

Community Improvement through Enhanced **Community Health Needs Assessments (CHNAs)**

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Abstract

In this study of how Community Health Needs Assessments operate, I analyze the history behind a CHNA, the current legislation in America regarding them, and the current state of practice for conducting them. This paper will pose the questions of how a standardized self-assessment checklist for conducting a CHNA will be beneficial for hospitals, community members, and the Treasury and IRS. Based on a review of literature on the topic, previous CHNAs, analysis of existing tools, and interviews with experts, this paper will assess common issues that inhibit the CHNA process and address possible ways to alleviate them. Atlanta, Georgia will be the region of study to simplify and standardize examples and results. At present, the CHNA environment is constantly changing as the IRS adjusts the requirements based on formal comments. New literature is published daily on the topic, indicating that several groups are researching the CHNA process and seeking to provide resources and assistance to hospitals.

Literature Review

Background & History of CHNA

A community health needs assessment (CHNA) seeks to determine what is “lacking in the physical, social, psychological, and environmental conditions under which residents of the area live and what can be done to improve them” (Bosworth, 2000). March 23, 2010 saw the adoption of the Patient Protection and Affordable Care Act (PPACA) in the United States. While the act expanded health coverage for millions of Americans, it also specifically addressed nonprofit hospital practices in Section 9007 (Georgia Watch, n.d.). Two new requirements are CHNAs and patient billing protections. This paper will focus on the former. CHNA requires non-profit hospitals (or organizations operating more than one non-profit hospital) to conduct a CHNA and adopt an implementation strategy every three taxable years to meet identified community health needs in order to achieve or maintain 501(c)(3) tax-exempt status.

Institutions dedicated to the pursuit of charitable purposes have always been exempt from the federal income tax structure: property taxes (about one quarter of the facility’s exemption), state and local income taxes, and taxes on bond-financing (Healthcare Georgia Foundation, 2011). Nonprofits are supposed to relieve the government of financial responsibilities associated with public responsibility and support the general welfare of the public (Folkemer, 2011). The uncollected tax dollars could have otherwise benefitted public schools, police departments, and other government-funded services (Healthcare Georgia Foundation, 2011). The Hill-Burton Act of 1946 required charity care as a condition of eligibility for federal construction funding. The increase in insured individuals as a result of Medicare and Medicaid led to hospitals rendering less uncompensated care. The IRS responded with requiring activities such as public health initiatives and health promotion called community benefits (Folkemer, 2011). After much congressional scrutiny focused on community benefits, a revised Schedule H released in 2008 outlined six provisions intended to address the lack of transparency in tax-exempt organizations and prevent abuse of the system. Previously, some hospitals could claim expenses such as golf tournaments or equipment purchases as benefits to the community (Georgia Watch). These six provisions are: 1. Charity Care and Certain Other Community Benefits at Cost, 2. Community Building Activities, 3. Bad Debt, Medicare, and Collection Practices, 4. Management Companies and Joint Ventures, 5. Facility Information, and 6. Supplemental Information (Folkemer, 2011).

Under the PPACA requirements, a non-profit hospital or organization will have to regularly perform assessments, create and publicize a financial assistance policy, impose limitations on charges, and adopt certain billing and collection policies (Lunder, 2011). A CHNA in accordance with PPACA will include input from persons who represent the broad interests of the community served by the hospital facility. These persons are considered to be those who have specialized knowledge or expertise in public health; agencies with current data regarding the community; and representatives or leaders of low-income and minority populations served by the hospital facility (Lunder, 2011). The results of the CHNA and a discussion of how the organization is or will be addressing the identified needs (or not addressing and reasons why) will not only be made available to the wider public (in report form) but will be included with its annual tax information via their Schedule H (Form 990), see the front page of the form attached in Appendix A. Documentation of the CHNA should include a description of the processes and methods used to conduct the assessment, including the sources and dates of the data and other information as well as the analytical methods applied to identify community health needs. The report will also address gaps in the hospital's ability to assess any needs. Collaborators, experts, community leaders, and others will be identified by name, title, organization, and expertise. The report will include descriptions of:

1. The community served
2. The process and methods used to complete the assessment
3. How the hospital took into account input from persons who represent the broad interests of the community
4. All community health needs identified
5. Existing health care facilities or other applicable resources (IRS, 2011)

The implementation strategies can be developed in collaboration with other organizations such as other hospital facilities or public health departments and must be approved by an authorized governing body (IRS, 2011). The Treasury and IRS intend to adopt rules that require hospitals to post the written reports on the hospital's website. (IRS, 2011). These new CHNA requirements are effective for taxable years beginning after March 23, 2012 (IRS, 2011). Organizations that operate more than one hospital facility, must complete the requirements separately with respect to each facility. (IRS, 2011) Any hospital or organization failing to meet these new requirements will have a \$50,000 excise tax imposed on them (Lunder, 2011).

Before being federally mandated, hospitals in some states, including Indiana, New York, and Texas were already conducting CHNAs as mandated by the state. As of March 2008, 15 states had community benefit requirements. In California, the mission statement of a nonprofit hospital must integrate the public interests into its responsibility and update a community needs assessment every 3 years and a community benefits plan annually, along with a report of the economic value of community benefits rendered (GAO, 2008). Alabama requires that at least 15% of a hospital's business be in charity care and a civil penalty of up to \$1,000 per day can be assessed for late filing in Indiana (GAO, 2008). However, communities do voluntarily conduct health needs assessments. For instance, in Dalton, Georgia, a concerned group of professionals responded to abnormally high rates of high school drop-outs and drunk driving convictions by conducting an assessment that led to elementary school health courses and expanded indigent care services (Bosworth, 2000). These communities found them worthwhile for four main reasons:

1. if a hospital had lost the trust of its community - a survey conducted by the Wisconsin Hospital Association found that almost two-thirds of respondents saw hospitals as business organizations rather than social-service organizations;
2. if bill-paying organizations required quality and performance standards;
3. there was potential for a public relations issues; or
4. if they simply wanted to look upstream to improve the health of their community and prevent public health crises (Bosworth, 2000).

In order to better understand the topic, the reader must first understand basic health terminology. According to the World Health Organization, health is defined as “a state of complete physical, psychological, and social wellbeing and not simply the absence of disease or infirmity” (Wright, 1998). Healthcare encompasses health education, disease prevention, diagnosis, treatment, rehabilitation, and terminal care. Health needs incorporate wider social and environmental determinants of health such as deprivation, housing, diet, employment, and education (Wright, 1998). Considering that hospitals receive all of the downstream patients in terms of diagnosis and treatment of medical problems, hospitals can be a natural catalyst for creating a healthier population upstream. Communities are more often looking to hospitals for the provision of improved health as well as prevention. Not only are hospitals economic contributors by being among the largest employers in a geographic location, but they are often community leaders and an obvious center for the healthcare community. They have the ability to enact programs that assist and protect vulnerable populations. This includes those who are without insurance, underinsured, sufferers of chronic conditions, and those without access to appropriate and/or timely care (Georgia Watch, n.d.).

At present, discounted medical services to the underinsured or uninsured are the primary form of charitable contributions of non-profit hospitals, but programs that go beyond the walls of the hospital can save money and keep people in better health. For example, through screenings with appropriate follow-up care, many health conditions can be affordably treated without the emergency room (Georgia Watch, n.d.). The presence of these types of programs tend to be low in numbers and spread over a small geographic area that lack the proper scales, targets, and design elements necessary to produce measurable outcomes (Barnett, 2012). However, Kaiser Permanente, as a strong proponent of a “prevention-driven approach to health”, is a leader in technical community health applications, and is an exception to this (Kaiser Permanente, n.d.). According to *Best practices for community health needs assessment and implementation strategy development: A Review of Scientific Methods, Current Practices, and Future Potential Public forum and interviews of experts*, a recent increase in community benefit roles, a recognition of the need for dedicated staff in this function, and the desire for an oversight structure for management as well as ensuring that any actions remain aligned with institutions’ charitable missions spurred the need for the meaningful and broad reform of PPACA (Barnett, 2012). Considering that nonprofit hospitals are tax-exempt institutions, they have “a responsibility to be good stewards of public resources, and to ensure that there is institution-wide engagement in the fulfillment of their charitable mission” (Barnett, 2012).

