COMMUNITY HEALTH NEEDS ASSESSMENT

GUIDANCE AND IMPLEMENTATION STRATEGY

2021

MHA
MISSOURI HOSPITAL ASSOCIATION

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SECTION ONE:
OVERVIEW

Introduction

The Patient Protection and Affordable Care Act, signed into law March 23, 2010, requires hospitals with a 501(c)(3) tax-exempt status to meet requirements to comply with the intent of a charitable hospital. (1) The final rule was issued by the U.S. Department of the Treasury on Dec. 29, 2014, regarding the charitable hospital requirements included in the ACA.

The following clarifications were included in the final rule.

- Expanded examples of health needs to encompass the prevention of illnesses while addressing social determinants of health.
- Gave hospitals leeway in cases where they are not able to gather required community input.
- Added a requirement to use community input when setting priority issues, including involvement in the assessment process.
- Required proof or documentation of the evaluation process and impact of any actions that were taken to address issues identified since the previous needs assessment.
- Removed the requirement that implementation strategies include a plan to evaluate planned actions, but requiring the strategy include the anticipated impact of planned actions.

A complete summary of the rule and IRS guidance may be found in the Jan. 6, 2015, MHA issue brief. (2)

This report provides guidance for the operational implementation of the community health needs assessment and subsequent community-based health improvement plans.

What Is The IRS Requirement For Tax-Exempt Hospitals?

Section 501(r) of the IRS tax code placed new requirements on 501(c)(3) organizations that operate at least one hospital facility. The following four provisions are required for each hospital facility. (1)

- establish written financial assistance and emergency medical care policies
- limit amounts charged for emergency or other medically necessary care to individuals eligible for assistance under the hospital's financial assistance policy
- make reasonable efforts to determine whether an individual is eligible for assistance under the hospital's financial assistance policy before engaging in extraordinary collection actions against the individual
- conduct a CHNA and adopt an implementation strategy at least once every three years

The CHNA must be conducted once every three years and incorporate input from "persons who represent the broad interests of the community served by the hospital, including those with special knowledge of, or expertise in, public health."(1,2) The final rule provides hospitals additional time to submit an implementation strategy following completion of the CHNA for the years that a full CHNA and implementation strategy are required. Based on the three-year renewal cycle, hospitals must submit a full CHNA once every three years but are allowed an additional four ½ months beyond the last day of the tax year to formally adopt the implementation strategy. The implementation strategy must be submitted by the 15th day of the fifth month following the last day of the tax year in which the CHNA is submitted.

CHNA and Implementation Schedule Example	
Previous CHNA and implementation plan submitted	June 30, 2019
Year one progress report	June 30, 2020
Year two progress report	June 30, 2021
New CHNA	June 30, 2022
New governance approved implementation plan	Nov. 15, 2022

The following are current IRS notices and resources.

- *Federal Register* vol. 79, no, 248 is the final rule.
- Notice 2010-39 provides the initial ACA IRS tax requirements for charitable hospitals.
- Notice 2011-52 provides an overview of the initial notice and instructions.
- Notice 2014-3 provides clarification and correction regarding hospitals that do not complete the requirements.
- Appendix A offers the current Form 990, Schedule H and instructions.

Which Hospitals Must Comply With The IRS Provision For Charitable Hospitals?

Organizations with a 501(c)(3) tax-exempt status that operate at least one hospital must comply with the requirements for charitable hospitals, including conducting a CHNA and adopting an implementation strategy at least once every three years. There is no exception for governmental hospital organizations. Governmental entities, which are exempt under IRC Section 115 instead of IRC 501(c)(3), do not have to file a Form 990 tax return AND are not subject to the 501(r) tax regulations. Therefore, these entities are not required to complete a CHNA. (1)

A "dual status" hospital is a governmental hospital that has received 501(c)(3) status to participate in certain employee benefits — typically a 403(b) pension plan. These hospitals are not required to file a Form 990; however, since they do have 501(c)(3) tax status, they are subject to 501(r) tax regulations, and thus are required to complete a CHNA.

The final rule provides the following clarification. Each 501(c)(3) facility with a unique state license is treated as an entity requiring a CHNA. If multiple facilities in different geographic areas and serving different communities operate under a single license, either of the following are acceptable. (3)

- one CHNA and implementation strategy that assesses and includes the aggregate of all geographic areas may be submitted
- the different geographic areas or populations served by the different buildings may be separated as sections within a single assessment and implementation strategy

The final rule also provides clarification about partnership relationships and requirements. If a hospital organization provides hospital care through a partnership, the activities of the partnership are considered activities of the hospital and thus, a CHNA and implementation strategy must be submitted to comply with the IRS provision for charitable hospitals. Likewise, if a hospital organization has capital or profit interest in a partnership that provides hospital care, the partnership's governing body also should be considered an authorized governance body of the hospital. (2)

What Information Should Be Included In The CHNA?

The CHNA must be documented in a written report and address each of the identified community health needs in a separate implementation strategy that follows the written CHNA report. The documentation must include the following information.

1. A description of the community served by the hospital and how it was determined, including but not limited to the following.

    - counties, ZIP codes
    - population density
    - demographics, including age, race, ethnicity and socioeconomic status
    - changes or trends throughout the last 10 years
    - known major risks for community safety

2. A description of the process and methods used to conduct the assessment, including the following.

    - a description of the sources and dates of the data and other information used in the assessment, including primary and secondary data sources
    - the analytical methods applied to identify community health needs
    - information gaps that impact the hospital's ability to assess the health needs of the community
    - If a hospital collaborates with other organizations in conducting a CHNA, the report should identify all of the organizations with which the hospital collaborated. If a hospital contracts with one or more third parties to assist in conducting a CHNA, the report also should disclose the identity and qualifications of the third parties. (1,3)

3. A description of the approach used to plan, develop and conduct the assessment and prioritize the health issues. The report must detail how the hospital took into account input from individuals who represent the broad interests of the community served by the hospital facility, including the following.

    - a description of when and how the organization consulted and/or collaborated with these individuals (whether through meetings, focus groups, interviews, surveys, written correspondence, etc.)
    - community leaders that were consulted and/or collaborated in the planning and implementation process
    - justification of why data sources were used and selected
    - justification of the approach for primary data collection
    - explanation of successful and unsuccessful approaches to seek broad-based community input, especially underserved or high-risk groups within the community
    - a description of people and processes used to prioritize the health issues for the implementation strategy
    - The written report should identify the organizations, including individual names and titles with whom the hospital consulted both for the assessment and the prioritization of health issues. In addition, the report must identify any individual providing input who has special knowledge of, or expertise in public health, by name, title and affiliation, and provide a brief description of the individual's special knowledge or expertise.

4. A prioritized description of all community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs. This section should include, but not be limited to, financial and other barriers to access; preventive health gaps; and indicators of nutritional, social, economic, environmental and behavioral health, all of which influence health status. This information should be collected through the following sources and processes.

    - priorities identified through primary and secondary data
    - other processes used to rank priorities

5. A description of the existing health care facilities and other resources within the community available to meet the community health needs identified through the CHNA.

See Appendix 6: Checklist

Where Is The CHNA Reported?

All tax-exempt hospitals are required to report on the IRS Form 990, Schedule H, a description of how the organization conducted a CHNA and is addressing the needs identified in the CHNA. Hospitals also must report a description of any needs that are not being addressed and the rationale used to omit any health issues in the implementation strategy (see Appendix A: Schedule H Form 990). The ACA and IRS code 501(r) also require that hospitals broadly disseminate to the community and other stakeholders the CHNA results and summary. (3) Instructions on how to receive a printed copy to accompany any reference to the CHNA or electronic version must be provided to ensure ease of access to the information for any interested person.

The final rule clarifies that in years not requiring a full CHNA, the hospital is expected to provide an update to the implementation strategy based on the last conducted CHNA.

When Is A CHNA Required?

Since the passage of the ACA, CHNAs are required to be completed every three years. For most hospitals, assessments were conducted in 2012 and 2013, with the requirement to reassess the community's health status in 2015 and 2016. The final rule largely adopted the interim guidance and thus, the time period has not changed significantly. Compliance with the final rule regulations began after Dec. 29, 2014. (1)

What Is The Penalty For Noncompliance?

A $50,000 excise tax will be imposed on any hospital that willfully fails to meet the requirements of a CHNA due to gross negligence, reckless disregard or willful neglect for any and all taxable years in any three-year period. The excise tax will be applied to any taxable years that a hospital organization fails to comply. (1) For example, if a hospital that reports on a calendar-year basis fails to conduct a CHNA by the last day of 2021, and also did not conduct a CHNA in 2020 or 2021, it will be subject to the tax for its 2022 taxable year. If the hospital then fails to conduct a CHNA by the last day of 2023, it will again be subject to the $50,000 tax for its 2023 taxable year (for not having conducted an assessment in 2021, 2022 or 2023).

The final rule does acknowledge that omissions may occur even with established, reasonable practices and procedures in place. Such omissions may be deemed minor and thus, corrective action, including revised practices and procedures to comply, may be accepted by the IRS as long as the collective omissions or error remains minor. However, if a minor omission or error is repeated after corrective action, the omission or error no longer may be considered inadvertent.

If a multihospital system fails to meet the requirements for all of its hospitals separately, it will be subject to the $50,000 excise tax for each hospital. In 2013, the IRS issued clarification in the Aug. 15, 2013, *Federal Register* providing guidance for hospitals that fail to meet CHNA requirements.

What Are The Benefits To My Hospital Beyond IRS Compliance?

A CHNA will identify assets and programs currently in place and existing gaps. This process reduces the likelihood of developing a well-intentioned but redundant program, or a program that does not address a priority health issue, as identified through quantitative or qualitative data. Assessments also reduce the potential of neglecting a critical need in a vulnerable population.

The transformation of the health care delivery system provides an opportunity for hospitals to incorporate the data and community input into the overall strategy to provide services that result in better health, better care and lower costs. A CHNA and subsequent improvement strategy have many potential benefits for the hospital and community. The following are a few examples of communitywide activities and initiatives that may result.

- coordinating services of care among multiple providers and settings, including prevention, early detection, chronic disease management, and acute and post-acute care
- addressing the behaviors and prevalence of chronic diseases, such as heart disease and smoking- and diet-related illnesses
- actions to address the issues of vulnerable populations and evidence of disparity

Not-for-profit hospitals that take a population-based view of health care may see the financial rewards of a reduced number of uncompensated hospitalizations while demonstrating their commitment to the community's well-being.

The implementation strategy should be thought of as an action guide to address pressing health needs in your community, not simply as an IRS requirement. Therefore, each hospital's strategy should be customized to state what health needs the hospital plans to meet, what needs the hospital will not address and the reasons why, a description of the resources the hospital plans to commit, and planned collaborations. This information should be described in enough detail so that community members can clearly understand what the hospital plans to do. It is recommended that hospitals consult with legal counsel to review what has been reported in recent guidance and what should be included in the implementation strategy, keeping in mind that the IRS wants hospitals to be transparent and accountable. (1)

MHA prepared a guide to help hospitals utilize this provision while promoting charitable programs and services. Hospitals must adopt an implementation strategy to meet the identified community health needs by the end of the same taxable year in which it conducts its CHNA.

SECTION TWO:
CONDUCTING A COMMUNITY HEALTH NEEDS ASSESSMENT

The following steps are suggested approaches for conducting the CHNA and meeting ACA requirements.

1. define the community served by a hospital facility
2. identify the partners and individuals representing the broad interests of the community
3. gather available secondary data and assessments
4. seek community perspectives about the community's health
5. aggregate primary and secondary research
6. identify and prioritize the health needs in your community
7. develop and widely disseminate the written assessment

ONE STRATEGY: COMMIT TO THREE

The following steps help outline a process to address community health issues. It is important to keep decision-makers informed and involved, and to maintain a realistic and practical approach to improving your community's health status.

- develop a CHNA process and plan to conduct the CHNA once every three years
- identify three community stakeholders or leaders to seek broad-based input in the CHNA data, information and process
- with your community partners, review current and available data from at least three reliable sources
- develop a primary data assessment tool and disseminate using as many as three formats to seek broad-based community input
- disseminate the aggregate CHNA results to the community at large through three different communication routes
- identify at least three priority areas for the hospital implementation strategy
- commit to a three-year collaborative process to address priority issues, and encourage partnership with other health providers and experts
- identify three staff who can share the responsibility and lead the effort
- identify three indicators of success for each health issue
- monitor and report the progress three times per year to the hospital, community leadership and community at large
- repeat the CHNA process every three years

STEP ONE

Defining The Community Served By A Hospital Facility

Hospitals must consider all of the relevant facts and unique community characteristics in defining the community a hospital facility serves. This especially is important because it determines the scope of the assessment and intervention. The IRS instructions — Part VI, Supplemental Information — advises hospitals to take into account the geographic service areas, demographics of the community, the number of other hospitals serving the community, and whether one or more federally designated medically underserved areas or populations are present in the community. (3) The definition of community should include at-risk, target populations and principal specialty areas served by the hospital and present within the community. It is important to realize that bringing community members and patients into the conversation is essential as it ensures that everyone's interests are understood. This inclusiveness helps to engage the community members, thus laying a good foundation for the implementation phase of the needs assessment.

The community may not be defined in a manner that circumvents the requirement to assess the health needs of (or consult with persons who represent the broad interests of) the community served by the hospital by excluding specific populations (i.e., medically underserved, low-income persons, minority groups, etc.).

The following definition has been used in several publications, including the *Massachusetts Attorney General's Community Benefits Guidelines for Nonprofit Hospitals.*

"While the geographic hospital service area is the natural definition of community for purposes of the needs assessment, the hospital service area should be the hospital's starting point for assessing health needs. The community examined may differ from the patient care population. Consider whether there are populations within that geographic area with particular unmet health needs." (1)

STEP TWO

Identifying Partners And Persons Representing The Broad Interests Of The Community

The CHNA must consider input from people who represent the broad interests of the community served by the hospital. The CHNA must, at a minimum, take into account input from the following.

1. people with special knowledge of or expertise in public health
2. federal, tribal, regional, state or local health, or other departments or agencies with current data or information relevant to the health needs of the community served by the hospital facility
3. leaders, representatives or members of medically underserved, low-income and minority populations, and populations with chronic disease needs in the community served by the hospital facility

The IRS acknowledges that certain people may fall into more than one category. For example, a government official with special knowledge of or expertise in public health may satisfy the requirements in number one and two above. A hospital also may consult with, and seek input from, other persons located in and/or serving the community, including the following.

- health care consumer advocates
- nonprofit organizations
- academic experts
- local government officials
- community-based organizations, including organizations focused on one or more health issues
- health care providers, including community health centers and other providers focused on medically underserved populations
- low-income people
- minority groups
- people with chronic disease needs
- private businesses
- health insurance and managed care organizations

It is not necessary to complete the CHNA alone. Coordinating the assessment with other stakeholders provides the opportunity to increase effectiveness and efficiency. (4) The coordination especially is important in setting a trusting relationship, thereby bringing about the needed engagement, which results in a stronger sense of joint ownership of the process. It is worth noting that it is important to consider approaching individuals currently involved in patient

and family advisory groups. This is because they can bring a community perspective to hospital programs and operations, and likely are to be enthusiastic about improving health through the CHNA process. IRS documents state that CHNAs "may be based on current information collected by a public health agency or nonprofit organizations, and may be conducted together with one or more organizations, including related organizations." (1) The final rule clarifies joint CHNAs must include the same basic information expected in a hospital organization CHNA. Hospitals collaborating on a joint CHNA should include any material differences in the communities served by the respective hospitals.

Identifying hospital staff who will participate in the CHNA process.
It is extremely important to identify a hospital team lead for the assessment. The following may include a suitable staff member.

- director of marketing or a member of the community benefit department
- staff from the strategic planning office
- staff from the population health office
- other staff with public health or community health expertise

Potential duties of the designated assessment lead within the hospital may include the following.

- forming the hospital's internal team
- identifying and collaborating with community partners
- identifying time and resources required for the assessment
- developing a timeline for the completion of the assessment
- utilizing a liaison to the board and senior leadership on progress, including barriers and key findings
- developing a prioritization criteria

One of the most important tasks of the team lead is to identify the hospital's internal team because this may determine the success or failure of the entire process. The selection process should be based on considerations such as the individual's expertise, interest and availability to contribute to the entire assessment process. Individuals with public health and statistical analysis are extremely valuable to this team, and for this reason, the lead should consider including them as part of the assessment team. The leader also should consider staff and managers from other hospital departments to establish a multifaceted group that will look at issues from different viewpoints, enriching the comprehensiveness of the final report. (3)

"*Select a combination of doers and influencers. Doers are those that will be willing to roll their sleeves and to do the physical work needed to see 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 that the staff team is large enough to accomplish the work, but small enough to make decisions and reach consensus. If necessary, subcommittees should be formed to handle specific tasks." (3)*

STEP THREE

Gather Available Data And Current Assessments

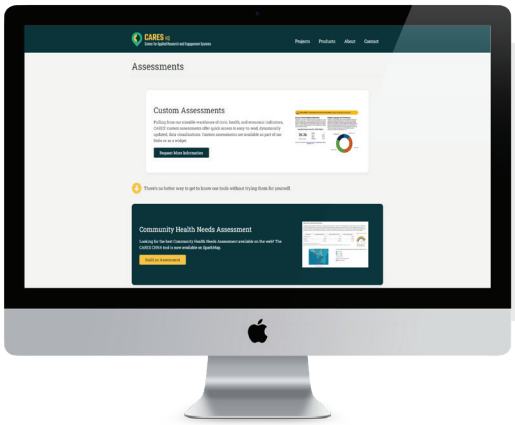
A fundamental step when preparing a CHNA is data collection. Although it can be resource-intensive, time and expenses may be reduced by using a variety of options. The assessment should include existing health status and public health data. These data will provide context and a framework for the subjective component of the CHNA.

Hospitals may base a CHNA on information collected by other organizations, including public health departments. A hospital also can conduct its CHNA in collaboration with other organizations, including related organizations, other hospitals, and state and local agencies. Involving persons that represent the broad interests of the community served by the hospital will meet a key requirement of the ACA, strengthen their commitment and potentially reduce the work required by hospital staff.

