is discouraged for most hospitals. The ability to collect a nonbiased sample is dependent upon valid sampling methods and analysis, which are typically too expensive and time-consuming for individual organizations. There may be instances where your organization may need to collect primary quantitative data about your community that is not available from secondary data sources. In these situations you should consult an epidemiologist or biostatistician for help in designing and implementing the survey.

Additionally, since community health needs assessments will need to be conducted at least every three years, the funding for ongoing primary data collection should be built into subsequent budgets. The same survey will need to be conducted for each subsequent assessment, since collecting information at a single time-point will not allow for data trending and tracking progress towards goals.

Secondary data is data that has already been collected and published by another party. An example of secondary data would be the death rate due to asthma in your community published by the state public health department.

Secondary data is often free or inexpensive and is accessible directly from the original source. County, city and state public health departments and federal agencies (e.g., Centers for Disease Control and Prevention) provide the majority of the reliable secondary data related to health.

Secondary data from other public agencies, such as parks and recreation, public safety, education and housing, can help identify the social determinants behind health needs. Data.gov, website of the U.S. government's open data, allows users to access local, state and federal government data across agencies and sectors.

You will want to evaluate the applicability of the secondary data to your community health needs assessment to ensure that the geographies and variables evaluated align with your data needs.

3.2

REVIEW AND EVALUATE PRIOR ASSESSMENTS AND REPORTS

Depending on the age and quality of prior assessments or reports, you may be able to reference information from previous efforts in your community health needs assessment. Your work can build upon prior assessments and reports by continuing to track previously-identified needs and efforts to address them in your community.

Identify existing needs assessments and reports that focus on special populations such as children, seniors and minorities in your community. In addition to internal documents, these resources may be available from public health departments, nonprofit organizations, universities or community organizations. You may want to revisit the list of potential partners provided in Section V for assistance in identifying existing needs assessments and reports.

UNITED WAY

The United Way focuses on education, income and health needs, and therefore can be an important partner in a needs assessment. United Way organizations, especially those in large cities, often conduct regional community needs assessments to determine health and human service needs. Although the purpose of a United Way needs assessment may differ from a hospital's community health needs assessment, it remains a valuable resource. To find your local United Way or the largest United Way in your area, visit <http://liveunited.org>.

Even though existing needs assessments and reports may have been published by respected organizations, it is necessary to review and evaluate all data and conclusions for time lines, validity and relevance to the scope of your community health needs assessment.

Consider the following questions in your review:

Who conducted the assessment or report?

You may want to contact the authors of the assessment or report for clarification of methods, suggestions of resources or to determine if any future reports are planned.

When was the report published? What time period does the data used in the assessment or report cover?

Due to the time it takes for data to be collected, analyzed, summarized and published, the information in a report that was published several years ago may be outdated. However, older reports should not be discarded, as they may still provide valuable information, especially about historical health needs. They will also be useful in helping to identify trends in your community.

What populations and subpopulations does the data describe?

Consider the populations (age, race/ethnicity, geography, income groups) described by the data. In some communities, the overall population has good outcomes for important health measures, but specific subpopulations have poorer outcomes for the same measures. You should obtain subpopulation data whenever possible, in order to better describe needs. For example, infant mortality rates may have decreased overall, but for low-income families and minority mothers, the mortality rates may have actually increased.

What data sources were used?

Determine the types of data included in the report, and the sources of this data. One would expect to find information about vital statistics, communicable diseases, chronic diseases and health risk behaviors from local, state or federal public health agencies.

Generally speaking, if the data source is a government agency, such as a health department or the Centers for Disease Control and Prevention, it can be assumed that the data is valid and reliable.

If the data in the previous assessment were collected specifically for the assessment or report, you will want to confirm that sound data collection methods were used and documented since there are many statistical issues involved in data collection and analysis that can lead to biased findings. Consult or partner with a statistician or epidemiologist to help assess the validity and reliability of this information. See Appendix C for a discussion of epidemiological principles.

In surveys conducted by nonpublic health entities, primary data is often collected based on a “convenience sample” instead of a scientific or random sampling of the population. An example of a convenience sample would

be shoppers at a grocery store willing to participate in a data collection effort or members of a community group responding to a telephone survey. A convenience sample may not, and often does not, accurately represent the population.

What were the findings?

Review the results of the previous needs assessments or reports. Consider how your needs assessment process can build on or further contribute to these findings. Investigate if information about any priority populations you have identified were included.

Also look for identification of community assets that can be used to help address community health needs.

How was the assessment or report used?

Determine if the findings of the assessment or report were used to develop programs to address identified needs, reallocate resources or enact policy change. The information in Section IV, Step 4, Select Approaches, may be useful in planning your implementation strategy. If the assessment or report was not used by the community, try to determine why, in order to avoid similar outcomes for your assessment.

COUNTY HEALTH RANKINGS

The *County Health Rankings* measure the health of nearly every county in the nation. Published online at countyhealthrankings.org, the *Rankings* help counties understand what influences how healthy residents are and how long they will live. The *Rankings* look at a variety of measures that affect health, such as high school graduation rates, access to healthy foods, rates of smoking, obesity and teen births. The *Rankings* are unique in their ability to measure the overall health of each county in all 50 states. They have been used to garner support for local health improvement initiatives among government agencies, health care providers, community organizations, business leaders, policymakers and the public.

Build upon prior assessments

Each assessment should build upon the last one by tracking and trending indicators related to priority issues that the hospital is addressing, either alone or in partnership with others. This will help the hospital understand what impact its community benefit efforts are having on the health needs that it has chosen to address. In order to trend data, however, certain parameters need to be met in order to ensure that comparisons are valid. See Appendix C for more information.

While subsequent assessments should track current priorities, they should also take a step back and ensure that new needs are not missed.

REVIEW COMMUNITY AND STATE PRIORITIES

Find out if your community has a dashboard – or some public website where indicators of community health or wellbeing or resilience are being tracked. Many local governments or nonprofits have built them for their communities. When you are selecting indicators for your assessment (see Step 3.4) consider aligning them with indicators being tracked by the community, if appropriate.

Also check to see if your state health department has a State Health Improvement Plan (SHIP). If your state has a SHIP, consider whether your assessment could measure the state's priorities locally.

3.3

DESCRIBE COMMUNITY DEMOGRAPHICS

To conduct a community health needs assessment, it is necessary to understand the demographics of your community. Examples of demographic information include population size, age structure, racial and ethnic composition, population growth and density.

Sources of demographic information

The U.S. Census is an important source of demographic information (see Section III, Step 3.5). Census Quickfacts (<http://quickfacts.census.gov>) provides county-level demographic information for all U.S. counties and compares county values to state values.

Demographic data is also available from various marketing and research organizations. The Economic and Social Research Institute (ESRI) and Nielsen Claritas are third-party vendors of demographic information. The benefit of using demographic information provided by a third-party vendor is that it is available at the ZIP code or Census tract level; however, you will usually have to purchase this data.

Check with your hospital administration or strategic planning office in advance of purchasing any demographic data, as many hospitals already purchase these demographic files for other purposes, and they may be able to share this data with you for use in your needs assessment.

3.4 SELECT INDICATORS

Indicators are measurements that summarize the state of health and quality of life in the community. A broad set of health and quality-of-life indicators should be included in the community health needs assessment. If you are conducting the assessment in partnership with other organizations, an indicator selection process might need to be developed to ensure that all participants have an equal voice in selecting indicators that align with the mission and purpose of the assessment.

Because each community is different, the indicator list you select for your community will differ from the indicator lists from other communities; however, there are certain categories of information that should be included in all assessments:

- ▶ Demographics and socioeconomic status.
- ▶ Access to health care (including access to mental health and dental services).
- ▶ Health status of overall population and priority populations.
- ▶ Risk factor behaviors (such as use of tobacco and other substances).
- ▶ Conditions related to top 10 causes of death.
- ▶ Child health.
- ▶ Infectious diseases.
- ▶ Natural environment.
- ▶ Social environment.
- ▶ Resources/assets.

Refer to Appendix D for suggested indicators for each of these categories.

THE COMMUNITY HEALTH STATUS INDICATORS REPORT

Published by the U.S. Department of Health and Human Services, it contains over 200 measures for each of the 3,141 United States counties, and may serve as a valuable resource for your community health needs assessment. For more information on Community Health Status Indicators, visit <http://wwwn.cdc.gov/communityhealth>.

Also consider the following when selecting indicators for the assessment:

- ▶ Standards and benchmarks.
- ▶ Organizational needs and priorities.
- ▶ Quality and usability of data indication.

Standards and benchmarks

In addition to indicators that reflect the categories listed above, it is also helpful to select indicators that relate to standards and benchmarks. The Department of Health and Human Service's Healthy People initiative provides national disease prevention and health promotion targets spanning many topic areas. The Healthy People website can be accessed at www.healthypeople.gov and provides topic overviews and specific objectives which can be helpful in the process of selecting indicators.

Many Healthy People objectives contain targets to be achieved by a certain year. Your community can use these targets to monitor progress towards Healthy People objectives (see Section III, Step 4.1).

You should also consider how your community compares to traditional standards, such as federal poverty standards, and alternate standards, such as benchmarks for a livable wage.

Finally, make sure you are aware of local and state health improvement priorities and consider how your assessment indicators might align with those priorities. Since what your organization or community coalition measures in its assessment will influence what activities or program will be implemented, this alignment can help ensure your implementation strategy supports broader health improvement efforts.

Organizational needs and priorities

Hospital needs or priorities may also influence which indicators you will select for the assessment:

- ▶ The indicators you select should provide the information you need to fulfill the purpose of the assessment as well as inform you about target geographic areas and priority populations. It is highly recommended that in addition to indicators of health status, your assessment should include indicators covering many of the social determinants of health. See Section III, Step 2.2, for more information on determinants of health.
- ▶ If your organization has a specialty or specific focus area, then your assessment may be more defined. For example, based on your hospital's primary focus, you may decide to address only children's behavioral and physical health, and choose indicators limited to this focus area.

- ▶ For hospitals and systems with specific priorities or missions, such as caring for homeless persons or preventing violence, include measures that reflect these issues, such as the number of homeless families or incidence of domestic violence.
- ▶ If your organization has a population management program for Medicaid beneficiaries, you may want to look at data and trends affecting this population.

Quality and usability of indicator data

Indicator data should be valid and reliable for both the target population and for subgroups of interest. For a discussion of validity and reliability, see Appendix C.

For analysis, it is helpful if the indicator data can be compared to:

- ▶ Other regions that are similar in population or size, or are in close proximity to your geographic region.
- ▶ Baseline data.
- ▶ A standard, such as Healthy People or the Federal Poverty Level.

The indicator data should be easily accessible and updated regularly. In selecting indicators, determine how often the data will be published – once, annually, biannually or every 10 years. Multiple data points will allow for analysis of trends and evaluation of interventions. If indicators rely on primary data, the continuing cost of collecting primary data should be considered.

DOCUMENT INDICATOR SOURCES

All indicator data sources should be carefully recorded. The Indicator Selection Tool (see Appendix E) provides a template for documenting your indicator selection process.

3.5

IDENTIFY RELEVANT SECONDARY DATA FOR INDICATORS

You will need to identify existing quantitative data that support the indicators you have selected to summarize the health and quality of life of your community.

Information about the health status of the U.S. population at the state and county level is routinely collected by governmental and non-governmental agencies through surveys and surveillance systems. Most of these data sources will be

accessible online. Hospital data is another important source of information about community health.

PUBLIC HEALTH SURVEILLANCE

Public health surveillance is an important source of secondary data. This is defined as the ongoing, systematic collection, analysis, interpretation and dissemination of data regarding health-related events for use in public health action to reduce morbidity and mortality and to improve health. This information may be collected and available from federal, state and sometimes local agencies.

You will need to revisit your indicator list after the available data sources have been identified, and may need to add or remove indicators based on data availability.

CHECK WITH YOUR STRATEGIC PLANNING OFFICE

Make sure to check with your hospital's office of strategic/business planning to see what information they have already collected for internal planning needs. They may have a significant amount of secondary data that you can use for the assessment process.

Federal government data sources

Health Data

There are many national surveys and surveillance systems available to assist you with your community health needs assessment. A comprehensive list of national, state and local public health data sources can be found on the Partners in Information Access for the Public Health Workforce's website (http://phpartners.org/health_stats.html) and several examples are provided in the text that follows.

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. More than 350,000 adults are interviewed each year, making the BRFSS the largest telephone health survey in the world. For more information, visit www.cdc.gov/BRFSS.

National Health and Nutrition Examination Survey

The National Health and Nutrition Examination Survey (NHANES) is designed to assess the health and nutritional status of adults and children in the United States. The survey is unique in that it combines interviews and physical examinations. Examples of data collected include percentage of adults age 20 and over with undiagnosed diabetes, mean daily caloric intake, and percentage of children aged one through five with elevated blood lead levels. For more information, visit <http://wwwn.cdc.gov/nndss/>.

National Notifiable Diseases Surveillance System

State health departments report data for over 60 selected nationally notifiable diseases to the CDC on a weekly basis. This information is collated and published weekly in the Morbidity and Mortality Weekly Report (MMWR). Examples of nationally notifiable diseases included gonorrhea, hepatitis A, rabies, and diphtheria. For more information, visit <http://wwwn.cdc.gov/nndss/>.

Census Data

The U.S. Census is constitutionally mandated and provides a complete count of the population every 10 years. The Census also releases population projections annually. Additionally, many state agencies provide population estimates.

The U.S. Census Bureau's American Community Survey (ACS) is a nationwide survey designed to provide to communities a look at how they are changing. The ACS collects population characteristics such as age, race and other demographic variables including transportation, housing and economic information.

Beginning with the 2005 ACS, and continuing every year thereafter, one-year estimates are available annually for geographic areas with a population of 65,000 or more. Three-year estimates are available for communities with populations greater than 20,000, and five-year estimates are available for all geographic areas (including Census tracts).

The U.S. Census online tool, the American Factfinder, is the easiest way to access data from the Decennial Census, the American Community Survey, the Puerto Rico Community Survey, the Population Estimates Program, the Economic Census and the Annual Economic Survey. The American Factfinder can be accessed at <http://factfinder2.census.gov/main.html>.

National Data Initiatives

The Community Health Data Initiative (CHDI), launched by the U.S. Department of Health and Human Services, is a collaboration between governmental and nongovernmental entities to provide community health data through a standard interface. Health data is available at the state level and selected data is available at the county level; however, depending upon your locality, data available

through CHDI may not be as recent as the data published by your state health department. The data available through the CHDI is currently available at www.healthindicators.gov.

State data sources

State Health Data

Nearly every state public health department operates surveillance systems, disease reporting systems, and behavioral health surveys. Additionally, almost all states have population-based cancer reporting systems. These sources often provide county-level data. This information can help you with your community health needs assessment.

Contact your health department to determine which survey and surveillance data are available. Several examples of state surveillance systems and surveys are listed below.

California Health Interview Survey

The California Health Interview Survey (CHIS) is the nation's largest state health survey. Conducted every two years on a wide range of health topics, CHIS data gives a detailed picture of the health and health care needs of California's large and diverse population. The survey provides statewide information on the overall population including many racial and ethnic groups and local-level information on most counties for health planning and important comparison purposes.

Minnesota Blood Lead Surveillance System

The Minnesota Blood Lead Surveillance System monitors lead testing activities and tracks the occurrence of elevated blood lead cases in the state.

Oregon Healthy Teens Survey

Oregon Healthy Teens is Oregon's effort to monitor the health and well-being of adolescents. An anonymous and voluntary research-based survey, Oregon Healthy Teens is conducted among 8th graders and 11th graders statewide.

State Vital Records

Vital records include birth certificates and death records, as well as marriage and divorce records. Because state law dictates vital records reporting, this information varies by state. Vital records can provide valuable information including birth and death rates, causes of death, birth outcomes and socioeconomic risk factors. Data is often available at the county level. Many state health departments provide vital record databases, which can be a valuable data source for your community health needs assessment.

County and Other Local Data Sources

County and local public health departments collect data in varying degrees. Check with your local public health agency to see what information is available.

Hospital information

Hospital and emergency department utilization data

Whenever possible, hospital utilization data should be included in your community health needs assessment. Your state hospital association or health department typically collects statewide data on hospital and emergency department utilization.

Within the hospital, quality assurance, medical records, strategic planning, marketing, or business intelligence (decision support) departments are likely to have access to hospitalization and emergency visit utilization data for your facility.

This health care utilization data can provide insight into the patterns and frequency of health care utilization. The Agency for HealthCare Research and Quality (AHRQ) has set the standard for defining preventable causes of hospital admission, as well as measures of quality of care. AHRQ's Prevention Quality Indicators (PQI) can be used to identify unnecessary hospitalization and the need for increased primary or preventive health services and interventions.