William Cox, former vice president of the Catholic Health Association, advocated for CHNA as a way to solve the “crisis of confidence” facing community healthcare providers. He claims that despite being conceived out of community need, many non-profit hospitals currently lack the previous closeness they had with communities, due to a lack of communication between the two. Given the abundance of government programs that assist the hospital in their mission to serve the elderly and poor, hospitals needed to rely less and less on the people they were serving (Bosworth, 2000). Today, these providers are rarely recognized for their community services that include free charity care, education of healthcare professionals, and medical research. Timothy Bosworth says, in *Community Health Needs Assessment: The Healthcare Professional’s Guide to Evaluating the Needs in Your Defined Market*, that it is possible that seeing a hospital doing this type of work can prompt other organizations and individuals to do similar work. Bruce Vladeck, former president of United Hospital Fund of New York, sees a CHNA as a valuable self-examination process that allows a hospital or organization to find out if it is living up to society’s expectations. He believes that the central determinant of a hospital’s long-time survival is the community’s perception that it is providing an “essential public service in a responsible, humane, and high quality way” (Bosworth, 2000).

Purpose of a CHNA

According to Stevens in *Needs assessment: from theory to practice*, conducting a health assessment is a way to gather the information required to bring about change beneficial to the needs of a population that develops consensus among planners, managers, and clinicians regarding priorities for service development. It is not a process of listening to patients or relying on personal experience, it is a systematic method of identifying unmet health needs that balances clinical, ethical, and economic considerations (Wright, 1998). Older versions of community health needs assessments answer the following questions:

- What is the health problem?
- What is the size and nature of the problem?
- What are the current services?
- What do patients want?
- What are the most appropriate and cost effective solutions?
- What are the resource implications?
- How can you evaluate success? (Wright, 1998)

Health needs assessments are more common in other countries. In fact, the United Kingdom has a long history of conducting them, dating back to the 19th century when medical officers were responsible for assessing health needs. In the 1970s, politics became involved when the Resource Allocation Working Party began to recommend fairer distribution of health services based on standard mortality ratios and socioeconomic deprivation. The British Health of the Nation Initiative in 1992 was the government's attempt to assess national health needs and determine priorities (Wright, 1998). In 1998, the National Health Service issued a white paper that required primary care groups to contribute to health authorities' health improvement programs (Stevens, 1998). In the United Kingdom, a health assessment is an approach to ensuring the health service uses its resources in the most efficient way (Wright, 1998). Assessments in countries with universal health coverage are more concerned with the epidemiology and costs associated with healthcare and health services as a means of reducing expenses. The US system is echoing a similar concern in the transition from fee-for-service to population burden focused healthcare.

Today, as required by the new PPACA legislation, a CHNA should as a minimum, “serve as a baseline to monitor improvements associated with actions taken to address one or more indices of health” (Barnett, 2012). The results will guide an implementation strategy to address previously unmet health-related needs. However, within the act, there is no official definition or method for a community health needs assessment or an implementation strategy.

There are advantages and disadvantages to the ambiguous wording of the legislation that requires a CHNA. To a hospital’s advantage, it allows an assessment and implementation strategy tailored to their community, since not every community is alike. Considering that this legislation is new, and the first round of reporting was due recently, it gives hospitals practice in an environment where several mistakes are likely and expected. They can learn lessons on how to improve future assessments and be more prepared should the IRS decide to have stricter regulations. However, it does allow for a slippery slope effect for hospitals to fall back into ways of lax reporting in which some questionable items were written off, labeled as community benefits. There is the possibility that ineffective programs can be exaggerated in the name of fulfilling a tax requirement. Prior to the legislation, hospitals or communities could conduct CHNAs to better understand the populations they serve and improve their health and well-being. The interventions they promote should minimize expense, increase the bottom line, and deal with the population focused funding structure; all opportunities for hospitals, not burdens.

The CHNA Process

While no exact framework exists that dictates a right or wrong way to conduct a CHNA, scholars seem to agree on some basic elements that one should contain and common steps that should be taken. This can be summarized in three phases: Planning, Assessment, and Implementation (Bosworth, 2000). Please see Table 1.