The final rule clarifies that a hospital organization may rely on data from another recent CHNA that pertains to the same geographic area. In this case, the hospital simply may cite the data sources rather than provide a comprehensive description of methodology. It is important to remember that even though other CHNAs may be used, the hospital must document their own CHNA process, including collection of primary data, in a separate written report from other organizations to meet ACA requirements.

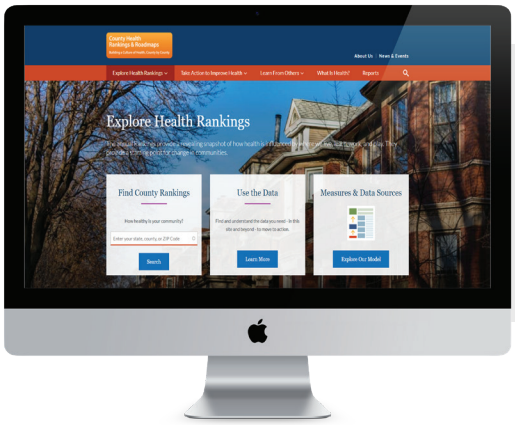
Gathering Existing Data About The Community — Secondary Data
Secondary data are existing data collected by someone else for a purpose other than the one being pursued. There are many publicly available sources that have reliable and valid county-level data that should be used to establish a quantifiable baseline of a community's health and medical needs. Early in the CHNA process, it is important to gather and review secondary data. Common categories for secondary data include the following.

- demographics
- health outcomes
  - mortality
  - morbidity
- health factors
  - health behaviors
  - clinical care (including access)
- social and economic factors
- physical environment



Center for Applied Research and Engagement Systems (CARES)

careshq.org/assessments/

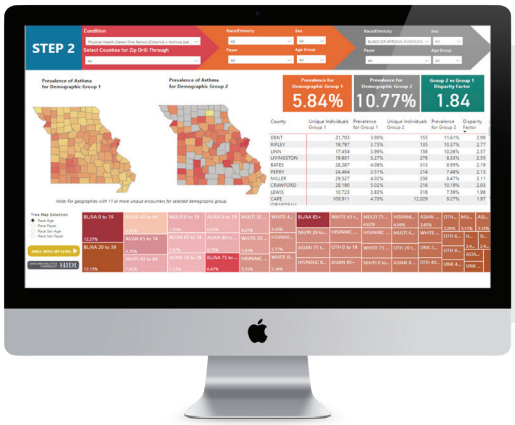


County Health Rankings & Roadmaps (CHR&R)

countyhealthrankings.org

exploreMOhealth Platform

exploremohealth.org/



MHA Health Equity Dashboards

www.mhanet.com/health-equity-dashboards

STEP FOUR

Seek Community Perspectives About The Community's Health – Primary And Secondary Data

Primary data are collected for the purpose of answering project-specific questions. Although this component may be more resource intensive, you will have the ability to collect the exact information needed and control the data collection process.

Following collection and initial review of secondary data, it is necessary to collect additional data to add breadth, depth and qualitative information, such as community perspective. Secondary data may not be available for all relevant health issues or populations. The potential lack of data does not negate the importance of these health issues. Therefore, if there is a health issue or population of interest and data is not available or insufficient, it still is important to include within the primary data survey.

Aggregating both primary and secondary data is extremely important in helping to prioritize the community's health needs. From a hospital's standpoint, involving patient and family engagement groups, and community stakeholders to provide information might be helpful to complement the qualitative findings through surveys, interviews, focus groups, and community or town meetings.

It will be necessary to collect qualitative data and perspectives from expert stakeholders in the community and the community at large. These data may be collected in various formats. Conducting one-on-one interviews with local public health officials, health care providers, school health nurses and others likely will be beneficial to your assessment. A focus group with these same officials may yield the same information and be more efficient. When seeking input from the broader community, you may wish to work with existing community groups that meet on a regular basis or use electronic communication.

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Data Collection Methods
There are a variety of methods to collect primary data for a CHNA, which do not have to be difficult, expensive or time intensive. Surveys provide a flexible means of assessing a representative sample of the population to gather information about attitudes and opinions, as well as measuring behaviors and population characteristics. A key decision in determining which survey methodology to use should be based on whether you are seeking individual or group responses.

Individual Survey Methodology
If seeking individual input, a simple survey may be compiled and disseminated in hard copy and/or electronically to maximize participant feedback. Using an online survey tool such as Survey Monkey (www.surveymonkey.com) provides a simple and cost-effective method for web-based surveys.

The survey should be widely disseminated on hospital, community and civic websites, and promoted through local newspapers, radio and other common community outlets. To be compliant with ACA requirements, survey responses must include all demographic groups and should specifically include the medically underserved, low-income and chronically ill populations within the hospital's community. Hospitals should work to collect a large number of surveys to establish baseline information.

Advantages of surveying for individual responses include the following.

- receiving direct feedback from clients, key informants and target populations about specific issues
- developing public awareness of problems
- building a consensus for solutions or action
- comparing self-reported incidence and prevalence with more objective data sources
- improving perception of quality of local health care services
- improving perception of the need for specific services either in existence or under consideration

Structured Group Surveying
Structured groups can supplement or be an alternative to individual surveys for data collection. Group interviews typically are low-cost but may have limited success if there is not adequate planning and use of a skilled facilitator. This technique increases community awareness and may create an expectation for action. The facilitator should clearly state the purpose of the interview to reduce this potential.

It is important to differentiate the data collected from key stakeholders, community leaders and public health experts from broad-based community input. Face-to-face interviews with community leaders on health issues to gleen their perspective is a traditional and effective means, but requires significant time to organize, conduct and aggregate the information. A separate survey tool may be an option.

Two common types of structured groups include focus groups and community forums.

- A **focus group** is defined as people who possess certain similar characteristics, assembled as a group to participate in a focused discussion to help understand the topic of interest.
- A larger group interview structure typically is referred to as a **community forum** or town meeting. These gatherings often are held in politically neutral locations and provide an opportunity to seek broad-based input on a broad topic such as "the health needs of a community."

Structured Group Surveying		
	Focus Groups	Community Forums
Size of Group	4-12	Large – at least 15, preferably more
Participants	Similar to each other	Diverse, cross-section of community members
Participant Recruitment	Invitation	Open and broad public invitations
Consensus as a Goal	No	No
Purpose of the Group	Obtain insight and perspective on a specific topic or issue	Obtain broad-based perspective and opinions
Interview Format	Focused questions requiring skilled facilitation	Typically informal with open-ended questions
Repetition	Focus groups are usually conducted several times to increase information validity	Typically each community forum is a unique group composition and should not be compared with other community forums
Sample Questions	In our community, 28% of adults smoke. • Does this concern you? • What should be the hospital's role in addressing this issue? (repeat for business, government, citizens) • Would you support local regulation to prohibit smoking in all public buildings? • Would you support local tax increases on the sale of tobacco products?	• What health services in the community do people use? • Is there anything that makes these services difficult to use? • Do you think services are getting better or worse? • Are there specific community health issues that concern you?
Sample Guidelines or Ground Rules	Strong facilitation to eliminate domination by one individual and/or "group think."	Time limit for response; Respectful behavior

STEP FIVE

Aggregate Primary And Secondary Data

After discussion of the questions among key hospital leaders, a systematic review of the secondary data may be the next logical step to identify and prioritize community health issues. It is important to note that most secondary data used in a CHNA is reported at the county level; therefore, hospital personnel will need to collect and analyze the secondary data for each of the key counties included in the community definition used for the CHNA. One way to analyze the data is to use the County Health Rankings model for population-based health initiatives to sort the specific indicators. This model includes two health outcomes — mortality and morbidity, as well as four health factors — that contribute to overall health status, which are areas for focused initiatives. (5)

- health behaviors
- clinical care
- social and economic factors
- physical environment

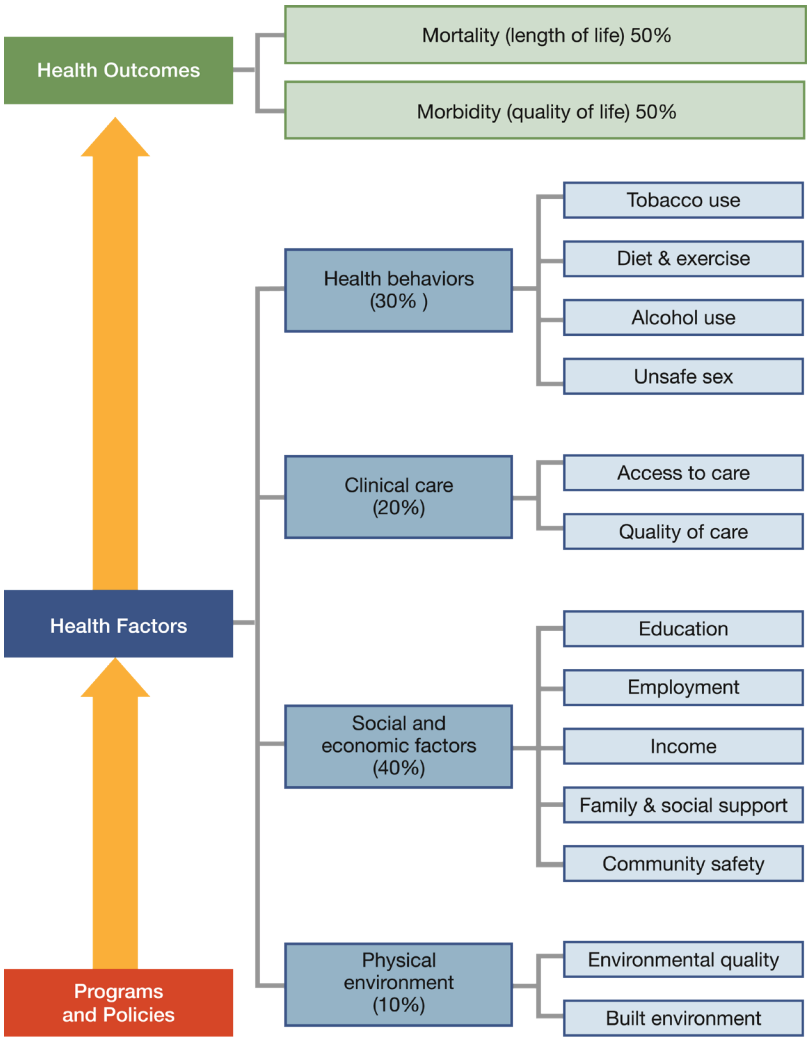
Additional databases are available to derive secondary, county-level data for needs assessments.

Community Commons – Community Commons offers access to national, state and county-level data with easy use of visualization. Using this platform, hospitals can identify assets and potential disparities in their region as it relates to community health and well-being; map a vulnerable population footprint by locating areas in their community with low educational attainment and poverty; and identify a location opportunity footprint where users can pin point areas in their community struggling with housing and transportation costs, school proficiency and availability of jobs.

The platform offers tools to help users gather relevant information in the following areas.

1. establishing and understanding the unique circumstances, or context, of the community through an equity lens
2. assessing economic vitality
3. exploring educational effects on health disparity
4. identifying natural and built environmental resources
5. examining food access, affordability and security
6. determining areas of health disparity and identifying vulnerable populations

COUNTY HEALTH RANKINGS MODEL



Missouri Information for Community Assessment — MICA is an interactive system that allows users to create and download tables based on selected variables from a variety of data files. Users can run reports by city, county and statewide levels respectively. The Missouri Department of Health and Senior Services, Bureau of Health Care Analysis and Data Dissemination provides a rich source of data and other resources essential in the needs assessment process. Examples of data sources include.

- Community Data Profile
- Behavioral Risk Factor Surveillance System
- Priorities MICA
- County-Level Study
- Healthcare-Associated Infection Reporting
- Births
- Deaths

Utilizing community health improvement resources, or CHIR, is important in helping hospitals utilize data-driven, evidence-based public health process to guide in decision-making, priority setting and intervention planning.

STEP SIX

Analyze Data And Prioritize Health Issues

This process may seem daunting, especially when considering the volume of data and statistics collected through primary and secondary sources. The final rule emphasizes the need to include input from other community leaders with health-related expertise in the prioritization process and to thoroughly describe the process used to select health issues for the improvement strategy. The following questions may help facilitate discussion within your organization.

The Hospital's Focus

- What is important to the hospital as defined by its mission and vision?
- What are the hospital's current strategic priorities related to population-based health initiatives?
- What are the hospital's current community health programs?
- What are the hospital's core lines of service and patient populations?
- What does the hospital do well?
- What does the hospital have the ability to influence and thus create positive change?

The Community's Focus

- What is important to the community as conveyed in the primary research?
- Has anything significant occurred within the community that may not be captured in any of the data? For example, the loss of a major industry or a high-profile incident may alter the immediate and subjective perspective of important community issues.
- Is there a community health issue that is especially relevant right now regardless of data?
- Are there other current community health programs?
- Have there been recent failed attempts to address community health issues?

Once sorted, evaluate each key indicator of the community's current status data against the following factors.

- Use the current data to establish a baseline or monitoring trend.
    - If a trend is available, is your community improving, staying the same or getting worse?
- Compare your county(ies) to state and national averages.
    - Are you above, below or near state and national averages?
- Compare your county(ies) to peer counties, especially peer counties in Missouri.
    - Is your rate for a particular issue above, below or near the peer counties?
- Compare your county ranking to the state ranking realizing Missouri ranks very low among most states in its health status.
- Compare your county to the national benchmark.

Identify Possible Areas of Focus

Following compilation of the secondary data, identify specific data elements that meet the following criteria.

- Demonstrate an opportunity for improvement either by rate, trend and comparison to other similar counties or rank.
- Determine if there are health indicators/issues that demonstrate an opportunity to improve the health status of the chronically ill, medically underserved, low-income or low-socioeconomic status populations.
- Refer to the County Health Rankings Model to determine the percentage of impact that the specific health indicator/issue has on a particular health factor.

The key health indicators/issues identified in the secondary data then should be compared against the synthesis of information gathered in the primary data collected from public health experts and the broader community. Input from patients and families also is very important. (6) In the comparison of secondary and primary data, the following questions should be answered.

- Are the health issues important to the hospital and key public health partners also included in the secondary data as a potential priority?
- Are the health issues that are important to the general community also included in the secondary data as a potential priority?

After identifying possible focus areas, consider the following questions to select the most important issues for immediate action. A hospital should engage public health, patients, families and other key partners in all steps, but especially in the selection of issues for community-based action. (6) Although the IRS does not mandate one prioritization methodology over another, they require hospitals to have criteria for prioritizing needs. The table below shows an example of one of many possible prioritization criterias that may be used.

Examples of Prioritization Criteria	
Magnitude of the Problem	The health need affects a large number of people within the community.
Severity of the Problem	The health need has serious consequences (morbidity, mortality and/or economic burden) for those affected.
Health Disparities	The health need disproportionately impacts the health status of one or more vulnerable population groups.
Community Assets	The community can make a meaningful contribution to addressing the health need because of its relevant expertise and/or assets as a community, and because of an organizational commitment to addressing the need.
Ability to Leverage	There is opportunity to collaborate with existing community partnerships working to address the health need, or to build on current programs, emerging opportunities, etc.

STEP SEVEN

Documenting And Disseminating The CHNA

The CHNA must be documented in a written report and address each of the community health needs identified in an implementation strategy, separate from the written report. The documentation must include the following information.

- a description of the community served by the hospital facility and how it was determined
- a description of the process and methods used to conduct the assessment, including the following
    - a description of the sources and dates of the data and other information used in the assessment
    - a description of any relevant information that was not available but would be useful (information gaps)
    - a list of community organizations that collaborated on the CHNA
    - disclosure of any third party that provided technical assistance on the CHNA
    - the analytical methods applied to identify community health needs
    - a description of how the hospital organization considered or included information and data from persons representing the broader interests of the community served by the hospital facility
    - a prioritized description of all the community health needs identified through the CHNA, as well as a description of the process and criteria used in prioritizing such health needs
    - a description of the existing health care facilities, services and other resources within the community available to meet the community health needs identified through the CHNA

A CHNA is not considered conducted until the written report of its findings (that includes all the information in the documentation section) is made widely available to the public. Fulfilling the "widely available" requirement requires the following.

- posting the CHNA on a website that clearly informs the reader that the document is available and provides instructions for downloading
- posting in a format that exactly reproduces the image of the report when accessed, downloaded, viewed and printed
- allows individuals with Internet access to access, download, view and print the report without the use of special hardware or software (other than software that is readily available without a fee)
- the hospital or other organization distributing the report provides individuals requesting a copy of the report with the direct website address
- the CHNA must remain widely available to the public until the next CHNA for that hospital is conducted and made widely available
- a paper copy should be available to the public without charge

TIPS FOR SUCCESS

Do not expend all of your resources and energy on the assessment.

- The resources (time, personnel and costs) required to plan and implement community-based initiatives can be significant.

Be honest in your intent.

- There are positive and negative considerations for each type of strategic approach, such as control, recognition, resource commitment, responsibility, politics, goodwill and partner engagement.
- If you call them 'patients,' then it is probably not 'community health.' There is a distinct difference between services for individuals and population-based programs.

Collaboration is not easy.

- You are not going to create world peace.

Be focused. Prioritize.

- Commit to no more than three issues.
- It is OK to simply contribute to some causes and take ownership of others.
- Use a structured approach and process for each health issue.

Measure and evaluate.

- If you cannot measure what you are doing, you are not likely to succeed or sustain.
- Develop your measures, methods and approach while you are developing your program.
- Scorecards and trend graphs are effective visual tools to demonstrate your progress.
- You only need a few process and outcome measures.

Do not wait for perfection or total commitment; just get started and plan for mid-course changes.

DEVELOPMENT OF AN IMPLEMENTATION STRATEGY

As stated previously, the IRS requires the implementation strategy be adopted on the 15th day of the fifth month after the end of the taxable year in which the CHNA was completed. Hospitals are required to attach the implementation strategy to its Form 990 or a link to the organization's website that provides public access to the document. (1, 2, 3)

TOP HEALTH ISSUES IDENTIFIED BY MISSOURI HOSPITALS

After careful review of CHNAs across Missouri hospitals, 14 priority health issues have been identified. These health issues are highly prevalent and cause significant health burdens to Missouri residents. Bringing the right people to the table and deploying best practice implementation strategies can help address these issues, leading to better outcomes.