PQIs can be used to identify ambulatory care-sensitive conditions, which are defined by AHRQ as "conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease." Examples of ambulatory care-sensitive conditions include hypertension and low birth weight. For more information on PQIs, visit <http://www.qualityindicators.ahrq.gov>.

INTERNAL DATA

When thinking about internal data, community benefit leaders should look at special programs the hospital may offer (such as a "super utilizer" program or community health workers) to vulnerable or underserved populations in the community. Information from these efforts can offer different insights about patients and the broader community.

Other hospital or health system data

You may also gain helpful information from community benefit programs and reports. Program data and reports can tell you about populations and needs the hospital is currently addressing. For example, review your charity care populations. Where do they live? For what are they being treated?

If your hospital or health system is related to other providers, such as primary care sites, long-term care facilities or physician clinics, include appropriate information from these organizations.

Guidelines for compiling secondary data

Consider the following guidelines when compiling data from secondary sources:

- ▶ Record all data sources and reporting periods using the Indicator Selection Tool (see Appendix E) or a similar method.
- ▶ Seek sources of data that are online and publicly available.
- ▶ Use the most recent data available.
- ▶ Incorporate data from prior years, if available. This will allow you to see changes over time.
- ▶ Collect data for other regions, such as the entire state, or all counties within the state. This will allow for comparisons and rankings.
- ▶ Find data that will allow for evaluation of disparities. For example, the Census provides data by census tract (statistical subdivisions of a county) and thus allows for identification of specific geographic areas that may differ from neighboring geographies in terms of population, economic status and living conditions.

A note of caution: if you plan to compare an indicator over time, or to other regions, make sure the data was collected using the same methodology. Data collection methods can change over time, so making direct comparisons may be invalid. Any changes in data collection methods can be found in an accompanying methods document. If this is not readily available, contact the data source's survey administrator.

COMMUNITY HEALTH NEED INDEX

Dignity Health, in partnership with Thompson Reuters, developed the Community Need Index (CNI) to identify neighborhoods with significant barriers to health care access. The CNI identifies the severity of health disparity for every ZIP code in the United States and demonstrates the link between community need, access to care and preventable hospitalizations. Find it at <http://cni.chw-interactive.org/>.

3.6

COLLECT COMMUNITY AND PUBLIC HEALTH INPUT AND FEEDBACK

Community input helps to determine the perceived needs of the community and the community's assets available to address these needs. Collecting community input also allows you to directly connect with specific populations in your community, such as disadvantaged or minority populations.

Here are a few examples of information you can collect:

- ▶ What health problems are most troubling to community members?
- ▶ What are issues of concern to public officials – school principals, police and the health department?
- ▶ Are any community-based organizations, such as the United Way or a community coalition, already addressing issues?

FEDERAL REQUIREMENTS REGARDING COMMUNITY INPUT

Federal law (P.L. 111-148) requires that an assessment must take into account “input from persons who represent the broad interests of the community serviced by the hospital facility, including those with special knowledge of or expertise in public health.”

Internal Revenue Service (IRS) regulations indicate that in order to meet this requirement, the CHNA must at a minimum solicit and take into account input from all of the following sources:

- A) At least one state, local, tribal or regional governmental public health department health (or equivalent departments or agencies), with knowledge, information, or expertise relevant to the health needs of that community.
- 2) Members of medically underserved, low-income, and minority populations in the community served by the hospital facility or individuals or organizations serving or representing the interests of such populations. Medically underserved populations include populations experiencing health disparities or at risk of not receiving adequate medical care as a result of being uninsured or under insured or due to geographic, language, financial, or other barriers.
- 3) Written comments received on the hospital’s most recently conducted CHNA and most recently adopted implementation strategy.

In addition to the sources described above, the IRS regulations note that hospitals may solicit and take into account input received from a broad range of persons located in or serving its community, including but not limited to, health care consumers and consumer advocates, nonprofit and community-based organizations, academic experts, local government officials, local school districts, health care providers and community health centers, health insurance and managed care organizations, private businesses, and labor and workforce representatives.

In the event a hospital solicits, but cannot obtain, input from a source above, the hospital’s CHNA report must describe the hospital facility’s efforts to solicit input from such source.

There are a number of methods to collect community and public health input and feedback. You will want to select at least one approach for collecting community input and at least one for collecting input from those with a special knowledge or expertise in public health. This will ensure you have not overlooked any community priorities and have met legislative requirements. Refer to Section V for suggested groups and persons to include in these efforts.

CONSIDER DIVERSITY

Community input should reflect the racial and ethnic makeup of the community.

Methods of collecting community input

You can collect community input through primary data collection. Most of the methods listed below are for qualitative data collection. An exception is survey development, which can be considered quantitative data collection.

RESOURCES FOR COLLECTING COMMUNITY INPUT

The following resources provide useful tools for collecting community input:

- ▶ *Meaningful Consumer Engagement: A Toolkit for Plans, Provider Groups and Communities*, Community Catalyst, <http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement>
- ▶ Community Engagement website, Minnesota Department of Health, www.health.state.mn.us/communityeng/needs/needs.html
- ▶ Community Health Assessment Guide Book, from the North Carolina Department of Health and Human Services, <http://publichealth.nc.gov/lhd/cha/docs/guidebook/CHA-GuideBook-June2014.pdf>
- ▶ The Community Tool Box, from the University of Kansas. See Table of Contents/Chapter 3. Assessing Community Needs and Resources, <http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources>

Key informant interviews for collecting community input or input from those with a special knowledge or expertise in public health

Key informant interviews are a method of obtaining input from community leaders and public health experts one-on-one. Interviews can be conducted in person or over the telephone.

In structured interviews, questions are prepared and standardized prior to the interview to ensure consistent information is solicited on specific topics. In less structured interviews, open-ended questions are asked to elicit a full range of responses.

Key informants may include leaders of community organizations, service providers and elected officials. Individuals with a special knowledge or expertise in public health may include representatives from your state or local health department,

faculty from schools of public health, and providers with a background in public health. Emergency responders can also identify unmet needs of vulnerable populations. See Section V for a list of potential interviewees.

INTERNAL STAFF CAN BE A VALUABLE SOURCE OF INFORMATION

As you plan key informant interviews, consider physicians, nurses and other hospital staff as important sources of information about community health needs. Consider interviewing colleagues who work in the emergency department, pharmacy, case management, social services, community benefit/outreach and strategic/business planning. Senior leaders and board members can also provide insights into the needs of the community.

Surveys for collecting community input or input from those with a special knowledge or expertise in public health

Surveys can be used to collect information from community members, stakeholders, providers and public health experts for the purpose of understanding community perception of needs. Surveys can be administered in person, over the telephone, or using a web-based program. Surveys can consist of both forced-choice and open-ended questions.

Surveys are generally targeted to a larger population than interviews or focus groups. In this context, surveys are recommended to gather qualitative information such as community-perceived health needs. There may be instances where your organization may need to use surveys to collect quantitative health data about your community that is not available from secondary data sources. For example, secondary data might not be timely or at the neighborhood level. However, public health experts recommend caution in using original unproven surveys for documentation of quantitative information, such as the prevalence of obesity in your community. To produce statistically valid results an original survey would need to use validated questions and scientific sampling methods, which can be very difficult and expensive to do.

Community focus groups for collecting community input

Community focus groups are group discussions with selected individuals. A skilled moderator is needed to lead focus group discussions. Members of a focus group can include internal staff, volunteers and the staff of human service and other community organizations, users of health services and members of minority or disadvantaged populations.

Community forums for collecting community input

Community forums are meetings that provide opportunities for community members to provide their thoughts on community problems and service needs.

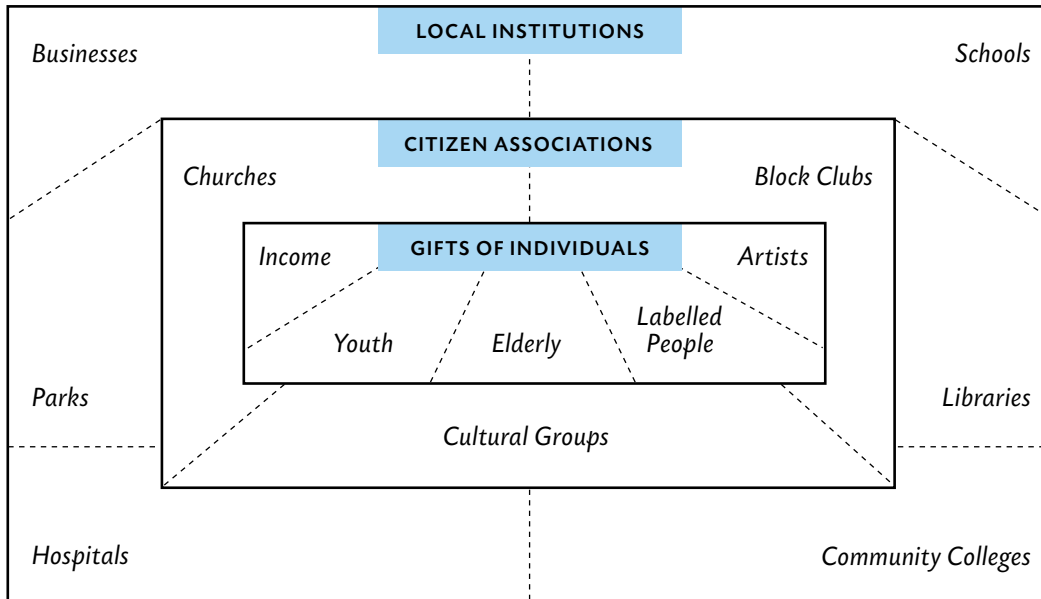
Community forums can be targeted towards priority populations. Community forums may require a skilled facilitator.

Tips for holding focus groups and forums:

- ▶ Be creative in reaching out to priority populations and consider holding multiple events to attract these groups.
- ▶ Hold focus groups and forums at convenient times (after traditional work hours).
- ▶ Hold focus groups and forums at convenient locations for priority populations, such as places of worship, senior centers, WIC centers or schools.
- ▶ Record the discussion. Ideally, take notes and use a voice recorder.
- ▶ Explore multiple points of view. Try not to let a single issue dominate the discussion.
- ▶ Clearly define the hospital's role: set expectations about what the hospital or partnership conducting the assessment can and cannot do.
- ▶ Monitor the time, and use time efficiently.
- ▶ Use a skilled facilitator to moderate focus groups and forums. Look among your advisory group and hospital for a person with this skill set. If not available, you will find it is a good investment to hire someone with this skill set.

Identifying assets

At this stage, it is also important to receive input about community resources, or assets available to respond to the health needs of the community. A community's assets include individual community members, local associations and institutions and religious congregations. Assessing assets allows you to focus on the strengths of your community and its capacity, skills and resources available to address identified needs. The asset map on the following page developed by Kretzmann and McKnight provides a framework from which to consider your community's assets. Consider including questions about community assets in your efforts to collect community input.



IRS NOTE

IRS regulations indicate that hospitals should include in their CHNA documentation a description of the resources potentially available to address the significant health needs identified through the assessment. The IRS regulations also note that hospitals should solicit and take into account from persons representing the broad interests of the community in identifying these resources.

STEP 4: UNDERSTAND AND INTERPRET THE DATA

In this step you will:

- 4.1 ANALYZE AND INTERPRET THE DATA
- 4.2 IDENTIFY DISPARITIES
- 4.3 IDENTIFY AND UNDERSTAND CAUSAL FACTORS
- 4.4 IDENTIFY MAJOR COMMUNITY HEALTH NEEDS

The goal of this step is to determine the major health needs in your community and related issues. At the end of this step, you should be able to provide a summary of your initially identified health needs.

DEFINE NEEDS CAREFULLY

Each statement of “need” should be carefully constructed. It should facilitate the development of strategic objectives to address the need, and thus should indicate:

- a) The subset of the population affected.
- b) The geographic area of focus.
- c) The specific health status problem (morbidity, mortality) or health access problem being addressed.

Keith Hearle, Verite Healthcare Consulting

4.1

ANALYZE AND INTERPRET THE DATA

Primary (original) and secondary (from other sources) data are reported in a variety of formats. It is critical to understand the measures reported in order to accurately interpret the data. A basic understanding of the principles of epidemiology will help you understand and interpret data for your community health needs assessment. A discussion of basic epidemiological principles is included in Appendix C.

There are several ways to consider and interpret the indicator data you have identified. Three methods for data analysis and interpretation are discussed below – comparisons, trends and benchmarks.

Comparisons

How does your community compare to other communities/the state/the U.S.?

In order to use comparisons, you must have values for your community, as well as other communities, the state or the United States.

To monitor the health and well-being of a community, it is often desirable to compare an indicator from your community to that of another community. Moreover, it may be informative to compare a measure of disease from the community of interest to the number of cases or rate of disease at the national level or state level. Care must be taken when making such comparisons.

Counts and crude rates from two different populations cannot be accurately compared because their underlying population structures (size and age) are rarely

the same. Proportions, ratios and rates are measures of disease that are better suited for comparing two populations and often these measures must be adjusted (e.g., age-adjusted) in order to create accurate comparisons. For additional information on this topic, refer to Appendix C.

For example, Trumbull County in Ohio wishes to see how its lung cancer death rate compares to other Ohio counties. To do this, Trumbull County identifies age-adjusted death rates due to lung cancer from the National Cancer Institute for all Ohio counties. Using age-adjusted rates allows you to compare counties with different population age distributions. Trumbull County then ranks the Ohio counties in order of age-adjusted lung cancer rates, and determines where Trumbull ranks in relation to other counties.

COMPARISONS

Areas where your community is doing worse than a majority of other communities, the state value or the national value, may indicate needs in your community.

Trends

Is the indicator data increasing, decreasing, or remaining the same over time?

In order to consider trends, you must have values for more than one time point. Often, secondary data sources publish data annually, which allows for the determination of trends. Take into account the confidence interval (see Appendix C for description) when determining the true direction of the trend.

For example, St. O hospital wants to analyze hospitalizations due to uncontrolled diabetes. St. O hospital looks at the number of hospitalizations due to uncontrolled diabetes/10,000 population over the last three years, and concludes that the hospitalization rate due to uncontrolled diabetes is increasing. Hospitalizations due to uncontrolled diabetes is a “Prevention Quality Indicator,” (as described earlier) and the increasing hospitalizations may signal a need for improved outpatient care or early interventions.

TRENDS

Indicators in which your community is getting worse over time may indicate priority needs in your community.

Benchmarks

Does the community meet benchmarks?

Benchmarks are standards against which something can be measured or judged. Examples of national benchmarks include Healthy People (see Section III, Step 3.4) and Environmental Protection Agency Air Quality Standards. If available, collect information about any state and local benchmarks. Consider how your community compares to these benchmarks for a variety of indicators.

BENCHMARKS
Indicators in which your community fails to meet benchmarks may indicate needs in your community.

4.2 IDENTIFY DISPARITIES

When available, data grouped by demographics such as race, income and age should be evaluated to identify disparities. You will find that some areas or populations experience a greater burden of disease. Consider possible disparities among both geographic areas and subpopulations.

For example:

To better understand a teen birth rate higher than the state average, Gila County in Arizona examined teen birth rates by race. Within Gila County, American Indians and Alaskan Natives had more than three times the teen birth rate of white teenagers, and almost twice the birth rate of Hispanic or Latino teenagers. This information helped Gila County clarify their high teen birth rates, and gave the county a focus for teen pregnancy prevention programs.

4.3 IDENTIFY AND UNDERSTAND CAUSAL FACTORS

In order to understand why observed problems exist, consider societal and physical environmental factors that may be influencing the observed needs.

For example, the data show that your community has a higher rate of obesity than neighboring communities. You can better understand the problem by looking at potential causal factors. For example:

- ▶ The density/availability/number of parks and community gardens.
- ▶ Availability of healthy food.
- ▶ Physical activity level of residents in the community.

Understanding causal factors will allow you to better understand the problem and will enable you to identify opportunities for improvement.

4.4

IDENTIFY SIGNIFICANT COMMUNITY HEALTH NEEDS

After analyzing your indicator data using comparisons, trends and benchmarks you will be able to identify and summarize the most severe and important needs facing your community. These needs should be documented in a data summary.

Every indicator included in your assessment should not be included in this summary. Instead, the assessment team should select a manageable number of the most important needs. You may further refine this data summary after the community health needs assessment priority-setting process.