CHNAs begin with an **assessment plan** that outlines why the non-profit hospitals are doing what they are doing, the goals and objectives, how they are going to reach them, how they will evaluate their progress, and specifies a strategy for developing community support and involvement (Bosworth, 2000). The assessment plan should be an outline for answering the questions above.

The second element of the assessment is a **community profile** that describes the community in terms of geography, demography and epidemiology (Dowell, 2001)(setting the prevalence and incidence of subcategories of the population) (Stevens, 1998). While not specifically discussed in reference to CHNA, incidence and prevalence are cited as major considerations when determining research priorities in Section 6301. (Health Reform Navigator) Data can be found from the US Census, hospital discharge inventories, health departments, private reports; (Bosworth, 2000) observations in the neighborhood, (Murray, 1999) or other sources. British models then suggest to outline the current services available, identify inequities to access, compare the effectiveness and cost-effectiveness of interventions and associated services, and identify barriers for successful delivery of healthcare in that community (Wright, 1998), (Stevens, 1998), (Dowell, 2001). Relevant assets can include community clinics, religious congregations, supply of physicians and dentists; school systems with active home and school associations (The Catholic Health Association, 2012); access to transportation, parks, fresh food, and more.

Table 1. Possible CHNA Process

Phase	Deliverable	Components	
Planning	<i>Assessment Plan</i>	Purpose	
		Goals & Objectives	
		Actions	
		Performance Measurements	
		Community Strategy	
Assessment	<i>Community Profile</i>	Geography	
		Demography	
		Epidemiology	
		<i>Determination of key health needs</i>	Qualitative
			Quantitative
Implementation	<i>Action Plan</i>	Responsive to impacts	
		Specific and Actionable	
		Experience-based and effective	
		Enforcable	
		Able to be monitored	
		Technically and politically feasible	
		Cost-effective	
		Unaccompanied by negative externalities	
		Implementable within regulatory framework	

This leads to the **determination of key health needs** in the community through a needs analysis. To aid in the process, several resources can be utilized for qualitative data. The Centers for Disease Control and Prevention (CDC) developed the Behavioral Risk Factor Surveillance System (BRFSS) questionnaire that can be used to guide surveys developed for the community (Bosworth, 2000). The Nationally Consistent Data Measures (NCDMs), developed by the CDC to ensure compatibility and comparability of data measures for usefulness in understanding impacts on environmental health, will be useful in this process (Rushing, 2012). It can be beneficial to compare the health status of the community to broader regions such as the county, Metropolitan Statistical Area (MSA), state, or nation to give targets to reach (Bosworth, 2000). The Healthy People 2020 (updated every ten years) also gives a list of national health priorities (topics and objectives) that can guide comparisons (Bosworth, 2000)(Minkler, 2003). Data is often provided at the county level, but there is a growing recognition of the need for data at smaller units of analysis such as zip code or census tract in order to identify areas of high prevalence or acuity for a particular health condition (Barnett, 2012). Adding new health questions to the American Community Survey can supplement data at the tract, block, or group level. In addition to this qualitative data, it is important to gather quantitative data. Commonly cited persons and groups to be involved in the community engagement process are:

- government leaders;
- business executives;
- local college faculty or administrators;
- social service agency representatives;
- physicians;
- union leaders;
- public health officials (Bosworth, 2000);
- faculty of public health, medicine, architecture, and planning; and
- private consultants (Dannenberg, 2008).

Once needs have been established and prioritized, an **action plan** will follow that outlines specific programs that the hospital will create or become involved in to address these priorities (Bosworth, 2000). The recommendation section of an HIA can be most closely associated with this, which should be responsive to identified needs; specific and actionable; experience-based and effective; enforceable; able to be monitored; technically feasible; politically feasible; cost-effective; unaccompanied by additional negative consequences; and implementable within the regulatory, administrative, or legislative framework of the proposal being considered (Rutt & Avey, 2012). That is to say, that the programs created address and solve the health problems as best as possible, are clear and implementable based on available resources and within the scope of the local law, and can be evaluated over a period of time.