- Access to Health Care
- Asthma
- Cancer
- Cardiovascular Health
- Chronic Disease Care
- Dental Health
- Diabetes
- Health Literacy
- Mental Health
- Obesity
- Smoking Cessation
- Substance Abuse
- Wellness and Prevention
- Women's Health Services

MHA developed evidence-based resources and strategies to address the aforementioned issues and provide hospitals with important information to begin working on these issues. Different settings require different interventions, thus, choosing the right approach can be a key determinant of success or failure.

Answers to the following questions will help determine the appropriate strategy for each health issue selected for action.

- Is it critical the initiative be included on the hospital's IRS Form 990 as part of its community benefit report?
- Is it efficient to align a community health issue with a current service and market expanded continuity of care without considering the initiative a community benefit?
- Is it important all community benefit contributions also be considered initiatives to improve community health outcomes?
- Is improvement likely if funding is provided, but not personnel or other resources?
- Is participating as a member in a broad, community-based initiative an appropriate role for a particular cause or health issue?
- Is it important the hospital lead an initiative with other invited partners to implement a focused and specific initiative targeting one specific population?

ENVIRONMENTS FOR IMPLEMENTATION

Below are examples of common settings to consider when implementing initiatives.

Community-Based Settings
This multifaceted approach focuses on strategies and activities to create change in the knowledge, attitudes, beliefs and skills that impact health. It is geared toward individuals and families, with the ultimate goal of making changes to organizational and environmental factors that impact health.

School-Based Settings
Prevention and interventions are aimed at helping students, parents, teachers and administrators prevent and manage chronic illnesses by providing programs, policies and environments that support healthy lifestyles.

Worksite-Based Settings
This group targets employees who spend most of their time away from home. Creating the necessary infrastructure to enable healthy diets and lifestyles is critical in helping prevent or manage many chronic illnesses.

Faith-Based Settings
Some communities believe that information delivered from the pulpit is more truthful, especially if delivered by their leaders, as opposed to information coming from other sources. This is an important consideration to make when implementing initiatives, as this can result in the difference between success and failure.

Health Care Facility-Based Settings
This initiative typically occurs in a health care or public health setting, such as a doctor's office, hospital or local public health agency.

Home-Based Settings
The home-based approach involves entire families to prevent and manage chronic illnesses, forming the basis for much needed social support for disease prevention and management.

SECTION THREE:
CONDUCTING A COMMUNITY HEALTH NEEDS ASSESSMENT IMPLEMENTATION STRATEGY

STEP ONE

Planning For The Implementation Strategy

Planning is essential and can mean the difference between success and failure. The following are key elements to consider during this phase of the implementation process.

- Has your organization completed the community readiness survey to assess whether the organization is prepared for the implementation strategy?
- Does your organization have a sustainable community benefit infrastructure with adequate staffing, budget, policies and leadership commitment to support the implementation strategy?
- Has your organization completed its CHNA and identified priority issues?
- Does your organization have solid community support of members and groups, including persons knowledgeable about the community and public health?
- Does your organization have the required political support of key decision-makers that will be essential in the execution of the implementation plan?
- Does your organization have an implementation team capable of executing the implementation plan?
- Does your organization have a designated team leader capable of spearheading the implementation team in the right direction? This is extremely important as it can determine the success or failure of the implementation strategy in general. Select a team leader who is knowledgeable of the key requirements of the community benefit program and has a vast knowledge of the CHNA and implementation process. Important qualities to consider when selecting a team leader for the implementation strategy include the following.

- **Effective communicator** — Team leaders should present expectations to team members in a way they will easily understand.
- **Organized** — Team leaders put processes and systems in place that maintain order and guide team members toward meeting the desired goals and objectives.
- **Confident** — Team leaders must be confident of their abilities, as well as in the abilities of other team members.
- **Respectful** — This quality specifically empowers team members by encouraging them to offer ideas and voice suggestions.
- **Equitable or Fair** — This trait ensures all members receive the same treatment.
- **Integrity —** Team leaders will gain the trust of team members because they follow through and treat others with the utmost respect.
- **Influential —** This quality will help motivate others to work toward meeting the goals and objectives set forth to be accomplished.
- **Delegator** — A team leader's ability to delegate tasks to others and trusting them to completion, with full confidence, is essential.
- **Facilitator** — The ability to help team members stay on task and guide them to meet the desired goals and objectives effectively is important.
- **Negotiator** — The ability to negotiate helps to streamline the decision-making process, as well as solve complex problems swiftly and decisively in the best interest of the team.

It also is extremely important to select a diverse implementation team to ensure that issues are viewed from different perspectives, which provides a key strength to achieving a well-rounded plan.

STEP TWO

Development Of Goals And Objectives Per Identified Health Issue

The entire group tasked with working on the implementation plan always should start with the end product in mind by deciding what aspects need to be evaluated. It also is important to consider what organizations that are funding the intervention anticipate in terms of the evaluation. During the evaluation process, it is recommended that organizations measure components such as the different processes used in identifying priority health issues, implementation of the intervention process, findings of the intervention as it relates to attainment of goals and objectives, and finally, the effectiveness of the group in planning, implementation and intervention processes and outcomes. Traditional program evaluation involves a study with very specific and measured interventions for a targeted population. Ideally, such an evaluation allows for baseline assessments, control groups and elimination of factors that would threaten the validity of findings. However, communities are complex and dynamic, creating significant challenges in program evaluation.

Further, use of mutually reinforcing strategies among multiple stakeholders creates opportunities for efficiency and effectiveness, but reduces the ability to demonstrate how much impact each intervention had on improving the health issue. However, the purpose of most community health initiatives is to demonstrate reasonable evidence of the following.

- Deliberate interventions likely are contributing to a positive change on a community health issue.
- Efficient, but not excessive, resources are contributing to a positive impact.
- The positive change may be sustained or improved with continued effort.

To achieve this, it is necessary to develop measures that will monitor activities, progress and change throughout the initiative. Typically, process and outcomes measures are used to monitor progress.

A **process** measure monitors the effectiveness of program implementation, allowing program revisions as necessary. Process indicators may include the following.

- type of programmatic activity
- frequency of service provided
- size of group receiving service

An **outcomes** measure is used to determine whether the change produced the desired result.

- Short-term examples include immediate organizational policy or program changes enacted as a result of the program.
- Long-term examples include measured change over a period of time based on program implementation.

Process and outcomes measures must be specific, measurable, attainable, relevant and time bound — referred to as SMART criteria. Process measures often must be written specifically for each intervention to effectively monitor the specific program implementation. However, many national resources have reliable and valid indicators for health behaviors and outcomes that serve as well-written outcomes measures. These indicators are established and provide credibility to your initiative and results. Whenever possible, use of national indicators as outcomes measures is recommended.

Using SMART Goals

SMART goals help the team know what to focus on during a predetermined timeframe, thus helping prioritize tasks as they determine how their work will affect established goals. Clear goals help increase motivation, group cohesion and engagement, as well as offer the team an opportunity to determine how their efforts are having an impact, thereby helping gauge progress toward achievement of their goals.

Below are two examples of **SMART** goals.

- Decrease the rate of readmissions in Missouri hospitals from 12% to 11% by 2023, as measured by the Centers for Medicare & Medicaid Services.
- Increase the rate of employee vaccination rates in Missouri from 90% to 95% by 2023, as measured by the Centers for Disease Control and Prevention.

It is important to develop an evaluation plan and specific measures at the onset of the initiative. The evaluation plan must include the following.

- what will be measured
- how each measure will be collected (e.g., data, interviews, observation)
- how each measure will be counted
- who will collect the data or information
- when, or at what intervals, will the data be collected
- how will each measure be calculated (e.g., totals, averages, ranges)
- how the results will be labeled and identified (e.g., blinded)
- how the results will be shared with stakeholders (e.g., aggregated by target populations)
- how the results will be shared with the community (e.g., summary report)

In a collaborative initiative, the measures should be the same and shared among all partners. For example, if a hospital and public health agency are sharing responsibility for collecting body mass biometric data during two school health fairs, the same test, procedures, criteria and environment should be used by both health care organizations to ensure consistent results.

STEP THREE

Consider Approaches To Address Prioritized Needs

During this phase of the implementation, it is critical for the team to review the organization's presence in the community (i.e., activities already occurring to address community need), potential collaborators, an assessment of health indicators of the community through available secondary data, and an evaluation of the feedback received from communication with other community partners, including the local public health department. Contrary to the saying "one size fits all," these data will help garner the information necessary to help the team determine possible approaches to address prioritized needs effectively.

The IRS requires that community input must be taken into consideration for prioritizing significant health needs from the following three groups: 1) at least one representative of a state, regional or local governmental health department with knowledge of the health needs of the 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; and 3) written comments received on the hospital facility's most recently conducted CHNA and most recently adopted implementation strategy. These prioritized needs form the basis for developing the implementation plan. IRS CHNA Rule 12/31/14.

Evidence-based strategies and interventions include practices, procedures, programs or policies that have been proven effective. The effects are clearly linked to the activities themselves, not to outside, unrelated events. This is extremely important and a step in the right direction to addressing identified priority health issues. Examples of evidence-based programs aimed at diabetes prevention and management include the following.

- Diabetes Empowerment Education Program
- Stanford Diabetes Self-Management Program
- Dining with Diabetes
- National Diabetes Education Program

Additionally, this step is critical as it helps teams identify gaps and resources needed to address priority issues, set realistic timeframes when tasks may be completed, and other essential components necessary to ensure successful implementation of the plan itself.

STEP FOUR

Select Approaches

Community input is essential as it ensures that everyone's voice is taken into consideration. The IRS requires hospital organizations to receive input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge of, or expertise in, public health. Getting the right people to the table from the beginning is fundamentally important and ensures engagement, which leads to a successful intervention.

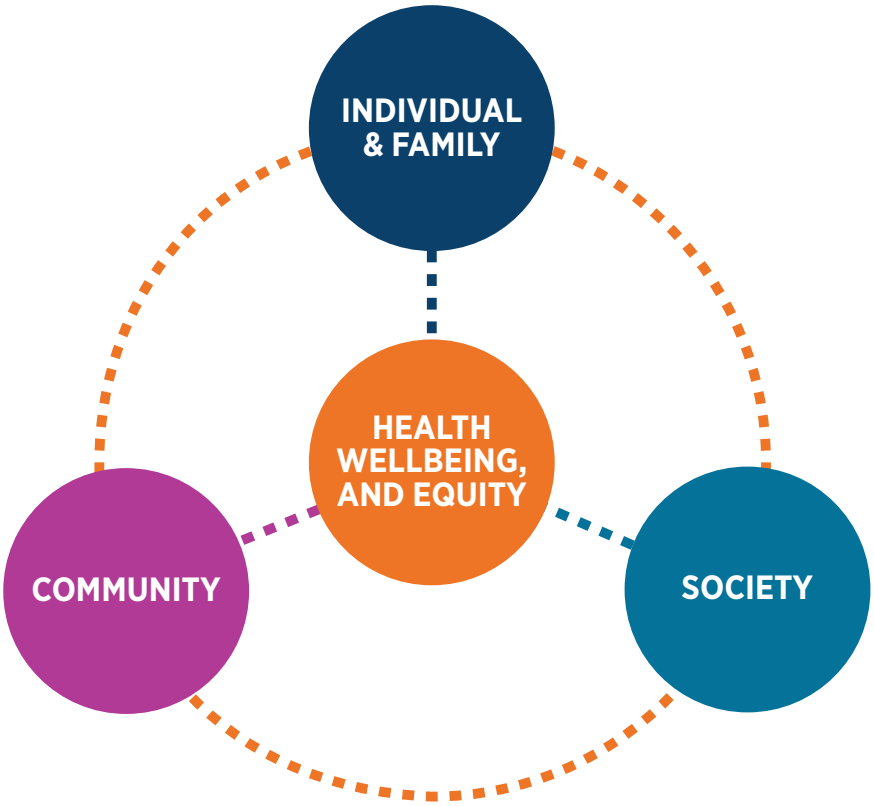
According to Intervention MICA, "Partnerships are formed for many different reasons, including: 1) increasing opportunities to learn and adopt new skills; 2) securing access to resources; 3) sharing financial risks and costs; 4) gaining input from more or different members of the community; and 5) enhancing the ability to respond rapidly to the changing needs of the community."

Using evidence-based approaches, such as Mobilizing for Action through Planning and Partnerships, is recommended instead of trying to reinvent the wheel. MAPP is a community-driven strategic planning process that aims to improve community health. It has widely been utilized in the public health sector and has helped communities apply strategic thinking to prioritize issues and identify resources to address them effectively. Including local public health agencies in the initial stages of the implementation process is critical because they can utilize the MAPP model process in addressing priority health issues identified in the CHNA. (7)

Missouri's WISEWOMAN is a best practice approach that offers screenings, such as blood pressure and cholesterol, to identify and proactively offer education on strategies to promote a healthy lifestyle. This program is open to women who participate in the Show-Me Healthy Women breast and cervical cancer control project and meet age and income guidelines. (8)

Considering approaches used by organizations like 100 Million Healthier Lives can help communities select the most appropriate interventions that match well with the needs of their communities. The 100 Million Healthier Lives global initiative recognizes that our mental, physical and spiritual well-being is interconnected and should be considered heavily while seeking solutions for health issues facing our communities. Driven by the insights of those who are affected and powered by innovative best practices, communities have access to an unlimited and unprecedented number of resources with multifaceted approaches that have worked in other communities across the nation. (10)

The diagram below shows the dimensions organizations should consider when implementing initiatives within their communities.



Source: *100 Million Healthier Lives*

STEP FIVE

Integrate The Implementation Strategy Accordingly

It is highly recommended that organizations link their implementation plan with their strategic and operational plans. Doing so creates the necessary alignment critical to ensuring a strong connection between these three components, creating required efficiency, streamlining organizational goals, uncovering potential pitfalls, and helping the organization identify gaps that pertain to internal efficiencies and efficacies.

Source: *Catholic Health Association of the United States*

STEP SIX

Develop A Written Implementation Strategy

Written hospital implementation strategies may include the following.

- organization's mission statement
- priority health issues
- special populations
- description of how the implementation plan was developed and adopted
- prioritization methodology used to determine priority health issues
- health needs in which the hospital anticipates addressing directly, as well as those it will address in collaboration with other community partners
- planned collaborations
- explanation of how the organization will address identified issues
- major health needs that the organization will not address in the implementation strategy and the rationale behind this decision

STEP SEVEN

Adopt And Report The Implementation Strategy

Adopting the Implementation Strategy

According to the IRS final rule, an implementation strategy is considered to be "adopted" on the date the strategy is approved by the organization's Board of Directors, by a committee of the board or other parties legally authorized by the board to act on its behalf.(11) Further, the formal adoption of the implementation strategy must occur by the end of the same taxable year in which the written report of the CHNA findings was made available to the public. Hospitals are required to have a policy that highlights the process for adopting the implementation plan, including how it is adopted and operationalized.

Reporting the Implementation Strategy

Additional reporting requirements were added to the IRS Code relating to Section 501(r) for hospitals to include in their annual reporting on Schedule H (Form 990). (11, 12) A description of the actions taken during the taxable year to address significant health needs identified in the CHNA now is required. If the organization did not address the issues identified in the CHNA, they are required to document the reasons why no action was taken.

STEP EIGHT

Update And Sustain The Implementation Strategy

According to IRS requirements, a CHNA and implementation plan should be done every three years to be in compliance with federal law. (13) However, implementation strategies may need to be updated more frequently based on factors such as changing community needs and priorities, changes in resources, and evaluation of results. (13, 14) This process is not any different from performance improvement processes used in health care and other industries, and should be ongoing to sustain the required momentum. This step of the process is critical as it helps the implementation team determine the next course of action. Based on evaluation of the results, the team may decide to keep doing what they are doing, tweak the process or use a completely different approach.

EXAMPLES OF COMMUNITY-BASED INITIATIVES

Blue Zones Project®
"The Blue Zones Project approach to improved well-being is to enhance the environment within critical sectors of the community by implementing evidence-based best practices. Coupled with an extensive community engagement and marketing program, and active support from civic and faith-based leaders, the Blue Zones Project drives heightened awareness, support, tools and programs for individuals and community organizations to improve well-being."

National Diabetes Prevention Program
"The National Diabetes Prevention Program is a partnership of public and private organizations working to reduce the growing problem of prediabetes and type 2 diabetes. Partners work to make it easier for people with prediabetes to participate in evidence-based, affordable and high-quality lifestyle change programs to reduce their risk of type 2 diabetes and improve their overall health."

Diabetes Empowerment Education Program
"DEEP was developed to provide community residents with the tools to better manage their diabetes in order to reduce complications and lead healthier, longer lives, based on principles of empowerment and adult education."

Diabetes and Cardiovascular Disease Self-Management Curriculum
"This program utilizes training that is focused on community and cultural approaches in prevention and management of diabetes and cardiovascular diseases."

Missouri Million Hearts
"The partnership of key health organizations in Missouri to raise awareness by highlighting the cooperation and individual work of partners to achieve the shared goal of saving lives from heart disease and stroke."

Missouri Diabetes Prevention and Control Program
"Collaborative members form practice teams to improve care of their patients with diabetes using proven models to manage disease."