For example, a county in California found that the rate of obesity was increasing in their community, and the percentage of obese adults in their community was much higher than the Healthy People target. This is how the issue was described in the data summary:

- ▶ County Z adults, 29.3 percent, are obese. This percentage has consistently increased over the 2003 – 2007 time frame. Latinos are leading at 34 percent with whites next at 26 percent. Males between the ages of 45 and 65 have the highest obesity rates. Healthy People 2010 national health target is to reduce the proportion of adults who are obese to 15 percent. If accomplished, this would be about a 50 percent reduction in the rate of obesity in County Z.

IRS NOTE

IRS regulations state that health needs include the requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as neighborhoods or populations experiencing health disparities). The regulations also note that these needs may include the need to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community. A hospital may determine whether a health need is significant based on all of the facts and circumstances present in the community it serves. Treas. Reg. § 1.501(r)-3(b)(4).

STEP 5: DEFINE AND VALIDATE PRIORITIES

In this step you will:

- 5.1 DETERMINE WHO WILL BE INVOLVED IN THE SETTING OF PRIORITIES.
 - 5.2 ESTABLISH CRITERIA FOR SETTING PRIORITIES.
 - 5.3 IDENTIFY PRIORITIES.
 - 5.4 VALIDATE PRIORITIES.
-

Your hospital probably will not have the resources to address all the community concerns identified in the assessment. Therefore, it will be necessary to identify and prioritize needs the hospital will address itself; the needs the hospital will address with others; and those needs the hospital will refer to others.

The data summary developed in Step 4.4 of the assessment process should help guide the prioritization process.

You may be part of two priority-setting processes – one that is led by a community coalition that sets community-wide priorities and the other that is conducted by the hospital to identify priorities for the organization. Alternatively, there may be one community-wide priority setting process, and the hospital will select priorities from that process to address – either on its own or with partners.

This section addresses how the hospital will identify and validate priorities.

5.1 DETERMINE WHO WILL BE INVOLVED IN THE SETTING OF PRIORITIES

For most hospitals, its internal assessment team, the assessment advisory committee and key partners will conduct an initial review of data and identify preliminary priorities. Key partners might include public health officials, other service providers and community leaders.

Also consider how community members themselves – not just the organizations that serve them - can be involved in setting priorities. Sometimes the hospital might find a need only moderately significant that is of great significance to community members. This should be reflected in the prioritization. Also, this direct engagement with community members can help build community interest, support and participation in efforts the hospital plans to implement.

Priorities can be shared with the hospital board and executive leadership, and others in the community for validation and consensus. See Section V for a list of persons and groups to involve.

IRS NOTE

Current IRS regulations state that input from persons representing the broad interests of the community should be taken into account in prioritizing significant health needs and identifying resources potentially available to address those health needs.

5.2**ESTABLISH CRITERIA FOR PRIORITY SETTING**

The priority-setting group should establish criteria for prioritizing the needs identified in the community health needs assessment. You may wish to revisit the original purpose of the assessment and ensure that the criteria selected reflect your original purpose.

IRS NOTE

IRS regulations state that a hospital may use any criteria to prioritize health needs identified in the assessment, including but not limited to burden, scope, severity, or urgency of the health need; the estimated feasibility and effectiveness of possible interventions; the health disparities associated with the need; or the importance the community places on addressing the need.

The regulations also note that the CHNA report should include a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs.

Examples of criteria that can be used include:

1. **Magnitude.** The magnitude of the problem includes the number of people impacted by the problem.
2. **Severity.** The severity of the problem includes the risk of morbidity and mortality associated with the problem.
3. **Historical trends.**
4. **Alignment of the problem with the organization's strengths and priorities.**
5. **Impact of the problem on vulnerable populations.**
6. **Importance of the problem to the community.**
7. **Existing resources addressing the problem.**
8. **Relationship of the problem to other community issues.**
9. **Feasibility of change, availability of tested approaches.**
10. **Value of immediate intervention vs. any delay, especially for long-term or complex threats.**

5.3

IDENTIFY PRIORITIES

There is not one generally accepted method for priority identification; instead, there are several processes that can be used to apply the criteria you established to determine priorities for action. You should choose the approach best suited to your organization.

The two methods described here are 1) ranking and 2) discussion and debate.

PRIORITIZATION PROCESS SHOULD BE TRANSPARENT

Make the prioritization process transparent, including criteria used and why certain decisions were made. Make note of why certain needs were identified as priorities and describe reasons why other needs will not be addressed.

Ranking

Participants in the priority-setting process can be asked to rank identified needs with a numerical score based on the criteria established earlier in this step. In their guide, *Needs Assessment in Public Health*, Peterson and Alexander suggest a process for ranking health needs. Members of the priority setting group rank a list of health needs with a numerical score; “1” would be assigned to the most pressing need, while “10” would be assigned to the least pressing need.

Individual rankings are then shared with the group and discussed. Consider the range of values assigned to each need. Participants should be encouraged to discuss how and why they arrived at their ranking. After discussion, participants can be given a chance to change their rankings, and individual rankings can be summed to yield a composite ranking. Peterson and Alexander note that “typically, no more than three renditions of this process should be needed to reach a fairly good consensus.”

A more complex model of ranking involves assigning weight to criteria. Criteria of overriding importance are weighted as “3”, important criteria are weighted as “2”, and criteria worthy of consideration, but not a major factor, are weighted as “1”. Criteria weighting can be conducted as a group or individually. Health needs are then assigned a rating ranging from one (low need) to five (high need) on each criteria. The total score for each need is calculated by multiplying weights by rating.

Rating can be done as a group or done by individuals and averaged. Using this method, higher values indicate a more pressing need. The example below illustrates this ranking method.

SAMPLE RANKINGS FOR ST. M HOSPITAL				
<i>Adult Obesity</i>	<i>rating</i>	<i>weight</i>	<i>score</i>	
How many people are affected by the problem?	_5	(2)	10	
What are the consequences of not addressing this problem?	_3	(3)	9	
Are existing programs addressing this issue?	_2	(1)	2	
How important is this problem to community members?	_2	(2)	4	
How does this problem affect vulnerable populations?	_4	(3)	12	
The total score for adult obesity for St. M Hospital would be 37				

SAMPLE RANKINGS FOR ST. M HOSPITAL – CONTINUED			
<i>Teenage Smoking</i>	<i>rating</i>	<i>weight</i>	<i>score</i>
How many people are affected by the problem?	_3	(2)	6
What are the consequences of not addressing this problem?	_4	(3)	12
Are existing programs addressing this problem?	_1	(1)	1
How important is this problem to community members?	_2	(2)	4
How does this problem affect vulnerable populations?	_2	(3)	6
The total score for teenage smoking for St. M Hospital would be 29			
<i>Result for St. M Hospital, adult obesity is a higher priority than teenage smoking.</i>			

Discussion and debate

Discussion and debate is a less quantitative approach to prioritization. In this approach your priority-setting group holds a meeting to discuss priorities.

Discuss the needs identified in the data summary, and apply the criteria (which can be weighted to assign greater importance to certain factors) to these needs to identify priorities. If an obvious consensus does not emerge from discussion, voting can be used to select priorities.

5.4

VALIDATE PRIORITIES

Once your priority-setting group has decided on initial priorities, it is necessary to validate the prioritized needs with your community. McKenzie et al. defines priority validation as “confirm[ing] that the need identified is the need that should be addressed.”

Describe the process used for setting priorities and present conclusions to community groups, hospital executives and board leaders, key stakeholders, and individuals with expertise in public health to confirm that the correct prioritization decisions were made.

Reconciling priorities

Needs identified as priorities in the priority-setting process may differ from the views of community members. For example, although high rates of diabetes leading to poor health and death may be evident from a review of mortality and

morbidity data, community members may cite gang violence as the most pressing health problem, despite statistical evidence to the contrary.

Health care organizations and community coalitions have addressed this situation using the strategies listed below:

- ▶ Addressing the community’s concern first, building trust and buy-in from community members.
- ▶ Embarking on an educational campaign to raise awareness of the priority needs.
- ▶ Addressing both needs, the problem clearly identified by public health data and the problem identified by community members.

DEVOTE SUFFICIENT TIME AND RESOURCES TO PRIORITIZATION

The health system is complex which makes deciding which needs to prioritize and validate challenging, especially for organizations that are doing it for the first time. This work can be particularly challenging if major stakeholders in the community each have different perspectives on what are the major issues. Be sure to devote sufficient time and resources to this phase of the assessment.

STEP 6: DOCUMENT AND COMMUNICATE RESULTS

The community health needs assessment should be presented in a manner easily understandable and accessible to your community.

In this step, you will:

-
- 6.1 WRITE THE ASSESSMENT REPORT.**
 - 6.2 DEVELOP TABLES, GRAPHS AND MAPS TO DISPLAY DATA.**
 - 6.3 DISSEMINATE RESULTS WIDELY.**
-

6.1

WRITE THE ASSESSMENT REPORT

IRS NOTE

IRS regulations state that hospitals must document the CHNA in a written report (CHNA report) that is adopted for the hospital by an authorized body of the hospital.

Your CHNA report should be presented in a manner that is easily understandable and accessible to your community and, at a minimum, include the following as required by the IRS:

A definition of the community served by the hospital and description of how it was determined. See Step 2.2 in this section for more detailed information about how to define community.

A description of the process and methods used to conduct the assessment, including:

- ▶ A description of the data and other information used in the assessment.
 - ▷ The methods of collecting and analyzing this data and information. In the case of data obtained from external source materials, the report may cite the source material rather than describe the method of collecting the data.
 - ▷ Any parties the hospital collaborated with to conduct the CHNA.
 - ▷ All third parties the hospital contracted with to assist in conducting the CHNA.

A description of how the hospital took into account input from persons who represent the broad interests of the community it served, including:

- ▶ A general summary of any input provided by such persons, including how and over what time period such input was provided (for example, whether through meetings, focus groups, interviews, surveys, written comments and between what approximate dates).
- ▶ The names of any organizations providing input and a summary of the nature and extent of their input.

- ▶ A description of the medically underserved, low-income and minority populations being represented by organizations or individuals that provided input. The regulations note that the report does not need to name or otherwise identify any specific individual providing input on the CHNA.
- ▶ In the event a hospital solicits, but cannot obtain, input from a required source the hospital's CHNA report must describe the hospital's efforts to solicit input from such source.

Step 3.6 of this section describes persons and groups the hospital is required to gather input from.

A prioritized description of the significant health needs of the community identified through the CHNA, along with 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 through the CHNA.

See Appendix F for a CHNA report template.

USING DATA IN YOUR REPORT

Do not feel that it is necessary to present all of the data from your assessment. Select those data that are important to convey major points, leaving other data to an appendix or making it available to program planners or analysts who are most likely to use it. Too much information or too long a report can discourage its use.

6.2

DEVELOP TABLES, GRAPHS AND MAPS TO DISPLAY DATA

Information about the health status of your community should be presented in a manner easy to understand and interpret. Use tables, graphs and maps to creatively present data to your audience. A long narrative will be harder for your audience to comprehend and use in future work. Tables, graphs and maps greatly increase the accessibility of your work.

WORK WITH DATA VISUALIZATION EXPERTS

There's a small but growing group of people with expertise in data visualization, the presentation of data in pictorial or graphical format. If possible, seek out people with this skill set to help you communicate your CHNA findings to your key audiences.

Tables

Tables are useful to organize and display data. The table below compares, by race and ethnicity, the rate of adults currently smoking in Miami-Dade County and the state. This table allows you to see the relationship between smoking status and race/ethnicity within Miami-Dade County and the state of Florida.

PERCENTAGE OF ADULTS THAT ARE CURRENT SMOKERS BY RACE/ETHNICITY (2007), MIAMI-DADE COUNTY AND STATE OF FLORIDA		
<i>Ethnicity</i>	<i>Miami-Dade County Florida</i>	<i>Florida State</i>
White	14.6%	20.6%
Black	15.0%	18.5%
Hispanic	16.4%	16.0%
Overall	15.4%	19.3%

Source: Florida Behavioral Risk Factor Surveillance System

GUIDELINES FOR TABLES AND GRAPHS

Peter Taintor of the Urban Institute provides several guidelines for developing tables and graphs:

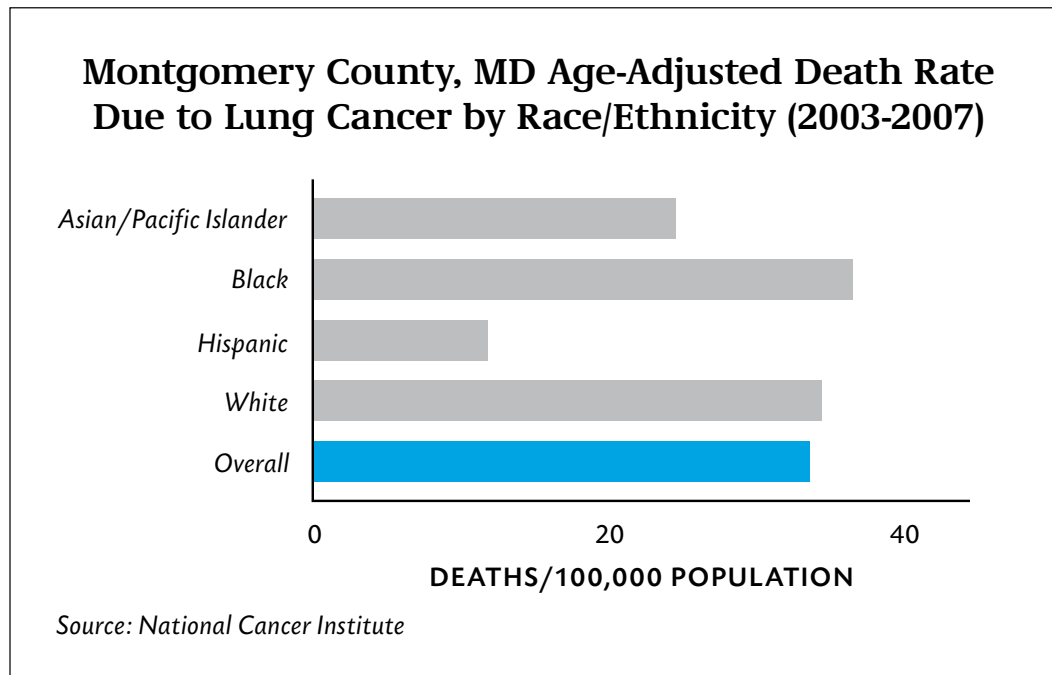
- ▶ The table or graph should tell a story.
- ▶ The table or graph can stand alone. The reader can interpret the table without any additional information.
- ▶ The title is clear and succinct. The title indicates the content of the table/graph, the time period and the geographies covered.
- ▶ For tables and bar graphs, the rows/bars are sorted in a meaningful order.
- ▶ The bars in bar graphs are visually distinct.
- ▶ The axes in graphs are clearly labeled.
- ▶ Table columns are lined up and formatted neatly.
- ▶ Values do not have too many decimal points.
- ▶ The use of lines is limited.
- ▶ The source of the data is provided.
- ▶ Some kinds of graphs should have confidence intervals to display the information accurately.

Graphs and charts

Graphs and charts provide a visual representation of data. Three main types will be discussed: bar graphs, line graphs and pie charts.

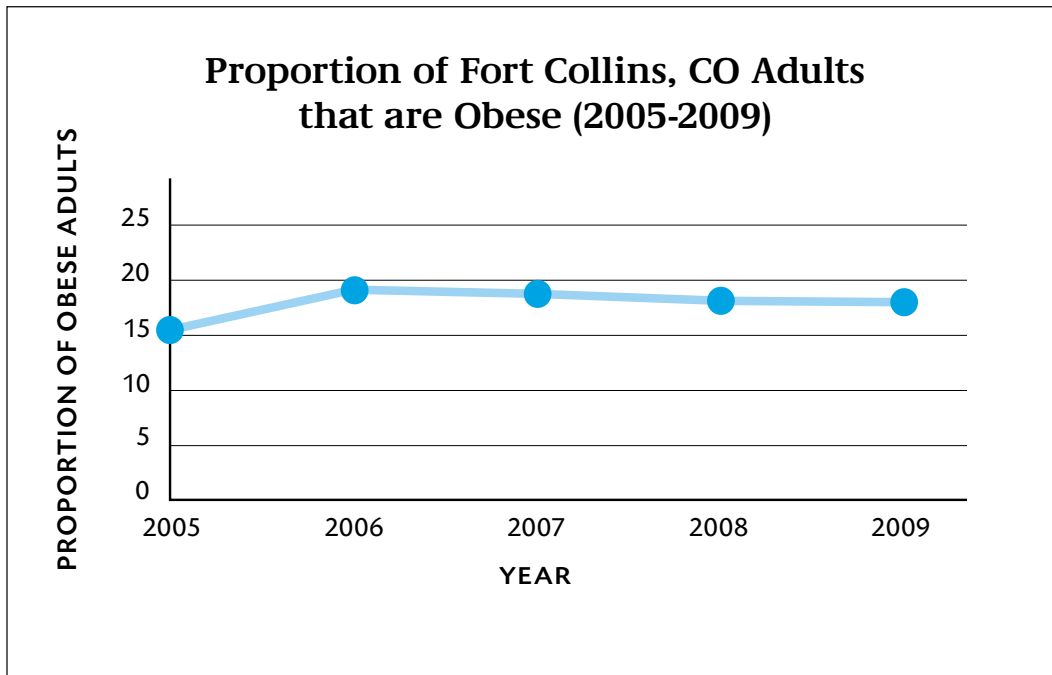
Bar Graphs

A bar graph shows bars whose length is proportional to the value they represent. Bars can be oriented either horizontally or vertically. Individual bars can represent subgroups (as shown in the example below) or time periods. A bar graph is useful for showing differences between groups or time periods.



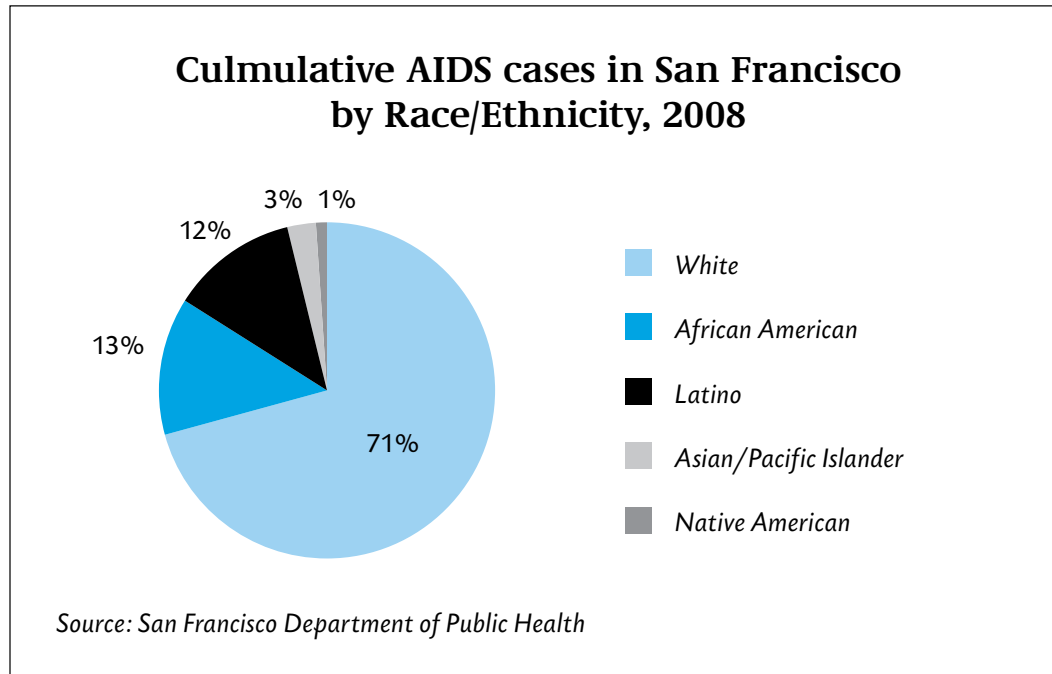
Line Graphs

A line graph uses a series of data points connected by a line. A line graph is most useful for showing changes over time and trends. The example provided below tracks the proportion of Fort Collins, Colorado adults that are obese over a period of five years.



Pie Charts

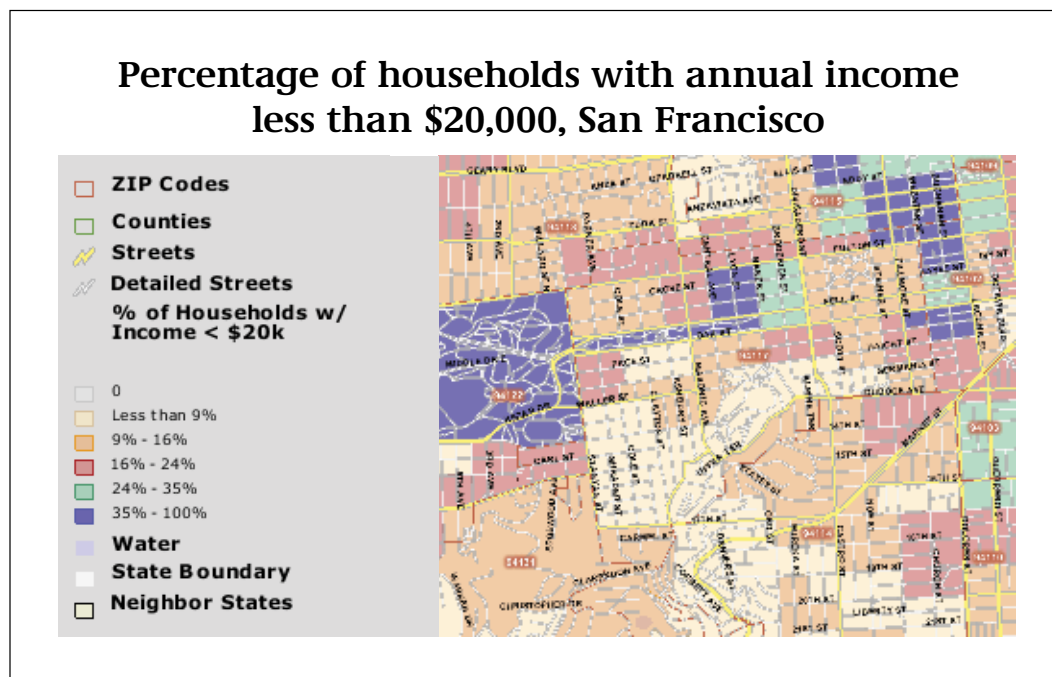
Pie charts are circular charts divided into different segments. The different segments illustrate proportion. Pie charts are helpful to display data as parts of a whole. Cumulative AIDS cases in San Francisco are presented by race/ethnicity in the pie chart below. The pie chart allows one to easily see the racial/ethnic distribution of total AIDS cases in San Francisco.



Maps

Maps are useful tools for displaying geographic information. Maps can be used for a variety of purposes, from highlighting health disparities to displaying resource availability. Geographic Information Systems (GIS) technology can be used to visualize assets and needs in your community. Using the Network for a Healthy California Map Viewer created by the California Department of Public Health, the percentage of households with annual income less than \$20,000 is displayed for several ZIP codes in California. Using this tool, the households with annual income less than \$20,000 can be easily visualized.

Visit CHNA.org, a free resource that uses demographic, health and environmental data, to create maps showing areas of need for your community.



6.3 DISSEMINATE RESULTS WIDELY

IRS NOTE

Federal law states that the assessment must be made “widely available to the public.” Current IRS regulations state that this requirement is met when the hospital:

- ▶ Makes the report widely available on a Web site at least until the date the hospital has made widely available on a Web site its two subsequent CHNA reports: and
- ▶ Makes a paper copy of the report available for public inspection upon request and without charge at the hospital at least until the date the hospital has made available for public inspection a paper copy of its two subsequent CHNA reports.

Refer to the current regulations for definition of “widely available on a Web site.”

Now that you have completed your community health needs assessment, set priorities and summarized the findings, you need to disseminate the appropriate information to the users/audiences that were identified in [Step 2 of the assessment process](#). This is also a good time to reexamine the audience list to see if others should be included.

Consider disseminating assessment results to some of the following groups and individuals:

Community organizations:

- ▶ State and local health departments.
- ▶ Social service agencies and other community groups.
- ▶ Boards of community agencies.
- ▶ Schools of medicine, social welfare and public health.
- ▶ School officials.
- ▶ Community libraries.
- ▶ Community development corporations.

Internal groups:

- ▶ Internal staff team.
- ▶ Community benefit department.
- ▶ Board and executive leadership.
- ▶ Strategic planning department.
- ▶ Advocacy/government relations department.
- ▶ General counsel.
- ▶ Communications department.
- ▶ Assessment advisory group.

Funders

- ▶ Foundations.
- ▶ Benefactors/Donors.
- ▶ Government agencies.

Public offices/Regulatory agencies

- ▶ Elected officials.
- ▶ State and local government.
- ▶ IRS [report required information on the IRS Form 990, Schedule H].

Others

- ▶ General public.
- ▶ Media.
- ▶ Business community/Chamber of Commerce.
- ▶ Environmental health experts.

Ways to share information

Consider how each group will use the information when deciding how to communicate your findings. Ways to share the information include:

- ▶ Written reports, available in hard copy and on your website.
- ▶ If your hospital uses an online assessment system, providing a web address to access the system.

- ▶ Providing web links on your organization’s website to electronic copies of your needs assessment.
- ▶ Using social media (Facebook, LinkedIn, Twitter) to share the results of your assessment or direct users to your needs assessment report.
- ▶ Developing one-page issue briefs highlighting needs identified in your community and priority areas.
- ▶ Holding a presentation to discuss your findings.
- ▶ Developing press releases.
- ▶ Preparing materials and presentations in languages other than English.
- ▶ Regulatory forms (state and local forms, IRS Form 990, Schedule H).
- ▶ Using existing organizational communication vehicles such as newsletters, e-newsletters and the Intranet.

Most health care organizations have a communications department that coordinates all of the organization’s communications efforts. A staff member from this department can be a valuable asset in helping to prepare the assessment findings for key audiences. In many cases the communications department will have worked with these user groups and will know the most effective ways to share the findings of your community health needs assessment.

Before releasing your assessment report, allow the communications department to check it for readability and identify any possible ideas that may need to be clarified or expanded.

IRS NOTE

IRS regulations contain an important clarification regarding the release of a draft CHNA report and the impact of that release on the date the assessment is considered “conducted.” The regulations state “... if a hospital facility makes widely available on a Web site (and/or for public inspection) a version of the CHNA report that is expressly marked as a draft on which the public may comment, the hospital facility will not be considered to have made the CHNA report widely available to the public for purposes of determining the date on which the hospital facility has conducted a CHNA.”

For additional resources on assessment, visit CHA’s website at www.chausa.org/guideresources.

Developing an Implementation Strategy



IV

SECTION IV

DEVELOPING AN IMPLEMENTATION STRATEGY

INTRODUCTION

An implementation strategy is the hospital's plan for addressing community health needs, including health needs identified in the community health needs assessment. The term "implementation strategy" was introduced in the Affordable Care Act provisions which mandated requirements for tax-exempt hospitals to conduct community health needs assessments and adopt a plan to address the needs identified in the assessment. Some hospitals used to refer to this (or still might) as a community benefit plan.

As described in the IRS instructions for the Form 990, Schedule H for Hospitals (the reporting form for community benefit and other related information), community need may be demonstrated through the following:

- ▶ A community needs assessment developed or accessed by the organization.
- ▶ Documentation that demonstrated community need or a request from a public agency or community group was the basis for initiating or continuing the activity or program.
- ▶ The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or programs.

This section focuses on the hospital's implementation strategy. Hospitals may also work with others in the community to develop broader community-wide strategies to address health needs. There are many public health texts and other references that provide excellent guidance for such community health planning. See the CHA website for more information – www.chausa.org/guideresources.

The implementation strategy, like the community health needs assessment, is both a *process* and will result in a *product*.

HOW AND WHEN – IMPLEMENTATION STRATEGY

The implementation strategy deals with the “how and when” of addressing needs.

While the community health needs assessment considers the “who, what, where and why” of community health needs, the implementation strategy takes care of the how and when components.

Keith Hearle, Verite Healthcare Consulting, LLC

IRS NOTE

IRS regulations define an implementation strategy as, “a written plan that, with respect to each significant health need identified through the CHNA, either –

- 1) describes how the hospital facility plans to meet the health need; or
- 2) identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address the health need.”

The *process*, described in this section, includes:

- Step 1:** Plan and prepare for the implementation strategy.
- Step 2:** Develop goals and objectives and identify indicators for addressing community health needs.
- Step 3:** Consider approaches to address prioritized needs.
- Step 4:** Select approaches.
- Step 5:** Integrate implementation strategy with community and hospital plans.
- Step 6:** Develop a written implementation strategy.
- Step 7:** Adopt the implementation strategy.
- Step 8:** Update and sustain the implementation strategy.

The *product*, which is described in Step 6 of the implementation strategy process, is a written summary of the implementation strategy and includes:

- ▶ Organization's mission and commitment to access, community health improvement and the needs of those living in poverty.
- ▶ Description of the community served.
- ▶ Description of how the implementation strategy was developed and adopted by the organization.
- ▶ Significant health needs identified in the community health needs assessment and through other means. How priorities were determined.
- ▶ What the organization will do to address community health needs.
- ▶ Community health needs not being addressed in the implementation strategy and the reasons they are not being addressed.

EIGHT STEPS FOR DEVELOPING AN IMPLEMENTATION STRATEGY TO ADDRESS COMMUNITY HEALTH NEEDS

STEP 1:

PLAN AND PREPARE FOR THE IMPLEMENTATION STRATEGY

Before you begin the process of developing or updating the implementation strategy you should first assess your readiness to begin the process. Do you have all the key elements in place? Consider forming an implementation team to carry out the development of the strategy and oversee its implementation.

Assess your readiness to develop the implementation strategy

Here are some questions to ask about your readiness to develop an implementation strategy:

Does the organization have a sustainable community benefit infrastructure – adequate staffing, budget, policies, and leadership commitment – to support the implementation strategy?

The implementation strategy will be built on the community benefit infrastructure described in CHA's *A Guide to Planning and Reporting Community Benefit*, including:

- ▶ A clearly articulated mission to address community needs.
- ▶ Leadership commitment to improving access and community health.
- ▶ A culture that values service to vulnerable persons.
- ▶ Adequate resources (staffing and budget).
- ▶ Policies supporting the community benefit program (including policies on financial assistance, physician services, and advocacy).

In addition, to ensure adequate support for the implementation strategy, it is advisable that the organization's overall strategic, operations and financial planning processes include information about the implementation strategy. For example, have specific goals related to meeting community health needs in the strategic plan.

Has the community health needs assessment been completed and priority issues identified and validated?

The hospital's community health needs assessment (or community health needs assessment used by the organization) should be current and should comply with federal and any state requirements.

If the plan did not prioritize needs identified in the assessment, this should be done before developing the implementation strategy. See Section III, Step 5, Define and Validate Priorities.

Does the organization have relationships with community members and groups including persons knowledgeable about the community and public health?

The input of community members and groups and public health experts is vital to designing and carrying out an effective implementation strategy.

- ▶ Community members and groups can provide information on community assets that the strategy may be built upon, including past programs that may not have been successful and why. Community review of a draft implementation strategy can reveal how target groups might react to proposed approaches, and what obstacles they would face in obtaining proposed community benefit services.
- ▶ Public health experts can help identify evidence-based interventions which have been proven to impact health, develop program goals and objectives and identify indicators that can be used to evaluate the effectiveness of the implementation strategy.

Has the organization reviewed all federal and state requirements for implementation strategies and community benefit planning?

Form the implementation strategy team

Form a team (internal, external or combination) to oversee the development and implementation of the strategy.

Evaluate the internal and/or community health needs assessment teams to determine which members should be asked to be part of the implementation strategy team. Do others need to be included?

THE COMMUNITY BENEFIT TEAM

Some hospitals may already have a community benefit team in place that oversees the planning and implementation of community benefit programs. This team should be used to develop/update the implementation strategy.

Consider including the following people on the implementation strategy team:

Hospital staff:

- ▶ People responsible for overseeing and coordinating the hospital's community benefit efforts.
- ▶ Strategic planning staff.
- ▶ Population health management staff.
- ▶ Physicians and other professional staff with clinical expertise and public health background.
- ▶ People from finance to help with budget/resource issues.

Community Partners:

- ▶ People knowledgeable about the community, including representatives from community groups and representatives of the priority populations identified in the assessment.
- ▶ People with public health expertise, including public health officials and staff, faculty from schools of public health, or others with knowledge of public health.
- ▶ People from other public agencies such as education, housing and law enforcement.

Team leader

As with the internal assessment team, one person should be selected to lead the effort to develop and oversee the execution of the implementation strategy.

Hospital staff who may be assigned responsibility to lead the implementation strategy team include:

- ▶ Senior leader responsible for community benefit.
- ▶ Community benefit or outreach program director or staff member.

- ▶ Mission director or staff member.
- ▶ Someone from the organization's strategic planning office.