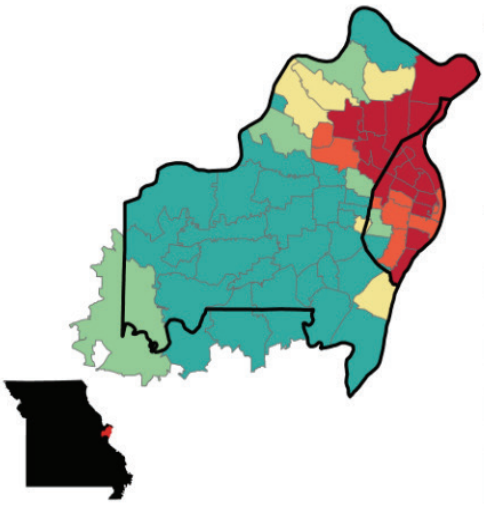
Missouri Diabetes Shared Learning Network
A network of organizations across Missouri working together to identify best practice approaches to address diabetes.

exploreMOhealth Platform

Where we live, work, learn and play affects our health. Access to data regarding health factors and health outcomes in the places where Missourians live provides communities and organizations with the information necessary to create and sustain a healthy state. Effectively engaging communities to address the social, economic, environmental, clinical and behavioral factors that affect health is critical for improving population health outcomes.

exploreMOhealth assists hospitals with CHNA secondary data analysis using county- and ZIP code-level data on health and social factors. Based on the County Health Rankings' population health framework, these data offer community health practitioners a rich set of information to explore sub-county variation in health and formulate targeted intervention strategies to deliver scarce population health improvement resources to areas in most need. Using the power of data and strategies that seek to promote health equity will help reduce the health disparities that have disproportionately impacted certain groups.

In collaboration with the Washington University School of Medicine, Robert Wood Johnson Foundation, and County Health Rankings & Roadmaps, researchers from MHA's Hospital Data Industry Institute, developed the Missouri ZIP Health Rankings model, which provides detailed data on health factors and outcomes at the ZIP code level.



St. Louis city and County Characteristics

Health Factors Rank: **114 & 3 of 115**
Health Outcomes Rank: **111& 20 of 115**
2015 Combined Population **1,319,047**
Percent Non-White: **35.9**

Top-Ranked ZIP Codes

ZIP	Name	Statewide Rank of 976
63005	Chesterfield	2
63038	Glencoe	4
63040	Grover	5

Bottom-Ranked ZIP Codes

ZIP	Name	Statewide Rank of 976	Top Health Determinant	Top Social Determinant
63107	North City E.	964	Asthma	Unemployment
63113	The Ville	963	Asthma	Unemployment
63115	North City W.	962	Asthma	Unemployment
63133	Pagedale-Wellston	942	Asthma	Single Parent Household
63136	Jennings	929	Asthma	Single Parent Household
63134	Berkeley	914	Asthma	Single Parent Household

Sources: Author's Calculations, 2016 County Health Rankings, and Roadmaps and U.S. Census Bureau QuickFacts

The platform features customizable data displays and interactive mapping functionality of content at both county and ZIP code levels, graphic and tabular data visualization, and expandable data layers to accommodate novel data sources. The platform allows users to evaluate data to prioritize health and socioeconomic indicators in defined service areas, as well as design customized reports and generate downloadable content in editable formats (Word, PDF, Excel) to assist in preparing personalized CHNAs. Enhancing the availability of community health data at the county and ZIP code levels in Missouri will help improve health outcomes, thus, informing health improvement initiatives and the allocation of scarce population health resources.

INCORPORATING HEALTH EQUITY INTO THE CHNA AND IMPLEMENTATION PLAN

In light of the COVID-19 pandemic where data have shown a significant burden of the disease among people of color, the American Hospital Association, Institute for Diversity and Health Equity released four different health equity toolkits to provide hospitals with a roadmap to address disparities. The toolkits cover broad areas, such as data-driven care delivery, which discusses data stratification and use; training and the culture of learning, which encourages cultural humility and implicit bias; diversity and inclusion in leadership and governance; and community partnerships to accelerate health equity. Incorporating information from these toolkits to the CHNA will help promote health equity.

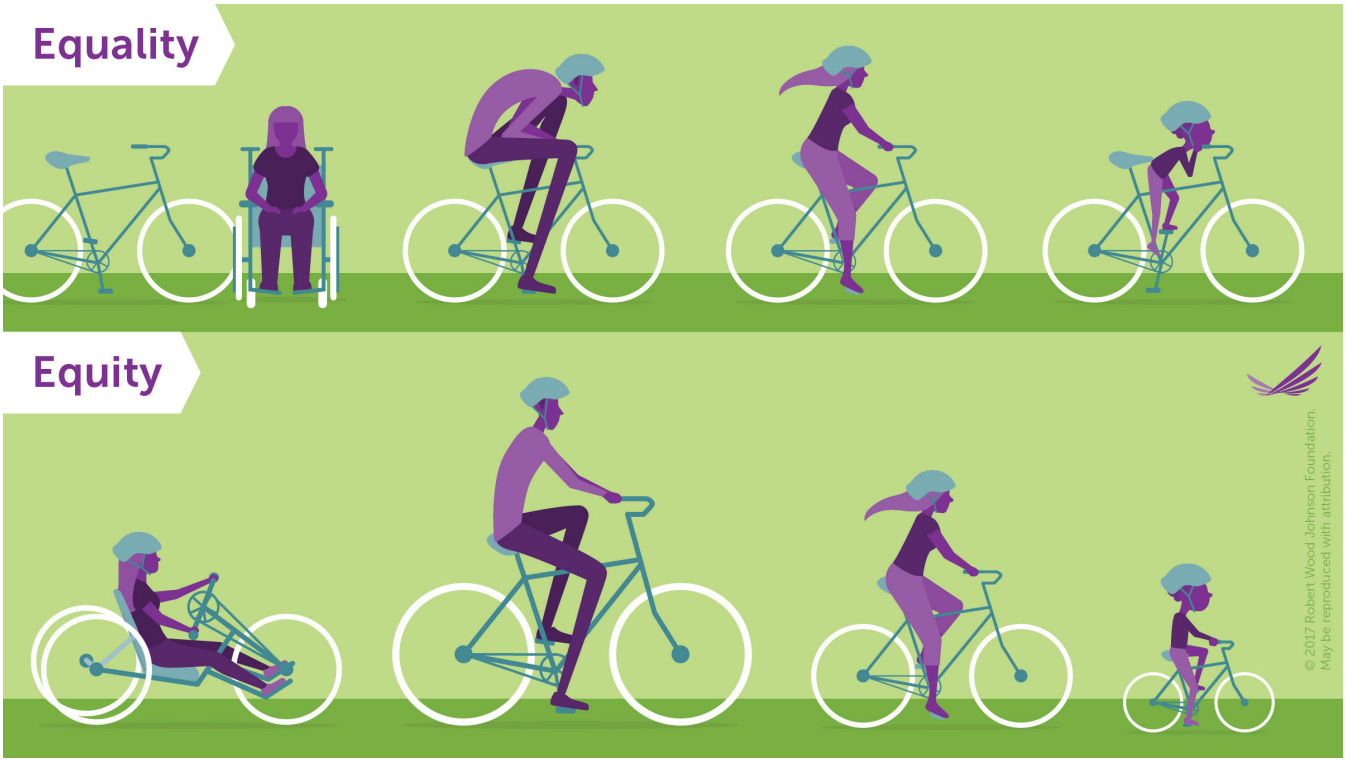
The pandemic brought the heath equity discussion to the forefront of the president's executive order on advancing racial equity, including support for communities through the federal government. A COVID-19 Health Equity Taskforce was established to guide efforts toward identifying and eliminating the underlying health and social disparities among groups disproportionately impacted by the pandemic.

MHA has made health equity a strategic focus through promoting health care that is safe, reliable and equitable, and that is of excellent quality and value.

MHA developed a set of interactive health equity dashboards that hospitals may use to integrate health equity into their CHNA. The dashboards provide analyses and data visualizations for health factors, outcomes and social determinants stratified by race, ethnicity, payer groups and other demographic groups across counties and ZIP codes in Missouri. This will help member hospitals to be engaged in promoting health equity and reducing health disparities, which in turn will strengthen their working relationship with the communities they serve. It also will help hospitals target their efforts with more specificity to meet the unique needs of their patients and community at large.

Using equity-centered approaches at the hospital and within the community will ensure that everyone has an opportunity to live healthy irrespective of their race, ethnicity and socioeconomic status, among other characteristics. Using platforms such as exploreMOhealth, Opportunity Atlas, County Health Rankings & Roadmaps, Vulnerable Populations Footprint and PLACES can help provide information necessary to promote health equity. The Robert Wood Johnson foundation #PromoteHealthEquity infographic on the next page provides a viable approach that advocates for meeting people where they are, as opposed to using a blanket approach to target interventions.

Integrating health equity into the CHNA process is key to creating the needed urgency to implement strategies and activities aimed at reducing health disparities we continue to see across the nation. This will require deliberate efforts that focus on approaches seeking to address avoidable inequalities. Hospitals and community stakeholders should work collaboratively in the best interests of the communities they serve.



Source: Robert Wood Johnson Foundation

The following are promising methods and strategies for identifying systemic inequalities.

- Conduct data collection and stratification by Race, Ethnicity and Language (REaL) data; Z codes for SDOH; sexual identity and orientation
- Adopt technology that allows for interoperability to integrate stratified data into EHR systems allowing the care team to identify inequalities in health outcomes.
- Use technology to alert providers of patients lacking certain social needs to help them target efforts with more specificity.
- Map the demographics of patients served with health outcomes to help identify gaps, thus creating the urgency to review and update agency policies as needed to bridge existing gaps.

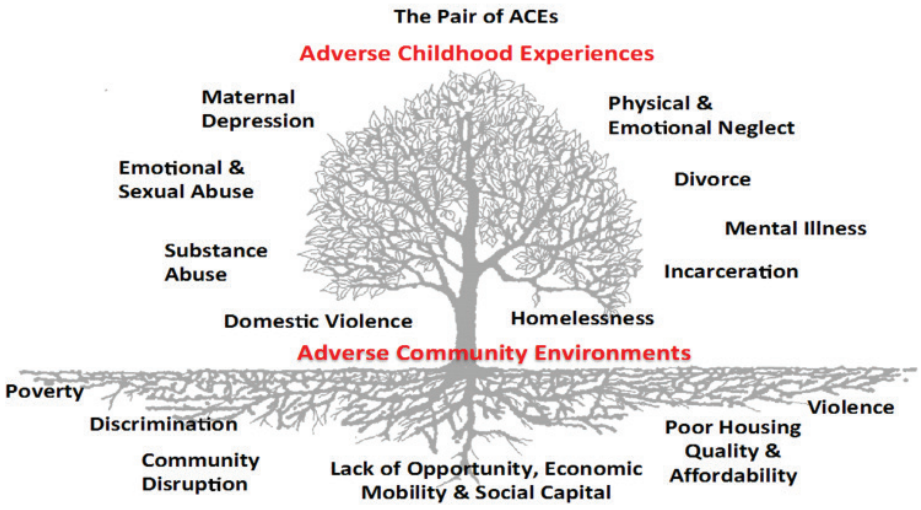
The following are promising strategies for assessing and promoting health equity in hospitals.

- Ensure that organizational mission, vision and values are all inclusive and comprehensive in nature.
- Adopt equity in all policies and ensure they are applied consistently across the organization. Audit the process to make sure staff at all levels adhere to equity policies.
- Promote the accurate collection of REaL data, Z codes for SDOH, sexual identity and orientation. This approach not only is important, but is necessary to ensure hospitals have the information needed to deliver the right care to all patients. This helps the care team make appropriate decisions by customizing each patient's needs and meeting them where they are on their journey.
- Implement health equity committees at board and organizational levels to ensure awareness of the strategic focus, including individual expectations.

- Ensure representation of the committee is reflective of the target groups as this is crucial in making meaningful progress toward equity.
- Convene stakeholders to build trust with underserved groups. In this case, it is critical to identify trusted voices and use them as a vehicle to reach your intended audience.
- Formulate and implement strategies that seek to address nonclinical barriers impacting underserved groups. Identifying and addressing these barriers in real time is necessary to ensure patients can focus on their health.
- Meet people where they are as opposed to implementing a blanket approach. This strategy ensures resources are allocated with precision for maximum impact.

EQUITY-CENTERED TRAUMA-INFORMED CARE

In 2020, MHA and Alive and Well Communities partnered to develop an equity-centered, trauma-informed care model for member hospitals. Alive and Well Communties provides information hospitals and community partners can utilize to promote health, wellness and fairness by creating awareness of how trauma and toxic stress influence health. Their multipronged approach of offering standard training, activation schools and activating communities lays a solid foundation that seeks to improve individual and community health. The Building Community Resilience model provides information on how Adverse Childhood Experiences and Adverse Community Environments impact individuals and communities. Addressing the root cause of problems can have a profound and positive impact, per the BCR model (shown below). Using the right data to measure progress in this journey is important.



Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

Integrating the BCR model as part of the CHNA process can help promote individual and community health.

Z CODES FOR SOCIAL DETERMINANTS OF HEALTH

Multiple studies have shown that nonclinical factors of health, specifically SDOH, can negatively impact individual and population health if they are not met. Addressing the factors is very important because it can promote health equity. Hospitals that complete CHNAs have the potential to influence the health of their communities in a significant manner by incorporating both clinical and nonclinical factors of health.

In November 2019, AHA published a document on ICD-10-CM coding for SDOH, which provides a listing of all SDOH Z codes available for hospitals. This document provides additional details on best practices that are key in the process of collecting this critical information. Below is a table of the Z codes, including the risk factors included in each category.

ICD-10-CM Code Category	Problem/Risk Factors Included in Category
Z55 – Problems related to education and literacy	Illiteracy, schooling unavailable, underachievement in a school, educational maladjustment, and discord with teachers and classmates
Z56 – Problems related to employment and unemployment	Unemployment, change of job, threat of job loss, stressful work schedule, discord with boss and workmates, uncongenial work environment, sexual harassment on the job, and military deployment status
Z57 – Occupational exposure to risk factors	Occupational exposure to noise, radiation, dust, environmental tobacco smoke, toxic agents in agriculture, toxic agents in other industries, extreme temperature, and vibration
Z59 – Problems related to housing and economic circumstances	Homelessness, inadequate housing, discord with neighbors, lodgers and landlord, problems related to living in residential institutions, lack of adequate food and safe drinking water, extreme poverty, low income, insufficient social insurance, and welfare support
Z60 – Problems related to social environment	Adjustment to life-cycle transitions, living alone, acculturation difficulty, social exclusion and rejection, target of adverse discrimination and persecution
Z62 – Problems related to upbringing	Inadequate parental supervision and control, parental overprotection, upbringing away from parents, child in welfare custody, institutional upbringing, hostility toward and scapegoating of child, inappropriate excessive parental pressure, personal history of abuse in childhood, personal history of neglect in childhood, Z62.819 Personal history of unspecified abuse in childhood, parent-child conflict, and sibling rivalry
Z63 – Other problems related to primary support group, including family circumstances	Absence of family member, disappearance and death of family member, disruption of family by separation and divorce, dependent relative needing care at home, stressful life events affecting family and household, stress on family due to return of family member from military deployment, alcoholism and drug addiction in family
Z64 – Problems related to certain psychosocial circumstances	Unwanted pregnancy, multiparity and discord with counselors
Z65 – Problems related to other psychosocial circumstances	Conviction in civil and criminal proceedings without imprisonment; imprisonment and other incarceration; release from prison; other legal circumstances; victim of crime and terrorism; and exposure to disaster, war and other hostilities

SOCIAL DETERMINANTS OF HEALTH SCREENING TOOLS

Promoting health equity while reducing health disparities depends on hospitals' and health systems' ability to capture clinical and nonclinical SDOH data. Using evidence-based, standardized screening tools to collect this information is a vital part of the process. Using clinical and nonclinical data harmoniously provides the best hope of promoting health and wellness for individuals and communities in general. Some commonly used tools follow.

- Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)
- American Academy of Family Physicians Social Needs Screening Tool
- CMS Accountable Health Communities Health-Related Social Needs Screening Tool
- Center for Health Care Strategies, Inc. OneCare Vermont: Self-Sufficiency Outcomes Matrix
- Roots to Health Survey

The collection and documentation of Z codes into EHRs has been low given knowledge gaps, confusion on who can document, and lack of support from administrators as there is no financial incentive tied to this process.

In 2018, MHA published the Decoding Social Determinants of Health policy brief highlighting the utilization of ICD-10 Z codes among Missouri hospitals. According to the brief, the monthly frequency of ICD-10-CM SDOH code for Missouri residents increased gradually from October 2015 to March 2018. This trend was evident in the January 2020 *HIDI HealthStats*, Z Codes for Social Determinants of Health, which revealed the frequency of Z code utilization among Missouri hospitals continued to increase from March 2018 to March 2019. While this is a step in the right direction, there is more work to be done to educate staff at all levels on the importance of capturing this information to ensure a holistic approach in care delivery. MHA continues to provide hospitals with tools, resources and adaptive support to help them improve the health outcomes of the communities they serve. The March 2020 *Trajectories*, Integrating Social Determinants in Care Delivery, highlighted the importance of addressing SDOH as a strategy to promote health equity. Capturing the right information, at the right place, and at the right time is necessary to help care teams develop appropriate care plans. Overlaying SDOH and REaL data on health outcomes data can help identify trends and gaps in care delivery for different populations, thus helping care teams develop strategies to address disparities that may be present.

In 2016, MHA conducted a comprehensive review and assessment of the CHNAs completed by member hospitals. Six priority health areas were identified: access to care, heart disease, diabetes, mental health, cancer and substance use/opioids. These priority issues were linked with SDOH Z codes most likely to impact them, thereby providing hospitals with important information for their CHNA implementation strategy. Following is an example of social factors represented by ICD-10 Z codes that lie along causal pathways of priority issues. (It is important to note that this is not an exhaustive list. There are many codes, aside from the four listed per domain, that influence each of the priorities identified.)