The duties of the team leader will vary, but potential responsibilities include:

- ▶ Forming and convening an implementation strategy team.
- ▶ Continuing work with community partners identified in the assessment process, identifying new partners if needed. This should include people with expertise in public health.
- ▶ Developing a budget of financial and other resources needed for the implementation strategy.
- ▶ Developing a time line for completing the strategy and ensuring that time lines are met.
- ▶ Developing a plan for generating, prioritizing and selecting approaches to address community health needs.
- ▶ Developing and carrying out a plan to obtain community feedback on the implementation strategy.
- ▶ Working with the board to adopt the implementation strategy.
- ▶ Working with the board and executive leadership to understand how the implementation strategy will impact community health needs.
- ▶ Maintaining communications with all people and groups interested in the implementation strategy.

Team members

The role of implementation strategy team members is to support the team leader in carrying out key aspects of the strategy development, including:

- ▶ Reviewing and advising on budgets, time lines and other implementation details.
- ▶ Collecting information about existing assets/programs that the implementation strategy can build upon.
- ▶ Establishing and maintaining community partnerships and/or relationships.
- ▶ Using expertise and skills to help generate, prioritize and select approaches to address community health needs.
- ▶ Being a champion for the implementation strategy within and outside the hospital.

IRS NOTE

IRS regulations state that if the hospital has documented its CHNA in a joint CHNA report (as described in Step 1.4 of Section III: Conducting a Community Health Needs Assessment in this guide) it may develop a joint implementation strategy if three requirements are met:

- ▶ The joint implementation strategy must be clearly identified as applying to the hospital facility.
- ▶ The joint implementation strategy must clearly identify the hospital facility's particular role and responsibilities in taking the actions described in the implementation strategy and the resources the hospital facility plans to commit to such actions.
- ▶ The joint implementation strategy must include a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relate to the hospital facility.

If your hospital plans to develop a joint implementation strategy, consider how planning activities will be carried out by partnering hospitals, particularly who will serve on the implementation strategy team.

STEP 2: DEVELOP GOALS AND OBJECTIVES AND IDENTIFY INDICATORS FOR ADDRESSING COMMUNITY HEALTH NEEDS

You will need to develop goals for addressing selected significant community health needs. Goals are broad statements that describe what you want to accomplish by addressing community health needs.

Here are some sample goals:

- ▶ Prevent diabetes-related complications in enrolled patients who have this disease.
- ▶ Increase birth weight and reduce premature births of infants born to teen mothers in the school district.
- ▶ Reduce the incidence of influenza among elderly people in the county.
- ▶ Decrease emergency department visits and school absenteeism among children with asthma.

For each goal, identify measurable objectives to be achieved within a specific time frame. Objectives should describe the specific change expected to occur as a result of the implementation strategy. A goal may have one or more objectives.

EXPERT ADVICE

Objectives, according to the Centers for Disease Control and Prevention should be **SMART**

Specific

Measurable

Achievable

Realistic

Time specific

The implementation strategy should also include *indicators*, that is, measurements used to determine whether the objectives were met. Indicators answer the question: how will I know if the objective was accomplished?

Here are examples of an implementation strategy goal, objective and indicator:

Goal: Reduce proportion of children with untreated dental decay by nine percent.

Objective: Children who are registered at mobile dental clinic will be found to have fewer dental caries in 2011 than in 2010.

Indicator: Proportion of children with dental decay.

See both CHA's *A Guide for Planning and Reporting Community Benefit* and *Evaluating Your Community Benefit Impact* for more information on developing goals, objectives and indicators.

STEP 3: CONSIDER APPROACHES TO ADDRESS PRIORITIZED NEEDS

Next, you will need to select interventions (also known as strategies or approaches) to address selected community health needs identified in the community health needs assessment and through other means.

To select interventions most likely to succeed in addressing community health needs, you and your team will need to:

-
- 3.1 UNDERSTAND PRIORITIZED HEALTH NEEDS AND THEIR CAUSES.
 - 3.2 IDENTIFY A RANGE OF POSSIBLE APPROACHES.
 - 3.3 INVESTIGATE EVIDENCE-BASED APPROACHES.
 - 3.4 REVIEW COMMUNITY ASSETS AND EXISTING HOSPITAL PROGRAMS.
 - 3.5 DISCUSS RESOURCE NEEDS, TIMETABLES AND OTHER IMPLEMENTATION LOGISTICS.
-

EXAMPLES OF INTERVENTIONS TO ADDRESS NEEDS

St. M Hospital identified adult diabetes as a priority in their community. They used the CDC's *Community Guide* to identify evidence-based practices to address adult diabetes. They chose to implement a self-management education program for adults with Type 2 diabetes to be held in community gathering places.

St. L Hospital in New York City identified obesity as a priority in their community. The data suggested that the high level of obesity they observed was due to poor diet. They decided to work to reduce the availability of trans fat in foods in their community and joined a city-wide partnership to address this issue. The partnership worked to pass an amendment to the NYC Health Code to phase out the use of artificial trans fat in all NYC restaurants and other food establishments.

3.1 UNDERSTAND PRIORITIZED HEALTH NEEDS AND THEIR CAUSES

The implementation strategy team should review data collected during the assessment process to better understand the prioritized needs and their root causes. If sufficient data is not available from the assessment process to fully understand the problem, the implementation strategy team may need to collect additional information.

To identify factors linked to need, ask what are the contributing factors to the problem:

- ▶ Is the problem related to access to needed health services or resources?
- ▶ Are services available, but not when and where they can be accessed by priority populations?
- ▶ Are there environmental problems, such as poor air quality or the presence of toxic and/or persistent materials?
- ▶ Is a lack of public policies exacerbating the problem, such as a lack of smoke-free public places?

For most health problems, social and economic factors are involved, such as poverty, lack of education, inadequate housing or other “social determinants of health.” See Section III, Step 2.2, for more information on root causes including the social determinants of health.

IRS NOTE

IRS regulations note that health needs identified in the CHNA may include ensuring adequate nutrition, or addressing social, behavioral, and environmental factors that influence health in the community.

Consider using a collective impact framework

The complex economic, environmental and social problems that often underlie health needs in a community cannot be solved by one organization. As you develop a better understanding of the factors that are at the root of your community's health needs, consider how your organization might lead or be part of a collective impact approach to addressing those factors.

The collective impact framework is a structured form of collaboration that brings together different sectors to solve specific social problems. As defined by the Collective Impact Forum website, the framework has five elements:

- ▶ **Common agenda** – A common understanding of the problem to be solved, agreed upon goals for the initiative as a whole and a joint approach for taking agreed upon action.
- ▶ **Shared measurement** – Agreed upon way to measure and report progress of the initiative. Shared measurement ensures that all efforts are aligned and supports accountability and continuous improvement.
- ▶ **Mutually reinforcing activities** – Participants focus on activities that are in their area of expertise and those activities are coordinated in a way to support and coordinate with the action of others.
- ▶ **Continuous communication** – Regular meetings to build up trust and relationships among participants.
- ▶ **Backbone organization** – An organization, separate from participating groups, with the staff and skills to plan, manage and support the initiative. Activities performed by the backbone organization could include facilitation and mediation, technology and communication support, data collection and reporting and logistical and administrative activities.

Visit the Collective Impact Forum website at <http://collectiveimpactforum.org/> for more information about collective impact and tools to help implement the collective impact approach.

3.2

IDENTIFY A RANGE OF POSSIBLE APPROACHES

After you have studied the possible causes of health needs, you will be ready to identify potential interventions. Consider:

- ▶ Will you try to prevent the health problem or risk related to the need?
- ▶ Will you work towards early detection and treatment of the problem, with an emphasis on reducing progression?
- ▶ Will you concentrate on managing the acute manifestations of the problem?

It will be helpful for the implementation strategy team to have a discussion of the full range of interventions and to consult with public health experts.

IDENTIFY A RANGE OF INTERVENTIONS

If lead poisoning of children from lead-based paint in low-income housing has been identified as a priority problem, possible approaches include:

- ▶ Work to prevent the risk. In the case of lead paint in the housing, collaborate with community partners to test paint in apartments and repaint when needed.
- ▶ Work for early identification of the problem. This could include testing children and treating them as early as possible after exposure.
- ▶ Treat acute illness related to the problem. This could include providing clinics to treat lead poisoning or conducting research on new treatment approaches.

In addition to programs and services, also consider how your organization can work with others to help change policies and systems in your community that contribute to poor health. The impact of programs and services to address health needs is limited if community members do not have access to healthy food, safe housing and neighborhoods and high quality education and jobs.

A BALANCED PORTFOLIO OF INTERVENTIONS

The Centers for Disease Control and Prevention's (CDC) Community Health Improvement Navigator (CHI Navigator) recommends a "balanced portfolio of interventions" across four action areas 1) socioeconomic factors, 2) physical environment, 3) health behaviors, and 4) clinical care. The CDC recommends that as you identify and select interventions for your community's health needs, consider using interventions that work across all four action areas and over time, increase investments in socioeconomic factors since these factors have the greatest impact on health and well-being. For more information visit <http://www.cdc.gov/chinav/index.html>.

3.3 INVESTIGATE EVIDENCE-BASED APPROACHES

To effectively use hospital resources you need to make sure you select approaches that are tested and likely to successfully address targeted needs. These are known as evidence-based interventions.

Sources for evidence-based approaches include:

- ▶ Community Health Improvement Navigator, CDC (<http://www.cdc.gov/chinav/database/index.html>).
- ▶ Evidence-based Practice Centers, AHRQ (<http://www.ahrq.gov/clinic/epc/>).
- ▶ Guide to Community Preventive Services, CDC (www.thecommunityguide.org).
- ▶ Healthy People interventions and resources (www.healthypeople.gov).
- ▶ Healthy Communities Institute (www.healthycommunitiesinstitute.com).
- ▶ County Health Rankings and Roadmaps (www.countyhealthrankings.org/roadmaps/what-works-for-health).
- ▶ National Resource for Evidence-based Programs and Practices, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services (www.nrepp.samhsa.gov).

Your local health department, public health institute or school of public health are also good sources of evidence-based approaches. They can also help you understand the evidence and implications for implementation

COMMUNITY INTERVENTIONS DATABASE

The Healthy Communities Institute (HCI) offers a database of more than 1,300 community-level interventions.

HCI has identified many promising practices – community interventions and policy changes – successful models of community health improvement strategies from across the U.S. and Canada. The HCI resource offers easy access to information about how a problem has been solved elsewhere, about the outcomes and about who to contact for implementation details (e.g., transit designs to reduce traffic congestion or community/workplace initiatives to increase physical activity). For more information, visit www.healthycommunitiesinstitute.com/index.html.

When looking at evidence-based practices that have been successful elsewhere, consider:

- ▶ Characteristics of the population where the program was used: do those characteristics match your community?
- ▶ Is the evidence based on credible public health research?
- ▶ Magnitude of impact: has the approach been proven to be very effective? Somewhat effective? Are results still pending?
- ▶ Replication of program: has program been effectively replicated elsewhere?
- ▶ Acceptability to community: is it a cultural fit in your community?
- ▶ Required resources: do you have or can you obtain resources needed to use the approach?

3.4

REVIEW COMMUNITY ASSETS AND EXISTING HOSPITAL PROGRAMS

As you determine what approach to take, consider building upon community assets and/or refocusing existing hospital programs to meet prioritized health needs. Collect information about community assets, including available health and other services, at this time if it was not done earlier in the assessment process. See Section III, Step 3.6, for a discussion of community assets.

Examples of existing assets/programs that could be expanded to meet prioritized needs:

- ▶ If parish nurses are taking blood pressures and doing hypertension education after Sunday services, could they add diabetes testing and education?
- ▶ If the hospital has a pediatric dentistry program, could it be expanded to serve uninsured adults?
- ▶ If the local schools have self-esteem classes for low-income girls, could education about diet and exercise be incorporated into the classes?

ASSESS EXISTING HEALTH RESOURCES IN THE COMMUNITY

The Health Resources and Service's Administration's *Promising Practices in MCH Needs Assessment: A Guide Based on a National Study* recommends using the following criteria to evaluate existing health resources in the community:

- ▶ **Accessibility:** Look at such indicators as the percent of the population in need who receive the appropriate services, the length of waiting lists for needed care, the geographic distribution of providers or services, the availability of bilingual or translation resources appropriate to the community and health care services for low-income persons.
- ▶ **Quality:** Measures for assessing quality can include coordination of care, client/patient satisfaction, and cultural competence. If information is available, include information on how effective the services are in producing desired outcomes.
- ▶ **Affordability:** This can be measured by examining the ability of the population to pay for the services, such as noninsurance rates and the extent to which public and private providers offer needed services to uninsured and underinsured persons.

For additional information on assessing existing health resources, go to <http://mchb.hrsa.gov/publications/needsassessdec2004.pdf>.

3.5 DISCUSS RESOURCE NEEDS, TIMETABLES AND OTHER IMPLEMENTATION LOGISTICS

The implementation team should discuss key details of implementing each proposed approach. These discussions should not focus on detailed action planning but rather on high-level issues that will help specify or refine the approach and guide implementation. There may be situations when the discussion of implementation details reveals that the approach is unfeasible

because certain key inputs (such as skilled staff, time frames, required organizational/policy changes, community support) cannot be easily obtained.

Consider:

- ▶ Community support.
- ▶ Actions that need to be taken.
- ▶ Time frames.
- ▶ Staff, including who will lead and implement the approaches selected.
- ▶ Infrastructure, including the need for steering committees, policies and leadership support.
- ▶ Budget, including sources of funding.
- ▶ Knowledge and expertise needed to carry out the strategy.
- ▶ Partnerships that will be needed to implement the strategy.
- ▶ Any possible need for outside experts and consultants.

If there is a gap between what you think you will need and what is available, consider either how the implementation strategy could be modified to fit your resources or how to augment available resources through community collaborations, partnering with a school of public health, or by securing outside funding.

Also consider how the organization can reallocate internal resources for these approaches. For example, redistributing funds previously earmarked for financial assistance but that may no longer be needed because of decreasing requests for charity care or redirecting community donations that were previously not targeted to groups or efforts aligned with the community health needs the hospital is addressing.

STEP 4: SELECT APPROACHES

Some final considerations in selecting approaches to be used to address community health needs include:

- ▶ Which approach or intervention will result in short-term results? While some approaches may be geared to the longer term, seeing early success

will be important, especially for hospitals and coalitions new to community health improvement.

- ▶ Does the approach lend itself to partnerships and can it generate community support? Is the approach consistent with your hospital's organizational strengths and community capabilities?
- ▶ Are there adequate hospital and/or community resources to carry out the approach/intervention? If not, can additional resources be obtained?
- ▶ What barriers might exist? In addition to insufficient resources, is there a lack of community support, legal, cultural or policy impediments or technological difficulties?
- ▶ Is the approach sustainable? Would members of the community be willing to assume leadership roles? Is the organization committed to the approach?

Community input

Solicit community input on proposed goals and approaches before making the implementation strategy final. When seeking input on the proposed strategy, the hospital should set expectations with the community about what approaches it can and cannot implement and how certain approaches can be carried out (for example, resource constraints, lack of expertise).

The hospital should also plan to come back to the community to share the final strategy and to involve community groups and members in evaluating the strategy's effectiveness. This can be one way to maintain and strengthen community involvement throughout the assessment and planning cycle.

THE CASE FOR INTEGRATING HEALTH INTO COMMUNITY DEVELOPMENT

Time to Act: Investing in the Health of Our Children and Communities, a report published by the Robert Wood Johnson Foundation, notes that "both the community development and health sectors aim to improve the lives of residents in low-income neighborhoods, but they are often focused on different elements." This lack of coordination often results in duplication of effort and inefficient use of resources.

When health and community development are integrated the various agencies and institutions addressing community problems have a comprehensive view of resident's needs. This view drives improvement efforts focused on the multiple factors that can have an impact on health, such as "access to high quality early child development programs, schools, health care, transportation, jobs, healthy food, safe streets and housing, and spaces for physical activity."

IRS NOTE

IRS regulations require a hospital facility, in conducting a CHNA, to take into account written comments received on its most recently conducted CHNA and most recently adopted implementation strategy. The public will be able to review a hospital facility's most recently adopted implementation strategy because its IRS Form 990 will have a copy of the strategy attached to the form or will include the URL of the Web page where it has made the implementation strategy widely available.

PRIORITIZING APPROACHES

The MAPP process recommends that a planning group prioritize potential approaches using the following criteria:

- ▶ Impact – what is the potential impact on the goal?
- ▶ Cost – what is the cost in terms of dollars, people and time?
- ▶ Probability of success – how likely is it that the approach can be successfully implemented?