Source: Missouri Hospital Association

Access to Health Care	Heart Disease	Diabetes	Mental Health	Cancer	Substance Use/Opioids
Problems related to education and literacy, unspecified (Z559)	Problems related to education and literacy, unspecified (Z559)	Problems related to education and literacy, unspecified (Z559)	Problems related to education and literacy, unspecified (Z559)	Problems related to education and literacy, unspecified (Z559)	Problems related to education and literacy, unspecified (Z559)
Insufficient social insurance and welfare support (Z597)	Lack of adequate food and safe drinking water (Z594)	Lack of adequate food and safe drinking water (Z594)	Personal history of physical and sexual abuse in childhood (Z62810)	Occupational exposure to toxic agents in other industries (Z575)	Personal history of adult physical and sexual abuse (Z91410)
Other problems related to housing and economic circumstances (Z598)	Patient's noncompliance with other medical treatment and regimen (Z9119)	Patient's noncompliance with other medical treatment and regimen (Z9119)	Problems related to primary support group, unspecified (Z639)	Patient's noncompliance with other medical treatment and regimen (Z9119)	Problems related to primary support group, unspecified (Z639)
Unemployment, unspecified (Z560)	Patient's other noncompliance with medication regimen (Z9114)	Patient's other noncompliance with medication regimen (Z9114)	Personal history of psychological abuse in childhood (Z62811)	Patient's other noncompliance with medication regimen (Z9114)	Personal history of psychological abuse in childhood (Z62811)

SOCIAL REFFERAL PLATFORMS

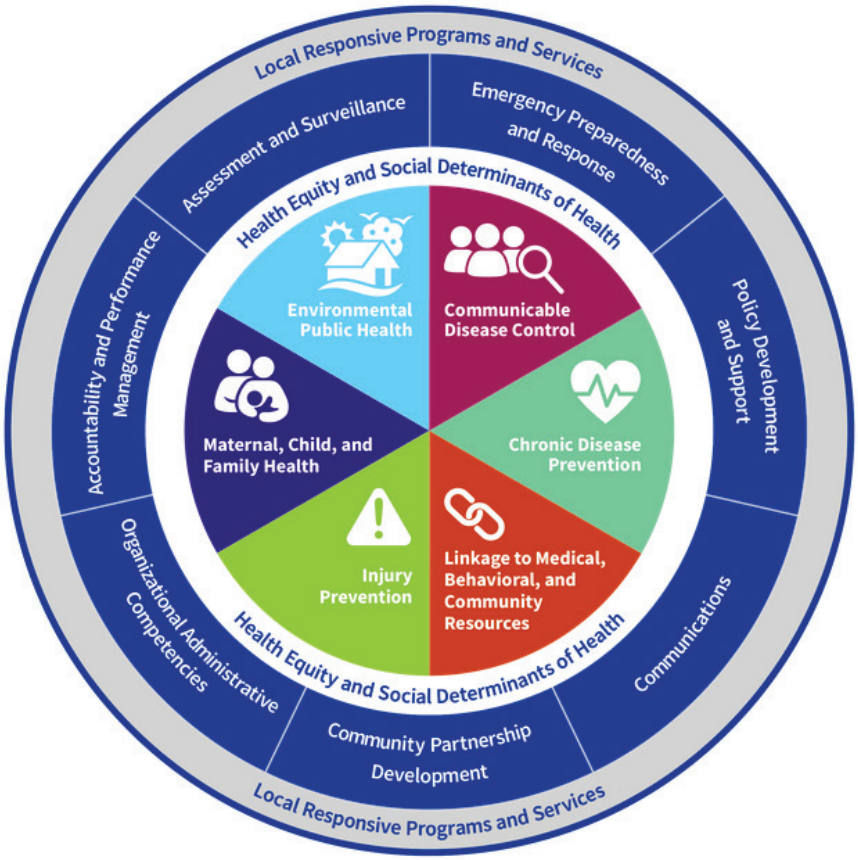
Building and implementing the infrastructure necessary to address SDOH is an important step to improving health outcomes for individuals and communities. While collecting SDOH is vital, connecting patients with nonmedical needs is necessary as it offers individuals the needed peace of mind by allowing them to focus on their health as opposed to the nonclinical barriers to their health. Building a strong foundation of programs, partners, people, processes and technology is key to establishing a sound process capable of delivering results. While all the foundational components are important, adopting closed-loop referrals that would allow patients, families, providers, case management, social workers, community health workers/patient navigators, nurses and community-based organizations to track the status of a referral, including ensuring that the sought needs are provided, is equally as important. The following is a list of referral platforms.

- UniteUS
- findhelp.org
- Charity Tracker
- First Call Technology
- Healthify
- Signify Community
- CrossTX

NOTE: Deploying innovative EHR technologies capable of helping care teams target their population heath management work while directing the outreach for SDOH will help address some of the most common gaps in care delivery.

MISSOURI'S FOUNDATIONAL PUBLIC HEALTH MODEL

Missouri's Foundational Public Health Model provides a roadmap for local public health agencies and partners to integrate health equity in all focus areas to ensure everyone has a just and fair opportunity to live heathy. In alignment with the IRS requirements, MHA recommends hospitals work with their local public health agencies to identify and prioritize health needs per the provisions of Section 338J of the Public Health Act. Collaboration between hospitals and community partners ensures they are leveraging each other's strengths, expertise and resources for the best interest of their communities. Whenever possible, aligning the CHNA and implementation plans with the public health model can ensure that local partners are guided by a unified approach that promotes health equity, as shown below.



Source: https://www.healthiermo.org/

University Health Physicians

In 2018, University Health Physicians, a safety net hospital and academic medical center located in Kansas City, Mo., embarked on a journey to better understand and provide support to its patients by addressing SDOH. With its focus on serving the most vulnerable patients and community members, UH committed to three guiding factors in their work.

1. Decisions need to be data-driven and formative in nature, looking at the data generated from a dual lens: micro (patient level) and macro (community/population health level).
2. The voice of both internal and external stakeholders needs to drive the process.
3. Shared decision-making, both internally between departments and with community members, is essential.

Nearly 100 patients were interviewed individually to determine their perspective regarding which social determinants were affecting them most, as well as which determinants they believed most affected their community at large. This feedback then was compared with data available from public data sources, such as exploreMOhealth.org and the CDC, to garner information about health behaviors, and socioeconomic and environmental factors. From this data, the team identified food insecurity, transportation barriers, financial strain and housing as the four areas of highest need. With the knowledge that UH's Behavioral Health Department already was involved in efforts to address housing through the 500 in 5 program, the SDOH team began focusing on screening and offering resources around the remaining three highest indicators of need: food, transportation and finances (as related to being able to afford medications).

Armed with this data, a multidisciplinary team developed and implemented a process to screen and connect patients who indicated a positive need with community resources that may assist in meeting the need. The team decided to initiate the work within the clinic setting, as well as offer a resource table at one of the main entrances of the hospital, allowing patients and visitors the opportunity to access a "walk-up" area for assistance. The program takes into consideration the special needs of individuals with limited English proficiency, as well as immigrant and refugee populations who, due to language barriers and other factors, require additional assistance to navigate the resources provided. These patients may enlist the assistance of a cultural health navigator who will assist patients with needs, such as making appointments, arranging transportation, etc. At one time, UH screened approximately 4,500 patients per month and data indicated a high amount of variance in need between clinics — at times varying by nearly 30%. The SDOH planning team used this data, along with city, county and state data, to assist in its planning of population health initiatives. Each step of the maturation process regarding implementation of SDOH screening and assistance involved and affected multiple stakeholders within the organization and the community at large. Open lines of communication and the ability to look at and consider multiple perspectives were imperative to the success of the project. Additionally, understanding this was an evolving process meant being comfortable with change, constantly referring to the data and taking action when the data indicated the need to do so.

CARROLL COUNTY MEMORIAL HOSPITAL

CCMH is transitioning toward more holistic care for each patient, and its CHNA identified a lack of transportation and resources as areas that need additional focus. Transportation in the small rural community has been a barrier to care for both medical and nonmedical needs for many years. In March 2020, CCMH signed a contract with OATS, Inc. for transportation to and from their facility five days a week. This relationship with OATS, Inc. continues to serve community members, even during the COVID-19 pandemic, and has allowed patients to receive needed care despite perceived transportation barriers.

Additionally, through various programs and initiatives, CCMH became an accredited Blue Cross and Blue Shield Patient-Centered Medical Home in 2019. Shortly after, they began requesting patients complete an SDOH questionnaire to better understand the needs of the population and provide necessary resources. The SDOH initiative led to the development of a resource guide to assist patients with finding access to resources they needed.

CCMH said, "When a patient knows we are here to help them with their health care journey, they can worry less about social determinants and focus more on their health and wellness."

FREEMAN HEALTH SYSTEM – SOCIAL REFFERAL PLATFORM – UNITE US

Beyond the identification of priority health conditions, a common theme in Freeman Health System's CHNAs in 2016 and 2019 was access to care. In 2017, the health system was awarded a grant from the Missouri Foundation for Health to focus on access to care in Southwest Missouri, in partnership with strategic health and social care organizations representing key SDOH: transportation, food, housing, justice, safety, ability, security and mental health.

Known as the Care Partners, this grassroots team examined issues around access to care for individuals with complex health and social needs. They realized one of the most significant issues faced by all organizations was a lack of communication around health and social care referrals, and how the burden of care coordination was unduly placed by all on the individual. By 2019, the Partnership endorsed a solution — a closed-loop referral network. The COVID-19 pandemic sharpened their focus, as basic needs became predominant concerns to many more families in the community. In July 2021, the Care Partner Network was launched utilizing Unite Us technology. Freeman carefully cultivated network champions, including the United Way of Southwest Missouri and Southeast Kansas, and Mercy Joplin, building a truly communitywide, robust referral network. The network build will continue during 2022, with Care Partners accessing rich data from Unite Us. In the short term, it will help them better understand referral patterns and challenges, as well as clarify met and unmet consumer needs. In the medium term, the data will be used to guide new collaboration opportunities. In the long term, the information can drive community investment at a high level to assure that individuals' needs are equitably met.

WALK WITH A DOCTOR PROGRAM

Studies have shown that diet and exercise are effective strategies to promote the health and well-being of individuals. The Walk With a Doctor Program is aimed at inspiring and engaging individuals to be active through movement and conversation. Their approach involves a physician leading the walk while educating participants on a health topic of interest. As part of the walk, participants are offered healthy snacks and optional blood pressure tests. The program offers a good opportunity to improve mental and physical health post-COVID-19 through the health benefits, interaction with others, free nature walks and education given by physicians during each walk. While hundreds of chapters have been launched since 2005, they continue to promote and offer the tools and resources necessary to begin a new chapter. Implementing the WWAD program and incorporating it into the CHNA process can offer hope to countless individuals willing and ready to improve their health.

Source: WalkWithADoc.org

HEALTH LITERACY

Health literacy is best defined as "the degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions." (15) However, health literacy is not simply an individual responsibility, but also the responsibility of all health care providers and systems. Health care providers must have health literacy skills that work to address this concern for the patient. These skills should include helping people find information and services, spending additional time with patients if needed to effectively communicate health issues and solutions, processing what patients are explicitly and implicitly asking, deciding which information and services work best for different situations and people, and considering how information is dispersed to ensure appropriate channels are being used for their communities.

Addressing health literacy concerns has been proven to improve health outcomes. A study released by UnitedHealth Group revealed that individuals living in counties with the highest health literacy levels experienced better outcomes than those living in counties with the lowest health literacy levels. Those with higher health literacy levels had higher rates of individuals who got their flu shots, 26% fewer avoidable hospitalizations and 9% fewer hospital readmissions. (16)

For improved outcomes, consider health literacy with the design of each intervention created in your organization's CHNA implementation plan. The patient's understanding of a particular health issue, treatment for the issue and resources available are key components to the success of the plan. Begin by asking the following about your organization's practices: Are patient education materials written at a fifth grade reading level per recommendation of The Joint Commission? (17) Is health information being disseminated through the appropriate channels for the community to access it? (18)

Health Literacy Media is available to help organizations with patient education materials to ensure they are written at the appropriate reading level, as well as review communication measures and provide guidance for best practices. Additionally, the CDC outlined goals in the National Action Plan to Improve Health Literacy that organizations should review.

CHNA Report Template

SECTION 501(r)

The following template provides the report sequence and general descriptions of information to include in your community health needs assessment report. This template is based on IRS 501(r)(c)(a) guidance provided in Notice 2011-52. This template addresses only the CHNA report; it does not include required components for the implementation plan.

ABOUT THIS TEMPLATE

The template is designed to provide a table of contents and detailed outline of required information in a CHNA report. The template offers one example of a logical sequence for the required information, but this should not be considered the only format option. There is no required or suggested length for this report.

The template format and content have not been reviewed or approved by the IRS or other governmental authority, but are based on currently available information. Revisions or further clarification from the IRS may result in modification of this template.

The following should be considered when writing your report.

- The report should include a table of contents and clear section headings and subheadings.
- All data should be clearly sourced.

The CHNA report must be widely disseminated to the public, including those with limited internet access, to be considered complete and conducted, as determined by the IRS' definition.

- It is important to write succinctly.
- Ensure detailed information is easily understood to nonhealth care readers.
- Appendices with additional details are encouraged to supplement the report.
- The use of graphs, maps and tables is encouraged for some sections of the report.

The template provides both the recommended outline, in bold, and suggestions, in italics.

Table of Contents and Recommended Content

I. Executive Summary

Considerations:
This section should be limited to one or two pages and include the following.

- *a short description of the community*
- *a short description of the overall CHNA process, including:*
  - *timeframe from beginning to completion*
  - *key partners*
  - *the source for public health input*
  - *the process for seeking input from the medically underserved, chronically ill and low-income populations*
  - *very short description or list of key sources of secondary data*
  - *very short description of process for primary data collection*
- *list of identified health issues based on secondary and data analysis*
- *short description of process to prioritize the health issues, including a list of key partners that participated*
- *a summary list of those health issues prioritized for action*
- *contact information for questions or involvement*

II. Community Health Needs Assessment: Community Defined

a. description of the community served by the hospital facility

- **i. geography**
  1. **list of counties**
  2. **ZIP codes**
  3. **square miles**
- **ii. population (may include additional information as an appendix)**
  1. **total**
  2. **population density**
  3. **at-risk (description and estimated percentage of population), source**
  4. **demographic description**
- **iii. unique community characteristics**
  1. **colleges, tourism, etc.**
- **iv. other health services available in the same community area**
  1. **federal designation for medically underserved**
  2. **community health center**
  3. **other hospitals, specialty providers**

Considerations:
This section should succinctly present the community served by the hospital. Several concise tables, maps and graphs would be appropriate. However, it is important to only include important and relevant information. Include a narrative summary of the demographic information. Additional geographic and population data may be included in an appendix.

The unique community characteristics should be in narrative format and should help the reader to better understand the community. What makes it special or unique? What makes the citizens proud of their community? This section does not need to be lengthy, but should be compelling.

A short description and list of other key health services available in the same community area should be included in this section. This information should help the reader understand the broader health care community. Lengthy lists of community health resources may be appropriate for an appendix.

III. Community Health Needs Assessment: Process

a. description of the process and methods used to conduct the assessment including:

- **i. identification of the personnel involved in planning by title, organization**
- **ii. description of the overall planned approach for developing and conducting the assessment**
- **iii. description of the process used to collect secondary data**
- **iv. description of the process used to develop and collect primary data**

Considerations:
This section is very important for compliance. The information presented throughout Section III will provide evidence of a comprehensive and systematic approach to the CHNA. Throughout this section, clearly identify participation and input from community partners, hospital leaders, citizens and public health experts. If that list is extensive, include the key participants in this section and refer to Section IV. Any tool used to collect primary data should be included as an appendix. The public health expert or faculty from an area college may be able to review this section and provide specific guidance.

- *signature of the CEO or chair of the governance structure*
  - **data and information sources for secondary data**
    - **agency or organization**
    - **retrieval date**
    - **year of data available and used**
    - **web address**
    - **rationale for use of these data sources**
  - **data and information sources for primary data collection**
    - **description of type of methodology (interviews, survey, focus group)**
    - **rationale for methodology selection**
    - **setting(s) of primary data collection**
    - **list specific target populations**
    - **response rate by setting and population (number interviewed, numerator and denominator of surveys sent and returned — include percentage and actual numbers)**
    - **description and list of successful approaches and identification**
    - **description and list of barriers, challenges and unsuccessful approaches**

Note: Section IV will provide more detail on broad input from the community.

Considerations:
This section is very important for compliance. In this section, clearly identify very specific and detailed information. The format likely will be short narrative passages with dot points and lists. Do not make the reader sort through lengthy narrative; this information may be succinctly written. However, it is essential for compliance that all relevant information be included. Efforts to gather information from and about the medically underserved, low-income, chronically ill or unique subgroups in the community should be thoroughly described.

A copy of the survey tool should be included in the appendix. If your community has a significant population of limited English-proficient citizens, a translated version of the report or key sections should be considered.

A public health expert or faculty from an area college may be able to review this section and provide specific guidance.

  - **analytical methods used to identify community health needs**
    - **description**
    - **statistical tests or processes**
    - **stakeholders and partners that participated in the prioritization process**
    - **methodology for selection, including group consensus processes**

Considerations:
This section is perhaps one of the most difficult for practitioners. Hospital or other IT staff may have experience in basic statistical tests beneficial in assessing the primary data. Most secondary sources of data include some descriptive statistics, although this information often is separate from the key fact sheets.

The description of how the group achieved consensus should include how participation and input from community partners, hospital leadership, citizens and public health experts was incorporated into this process. If the participant list is extensive, include the key participants in this section and refer to Section IV. If specific process tools were used, identify and describe those tools. It also may be appropriate to include a sample tool as an appendix. A public health expert or faculty from an area college may be able to review this section and provide specific guidance.

a. gaps in information that limited the ability to assess the community served
v. description and list of specific gaps
b. community organizations that collaborated or contributed to the CHNA
vi. list by organization
vii. identify personnel by name, title, credentials
c. identification of third-party agents to assist with the CHNA, including qualifications; describe the outside party's specific role and products developed

Considerations:
This section is very important for compliance. It is acceptable and encouraged that gaps in information be identified and explained. It may not be possible to collect specific information on specific topics. Documenting gaps demonstrates an understanding about the issue and efforts to gather information. It is important to note that health topics deemed important through group input but lack data, define that the issue still should be included in the prioritization of health issues.

If any consultants, faculty from area colleges or other third-party agents assisted with the CHNA, specific information must be included in this section.

IV. Community Health Needs Assessment: Input from Community
a. description of how the hospital sought input from broad interests in the community
i. target populations, including lower socioeconomic status, chronically ill, medically underserved; for each list include:
1. what methods (focus groups, meetings, surveys, interviews)
2. when (dates and association with other events)
3. locations
ii. representative organizations (may repeat Section II.f)
1. name
2. title
3. organization
4. describe the nature of representation: what organizations, populations and qualifications represent this population
5. describe leadership role, if applicable
iii. individual(s) included with expertise in public health (may repeat Section II.f)
1. name
2. title
3. affiliation(s)
4. brief description of individuals knowledge or expertise
5. describe leadership role, if applicable

Considerations:
In this section, clearly identify participation and input from community partners, hospital leaders, citizens and public health experts. The description of how input was sought and collected from the stakeholders and citizens, especially the lower socioeconomic status, medically underserved and chronically ill, should be thoroughly described. It will be important to reiterate how each contributed and at which phases in the assessment.

If your community has a significant population of limited-English proficient citizens, it is important to include a description of the methods used to seek input from this population.

This is this section that should include all detailed information about partnering organizations and individuals. If that list is extensive, include the key participants in this section, and then list all participants and their required information in an appendix.

This section may be written as a short narrative and then may include a roster format with the above information, either in the report or as an appendix.

V. Community Health Needs Assessment: Findings
(Note: this section will complement the implementation plan.)

- **a. identified health issues through assessment process**
- **b. process to prioritize health issues**
  - **i. description of process**
  - **ii. use of any tools (e.g., prioritization matrix)**
- **c. list of priority health issues identified and description of why these issues were identified**
- **d. description of rationale used not to address health issues**

Considerations:
This section is very important for compliance. In this section, clearly identify very specific and detailed information; it is essential for compliance that all relevant information be included. This section should be used to establish the foundation for the implementation plan. The format likely will be narrative passages; however, do not make the reader sort through lengthy narrative. This section should be compelling for the reader.

A public health expert or faculty from an area college may be able to review this section and provide specific guidance.

VI. Resource Inventory

- **a. description of existing health care facilities within the same community description, including specialty services**
- **b. other resources available to meet the community health needs identified**
- **c. other resources available to meet the priority community health needs**

Considerations:
This section should include succinct but complete inventories of available resources. If the list is too extensive, include key resources in this section and the full listing as an appendix.

VII. Community Health Needs Assessment: Dissemination Plan

- **a. description and date of report release to public**
- **b. list of websites, including URL**
- **c. describe the process to provide printed copies upon request**
- **d. describe the process to share information with the broad community, including the medically underserved, chronically ill and lower socioeconomic populations**

Considerations:
Efforts to disseminate the report to the public and to medically underserved, low-income, chronically ill or unique subgroups should be thoroughly described. This section is very important for compliance. In this section, clearly identify very specific and detailed information. The format likely will be short narrative passages with dot points and lists. Do not make the reader sort through lengthy narrative. It is essential for compliance that all specific methods and exact locations (websites or geographic) of the report be listed in addition to the instructions for obtaining a printed copy.

If your community has a significant population of limited-English proficient citizens, a translated version of the report (or key sections) should be considered.

VIII. Appendices

- **a. model or approach for CHNA process (e.g., the county health rankings model)**
- **b. additional demographic or population information**
- **c. additional secondary reports, maps and graphs**
- **d. primary data collection tool (e.g., survey)**
- **e. summary of primary data analysis**
- **f. tools used to prioritize health issues**
- **g. complete community resource inventory**

Considerations:
This section should be very neatly and carefully ordered to provide the reader immediate access to more detailed information that is not included in the report. Each document should be labeled as a separate appendix. The appendices provided throughout this template only are suggestions; there are no specific requirements for appendices.

TIPS FOR CREATING GRAPHS AND TABLES

Each graph or table should be able to stand alone and provide complete information without explanation. There are many options to embellish graphs; use these options sparingly because a simple, clear, concise graph often is more effective at displaying data than a highly intricate, colorful graph. The following tips and resources provide additional information.

- Consider your audience: What is the point you are trying to convey?
- Check the data; verify the accuracy and completeness.
- Include a legend unless the graph is very basic.
- Explain encodings: A color code only is helpful with a key.
- Label axes even if it seems obvious to you.
- Include units of measure in the graph. If this becomes too cluttered, you may have too many data points.
- Include data sources and dates.

REFERENCES

Goldberg, L. (2015). *IRS issues final rule providing guidance for charitable hospitals.* Issue Brief. Missouri Hospital Association.

Internal Revenue Service. (n.d.). *New requirements for 501(c)(3) hospitals under the Affordable Care Act*. Retrieved from http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/ New-Requirements-for-501%28c%29%283%29-Hospitals-Under-the-Affordable-Care-Act

Internal Revenue Service. (2010). *Notice and request for comments regarding the community needs assessment requirements for tax-exempt hospitals*. Notice 2011-52. Retrieved from http://www.irs.gov/irb/2011-30_IRB/ ar08.html

CHNA Timeline

The CHNA requirement is effective with the tax reporting periods after March 23, 2012. Hospitals with a fiscal year from April 1 through March 30 need to complete the CHNA, develop a report for publication and include findings in the 990 Schedule H in the 2012 Tax Return. Below is a basic timeline to assist hospitals in meeting the requirements of the CHNA. It is anticipated the process outlined below would take approximately one year to complete to thoroughly review data and gain broad community input.

	TASK 1	TASK 2	TASK 3
Month 1	Establish Assessment Infrastructure • Identify process facilitator • Identify steering committee members • Identify data "gatherer"	Establish Assessment Process Timeline • Review requirements • Review steps • Tailor timeline to hospital and community	Identify Community Representatives • Begin discussions on identifying "community" • Identify interest groups for representation input • Discuss key community representatives to include
Month 2	Convene CHNA Committee • Educate Community Committee on CHNA • Requirements • Process • Timeline • Resources Needed • Roles	Establish Meeting Schedule • Decide how often and when the Committee will meet	Establish Community Definition • Discuss the appropriate definition of geographical area for "community" • May be both geographic and population *note may add population later in process as needs are identified
Month 3	Data Collection and Gathering • Establish list of important data on community • Identify appropriate and reliable data resources	Demographic Data • Gather and review demographic data to better understand community	Health Status Data • Chronic disease • Special health populations
Month 4	Data Collection and Gathering • Review inpatient and outpatient data • Patient origin and migration • Top diagnoses • Request data from MHA if needed	Review of Availability of Other Health Providers in Community • Primary care and specialty	Establish Data Summary Report
Month 5	Convene CHNA Committee • Review data summary report • Identify missing data or information	Establish Preliminary List of Needs Identified	Discuss Process for Broad Community Input
Month 6	Plan and Develop Broad Process for Obtaining Broad Community Input • Internal steering committee process	Consider Opportunities for Community Input: • Town hall • Paper survey (consider distribution) • Electronic survey • Focus groups	Refine Process for Input • Develop survey questions
Month 7	Consider Multiple Locations to Provide Opportunities for Special Interest Groups	Gather Community Input • Implement survey or input process	
Month 8	Review Information Gathered from Community Input	Develop Draft Report of Data Collected and Analyzed	
Month 9	Convene Community Committee • Review survey information • Identify significant needs	Identify Needs • Ask the community committee to make recommendations on • significant needs • Identify needs that should not be addressed and why	Steering Committee Finalizes Needs List • Review data and input from community and community committee • Identify which needs are appropriate and financially feasible for the hospital to meet • Identify which needs cannot be met and why
Month 10	Develop Draft CHNA Report for Public		
Month 11	Convene Community Committee Final Time • Provide draft report overview • Seek final recommendations		
Month 12	Finalize Report for Publication and Reporting in Schedule H, Form 990 Convene Community Committee Final Time • Provide draft report overview • Seek final recommendations	Make Available on Hospital Website	

Schedule H (Form 990)

SCHEDULE H (Form 990)

Department of the Treasury
Internal Revenue Service

Hospitals

► **Complete if the organization answered "Yes" on Form 990, Part IV, question 20.**
► **Attach to Form 990.**
► **Go to *www.irs.gov/Form990* for instructions and the latest information.**

OMB No. 1545-0047

2020

Open to Public Inspection

Name of the organization | **Employer identification number**

Part I Financial Assistance and Certain Other Community Benefits at Cost

		Yes	No
1a	Did the organization have a financial assistance policy during the tax year? If "No," skip to question 6a		
b	If "Yes," was it a written policy?		
2	If the organization had multiple hospital facilities, indicate which of the following best describes application of the financial assistance policy to its various hospital facilities during the tax year. ☐ Applied uniformly to all hospital facilities ☐ Applied uniformly to most hospital facilities ☐ Generally tailored to individual hospital facilities		
3	Answer the following based on the financial assistance eligibility criteria that applied to the largest number of the organization's patients during the tax year.		
a	Did the organization use Federal Poverty Guidelines (FPG) as a factor in determining eligibility for providing *free* care? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: ☐ 100% ☐ 150% ☐ 200% ☐ Other _____ %		
b	Did the organization use FPG as a factor in determining eligibility for providing *discounted* care? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: ☐ 200% ☐ 250% ☐ 300% ☐ 350% ☐ 400% ☐ Other _____ %		
c	If the organization used factors other than FPG in determining eligibility, describe in Part VI the criteria used for determining eligibility for free or discounted care. Include in the description whether the organization used an asset test or other threshold, regardless of income, as a factor in determining eligibility for free or discounted care.		
4	Did the organization's financial assistance policy that applied to the largest number of its patients during the tax year provide for free or discounted care to the "medically indigent"?		
5a	Did the organization budget amounts for free or discounted care provided under its financial assistance policy during the tax year?		
b	If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		
c	If "Yes" to line 5b, as a result of budget considerations, was the organization unable to provide free or discounted care to a patient who was eligible for free or discounted care?		
6a	Did the organization prepare a community benefit report during the tax year?		
b	If "Yes," did the organization make it available to the public?		

Complete the following table using the worksheets provided in the Schedule H instructions. Do not submit these worksheets with the Schedule H.

7 Financial Assistance and Certain Other Community Benefits at Cost

	Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a	Financial Assistance at cost (from Worksheet 1)						
b	Medicaid (from Worksheet 3, column a)						
c	Costs of other means-tested government programs (from Worksheet 3, column b)						
d	**Total.** Financial Assistance and Means-Tested Government Programs						
	Other Benefits						
e	Community health improvement services and community benefit operations (from Worksheet 4)						
f	Health professions education (from Worksheet 5)						
g	Subsidized health services (from Worksheet 6)						
h	Research (from Worksheet 7)						
i	Cash and in-kind contributions for community benefit (from Worksheet 8)						
j	**Total.** Other Benefits						
k	**Total.** Add lines 7d and 7j						

Source: https://www.irs.gov/pub/irs-pdf/f990sh.pdf

Sample Written Survey

1. **What is your ZIP code?** _____

2. **Gender?**
   ❑ Male ❑ Female

3. **What is your race?**
   ❑ White ❑ Black or African American ❑ American Indian or Alaska Native
   ❑ Asian ❑ Hispanic or Latino ❑ Native Hawaiian & Other Pacific Islander
   ❑ Other ____

4. **What are the ages of the people who live in your household?**

Yourself					18-24	25-44	45-54	55-64	65+
Person 2	0-35 mos.	3-5	6-12	13-17	18-24	25-44	45-54	55-64	65+
Person 3	0-35 mos.	3-5	6-12	13-17	18-24	25-44	45-54	55-64	65+
Person 4	0-35 mos.	3-5	6-12	13-17	18-24	25-44	45-54	55-64	65+
Person 5	0-35 mos.	3-5	6-12	13-17	18-24	25-44	45-54	55-64	65+
Person 6	0-35 mos.	3-5	6-12	13-17	18-24	25-44	45-54	55-64	65+

5. **How long have you lived in the area?**
   ❑ Less than a year ❑ 1-2 years ❑ 3-5 years ❑ 6-10 years ❑ 11-20 years
   ❑ More than 20 years

6. **How often do you use seat belts when you drive or ride in a car?**
   ❑ Always ❑ Nearly always ❑ Sometimes ❑ Seldom ❑ Never

7. **During the past 12 months, have you received a flu shot?**
   ❑ Yes ❑ No

8. **Have you ever been told by a doctor you had high blood pressure?**
   ❑ Yes ❑ No

   8a. If yes, is any medication currently prescribed for your high blood pressure?
   ❑ Yes ❑ No

9. **Have you ever been told by a doctor you should lose weight for health reasons?**
   ❑ Yes ❑ No

10. During the past month have you participated in any physical activities or exercise, such as running, walking, golf, etc.?

❑ Yes ❑ No

10a. If yes, how many times a week do you take part in this activity?

❑ 1-2 days ❑ 3-4 days ❑ 5-7 days

10b. How many minutes or hours do you usually perform this activity?_____

11. Are you currently trying to lose weight?

❑ Yes ❑ No

11a. If yes, how are you trying to lose weight? *(check all that apply)*

- ❑ Eating fewer calories
- ❑ Increasing physical activity
- ❑ Both
- ❑ Other _____

12. Have you smoked at least 100 cigarettes in your life?

❑ Yes ❑ No

12a. If yes, how old were you when you first started smoking regularly?_____

13. Do you smoke now?

❑ Yes ❑ No

13a. If yes, how many cigarettes do you smoke on an average day?_____

14. Have you ever been told by a doctor that you have one of the following conditions? *(check all that apply)*

- ❑ Adult asthma
- ❑ Angina or coronary artery disease
- ❑ Bacterial pneumonia
- ❑ Cancer (If yes, type: _____)
- ❑ CHF (congestive heart failure)
- ❑ COPD (chronic obstructive pulmonary disease)
- ❑ Diabetes or high blood sugar
- ❑ Heart attack
- ❑ High cholesterol
- ❑ Hypertension (high blood pressure)
- ❑ Stroke

15. Has a child in your household (age 17 or younger) been told by a doctor that they have one of the following conditions? *(check all that apply)*

- ❑ Asthma
- ❑ Diabetes
- ❑ Overweight or obesity

16. If a child in your household has asthma, how many times during the past 12 months did you visit an emergency room because of the asthma? _____

17. Has a child in your household (age 17 or younger) used the following? *(check all that apply)*

- ❑ Alcohol
- ❑ Drugs
- ❑ Tobacco

18. Has a child in your household (age 17 or younger) become pregnant?

❑ Yes ❑ No

19. Have you used opiate medicine in the last year?

❑ Yes ❑ No

20. Have you used opiate medicine in the last month?

❑ Yes ❑ No

21. Have you used opiate medicine in the last week?

❑ Yes ❑ No

21a. As a result of taking opiates in the last week, I have had trouble concentrating or remembering.

❑ Yes ❑ No

22. Opiate medicine makes it hard for me to think clearly.

❑ Yes ❑ No

23. Opiate medicines have caused me to feel slow, sluggish or sedated.

❑ Yes ❑ No

24. The side effects of opiate medicine have interfered with my work, family and/or social responsibilities.

❑ Yes ❑ No

25. I have wanted to stop using opiate medicines that I used in the last year.

❑ Yes ❑ No

26. Including yourself, how many members of your household are disabled?

0 1 2 3 or more

27. Including yourself, how many adults (age 18 or older) in your household are in fair-to-poor health?

0 1 2 3 or more

28. Is any child (age 17 or younger) in your household in fair-to-poor health?

❑ Yes, 1 ❑ Yes, 2 or more ❑ No

29. Are you or any household member a PRIMARY caregiver for an aged, disabled or chronically ill person? (including a parent, spouse or other relative)

❑ Yes ❑ No

30. How long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general visit, not a visit for a specific injury, illness or condition.

❑ Within the past year ❑ Within the past two years ❑ Within the past five years
❑ Five or more years ago ❑ Never

31. If your last visit was more than two years ago, is it because you:

- ❑ Do not have a medical condition that requires any care and receive health screenings from another provider service
- ❑ Do not routinely receive any health screenings
- ❑ Could not schedule due to work or personal conflicts with normal business hours
- ❑ Could not afford the payments due, regardless of insurance status
- ❑ Could not arrange transportation

32. If you or a household member have a health care need:

32a. Do you have a doctor you can go to? ❑ Yes ❑ No
32b. Do you have a dentist you can go to? ❑ Yes ❑ No
32c. Do you have a mental health specialist you can go to? ❑ Yes ❑ No
32d. Do you have a substance abuse counselor you can go to? ❑ Yes ❑ No

33. How many times during the past 12 months have you or any household member used a hospital emergency room? *(check only one)*

❑ None ❑ 1-2 times ❑ 3-5 times ❑ 6 or more times

34. If you or a household member used a hospital emergency room in the past 12 months, was it due to:

- ❑ An injury that required immediate attention
- ❑ An injury that did not require immediate attention, but it was the most convenient/only service available
- ❑ An ongoing illness

35. Have you or anyone in your household had any difficulty finding a doctor within the past two years?

❑ Yes ❑ No

35a. If yes, why would you say you had trouble finding a doctor?

- ❑ Couldn't get a convenient appointment
- ❑ Didn't know how to get in contact with one
- ❑ Doctor was not taking new patients
- ❑ No transportation
- ❑ Would not accept your insurance
- ❑ Other _____

36. Have you or anyone in your household had any difficulty finding a doctor that treats specific illnesses or conditions in your area within the past two years?

❑ Yes ❑ No

36a. If yes, what kind of specialist did you look for?

- ❑ Bone and joint specialist
- ❑ Cancer specialist
- ❑ Children's specialist
- ❑ Dentist
- ❑ Diabetes specialist
- ❑ Heart specialist
- ❑ Lung and breathing specialist
- ❑ Mental health specialist
- ❑ Nerve and brain specialist
- ❑ Women's health specialist
- ❑ Other

36b. If you were unable to visit a specialist when you needed one, why?