An approach that the group believes would have a significant impact on one or more goals, minimize the use of resources, and have a high probability of success would be ranked as a high priority.

For more information about the MAPP process, review the MAPP Framework on the National Association of County and City Health Officials website at www.naccho.org/topics/infrastructure/mapp/framework/index.cfm.

COMMUNITY BENEFIT PROGRAMS

Selected approaches will form the basis of individual community benefit programs. These community benefit programs will have their own specific goals, objectives and indicators which support the overall goals and objectives of the implementation strategy. See www.chausa.org/guideresources for a program planning worksheet.

STEP 5: INTEGRATE THE IMPLEMENTATION STRATEGY WITH COMMUNITY AND HOSPITAL PLANS

The community health needs assessment will inform several types of planning, both in the community and in the hospital itself.

Plans that could use information from the community health needs assessment include:

- ▶ Community-based plans which lay out community-wide actions or programs to address needs.
- ▶ Hospital's implementation strategy for addressing community health needs (community benefit plan).
- ▶ Hospital strategic and operational plans which set out strategic and performance goals for the organization.

Since these plans will impact and be impacted by each other they should be coordinated.



A community health need may be addressed by a community-based plan, a hospital implementation strategy and/or the hospital's strategic plan.

For example, several communities have tackled the problem of childhood obesity with multipronged approaches to the problem:

Hospital community benefit program

- ▶ Hospital dietitians and therapists teach a weekly after-school program on healthy eating and staying fit.

Other hospital efforts

- ▶ A hospital develops a treatment center for obese children and conducts medical research on the effects of obesity on children recovering from surgery.

Joint hospital-community efforts

- ▶ A hospital joins other community organizations to advocate removing soft drink vending machines from schools.

- ▶ A hospital is a partner in creating a summer camp with an emphasis on healthy lifestyles.

Other community member efforts

- ▶ A department of recreation offers camps with an emphasis on fitness.
- ▶ Local restaurants offer nutritious meal options for children.
- ▶ Local organizations plant community gardens and invite children to participate and learn about the benefits of eating fresh fruits and vegetables.
- ▶ A city builds bike paths and parks.

How to link the implementation strategy and the organization's strategic and operations plans.

- ▶ Include strategic planning staff in the leadership of the implementation strategy team.
- ▶ Include information from the community health needs assessment as a component of the data analysis in the organization's overall strategic planning processes.
- ▶ Integrate the implementation strategy into the organization's overall strategic and operational plans and budget.
- ▶ Keep the organization's governing board and executive leaders informed about community health needs and have them approve priorities and the integrated strategic plan.
- ▶ Include progress on the implementation strategy as a regular agenda item at board and management meetings (similar to all other strategic initiatives).
- ▶ Integrate implementation strategy goals into the hospital/system's overall dashboard or metric reporting.
- ▶ Consider the impact of all major strategic decisions (such as adding or eliminating services) in light of their effects on:
 - Community health.
 - Access to health services.
 - People in the community living in poverty and other vulnerable populations.
 - Community health care costs.

STEP 6: DEVELOP A WRITTEN IMPLEMENTATION STRATEGY

A written implementation strategy will be a summary describing what the hospital plans to do to address significant community health needs. The IRS requires hospitals to formally adopt the implementation strategy.

The written summary will be used by the organization's leaders to understand and communicate the goals, objectives and approaches the hospital will undertake to address community needs, and by community members to understand the health care organization's role in addressing community health problems.

The written summary will also serve as a resource for community organizations who want to work with the health care organization on community-based approaches. A written plan is also required by some state laws.

Written hospital implementation strategies can include:

The organization's mission. Describe the organization's mission, including its commitment to access, community health improvement and the needs of those living in poverty.

Community served. The geographic areas and populations that will be addressed by the implementation strategy.

A description of how implementation strategy was developed and adopted. Explain how the implementation strategy was developed, including who advised or participated in the process. Also, describe how the implementation strategy was adopted by the governing body of the hospital or a delegated entity.

Significant health needs and how priorities were determined. Summarize the significant community health needs identified through the community health needs assessment or through other means. Describe the assessment process and criteria used to identify priorities. (See Section III, Steps 4.5 and 5).

What the organization will do to address selected significant community health needs. Describe the actions that will be undertaken to address selected community health needs (this could include both hospital initiatives and initiatives that will be joint efforts with community partners) and the anticipated impact of these actions. This description should include any planned collaboration between the hospital and other facilities or organizations. Also describe the resources the hospital plans to commit to address community health needs.

Significant community health needs not addressed in the implementation strategy and any reason(s) they are not being addressed. Describe which significant community health needs identified in the community health needs assessment are not being addressed in the implementation strategy but which are expected to be a continuing concern in the community. Explain the reasons the hospital will not address these issues.

See Appendix F for an implementation strategy template.

DOCUMENT SIGNIFICANT NEEDS THAT WON'T BE ADDRESSED
<p>Federal law requires hospitals to report needs not being addressed and the reasons why those needs are not being addressed. Comprehensive assessments of community need will inevitably identify more needs than the hospital and community partners can or should address. It would not be prudent to spread hospital and community resources across too many initiatives; instead focusing attention on priority areas helps ensure that sufficient resources are available.</p> <p>As described earlier, some reasons the hospital might decide not to address certain needs include:</p> <ul style="list-style-type: none"> ▶ Need being addressed by others. ▶ Insufficient resources (financial and personnel) to address the need. ▶ Issue is not a priority for community members and therefore approach is unlikely to succeed. ▶ Lack of evidence-based approach for addressing the problem. ▶ Need is not as pressing as other problems. ▶ Need is not as likely to be resolved as other problems. ▶ Hospital does not have expertise to effectively address the need.

There may be overlap of the items in the written implementation strategy with items in the report of the community health needs assessment. Most hospitals will produce the community health needs assessment and implementation strategy as separate documents. This allows for the assessment information to be available as soon as possible.

STEP 7: ADOPT AND REPORT THE IMPLEMENTATION STRATEGY

Adopting the implementation strategy

An authorized body of the hospital must adopt the implementation strategy to be compliant with the provisions in the Affordable Care Act. In addition to meeting legal requirements, adoption of the implementation strategy also demonstrates that the board is aware of the findings from the community health needs assessment, endorses the priorities identified and supports the strategy that has been developed to address prioritized needs.

An alternative to full board action would be to have a committee of the board (for example, a community benefit committee) or board advisory committee approve the implementation strategy.

Hospital policies should specify how the implementation strategy will be adopted and hospitals should document in the implementation strategy how the strategy was formally adopted.

IRS NOTE

IRS regulations indicate that the implementation strategy:

- ▶ Is considered adopted on the date the implementation strategy is approved by an authorized governing body of the hospital organization.
- ▶ Should be approved on or before the 15th day of the fifth month after the end of the taxable year in which the hospital completes the final step for the CHNA.
- ▶ Should be a separate document for each individual hospital unless a joint CHNA is conducted.

Reporting the implementation strategy

The Affordable Care Act added additional reporting requirements to the Internal Revenue Code related to Section 501(r) including a requirement for hospitals to include on their annual information return (Schedule H, Form 990) a description of the actions taken during the taxable year to address significant health needs identified through the most recently conducted CHNA or, if no actions were taken with respect to one or more of these health needs, the reasons(s) why no actions were taken.

STEP 8: UPDATE AND SUSTAIN THE IMPLEMENTATION STRATEGY

The community health needs assessment and implementation strategy development process is usually conducted on a three-year cycle. (Federal law requires community health needs assessment to be conducted at least every three tax years.)

However, implementation strategies may need to be updated more frequently based on:

- ▶ Changing community needs and priorities.
- ▶ Changes in hospital resources.
- ▶ Evaluation results.

Changing community needs and priorities

Community health needs are not static and can change in the time between assessment cycles. New, high-priority needs can arise, existing needs can become significantly less pressing, or new community resources or programs can become available that help address health needs already being addressed by the hospital.

The hospital may become aware of these changes in a variety of ways:

- ▶ Through work with community groups and partners.
- ▶ Significant changes in patient populations and services provided by the hospital.
- ▶ Information gathered by the hospital's strategic planning department.
- ▶ Evaluation of community benefit programs.

For example:

- ▶ If a community experiences profound change (for example, a natural disaster, a large influx of immigrants, loss of major employer), the implementation strategy should be revised to reflect new needs and priorities.
- ▶ New resources may become available, such as a federal grant to support a community-wide coalition to address childhood obesity. If the hospital's implementation strategy did not include childhood obesity and the hospital will be involved in the coalition, the implementation strategy should be updated to include this effort.

- ▶ New community assets may become available that suggest major or minor changes, such as establishment of a new Federally Qualified Health Center or active parish nurse programs. The availability of these community resources may lessen the need for certain programs or services offered by the hospital and the implementation plan should reflect this change.

Changes in resources

Reviews and updates of the implementation strategy should be part of the organization's overall planning and budget cycles. This will ensure that changes in hospital and other resources that may impact the implementation strategy are identified and addressed in a timely manner.

If all needed resources cannot be obtained (for example, hospital financial status has changed and community benefit programs are scaled back or grant funds are not renewed), the implementation strategy will need to be revised to reflect how available resources will be redistributed among the different approaches in the implementation strategy.

Subsequently, if new resources are made available by the hospital, or if community partners are able to contribute funds or personnel, or new grant funds are obtained, the implementation strategy may need to be updated to reflect new or expanded programs.

Evaluation results

Evaluate the individual community benefit programs within the implementation strategy to see if they are being carried out as planned and are achieving desired results.

Refer to CHA's resource *Evaluating Your Community Benefit Impact* for more information on how to evaluate community benefit programs and how to use evaluation findings. For more information about this resource, visit www.chausa.org/communitybenefit.

As the strategy and programs are evaluated, the implementation strategy team may make recommendations to:

- ▶ Change a program to improve its quality or effectiveness,
- ▶ Expand a program to other geographic areas or populations, or
- ▶ Eliminate or replace a program with an alternative approach.

For additional resources on implementation strategies, visit the CHA website at www.chausa.org/guideresources.

Build (on) Community Relationships



V

SECTION V

BUILD (ON) COMMUNITY RELATIONSHIPS

INVOLVE THE COMMUNITY EARLY AND OFTEN

The process of conducting a community health needs assessment and developing an implementation strategy to address community health needs presents an excellent opportunity to forge new relationships with other providers, agencies, and community organizations and to strengthen existing relationships.

Jessica Curtis, Community Catalyst

Hospitals can be involved in various types of community relationships – from formal partnerships where partner roles, responsibilities and resource sharing are clearly defined in written agreements, to informal relationships where the hospital involves community members and groups in various steps of the assessment and planning process through planning committees, interviews and other methods.

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BENEFITS OF COMMUNITY RELATIONSHIPS

Working with community members and organizations, if done effectively, can result in a better assessment and implementation strategy, maximize resources and form the basis for future collaborative efforts.

Information exchange

Community members and groups have valuable information about community health needs, concerns within the community, community assets and the

community's attitude toward the health care organization – necessary for the assessment of need, setting priorities and the development of plans.

Hospitals have valuable information to contribute to community efforts to improve community health – e.g., why patients come to the emergency room and if the reason could have been prevented, how many patients lack access to care and health insurance, and other needs the hospital has identified but may be unable to address.

Coordinated activity

By coordinating their efforts, community stakeholders (for example, public health agencies, providers, community groups, consumer advocates) can develop a shared vision and goals for health in the community and a coordinated approach that focuses attention and resources on achieving those goals. A coordinated approach to addressing community health needs allows community stakeholders to have greater impact than addressing needs independently.

This is certainly true in communities addressing the problem of childhood obesity and other complex problems. No single hospital or community organization or agency is likely to solve the problem, but together, working in a coordinated way, there is great potential for finding solutions.

Shared resources and skills for expanded capacity

Resources are scarce – everywhere. When hospital, public health and community organizations pool their talents, financial resources and other assets, they are able to do more than what a single entity could accomplish. This also avoids unnecessary and wasteful duplication of efforts.

Who to work with

Working with a wide range of individuals and groups from the community will give the hospital a comprehensive view of community-perceived needs, community assets, and can help identify what approaches may or may not be successful in addressing needs.

Examples of community members and organizations a hospital could work with to conduct an assessment and develop a community benefit plan include:

Consumers

- ▶ Uninsured/underinsured people.
- ▶ Members of at-risk populations.
- ▶ Other consumers of health care in the community.
- ▶ Organizations made up of or working on behalf of consumers.

Community leaders and groups

- ▶ Local clergy and congregational leaders.
- ▶ Consumer advocates.
- ▶ The hospital organization's board members.
- ▶ Neighborhood and civic associations.
- ▶ Representatives from businesses.
- ▶ Representatives from organized labor.
- ▶ Political and elected leaders.
- ▶ Foundations.
- ▶ United Way organizations.
- ▶ Coalitions working on health or other issues.

Public and other organizations

- ▶ Public health officials.
- ▶ City planning, housing and development officials.
- ▶ Individuals with business and economic development experience.
- ▶ Welfare and social service agency staff.
- ▶ Education officials and staff.
- ▶ Public safety officials.
- ▶ Staff from state and area agencies on aging.
- ▶ Law enforcement agencies and emergency responders.
- ▶ Local colleges and universities.

PUBLIC HEALTH ORGANIZATIONS

Many local health departments have undertaken community health needs assessment and are working to identify and address community health needs with local partners and stakeholders. Engaging your local health department will ensure that data collection and planning and assessment activities are not duplicated, and that your work will complement other community health improvement activities. In addition, working with your local health department will help fulfill the PPACA requirement of working with persons “with special knowledge of or expertise in public health.”

To find your local health department, visit www.naccho.org.

Source: NACCHO comment letter

Other providers

- ▶ Physicians.
- ▶ Leaders in other not-for-profit health care organizations, such as hospitals, clinics, nursing homes and home-based and community-based services.
- ▶ Leaders from Catholic Charities and other faith-based service providers.
- ▶ Mental health providers.
- ▶ Oral health providers.
- ▶ Administrators of housing programs: homeless shelters, low-income-family housing and senior housing.
- ▶ Health insurers.
- ▶ Parish and congregational nursing programs.

Most of the people and groups listed above can, in combination, represent the broad interests of the community, as required by federal law.

Sources for expertise in public health, also required by law and a good practice include:

- ▶ University schools of public health and public administration.
- ▶ Local and state health departments.
- ▶ Research organizations.

- ▶ Volunteers or personnel within partner organizations.
- ▶ Clinicians (physician, nurse and others) within your own organization who are trained in public health.
- ▶ Public health consultants.

Advice for working with community members and groups

Community members, including people from at-risk populations, have valuable information needed for the assessment, priority-setting and developing the implementation strategy. They may be aware of health issues and concerns within neighborhoods that public health data do not reveal. They will know about barriers to care. They may be knowledgeable about cultural and ethnic issues that impact how health needs are perceived by the community and whether implementation strategies will be successful with various populations.

However, some community members may not have experience or skills needed to be effective members of a community health partnership or coalition. They may need support and encouragement to make sure their voices are heard and their concerns addressed. Others may be eager to participate, but will face constraints as they juggle work, family life and other responsibilities. Ensuring that the process works efficiently for them is a very good way to honor their investment of time.

Some ways to ensure effective involvement of community members include:

- ▶ Understanding the history of communication and relationships between the hospital and the community.
- ▶ Using a skilled facilitator for meeting to ensure that all group members participate.
- ▶ Setting ground rules for all parties that encourage differing perspectives to be heard.
- ▶ Eliminating surprise as much as possible by sharing goals, invitee lists, time frames for discussion, and relevant background materials in advance.
- ▶ Avoiding jargon and translating data and complex background materials into “lay” language.
- ▶ When feasible, providing the appropriate translation, transportation, and child care or respite care services. This is particularly important for the purposes of engaging key vulnerable populations, such as people living with disabilities, elders or family caregivers, certain minority populations.

- ▶ Being clear to community members and others in the partnership about why community members have been invited to the process and the value of their information and insights.
- ▶ Holding meetings in community settings, where community members may be more comfortable, and at convenient times.
- ▶ Paying attention to the racial and ethnic makeup of the partnership or coalition.
- ▶ Setting realistic expectations about what the hospital and/or partnership will be able to accomplish and being clear that while all concerns are valued, all may not be acted upon. Explain why.
- ▶ Following up with community members and keeping them informed and involved in the implementation strategy and evaluation of resulting programs.
- ▶ Offering clear opportunities for community members to provide feedback and comment throughout the process.

CONSIDER THE COLLECTIVE IMPACT FRAMEWORK

Collective impact is a structured approach for bringing people and groups in a community together to achieve social change. For more information see Section IV, Step 3 in this book and visit the Collective Impact Forum website at <http://collectiveimpactforum.org/>.