- ❑ No appointments were available
- ❑ No specialist was available in this area
- ❑ Did not have a car or transportation to get to the office
- ❑ Could not get to the office while they were open
- ❑ Did not know how to find one
- ❑ Could not afford to pay for the specialist
- ❑ Other _____

37. How long has it been since you had your blood cholesterol level checked?

❑ Within the past year ❑ Within the past two years ❑ Within the past five years
❑ Over five years ago ❑ Never

38. Have you ever been told by a doctor or other health care professional that your blood cholesterol level is too high?

❑ Yes ❑ No

39. How long has it been since your blood was checked for diabetes?

❑ Within the past year ❑ Within the past two years ❑ Within the past five years
❑ Over five years ago ❑ Never

40. Have you ever been told by a doctor or health care professional you have high blood sugar or diabetes?

❑ Yes ❑ No

41. How long has it been since you had an exam or screening for colon cancer?

❑ Within the past year ❑ Within the past two years ❑ Within the past five years
❑ Six years or more ❑ Never

42. How long has it been since your last mammogram for breast cancer?

❑ Within the past year ❑ Within the past two years ❑ Within the past five years
❑ Six years or more ❑ Never

43. How long has it been since your last breast exam by a doctor or nurse?

❑ Within the past year ❑ Within the past two years ❑ Within the past five years
❑ Six years or more ❑ Never

44. How long has it been since your last Pap smear for female-related cancers?

❑ Within the past year ❑ Within the past two years ❑ Within the past five years
❑ Six years or more ❑ Never

45. What do you think are the most pressing health problems in your community? *(check all that apply)*

- ❑ Ability to pay for care
- ❑ Alcohol – dependency or abuse
- ❑ Alcohol – underage binge or abuse
- ❑ Drug abuse – prescription medications
- ❑ Drug abuse – illegal substances
- ❑ Cancer
- ❑ Child abuse
- ❑ Cost of health care
- ❑ Domestic violence
- ❑ Lack of health insurance
- ❑ Lack of transportation to health care services
- ❑ Lack of dental care
- ❑ Lack of prenatal care
- ❑ Mental health
- ❑ Obesity in adults
- ❑ Obesity in children and teenagers
- ❑ Prescription medication too expensive
- ❑ Teen pregnancy
- ❑ Tobacco use/smoking among adults
- ❑ Tobacco use/smoking among teenagers
- ❑ Other

46. What medical services are most needed in your community? *(check all that apply)*

- ❑ Adult primary care services
- ❑ Alcohol and drug abuse treatment
- ❑ Cancer treatment
- ❑ Counseling/mental health services
- ❑ Diabetes care
- ❑ Emergency/trauma care
- ❑ Heart care services
- ❑ Orthopedic care (bone and joint)
- ❑ Pediatric services
- ❑ Women's services, such as obstetrics/gynecological services
- ❑ Other

47. Please check the types of health education services most needed in your community. *(check all that apply)*

- ❑ Alcohol abuse
- ❑ Alzheimer's disease
- ❑ Asthma
- ❑ Cancer screening
- ❑ Child abuse/family violence
- ❑ Diabetes
- ❑ Diet and/or exercise
- ❑ Drug abuse
- ❑ HIV/AIDS
- ❑ Sexually-transmitted diseases
- ❑ Smoking cessation and/or prevention
- ❑ Stress management
- ❑ Other

48. What health or community services should [Hospital Name] provide that currently are not available?

49. What ideas or suggestions do you have for improving the overall health of the area community?

50. What is your highest level of education?

- ❑ Left high school without a diploma
- ❑ High school diploma
- ❑ GED
- ❑ Currently attending or have some college
- ❑ Two-year college degree
- ❑ Four-year college degree
- ❑ Graduate-level degree

51. Including yourself, how many adults in your household are retired?

❑ None ❑ 1 ❑ 2 ❑ 3 ❑ 4 or more

52. Including yourself, how many adults (18+) in your household are employed full time, year-round?

❑ None ❑ 1 ❑ 2 ❑ 3 ❑ 4 or more

53. How many household members currently are covered by health insurance?

Number of adults covered by health insurance:

Number of children covered by health insurance:

Number of household members not covered by health insurance:

54. If you or members of your household have health insurance coverage, how is it obtained?
(check all that apply)

- ❑ Medicare A
- ❑ Medicare B
- ❑ Medicaid
- ❑ Through a retirement insurance plan
- ❑ Through an employer's health insurance plan
- ❑ Veterans' Administration
- ❑ Privately purchased

55. Do you have trouble getting transportation to health care services?

❑ Yes ❑ No

55a. How many miles do you travel, one way?

To see a doctor?	1-5	6-10	11-20	21-30	>30
To a hospital?	1-5	6-10	11-20	21-30	>30
To school or job training?	1-5	6-10	11-20	21-30	>30
To a job	1-5	6-10	11-20	21-30	>30

56. Counting all income sources from everyone in your household, what was the combined household income last year? *(check only one)*

- ❑ Less than $20,000
- ❑ $20,000 - $29,999
- ❑ $30,000 - $39,999
- ❑ $40,000 - $49,999
- ❑ $50,000 - $59,999
- ❑ $60,000 - $69,999
- ❑ $70,000 - $79,999
- ❑ $80,000 - $89,999
- ❑ $90,000 - $99,999
- ❑ $100,000 - $199,999
- ❑ $200,000 or more

57. How would you describe your housing situation? *(check only one)*

- ❑ Own a house or condo
- ❑ Rent a house, apartment or room
- ❑ Living in a group home
- ❑ Living temporarily with a friend or relative
- ❑ Multiple households sharing an apartment or house
- ❑ Living in a shelter
- ❑ Living in a motel
- ❑ Living in senior housing or assisted living
- ❑ Other (explain)

58. Household issues

Some of the following may have been a problem for you or someone in your household. If it has been a problem in your household during the past 12 months, please tell us how much of a problem it has been. *(check one on each line)*

Adult substance abuse (alcohol or legal medications)

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Adult substance abuse (illegal drugs)

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Youth substance abuse (alcohol, drugs, etc.)

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Caring for an adult with disabilities

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Caring for a child with disabilities

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Child abuse

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Physical violence against adults

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Depression

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Not having enough money for food

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Not able to afford nutritious food (fresh vegetables and fruits)

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Not able to afford transportation

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Not having enough money to pay for housing

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Not having enough money to pay the doctor, dentist or pharmacy

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Not having enough money to pay for a mental health counselor

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Use of tobacco products

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Not being able to find or afford after-school child care

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Sexual abuse

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Teen pregnancy

❑ Not a problem ❑ Minor Problem ❑ Major Problem ❑ Don't know

Other issues (explain)

Does your health care provider connect you with local organizations to address the nonmedical care needs, such as food, transportation, housing, etc.?

❑ Yes ❑ No

COVID-19 Pandemic

Did you or a loved one get COVID-19? ❑ Yes ❑ No

Did you or a loved one require hospitalization as a result of COVID-19 infection?

❑ Yes ❑ No

Did you or a loved one experience or continue to experience the lingering side effects of COVID-19?

❑ Yes ❑ No

Did everyone in your household get vaccinated? ❑ Yes ❑ No

Sample Focus Group Questions

COMMUNITY HEALTH NEEDS ASSESSMENT

Introduction and Purpose
Question 1: What is your vision for a healthy community?

Ask community members to share their ideas of a healthy community.
What is healthy about their community and what is unhealthy?

Question 2: What is your perception of the most serious health issues facing this community?

Ask community members to share specific concerns. Keep this conversation focused and do not allow the conversation to digress into a venue for complaints.

Question 3: What is your perception of the most beneficial health resources or services in this community?

Ask community members to share specific examples.

Question 4: What is your perception of the hospital overall and of specific programs and services?

Community members' views will identify opportunities for improving current programs and services, as well as highlight service and program gaps.

Question 5: What is your perception of your physician and medical services?

Community members' views will identify opportunities for improving current medical services, as well as highlight service gaps.

Question 6: What can the hospital do to improve health and quality of life in the community?

This question may be the most important because it elicits ideas for how to improve services and relationships in the community and provide direction for new activities or strategies.

Adapted from: Rural Health Works, Retrieved from http://ruralhealthworks.org/wp-content/files/2a-MSTR-CHNA-Template-APPs-F-J-FINAL-Dec-2011-scan-copy.pdf

CHNA Facilitator Checklist

- ❑ Establish In-house Steering Committee members (administrator, planner, financial officer, data collector/analyzer)
- ❑ Establish a timeline to complete CHNA process
- ❑ Identify community stakeholder representatives:
  - Public health
  - Local government
  - Primary care
  - Special interest groups (e.g., poor, chronic disease, disabled, elderly, blind, hearing impaired, non-English speaking populations, etc.). Note: this suggested list is a recommendation. Your hospital's committee may not include all these groups and may include representatives of groups not listed here.
- ❑ Invite community stakeholders to a meeting:
  - Provide overview of requirements and seek input and support
  - Establish a timeline and meeting schedule
- ❑ Define the "community" on which the report will be based
- ❑ Gather demographic data on the community
- ❑ Gather data on health status of the community
- ❑ Gather utilization data
  - Inpatient migration/origin
  - Top DRGs for population
  - ED visit data
- ❑ Develop data summary report
- ❑ Convene Community Stakeholder Committee
  - Review data
  - Identify missing data elements
- ❑ Establish list of preliminary needs that have been identified
- ❑ Discuss and identify most appropriate survey instrument for broad community input. This may include one or more of the following:
  - Electronic survey (consider free online process like Survey Monkey)
  - Mail surveys
  - Community focus groups or town hall meetings
- ❑ Advertise opportunity for community input (e.g., at the hospital, on the radio, in the newspaper, etc.)
- ❑ Plan and convene broad community input activities (logistics):
  - If holding town hall or focus groups, find neutral location and identify neutral third party facilitator
- ❑ Analyze and summarize findings from broad community input sources
- ❑ Convene Community Stakeholder Committee to review community input:
  - Review significant needs identified
  - Seek recommendations on needs to be addressed.
- ❑ Convene In-house Steering Committee to review needs and recommendations from community stakeholder group and finalize plan for addressing needs:
  - Consider financial feasibility of meeting some needs
- ❑ Develop draft report
- ❑ Convene Community Stakeholder Committee for final review of report and input
- ❑ Finalize report for public view and publish on hospital website
- ❑ Work with finance representative to meet Schedule H requirements

CHNA Implementation Plan Timeline

The U.S. Department of the Treasury and the IRS consider an implementation strategy as being "adopted" on the date the implementation strategy is approved by an authorized governing body of the hospital organization. Below is a basic timeline to assist hospitals in meeting the requirements of the CHNA implementation plan. It is anticipated the process outlined below will take approximately one year to complete, thoroughly reviewing and addressing all key aspects pertaining to the plan. (2)

	Tier 1	Tier 2	Tier 3
Month 1	Establish Implementation Infrastructure Meet leadership team Identify process facilitator Identify steering committee members Identify data "gatherer"	Establish Implementation Process Timeline Review requirements Review steps Tailor timeline to hospital and community	Identify Community Representatives Begin discussions on identifying "community" Identify interest groups for representation Discuss key community representatives to include in the collaboration
Month 2	Convene CHNA Implementation Committee Educate Community Committee on implementation requirements Lay out the process Set a timeline Identify needed resources Assign roles	Establish meeting schedule Decide how often and when the committee will meet Conduct a survey – readiness gap analysis using the Assessing Your Readiness Worksheet	Establish scope of plan (county, region, etc.) Discuss results and agree on strategies to close identified gaps Establish focus groups to make progress on different fronts Identify team leads Assign tasks, roles and expectations
Month 3	Collect and gather data (Steering Committee) Identify appropriate and reliable data resources that will be used for various goals based on priority health issues identified in the CHNA	Gather demographic data to better understand community for area to be covered Review data	Gather health status data Identify priority health issue per CHNA Note special health populations from the implementation start Review data and communicate information vital to the group
Month 4	Collect and gather data (Steering Committee) Review utilization data Review patient origin and migration Identify top diagnoses by REal data (if applicable) Conduct ZIP code analysis for specificity	Review vailability of other health providers in community Review primary care and specialty Review access of care Review insurance coverage	Establish data summary report Review relevant data with group Brainstorm on emerging trends and possible recommendations to focus groups
Month 5	Reconvene entire CHNA Implementation Committee Review data summary report Report out by focus groups Hold brainstorming sessions	Establish preliminary list of needs identified and assign tasks for report out for future	Identify potential community events/activities completed and planned by focus groups Review all areas completed relating to activities included on the implementation template Grade progress toward achievement of goals set and strategize as needed
Month 6	Convene focus groups to review progress Identify barriers and successes Determine next steps	Update group on progress of entire project	Align focus group progress report with the project timetable
Month 7	Report out by focus groups on progress made in addressing group focus as assigned, highlighting successes and challenges	Review working document template and update the event form as required	Grade completion of tasks against initial timeline set at the beginning of the project
Month 8	Review information gathered from focus groups (Steering Committee)	Develop draft report of data collected and analyzed to date	
Month 9	Convene Community Committee Review current implementation process status Identify successes and challenges Determine next steps	Identify needs Ask Community Committee to make recommendations on current progress Identify opportunities to address any unmet needs	Finalize needs list (Steering Committee) Review data and input from community and Community Committee
Month 10	Develop draft CHNA Implementation Report for public		
Month 11	Convene Community Committee Provide draft report overview Seek final recommendations		
Month 12	Finalize report for publication and reporting in Schedule H (Form 990) Convene Community Committee for final time Provide draft report overview Seek final recommendations	Make available on hospital website	

Community Health Improvement Implementation Plan — Diabetes

Community Health Improvement Implementation Plan				
HEALTH ISSUE #1 (very specific): **Obesity and Sedentary Lifestyle — Diabetes**				
Contributing **FACTORS** to Health Issue #1 (including social determinants): **Lifestyle and diet-related (environmental factors/food/education/ community and social context factors)**				
Three-Year **GOAL** for Improvement (written as a **SMART** objective): Specific – Measurable – Achievable – Realistic – Time bound **Example: Decrease the percentage of adults in Missouri county reporting a *BMI >30* from 20% to 19.5% by 2021.**				
BUDGET for Health Issue #1 (consider direct and indirect costs): **Money allocated by hospital for this health issue**				
Strategies to Achieve Goal	Specific **Actions** to Achieve Strategies	Specific **Partners** and Roles for Each Strategy	Specific Three Year **Process Measure(s)** for Each Strategy	Specific Three Year **Outcomes Measures** for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Promotion of an active lifestyle with weight reduction or maintenance, access to low-cost fitness classes, and sponsorship of community walking/running/ biking events for individuals and families • Resources to the community related to weight management are provided, along with community education classes promoting a healthy lifestyle to impact risk reduction for chronic conditions associated with obesity **Remember:** *Change as needed to align with the desired strategy.*	**Example of key actions** • Sponsor annual day of dance free community event, promoting fun exercise options and free screenings, reaching at least 1,000 attendees • Support community fitness events (walking/running/biking) for adults and families • Offer low-cost weight management courses three times/year with participants' average weight loss of at least 3% • Offer low-cost fitness classes to the community, as well as medically supervised exercise classes specifically targeting those with osteoporosis, Parkinson's disease, cancer, diabetes and pelvic floor issues **Remember**: *Target above baseline performance in these categories.*	**Example of key partners** • Medical group physicians • American Heart Association • American Diabetes Association • Health department • Area employers, i.e., hospitals, schools and other employers as needed • Chamber of Commerce • County government **Remember:** *Add more categories representing your community.*	**Example of key process measures** • Increased level of physical activity • Increased access to screenings • Increased fitness events • Increased weight management educational offerings Please include baseline and target for each strategy. **Remember:** *Add more process measures as needed.*	**Example of key outcomes measures** • Decreased BMI among adults leading to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations Please include baseline and target for each outcome. **Remember:** *Make changes as needed.*

Community Health Improvement Implementation Plan				
HEALTH ISSUE #1 (very specific): **Obesity and Sedentary Lifestyle — Diabetes**				
Contributing **FACTORS** to Health Issue #1 (including social determinants): **Lifestyle and diet-related (environmental factors/food/education/ community and social context factors)**				
Three-Year **GOAL** for Improvement (written as a **SMART** objective): Specific – Measurable – Achievable – Realistic – Time bound **Example: Decrease the percentage of adults in Missouri county reporting a *lifestyle without physical activity* from 21% to 20% in 2021.**				
BUDGET for Health Issue #1 (consider direct and indirect costs): **Information not available**				
Strategies to Achieve Goal	Specific **Actions** to Achieve Strategies	Specific **Partners** and Roles for Each Strategy	Specific Three Year **Process Measure(s)** for Each Strategy	Specific Three Year **Outcomes Measures** for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Promotion of an active lifestyle with weight reduction or maintenance, access to low-cost fitness classes, and sponsorship of community walking/running/biking events for individuals and families • Resources to the community related to weight management are provided, along with community education classes promoting a healthy lifestyle to impact risk reduction for chronic conditions associated with obesity **Remember:** *Change as needed to align with the desired strategy.*	**Example of key actions** • Sponsor annual day of dance free community event, promoting fun exercise options and free screenings, reaching at least 1,000 attendees. Baseline: 2016 - 800 • Support community fitness events (walking/ running/biking) for adults and families. Baseline: 5 • Offer low-cost weight management courses three times/year with participants' average weight loss of at least 3%. Baseline: FY16 - 2.73% • Offer low-cost fitness classes to the community, as well as medically supervised exercise classes specifically targeting those with osteoporosis, Parkinson's disease, cancer, diabetes and pelvic floor issues **Remember:** *Target above baseline performance in these categories.*	**Example of key partners** • Medical group physicians • American Heart Association • Health department • Area employers. i.e., hospitals, schools and other employers as needed • Chamber of Commerce • County government **Remember:** *Add more categories representing your community.*	**Example of key process measures** • Increased level of physical activity • Increased access to screenings • Increased fitness events • Increased weight management educational offerings Please include baseline and target for each strategy. **Remember:** *Add more process measures as needed.*	**Example of key outcomes measures** • Increase in people participating in a lifestyle with physical activity leading to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations Please include baseline and target for each outcome. **Remember:** *Make changes as needed.*

Community Health Improvement Implementation Plan				
HEALTH ISSUE #3 (very specific): **Prevent Chronic Conditions — Diabetes**				
Contributing **FACTORS** to Health Issue #3 (including social determinants): **Lifestyle and diet-related (environmental factors/food/education/ community and social context factors)**				
Three-Year **GOAL** for Improvement (written as a **SMART** objective): Specific – Measurable – Achievable – Realistic – Time bound **Example: Decrease the percentage of adults diagnosed with *high blood pressure* in Missouri county from 154 per 100,000 in 2019 to 100 per 100,000 in 2021.**				
BUDGET for Health Issue #3 (consider direct and indirect costs): **Information not available**				
Strategies to Achieve Goal	Specific **Actions** to Achieve Strategies	Specific **Partners** and Roles for Each Strategy	Specific Three Year **Process Measure(s)** for Each Strategy	Specific Three Year **Outcomes Measures** for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Focus on hyperlipidemia, hypertension screening and education in prevention of chronic conditions in your county **Remember:** *Change as needed to align with the desired strategy.*	**Example of key actions** • Provide free blood pressure screenings to community and increase number of screening offerings annually • Provide free community education classes and handouts on importance of diet and exercise to prevent and manage HBP, high cholesterol and type 2 diabetes by increasing number of programs offered • Increase the number of wellness/ screening programs targeting blood pressure, cholesterol, glucose screenings and educational venues for adults in the workplace **Remember:** *Target above baseline performance in these categories.*	**Example of key partners** • American Diabetes Association • American Heart Association • Local school nurses/dieticians • Wellness groups • Community partnerships • Medical group physicians • health department **Remember:** *Add more categories representing your community.*	**Example of key process measures** • Increased blood pressure screenings • Increased health literacy programs participation • Increased wellness screening programs targeting blood pressure, cholesterol, glucose, etc. • Partner with local public health agency to provide educational programs on chronic disease management Please include baseline and target for each strategy. **Remember:** *Add more process measures as needed.*	**Example of key outcomes measures** • Decreased blood pressure diagnosis for adults leading to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations. Please include baseline and target for each outcome. **Remember:** *Make changes as needed.*

Community Health Improvement Implementation Plan				
HEALTH ISSUE #2 (very specific): **Prevent Chronic Conditions — Diabetes**				
Contributing **FACTORS** to Health Issue #3 (including social determinants): **Lifestyle and diet-related (environmental factors/food/education/ community and social context factors)**				
Three-Year **GOAL** for Improvement (written as a **SMART** objective): Specific – Measurable – Achievable – Realistic – Time bound **Example: Decrease the percentage of adults diagnosed with *high cholesterol* in Missouri county from 20% in 2014 to 18.5% in 2021.**				
BUDGET for Health Issue #3 (consider direct and indirect costs): **Information not available**				
Strategies to Achieve Goal	Specific **Actions** to Achieve Strategies	Specific **Partners** and Roles for Each Strategy	Specific Three Year **Process Measure(s)** for Each Strategy	Specific Three Year **Outcomes Measures** for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Focus on hyperlipidemia, hypertension and diabetes prevention screening and education in prevention of chronic conditions in your county **Remember:** *Change as needed to align with the desired strategy.*	**Example of key actions** • Provide free blood pressure screenings to community and increase number of screening offerings annually • Provide free community education classes and handouts on importance of diet and exercise to prevent and manage HBP, high cholesterol and type 2 diabetes by increasing number of programs offered • Increase the number of wellness/screening programs targeting blood pressure, cholesterol, glucose screenings, as well as educational venues for adults in the workplace • Partner with health department **Remember:** *Target above baseline performance in these categories.*	**Example of key partners** • American Diabetes Association • American Heart Association • Wellness centers, YMCA • Community centers • Grocery stores • Health department • Local hospitals • Chamber of Commerce • Elected officials as needed **Remember:** *Add more categories representing your community.*	**Example of key process measures** • Increased health literacy programs participation • Increased wellness screening programs targeting blood pressure, cholesterol, glucose, etc. • Partner with programs to increase outreach to individuals at risk in the community • Partner with local public health agency to provide educational programs on chronic disease management Please include baseline and target for each strategy. **Remember:** *Add more process measures as needed.*	**Example of key outcomes measures** • Decreased blood pressure diagnosis for adults • Decreased high cholesterol diagnosis • Decreased diabetes hospital admission rate This eventually will lead to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations. Please include baseline and target for each outcome. **Remember:** *Make changes as needed.*

Community Health Improvement Implementation Plan				
HEALTH ISSUE #2 (very specific): **Prevent Chronic Conditions — Diabetes**				
Contributing **FACTORS** to Health Issue #3 (including social determinants): **Lifestyle and diet-related (environmental factors/food/education/ community and social context factors)**				
Three-Year **GOAL** for Improvement (written as a **SMART** objective): Specific – Measurable – Achievable – Realistic – Time bound **Example: Decrease the *diabetes hospital admission rate* for Missouri county from 174 per 100,000 in 2015 to 150 per 100,000 in 2021.**				
BUDGET for Health Issue #3 (consider direct and indirect costs): **Information not available**				
Strategies to Achieve Goal	Specific **Actions** to Achieve Strategies	Specific **Partners** and Roles for Each Strategy	Specific Three-Year **Process Measure(s)** for Each Strategy	Specific Three-Year **Outcomes Measures** for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Focus on hyperlipidemia, hypertension and diabetes prevention screening and education in prevention of chronic conditions in your county. **Remember:** *Change as needed to align with the desired strategy.*	**Example of key actions** • Provide free community education classes and handouts on importance of diet and exercise to prevent and manage HBP, high cholesterol and type 2 diabetes by increasing number of programs offered • Increase the number of wellness/ screening programs targeting blood pressure, cholesterol, glucose screenings, as well as educational venues for adults in the workplace • Wellness programs **Remember:** *Target above baseline performance in these categories.*	**Example of key partners** • American Diabetes Association • American Heart Association • Wellness centers • Area employers • Physicians • health department **Remember:** *Add more categories representing your community.*	**Example of key process measures** • Increased health literacy programs participation • Increased wellness screening programs targeting blood pressure, cholesterol, glucose, etc. • Increased outreach to women and their families • Partner with local public health agency to provide educational programs on chronic disease management • Partner with churches on screening programs Please include baseline and target for each strategy. **Remember:** *Add more process measures as needed.*	**Example of key outcomes measures** • Decreased blood pressure diagnosis for adults • Decreased high cholesterol diagnosis • Decrease diabetes hospital admission rate This eventually will lead to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations. Please include baseline and target for each outcome. **Remember:** *Make changes as needed.*

Activity Document — This is a working document for each goal identified per health issue.

Health Issue: Obesity and Sedentary Lifestyle — Diabetes				
SMART Goal: Example: Decrease the percentage of adults in Missouri county reporting a BMI >30 from 20% to 19.5% by 2021.				
Strategy: Promotion of an active lifestyle with weight reduction or maintenance, access to low-cost fitness classes, and sponsorship of community walking/running/biking events for individuals and families. Resources to the community related to weight management are provided, along with community education classes promoting a healthy lifestyle to impact risk reduction for chronic conditions associated with obesity.				
	Activities/Tactics	**Person Responsible**	**Met or Not Met**	**Barriers Identified**
Activities to be completed in 1-3 months	1.			
	2.			
	3.			
Activities to be completed in 3-6 months	1.			
	2.			
	3.			
Activities to be completed in 6-9 months	1.			
	2.			
	3.			
Activities to be completed in 9-12 months	1.			
	2.			
	3.			
Year 2 activities	1.			
	2.			
	3.			
Year 3 activities	1.			
	2.			
	3			
Partners involved in this goal: Medical group physicians, American Heart Association, American Diabetes Association, health department, area employers, Chamber of Commerce, county government				

Community Health Improvement Implementation Plan — Heart Disease

Community Health Improvement Implementation Plan				
HEALTH ISSUE #3 (very specific): **Prevent Chronic Conditions — Heart Disease**				
Contributing **FACTORS** to Health Issue #3 (including social determinants): **Lifestyle and diet-related (environmental factors/food/education/ community and social context factors)**				
Three-Year **GOAL** for Improvement (written as a **SMART** objective): Specific – Measurable – Achievable – Realistic – Time bound **Example: Decrease the percentage of adults diagnosed with *high cholesterol* in Missouri county from 20% to 18.5% by 2021.**				
BUDGET for Health Issue #3 (consider direct and indirect costs): **Information not available**				
Strategies to Achieve Goal	Specific **Actions** to Achieve Strategies	Specific **Partner**s and Roles for Each Strategy	Specific Three Year **Process Measure(s)** for Each Strategy	Specific Three Year **Outcomes Measures** for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Focus on hyperlipidemia, hypertension and heart disease prevention screening • Education in prevention of chronic conditions in your county is important **Remember:** *Change as needed to align with the desired strategy.*	**Example of key actions** • Provide free community education classes and handouts on importance of diet and exercise to prevent and manage HBP, high cholesterol and type 2 diabetes by increasing number of programs offered • Increase the number of wellness/ screening programs targeting blood pressure, cholesterol, glucose screenings and educational venues for adults in the workplace • Wellness programs • Partner with health department **Remember:** *Target above baseline performance in these categories.*	**Example of key partners** • American Diabetes Association • American Heart Association • Wellness centers, YMCA • Community centers • Grocery stores • Health department • Local hospitals • Chamber of Commerce • Elected officials as needed **Remember:** *Add more categories representing your community.*	**Example of key process measures** • Increased health literacy programs participation • Increased wellness screening programs targeting blood pressure, cholesterol, glucose, etc. • Partner with programs to increase outreach to individuals at risk in the community • Partner with local public health agency to provide educational programs on chronic disease management Please include baseline and target for each strategy. **Remember:** *Add more process measures as needed.*	**Example of key outcomes measures** • Decreased blood pressure diagnosis for adults • Decreased high cholesterol diagnosis • Decreased diabetes hospital admission rate This eventually will lead to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations. Please include baseline and target for each outcome. **Remember:** *Make changes as needed.*

Community Health Improvement Implementation Plan				
HEALTH ISSUE #3 (very specific): **Prevent Chronic Conditions — Heart Disease**				
Contributing **FACTORS** to Health Issue #3 (including social determinants): **Lifestyle and diet-related (environmental factors/food/education/ community and social context factors)**				
Three-Year **GOAL** for Improvement (written as a **SMART** objective): Specific – Measurable – Achievable – Realistic – Time bound **Example: Decrease the percentage of adults diagnosed with *high blood pressure* in Missouri county from 300 per 100,000 in 2019 to 100 per 100,000 in 2021.**				
BUDGET for Health Issue #3 (consider direct and indirect costs): **Information not available**				
Strategies to Achieve Goal	Specific **Actions** to Achieve Strategies	Specific **Partners** and Roles for Each Strategy	Specific Three Year **Process Measure(s)** for Each Strategy	Specific Three Year **Outcomes Measures** for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Focus on hyperlipidemia, hypertension screening and education in prevention of chronic conditions in your county **Remember:** *Change as needed to align with the desired strategy.*	**Example of key actions** • Provide free blood pressure screenings to community and increase number of screening offerings annually • Provide free community education classes and handouts on importance of diet and exercise to prevent and manage HBP, high cholesterol and type 2 diabetes by increasing number of programs offered • Increase the number of wellness screening programs targeting blood pressure, cholesterol, glucose screenings, as well aseducational venues for adults in the workplace **Remember**: *Target above baseline performance in these categories.*	**Example of key partners** • American Heart Association • Local school nurses/dieticians • Wellness groups • Community partnerships • Medical group physicians • health department **Remember:** *Add more categories representing your community.*	**Example of key process measures** • Increased blood pressure screenings • Increased health literacy programs participation • Increased wellness screening programs targeting blood pressure, cholesterol, glucose, etc. • Partner with local public health agency to provide educational programs on chronic disease management Please include baseline and target for each strategy. **Remember:** *Add more process measures as needed.*	**Example of key outcomes measures** • Decreased blood pressure diagnosis for adults leading to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations. Please include baseline and target for each outcome. **Remember:** *Make changes as needed.*

Community Health Improvement Implementation Plan				
HEALTH ISSUE #3 (very specific): **Obesity and Sedentary Lifestyle — Heart Disease**				
Contributing **FACTORS** to Health Issue #1 (including social determinants): **Lifestyle and diet-related (environmental factors/food/education/ community and social context factors)**				
Three-Year **GOAL** for Improvement (written as a **SMART** objective): Specific – Measurable – Achievable – Realistic – Time bound **Example: Decrease the percentage of adults in Missouri county reporting a *BMI >30* from 20% to 19.5% in 2021.**				
BUDGET for Health Issue #1 (consider direct and indirect costs): **Money allocated by hospital for this health issue**				
Strategies to Achieve Goal	Specific **Actions** to Achieve Strategies	Specific **Partners** and Roles for Each Strategy	Specific Three Year **Process Measure(s)** for Each Strategy	Specific Three Year **Outcomes Measures** for Strategies (should align with SMART Goal for Health Issue)
Example of key strategies • Promotion of an active lifestyle with weight reduction or maintenance, access to low-cost fitness classes, and sponsorship of community walking/ running/ biking events for individuals and families • Resources to the community related to weight management are provided, along with community education classes promoting a healthy lifestyle to impact risk reduction for chronic conditions associated with obesity **Remember:** *Change as needed to align with the desired strategy.*	**Example of key actions** • Sponsor annual day of dance free community event, promoting fun exercise options and free screenings, reaching at least 1,000 attendees • Support community fitness events (walking/running/biking) for adults and families • Offer low-cost weight management courses three times/year with participants' average weight loss of at least 3% • Offer low-cost fitness classes to the community, as well as medically supervised exercise classes, specifically targeting those with osteoporosis, Parkinson's disease, cancer, diabetes and pelvic floor issues **Remember**: *Target above baseline performance in these categories.*	**Example of key partners** • Medical group physicians • American Heart Association • Health department • Area employers, i.e., hospitals, schools and other employers as needed • Chamber of Commerce • County government **Remember:** *Add more categories representing your community.*	**Example of key process measures** • Increased level of physical activity • Increased access to screenings • Increased fitness events • Increased weight management educational offerings Please include baseline and target for each strategy. **Remember:** *Add more process measures as needed.*	**Example of key outcomes measures** • Decreased BMI among adults leading to better health outcomes related to morbidity, mortality, life expectancy, health care expenditures, health status and functional limitations Please include baseline and target for each outcome. **Remember:** *Make changes as needed.*

Activity Document — This is a working document for each goal identified per health issue.

Health Issue: Obesity and Sedentary Lifestyle — Heart Disease				
SMART Goal: Example: Decrease the percentage of adults in Missouri county reporting a BMI >30 from 20% to 19.5% in 2021.				
Strategy: Promotion of an active lifestyle with weight reduction or maintenance, access to low-cost fitness classes, and sponsorship of community walking/running/biking events for individuals and families. Resources to the community related to weight management are provided, along with community education classes promoting a healthy lifestyle to impact risk reduction for chronic conditions associated with obesity.				
	Activities/Tactics	**Person Responsible**	**Met or Not Met**	**Barriers Identified**
Activities to be completed in 1-3 months	1.			
	2.			
	3.			
Activities to be completed in 3-6 months	1.			
	2.			
	3.			
Activities to be completed in 6-9 months	1.			
	2.			
	3.			
Activities to be completed in 9-12 months	1.			
	2.			
	3.			
Year 2 activities	1.			
	2.			
	3.			
Year 3 activities	1.			
	2.			
	3.			
Partners involved in this goal: Medical group physicians, American Heart Association, health department, area employers, Chamber of Commerce, county government				

From January 2020 through December 2020, the following events included information for chronic disease prevention relating to diabetes and heart disease. Hospitals should customize this document to reflect their specific activities.

Date of Event	Example — Event Description
January 14, 2020	(**Name of Hospital**) sponsored the annual "Healthy Heart Day" at the local mall where free blood pressure screenings were provided to 204 attendees, and free prevention information on stroke, heart attack and cardiac arrest was distributed.
February 20, 2020	(**Name of Hospital**) offered a free lecture focused on diabetes prevention. A total of 200 attendees were provided free blood pressure screenings.
March 27, 2020	(**Name of Hospital**) participated in the annual 5K Run for Stroke Awareness and provided free screenings and educational materials to 253 participants.
May 1, 2020	**(Name of Hospital)** hosted a "Walk to Wellness" program in partnership with other area hospitals, and the local county Parks and Recreation Department. Staff provided free information on nutrition and chronic disease prevention to 208 participants.
July 15, 2020	(**Name of Hospital**) hosted its annual "Night Out" event. It was attended by 400 community members in the service area and provided free information on diet and exercise. Brochures on preventing chronic illnesses also were provided.
September 21, 2020	(**Name of Hospital**) participated in the local county fair. Staff provided free information on nutrition, chronic disease prevention and blood pressure screenings to 142 attendees.
November 28, 2020	(**Name of Hospital**) organized a local health fair and provided free information on stroke and heart health to 200 attendees.
December 12, 2020	(**Name of Hospital**) coordinated a free community outreach event in partnership with local organizations. The event focused on diabetes and stroke prevention and was advertised to the primary service area. More than 600 participants attended and a total of 204 participants received free hyperlipidemia and blood pressure screenings.
December 20, 2020	(**Name of Hospital**) sponsored a free wellness check day in the hospital parking lot. The event was attended by 523 community members. Heart disease prevention screenings and other screenings targeting blood pressure, cholesterol and glucose also were conducted.

Documentation of the different events and when they were completed is essential as it provides the information and data necessary to complete the implementation plan.

Community Health Resources

COMMUNITY HEALTH CENTERS	
City or County	
City A	
City B	
County A	
County B	
DIAGNOSTIC AND TESTING CENTER	
City or County	
City A	
City B	
County A	
County B	
FREE STANDING AMBULATORY CENTER	
City or County	
City A	
City B	
County A	
County B	
FREE STANDING OUTPATIENT SURGERY CENTER	
City or County	
City A	
City B	
County A	
County B	
HOSPITAL	
City or County	
City A	
City B	
County A	
County B	
HOME HEALTH	
City or County	
City A	
City B	
County A	
County B	

MEDICAL GROUP PRACTICE	
City or County	
City A	
City B	
County A	
County B	
PUBLIC HEALTH CLINIC	
City or County	
City A	
City B	
County A	
County B	
RECREATIONAL FACILITIES	
City or County	
City A	
City B	
County A	
County B	
RURAL HEALTH CLINICS	
City or County	
City A	
City B	
County A	
County B	
CRITICAL ACCESS HOSPITALS	
City or County	
City A	
City B	
County A	
County B	
SKILLED HEALTH FACILITIES	
City or County	
City A	
City B	
County A	
County B	

RESOURCES

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