PARTNERSHIPS

One way hospitals can work with other community organizations is to participate in a partnership (also known as coalition or collaborative). The partnership can conduct the community health needs assessment and may also develop community-wide plans to meet identified needs.

In order to be successful, partnerships require certain key elements from participants – trust, time and a willingness to share resources, risks and rewards.

Partnership strategies

Arthur Himmelman, an internationally recognized consultant on community and systems change collaboration, has defined four partnership strategies for working together – *networking, coordinating, cooperating, and collaboration*. These strategies can be seen as a continuum, with networking being the most basic type of partnership strategy, and collaboration the most advanced. Himmelman notes that each strategy can be appropriate for a particular situation.

Networking requires limited trust, time and sharing of resources, risk and rewards. Collaboration is at the other end of the continuum with organizations willing to commit significant amounts of staff time and resources and to alter their own actions in order to achieve the shared vision and goals of the partnership. As the amount of shared commitment, risk and resources increases so does the partnership's capacity to produce significant change.

For more information about Arthur Himmelman's work on effective collaboration, read *Collaboration for a Change, Definitions, Decision-making models, Roles and Collaboration Process Guide* (revised January 2002) at http://depts.washington.edu/ccph/pdf_files/4achange.pdf.

PARTNERSHIP ROLES CAN VARY

Not all partners will play the same role in a partnership. The role will depend on the expertise, time and resources the partner can contribute:

- ▶ Active Participants: take part in most activities
- ▶ Occasional Participants: involved on an irregular basis, usually only when major decisions are made
- ▶ Supporting Participants: seldom involved, may contribute in nonactive ways or through financial contributions

Planning, Implementing & Evaluating Health Promotion Programs: A Primer, by McKenzie, Neiger, Smeltzer

Joining/Forming a partnership

If your hospital is not already part of a community partnership, you might want to investigate whether there is an existing partnership working on community health issues and gather information about the partnership's vision, goals, and existing members. Are the organizations in the partnership interested and willing to work on an assessment? Do they have the capacity to work on the effort?

If joining an existing partnership is not an option, your organization might consider working with interested groups to establish a partnership. Before taking this step, assess your organization's readiness to undertake this effort and what benefits the partnership could realistically provide. Whether you decide to join an existing partnership or to work with community groups to establish a new partnership, review Appendix B, Factors Influencing the Success of Collaboration, to make sure that the partnership is positioned to achieve its goals.

MOBILIZING FOR ACTION THROUGH PLANNING & PARTNERSHIP (MAPP)

MAPP is a community-wide strategic planning process for improving community health and strengthening the local public health system. By engaging in MAPP, hospitals build new partnerships and benefit from the community's strengthened public health infrastructure and improved ability to anticipate and manage change. United with a common framework and shared values, non profit hospitals, local health departments, and local public health system partners can collectively move communities closer to the ultimate goal of improving the public's health. Your hospital may want to determine if a MAPP process is underway in your community, and consider joining this effort. For more information on MAPP, visit www.naccho.org/topics/infrastructure/mapp/index.cfm.

Source: National Association of County and City Health Officials FACT SHEET

Initiating relationships

When initiating a relationship with community partners to conduct a community health needs assessment, make sure all partners share a common vision and purpose in regard to the assessment and that roles, responsibilities and resource commitments are clearly understood and agreed upon.

- ▶ Identify existing and potential groups and people to work with.
- ▶ Identify a champion or point person in each organization.
- ▶ Develop a common vision, goals and initial plan for the assessment that is supported by all partners.
- ▶ Define the role of partners. Some assessment and planning processes are true partnerships with shared contributions and decision making. Others will be looser collaborations, with different organizations taking different roles at various times.
- ▶ Agree upon an action plan for the assessment and/or planning process, such as identification of other partners to involve, and outside experts. Some action steps for collaborative activity include:
 - ▷ Form a steering group.
 - ▷ Form work groups (for example: data collection, communications).
 - ▷ Establish a preliminary timetable.
 - ▷ Decide how the information will be reviewed, prioritized and disseminated.

- Identify needed outside resources, such as web tools.
- ▶ Develop a budget and identify funding sources.

Also see overall steps in the assessment process in Section III.

WEB-BASED TOOLS FOR COLLABORATION

Free tools that permit discussion and idea sharing include Nabble (www.nabble.com), Google Groups (groups.google.com), and Yahoo Groups (groups.yahoo.com). Some online tools, such as Google Documents (docs.google.com) and Dropbox (www.dropbox.com), also allow document sharing to promote the collaborative process.

COMMUNITY VISION

Here is an example of a community vision developed as part of a Mobilizing for Action through Planning and Partnership (MAPP) strategic planning process facilitated by the Northern Kentucky Health Department.

“Northern Kentucky will be recognized, both nationally and internationally, as a great place to live,” is one of Vision 2015’s goals. One of the strategies to achieve this goal is to conduct a health and social needs assessment and planning process.

The Northern Kentucky Health Department facilitated the MAPP strategic planning process with Vision 2015 and Cincinnati Children’s Hospital Medical Center. The MAPP process uses four unique assessments to determine community priorities. The four assessments are Community Health Status, Local Public Health System, Community Themes and Strengths, and Forces of Change.

While Vision 2015 extends across nine counties, this assessment focused on the four counties served by the Northern Kentucky Health Department. These are Boone, Campbell, Grant and Kenton counties. More than 200 individuals and 120 organizations participated in the assessments, and nearly 2,000 residents responded to a community survey.

To achieve the vision of “thriving people living healthy lifestyles in a vibrant community,” four strategic issues were developed. Those issues are:

STRATEGIC ISSUE I: How does the region improve access to primary care, mental health services, substance abuse services and dental services to low-income families in the most cost effective and coordinated manner?

STRATEGIC ISSUE II: How can we achieve a defined and measurable collaborative effort between businesses, government and non profit sectors to comprehensively address the interrelated issues facing our community?

STRATEGIC ISSUE III: How do we make real change in the nutrition and physical activity choices families make that affect their children’s health?

STRATEGIC ISSUE IV: How can we best provide education and awareness activities to improve lifestyle choices that impact health, i.e. smoking, nutritious foods, physical activity, preventative or regular health care and prenatal care?

The complete report can be found at www.chausa.org/guideresources under Planning for Community Benefit > Community Relationships/Partnerships.

Partnership etiquette

You and your partners can strengthen your relationships by following some common-sense guidelines:

- ▶ Establish trust before trying to make major decisions.
- ▶ Don't dominate the process.
- ▶ Let various partners host meetings if possible.
- ▶ Respect the strengths and views each organization brings.
- ▶ Resolve concerns and disputes quickly and respectfully.
- ▶ Clarify the role of each partner.
- ▶ Celebrate progress and success.
- ▶ Communicate, communicate, and communicate.

For additional resources on building community relationships, visit CHA's website at www.chausa.org/guideresources.

Appendices



A

APPENDIX A

SUMMARY OF NEW FEDERAL REQUIREMENTS AND RECOMMENDED PRACTICES

This book describes a variety of ways hospitals may conduct community health needs assessments and develop implementation strategies. The approach taken may depend on the size of the hospital, the size and makeup of the community, the existence of a current valid assessment and the presence of on-going community assessment efforts.

This appendix summarizes new federal requirements for tax-exempt hospitals and recommendations from community benefit and public health experts on conducting assessments and developing implementation strategies described in this book.

Please note that the final rules on what constitutes compliance with community health needs assessment and implementation strategy provisions of the Affordable Care Act can be viewed at <https://federalregister.gov/a/2014-30525>. The information in this booklet is provided for educational purposes only and should not be considered legal or tax advice.

Community Health Needs Assessment (CHNA)

Provisions in the Affordable Care Act require a tax-exempt hospital facility to:

- ▶ Conduct a CHNA at least every three years.
- ▶ Take into account input from persons who represent the broad interests of the community.
- ▶ Take into account input from persons with special knowledge of or expertise in public health.
- ▶ Makes the CHNA widely available to the public.

Additional requirements described in the IRS rules:

- ▶ Steps in conducting a community health needs assessment include:
 - Define the community.
 - Assess the health needs of the community.

- Solicit and take into account input from the community and public health.
 - Document the CHNA in a written report approved by an authorized body.
 - Make the CHNA report widely available to the public.
- ▶ In defining community to assess, consider geographic area served, and the hospital's target populations and principal functions.
 - ▶ Community may not be defined in a way that excludes certain populations served by the hospital (for example, low-income persons, and minority groups).
 - ▶ Hospitals must solicit and take into account, for the CHNA and priority setting, input from:
 - At least one state, local, tribal or regional public health department or equivalent, and
 - Members of medically underserved, low-income and minority populations served by the hospital or their representatives, and
 - Written comments received on most recently conducted assessment and most recently adopted implementation strategy.
 - ▶ CHNA must identify and prioritize significant health needs of the community. Hospitals may determine whether a need is significant based on all of the facts and circumstances present in the community it serves.
 - ▶ Health needs of the community include:
 - Requisites for the improvement or maintenance of health in both the community at large and in particular parts (such as neighborhoods or population experiencing health disparities).
 - Needs to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community.
 - ▶ Written CHNA report must include:
 - Definition of the community served by the hospital and a description of how the community was determined.
 - Description of the process and methods used to conduct the assessment, including all of the following:
 - Data and other information used in the assessment.

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- Methods of collecting and analyzing information.
- In the case of data obtained from external source material, the CHNA report may cite the source material rather than method of collection.
- Any parties the organization worked or contracted with.
- Description of how the hospital took into account input from persons who represent the broad interests of the community, including all of the following:
 - Summary of community and public health input, how it was obtained, and over what period of time.
 - Names of organizations providing input and the nature and extent of their input.
- Description of medically underserved, low-income and minority populations represented by organizations or individuals that provided input.
- Written comments received on most recently conducted assessment and most recently adopted implementation strategy.
- A prioritized description of significant community health needs identified through the community health needs assessment, including a description of the process and criteria used in identifying certain health needs as significant and prioritizing those health needs.
 - Hospital may use any criteria to prioritize significant health needs including, but not limited to, the burden, scope, severity, or urgency of the health need, the estimated feasibility and effectiveness of possible interventions, the health disparities associated with the need or the importance the community places on addressing the need.
- A description of the resources potentially available to address the significant health needs identified in the CHNA.
- An evaluation of the impact of any actions that were taken since the hospital finished conducting its immediately preceding CHNA to address the significant health needs identified in the prior CHNA.
- ▶ CHNA report will be considered widely available if the hospital:
 - Makes a copy of the CHNA report widely available on a website, at least until the date the hospital has made widely available on a website two subsequent CHNA reports, and

- Makes a paper copy of the CHNA report available for public inspection without charge at the hospital at least until the date the hospital has made available a paper copy of its two subsequent CHNA reports.
- ▶ Widely available on a website means all of the following:
 - A complete and current version of the CHNA report is conspicuously posted on the hospital's website, the hospital system's website or website of another entity (given certain conditions).
 - Individuals with access to Internet can access, download software, view and print a hard copy of CHNA report without special hardware or fee and without having to create an account or otherwise provide personally identifiable information.
 - Hospital provides individuals who ask how to access report online with direct website address of the page where the report is posted.

Recommended practices

- ▶ When possible, conduct the assessment in collaboration with other hospitals, local health departments and/or community partners.
- ▶ Form assessment team/advisory committee that include key staff within the organization and public health and community representatives.
- ▶ Use public health data collected by government agencies and other authoritative sources.
- ▶ Consider the following types of information: demographics (age, income, race), health indicators (leading causes of death and hospitalization), health risk factors (tobacco use, obesity), access to health care (rates of uninsured, availability of primary care), and social determinants of health (education, environmental quality, housing).
- ▶ Collect community input using one or more of the following methods: community forums, focus groups, interviews, and/or surveys.
- ▶ Seek community input that reflects the racial, ethnic and economic diversity of the community.
- ▶ Analyze data collected using comparisons with other communities and with federal or state benchmarks and, when available, trends within the community. Look for disparities and contributing causes of health problems.
- ▶ Use knowledge of community assets in determining priorities.

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- ▶ Identify from three to 10 priorities.
- ▶ Align priorities with organizational, state and national priorities.
- ▶ Distribute report to all partners and contributors.

Implementation strategy

Provisions in the Affordable Care Act require a tax-exempt hospital to:

- ▶ Adopt an implementation strategy to meet community health needs identified in the CHNA.
- ▶ Describe how it is addressing needs identified in the CHNA.
- ▶ Describe any needs identified in the CHNA that are not being addressed and the reasons for not addressing them.

Additional requirements described in IRS proposed rules

- ▶ The written implementation strategy describes either:
 - How the hospital plans to meet the significant health need.
 - The actions the hospital facility intends to take to address the significant health need.
 - The anticipated impact of these actions.
 - The programs and resources the hospital plans to commit to address the health need.
 - Any planned collaboration between the hospital facility and other facilities or organizations.

OR

- The significant health need the hospital does not intend to meet, explaining why the hospital does not intend to meet the health need.
- ▶ A hospital that collaborates with other facilities and organizations in developing its implementation strategy must still document its implementation strategy in a separate written plan that is tailored to the particular hospital, taking into account its specific programs, resources and priorities.

- ▶ The implementation strategy is “adopted” on the date it is adopted by the governing body of the hospital (the governing body, a committee of the governing body, or others authorized).
- ▶ Implementation strategy must be adopted on or before the 15th day of the fifth month after the end of the taxable year in which the CHNA is conducted.
- ▶ Copy of most recently adopted implementation strategy may be attached to hospital’s IRS Form 990 or hospital may provide on the Form 990 the URL(s) of the web page(s) on which the hospital has made the implementation strategy widely available.
- ▶ Hospitals must describe on Form 990 actions taken during the taxable year to address the significant health needs identified through its most recent CHNA or, if no actions were taken with respect to one or more of these needs, the reason or reasons why no actions were taken.

Recommended practices

- ▶ Coordinate hospital and community strategies to ensure the most effective use of resources.
- ▶ Give priority to persons who are low-income and disadvantaged.
- ▶ Build on existing programs and other community assets when possible.
- ▶ Understand root causes of needs being addressed and identify a range of possible interventions.
- ▶ Investigate evidence-based approaches to ensure effective use of hospital and community resources.
- ▶ For each prioritized need, identify the goal to be achieved, measurable objectives(s), indicators for determining whether objectives were met and evaluation plan.
- ▶ Make the implementation strategy publicly available by posting on hospital website and in other ways.
- ▶ Update the implementation strategy upon major changes in community health status and at least every three years.

B

APPENDIX B

FACTORS INFLUENCING THE SUCCESS OF COLLABORATION

The list below defines elements of successful collaboration. It was taken from *Bridges Out of Poverty: Strategies for Professionals and Communities*, a resource for social workers, employers and community organizations designed to help them implement strategies to improve services for clients, raise retention rates for new hires from poverty, and increase understanding of the differences in economic cultures and how those differences affect opportunities for success.

Factors influencing the success of collaboration

ENVIRONMENT	
1. History of collaboration in community.	History of collaboration or cooperation exists which offers potential partners understanding of roles and expectations, enabling them to trust process.
2. Collaborative group seen as leader in community.	Collaborative group is seen as leader, at least related to goals and activities it intends to accomplish.
3. Political/social climate favorable.	Political leaders, opinion-makers, those who control resources, public support, no obvious opposition to mission of group.
MEMBERSHIP	
4. Mutual respect, understanding, and trust.	Members share understanding of each other and their respective organizations (i.e., how they operate, cultural norms, values, limitations, and expectations).

MEMBERSHIP (continued)	
6. Members see collaboration as being in their self-interest.	Partners feel that collaboration, with its resulting loss of autonomy and “turf,” will have benefits for them that exceed costs.
7. Ability to compromise.	Partners are able to compromise, since all decisions cannot possibly be molded to conform perfectly to preferences of each member.
PROCESS/STRUCTURE	
8. Members share stake in both process and outcome.	Group members feel “ownership” both in how group works and results of its work.
9. Multiple layers of decision-making.	Every level (upper management, middle management, operations) within each organization that is part of collaborative structure needs to participate in decision-making.
FACTOR	DESCRIPTION
10. Flexibility.	Group remains open to varied ways of organizing itself and accomplishing its work.
11. Development of clear roles and policy guidelines.	Group clearly understands roles, rights, responsibilities – and how to carry out those responsibilities.
12. Adaptability.	Group has ability to sustain itself in midst of major changes, even if it needs to change some major goals or members in order to deal with changing conditions.

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COMMUNICATION	
13. Communication.	Group members interact often, update one another, discuss issues openly, convey all necessary information to one another and to people outside group.
14. Establish informal and formal communication links.	Channels of communication exist on paper, so that information flow occurs; members also establish personal connections that will produce better informed, more cohesive group working on common project.
PURPOSE	
15. Concrete, attainable goals and objectives.	Goals and objectives of group appear clear to partners and can realistically be attained.
16. Shared vision.	Partners share same vision with clearly agreed-upon mission, objectives, and strategy.
17. Unique purpose.	Mission and goals or approach of collaborative structure differ, at least in part, from mission and goals or approach of member organizations.
RESOURCES	
18. Sufficient funds.	Group requires adequate, consistent financial base to support its operations.
19. Skilled convener.	Individual who convenes group has organizing skills, interpersonal skills, reputation for fairness, and perceived legitimacy in convener role.

From Bridges out of Poverty: Strategies for Professionals and Communities. Ruby K. Payne, Phillip E. DeVol, Terie Dreussi Smith. Aha! Process, Inc. revised edition, 2009.

APPENDIX C

OVERVIEW OF TERMS AND CONCEPTS USED IN HEALTH RESEARCH AND EPIDEMIOLOGIC STUDIES

C

Epidemiology is defined as the study of the distribution and determinants of disease frequency in human populations and the application of this study to control health problems (Aschengrau and Seage, 2008). This appendix provides an overview of terms and concepts used in health research that you may encounter as you conduct your community health needs assessments and develop your implementation strategies.

Data quality

Evaluate the reliability and validity of data that will be used in the community health needs assessment.

Reliability – Reliability refers to consistency of measurements. A reliable measure will give identical or nearly identical values when measuring the same thing over time.

Validity – Validity refers to accuracy of measurements. A valid measure accurately measures what it is intended to measure.

Example: A woman is conducting a study on obesity. She weighs each study participant twice, and notes that the weights are identical. However, the scale is improperly calibrated, and adds five pounds to each person's weight. The scale is a reliable instrument, but it is not a valid instrument. The data is consistent, but is not accurate.

Measures of disease: prevalence and incidence

The prevalence of a disease is the number of existing cases at a specific point in time, while *incidence* reflects the number of new cases that arise within a given time period.

Here is an example that illustrates the difference between prevalence and incidence measures:

A team of researchers are interested in studying asthma in a particular community. In 2010, the research team determines how many people living in the community have been diagnosed with asthma - these are the *prevalent* cases of asthma. In other words, this is the prevalence of asthma in 2010 for this particular community.

C

The research team decides to proceed with the asthma study. In 2011, they enroll the members of the community who have *not* been diagnosed with asthma in their study. The research team monitors this group of people over two years. Because the research team is following the population over time, they know when a new case of asthma - an *incident* case - occurs. Therefore, the number of cases that occur during the study is the asthma incidence rate for this particular community between 2010 and 2011. It is important to note that the existing cases of asthma at the beginning of the study (the prevalent cases) are not included in the incidence measure.

Types of disease measurement: counts, proportions, ratios and rates

In common usage, a proportion, ratio, and true rate are all referred to as rates; however, they are different measures. Proportions, ratios, and rates all contain a denominator, and are useful for comparison purposes. *Rates* are different from proportions and ratios because a unit of time (i.e., minutes, years) is included in the denominator. *Counts* simply list the number of events (births, deaths, disease) and are most informative when they are given in the context of the time period in which they occurred and with a geographic context.

A *proportion* is a division of two related numbers (Aschengrau and Seage, 2008). In a proportion, the numerator is included in the denominator. A percentage is a common example of a proportion. For example, the number of babies born at a certain hospital weighing less than 2,500 grams expressed over the total live births that occurred at the hospital would provide the proportion of low birth weight babies in a specified community over a specified time period.

A *ratio* is a division of two unrelated numbers (Aschengrau and Seage, 2008). The numerator is not included in the denominator in a ratio. An example of a ratio would be the number of doctors in a community divided by the number of hospital beds in the same community.

A *rate* is a division of two numbers and, as was previously stated, time is an integral part of the denominator (Aschengrau and Seage, 2008). A commonly encountered rate is miles per hour. In health-related data, an example of a rate would be 700 new cases of asthma per 100,000 population from 2011 to 2013. This is a rate because the time period, "from 2011 to 2013," is specified.

To monitor the health and well-being of a community, it is often desirable to compare a measure of disease from the community to that of another community. Moreover, it may be informative to compare a measure of disease from the community of interest to the number of cases or rate of disease at the national or state levels. Care must be taken when making such comparisons. Crude counts and rates from two different populations can rarely be accurately compared because their underlying population structures (size and age) are rarely the same. Proportions, ratios and rates are measures of disease that are better suited for

comparing two populations and often these measures must be adjusted to make completely accurate comparisons.

Consider the two populations described below:

	COUNTY A	COUNTY B
Number of new cases of disease X in 2009	125	300
Population size	1,500	10,000

First, it is important to note that the number of cases of disease X in 2014 represent the incident cases. County B has more than double the number of incident cases than County A and so it is tempting to conclude that it has a higher incidence of disease X; however, their differing population sizes have not been taken into account. The number of incident cases must be examined in the context of the population size from which they arose to permit an accurate comparison. In order to take the population sizes into account, divide the number of incident cases by the population size of each county and multiply this fraction by the conversion factor, “100,000 population.” These numbers are now comparable and it can be concluded that County A had a greater incidence of disease than county B in 2014.

	COUNTY A	COUNTY B
Number of new cases of disease X in 2009	125	300
Population size	1,500	10,000
Incidence of Disease X	8,333 cases of disease X per 100,000 population	3,000 cases of disease X per 100,000 population

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Please note that it is most common to express these types of incidence measures in terms of “100,000 population” because larger numbers are easier to conceptualize and work with; however, if the original fraction (number of incident cases divided by population size) is quite large, a conversion factor of “1,000 population” can be used. Drawing on the same example, the equivalent incidence measures using the smaller conversion factor are 83.3 cases per 1,000 population in county A and 30 cases per 1,000 in county B.

Population size is not the only thing that varies between communities; the age structures may also be different. As with population size, the age structure must be taken into account in order to accurately compare disease measurements between two populations. Age is very related to disease occurrence; most diseases and health outcomes occur at different rates within different age groups. For example, even without looking at data from a specific population, it is intuitive that older people are more likely to suffer from arthritis than younger people. Therefore, a community with a larger proportion of older adults will have a higher overall incidence of arthritis compared to a community with a higher proportion of young people, such as a university town.

In order to accurately compare populations with different age structures, disease measures must be age-adjusted to a standard population. Any population can be used as a standard population, and the U.S. population is often used.

Age adjustment can be used to answer the following question, “How many cases of disease will occur if the standard population experiences the same incidence (or rate) of disease as the community of interest?”

To do this, the age-structure of the standard population must be known; this is the number of people in designated age groups (e.g., the number of people aged 0 to 5 years, 6 to 10 years, 11 to 15 years, etc.). Also, the incidence or rate of disease for these age groups must be known from the communities of interest; these are called age-specific rates. Typically, such rates are obtained in the same manner as the incidences of counties A and B for disease X in 2014 that were obtained above, but for each age group; therefore, the incident cases and numbers of people in each age group must be known for the populations of interest. These age-specific rates are applied to a standard population distribution, and the number obtained represents the number of cases of disease *if the standard population had the same incidence (or rate) of disease as the communities of interest*. If two populations are age-adjusted to the same standard populations, the numbers can be compared directly. This method is known as direct age standardization – it is a method for controlling the differences in population age structure when comparing two different populations.

Confidence intervals

Confidence intervals indicate the reliability of a measurement. Most often 90 percent or 95 percent confidence intervals are presented around disease measurements. A 95 percent confidence interval is interpreted as follows: If the data collection and analysis could be replicated many times, the confidence interval should include the true value of the measurement 95 percent of the time (Rothman, 2002).

Trends

A change in value for an indicator from one measurement period to another does not always signify a trend. When considering estimates from two time points, examine the confidence intervals. If the confidence intervals overlap, the trend is not likely to be significant. In order to determine if a true increase or decrease has occurred in the measure of disease between two measurement periods, it is necessary to conduct a statistical test for trends.

Stability

If a measurement is based on a small number of disease counts, there is a high level of uncertainty in the measure and the value is considered unstable or unreliable. This is indicated by a broad confidence interval. The stability of the measurement can be improved by combining several years of data or by combining geographies. For example, instead of reporting the incidence of oral cancer in 2012, report the incidence of oral cancer from 2008 to 2012. There will be more cases of oral cancer over five years than in one year and the number will be more stable. Moreover, instead of considering the rate of disease for one ZIP code in a city, consider the rate of disease for a region in the city comprising 20 ZIP codes. Increasing stability in these ways will reduce the uncertainty surrounding the estimate and the confidence interval will become narrower.

Error

Errors can occur in health research and epidemiologic studies that distort the true measurement of disease in a population or that distort the true relationship between an exposure and a disease. Errors come in two types: random error and nonrandom error (also known as bias).

Random error can occur chiefly in two ways, through sampling variability and measurement errors. Nonrandom error can occur when there are systematic differences in the study sample (selection bias), systematic differences in measurement of exposure or outcome (information bias) or confounding (a third variable either makes it appear as if there is a relationship between an exposure and a disease when there is not a true relationship or vice versa). Measurement error can also be nonrandom error (bias) in the case that it causes misclassification of the exposure or disease in a systematic way (i.e., it is not due to chance). For example, a woman is conducting a study on obesity. She weighs

each study participant twice, and notes that the weights are identical. However, the scale is improperly calibrated, and adds five pounds to each person's weight each time. These are biased measurements. It is important to consider the possibility of error in your study measurements and data sources.

For additional information on the topics covered in this section, the following resources are available:

Aschengrau, Ann and George R. Seage III. *Essentials of Epidemiology in Public Health*. Sudbury: Jones and Bartlett, 2008.

Gordis, Leon. *Epidemiology*. 4th edition. Philadelphia: Saunders, 2009.

Jewell, Nicholas P. *Statistics for Epidemiology*. Boca Raton: Chapman & Hall/CRC, 2004.

Rothman, Kenneth J. *Epidemiology: An Introduction*. New York: Oxford University Press, 2002.

APPENDIX D

SUGGESTED INFORMATION TO BE INCLUDED IN A COMMUNITY HEALTH NEEDS ASSESSMENT

D

Availability and cost of data may vary by region/county.

Demographics and socioeconomic status

- ▶ Community overview, age, sex, race, socioeconomic status and academic attainment.
- Poverty by age and racial/ethnic subgroups.
- Unemployment rate.

Access to health care

- ▶ Health staffing shortages by Health Professional Shortage Area (HPSA), Primary Care HPSA, Dental HPSA.
- ▶ Physicians (MDs and DOs), Primary Care per 10,000 population.
- ▶ Hospitals and number of beds per 10,000 population.
- ▶ Percent uninsured.
 - Uninsured adults (Ages 18+).
 - Uninsured children (<17).
- ▶ Percent Medicaid and Medicare.

Health status of overall population and priority population (uninsured, low-income and minority groups)

- ▶ Leading causes of death (age-adjusted rates if available).
- ▶ Inpatient admissions rates, top 10 causes.
- ▶ Rates of “preventable” hospitalization (CHF, asthma, diabetes, COPD, and pneumonia).

Risk factor behaviors and conditions related to top 10 causes of death

- ▶ Tobacco use, obesity rates, and related behaviors.
- ▶ Screenings utilization rates.

Child health

- ▶ Infant mortality rate.
- ▶ Low birth weight rates.
- ▶ Proportion of women who receive late or no prenatal care.
- ▶ Teen pregnancy rate.

Infectious diseases

- ▶ Sexually transmitted infection incidence rates (chlamydia, gonorrhea, syphilis).
- ▶ HIV incidence rate.
- ▶ Tuberculosis incidence rate.

Natural environment

- ▶ Air quality annual rating.

Social environment

- ▶ Violent crime rate.
- ▶ Child abuse rate.
- ▶ Housing affordability rate.

Resources/Assets

- ▶ Resources available to address community health needs (such as federally qualified health clinics, school clinics).

APPENDIX E

INDICATOR SELECTION TOOL

Use this tool to document information about indicators. This tool can be downloaded from the CHA website at www.chausa.org/guideresources. See [Planning for Community Benefit > Assessment-Indicators](#).

INDICATOR TITLE	GEOGRAPHIC LEVEL	COMPARISON VALUES AVAILABLE?	HISTORICAL DATA AVAILABLE?	BENCHMARKS AVAILABLE?	DATA SOURCE	DATA URL
Age-Adjusted Rate Due to Breast Cancer	County	Yes, other counties in state and state value	Yes	Healthy People 2010 target	National Cancer Institute	http://statecancerprofiles.cancer.gov/deathrates/deathrates.html
Annual Particle Pollution	County	Yes, Counties in United States	yes	No	American Lung Association	http://www.stateoftheair.org



APPENDIX F

CHNA REPORT AND IMPLEMENTATION STRATEGY TEMPLATES

While these templates are consistent with IRS regulations they should not be considered tax or legal advice. It is provided for educational purposes.

COMMUNITY HEALTH NEEDS ASSESSMENT REPORT TEMPLATE

F

I. Community Served by the Hospital

- ▶ A definition of the community served by the hospital and description of how the community was determined.

II. Community Health Needs Assessment Process

- ▶ A description of the process and methods used to conduct the assessment.
 - A description of the data and other information used in the assessment.
 - The methods of collecting and analyzing this data and information. In the case of data obtained from external source material, the report may cite the source material rather than describe the method of collecting the data.
 - Any parties with whom the hospital collaborated in conducting the CHNA.
 - Any parties with whom the hospital contracted for assistance in conducting the CHNA.

III. Community Input

- ▶ A description of how the hospital took into account input from persons who represent the broad interests of the community it serves. The description must include:
 - Summary, in general terms, of any input provided by such persons, including how and over what time period such input was provided (for example, whether through meetings, focus groups, interviews, surveys, written comments and between what approximate dates).

- The names of any organizations providing input, and a summary of the nature and extent of their input.
- A description of the medically underserved, low-income, and minority populations being represented by organizations or individuals that provide input. The regulations note that the report does not need to name or otherwise identify any specific individual providing input on the CHNA.
- In the event a hospital solicits, but cannot obtain, input from a source described in IRS regulations the hospital's CHNA report must describe the hospital's efforts to solicit input from such source.

IV. Prioritized Significant Community Health Needs

- ▶ A prioritized description of the significant health needs of the community identified through the CHNA.
- ▶ A description of the process and criteria used in identifying certain health needs as significant and in prioritizing those significant health needs.

V. Potentially Available Resources

- ▶ A description of resources potentially available to address the significant health needs identified through the CHNA.

VI. Evaluation of Impact

- ▶ An evaluation of the impact of any actions that were taken, since the hospital finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital's prior CHNAs.

_____/_____/_____

Date adopted by authorized body of hospital

IMPLEMENTATION STRATEGY REPORTING TEMPLATE

I. Organization Mission

- ▶ Description of the organization's mission, including its commitment to access, community health improvement and the needs of those living in poverty.

II. Community Served

- ▶ Description of the geographic areas and populations that will be addressed by the implementation strategy.

III. Implementation Strategy Process

- ▶ Explanation of how the implementation strategy was developed, including who advised or participated in the process. Also, describe how the implementation strategy was adopted by the authorized body of the hospital.

IV. Prioritized List of Significant Health Needs Identified in CHNA

- ▶ Describe the process and criteria used to identify priorities

For each significant health need identified in the CHNA or through other means either describe how the hospital intends to address the health need or why the hospital does not intend to address the need.

V. Significant Health Needs to be Addressed*

For each need to be addressed include:

- ▶ Description of the actions the hospital intends to take to address the health need and the anticipated impact of these actions;
- ▶ Resources the hospital plans to commit to address the health need; and
- ▶ Description of any planned collaboration between the hospital and other facilities or organizations in addressing the health need.

VI. Significant Health Needs Not Addressed*

For each need not addressed include:

- ▶ Health need identified as one the hospital facility does not intend to address and explanation why the hospital facility does not intend to address the health need.

- A brief explanation of the hospital facility's reason for not addressing the health need is sufficient. Such reasons may include, for example, resource constraints, other facilities or organizations in the community addressing the need, a relative lack of expertise or competency to effectively address the need, the need being a relatively low priority, and/or a lack of identified effective interventions to address the need.

_____/_____/_____

Date adopted by authorized body of hospital

ATTACHMENT: CURRENT CHNA REPORT

F

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1875 Eye Street NW, Ste. 1000
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202.296.3997 fax

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