Strengths and Challenges of a CHNA

A health assessment can aid in cost-benefit analysis (using incidence and prevalence statistics), inform decision-makers, and highlight disparities among racial and socioeconomic groups (Dannenberg, 2008). They are considered successful when they are community-oriented, involve lay people in planning and assessing, are multi-sectoral in nature, promote equality, are flexible, and satisfy community leaders and researchers (Murray, 1999). However, several challenges threaten the success of a health assessment. These include: lack of staff time, commitment, or resources; an unclear framework;(Wright, 1998) participation rates of low-income individuals, people of color, and the elderly (Ross, 2012); obtaining quality data that is pertinent within given population boundaries (Greenberg, 2006); the marginalization of public input by professionals (Jordan, 1998); resetting the doctor-patient role; the perception of a health assessment as an “arcane preserve of public health specialists”;(Stevens, 1998) freely discussing failures to hospital administrators or others with whom a relationship has been established (Dowell, 2001); diffuse populations; staff training; researcher bias; logistical coordination;(Murray, 1999) timelines that may be extended as relationships unfold; and funding flexibility (Minkler, 2003).

There are many ways that these challenges can be overcome with the two biggest opportunities found in collaborative partnerships and community-based participatory research (CBPR). The National Association of County and City Health Officials (NACCHO) cites that collaborative work can build on existing relationships; share and align resources; share costs; set clear expectations, roles, and responsibilities; align public health and hospital objectives and requirements; participate in ongoing communication and trust; capitalize on individual and organizational expertise; share wins and common language; maintain flexibility; and build on the population health movement (NACCHO, 2011). In relation to CHNAs, it gives multiple healthcare organizations (primarily hospitals and local health departments) the opportunity to stop wasting resources and duplicating research, since the two entities typically overlap on projects without knowing it (NACCHO, 2011). See Table 2 for a list of challenges and possible solutions, according to the review of literature.

Table 2. Strengths and Challenges of a CHNA

CHALLENGES OF A CHNA		POSSIBLE SOLUTIONS
Unclear framework		
Staff training		
Logistical coordination		
Lack of staff time, commitment, or resources		Collaborative Partnerships
Unclear timeline		
Inflexible funding		
Obtaining quality data		
Diffuse populations		
Disproportionate participation rates		
Marginalization of public input		CBPR
Researcher bias		
Resetting the doctor-patient role		
Arcane perception of a CHNA		

CBPR is “a collaborative process that equitably involves all partners in the research process” and recognizes the unique strengths that everyone can bring to the table (Minkler, 2003). It is consistent with the goals of results-oriented philanthropy and the Institute of Medicine cites it as one of eight new areas that schools of public health should be supplementing their traditional curricula with (Dowell, 2001). CBPR builds on the community as a unit of identity; builds on the strengths and resources within the community; facilitates collaborative partnerships in all phases of the research; integrates knowledge and action for mutual benefit of all partners; promotes co-learning and an empowering process that attends to social inequities; involves a cyclical and iterative process; addresses health from both positive and ecological perspectives (to prove that health does not occur in a vacuum); disseminates findings and knowledge gained to and with all partners; (Greenberg, 2006) promotes participation in decision-making processes; stresses data collection; and aims to build capacity within low-income communities (Minkler, 2011).

An example of the combination of these strategies - collaborative partnerships and community-based participatory research - can be found in the University of Maryland and Seat Pleasant, MD campus-community partnership. A needs assessment was conducted as part of one facet of their partnership – the health partnership. A door-to-door survey was determined to be the best method to counter the low participation they realized using traditional outreach methods such as focus groups and surveys. The partnership’s board of directors (made up of community members such as clergy, elders, youth, apartment complex managers, school principals, etc.) chose trusted residents to administer the surveys. The surveyors were trained and paid \$20 per hour and the respondents received \$10 grocery cards as an incentive to participate (Greenberg, 2006). Not only did this solve the problem of under-representation of certain groups, but it had long-lasting community benefits as well, one being the surveyors obtaining future research jobs as a result of the training they received (Greenberg, 2006).

Perhaps the biggest impact of employing these two strategies is realizing that community priorities may not always be in line with what professionals think. Healthcare professionals have a tendency to focus on epidemiological factors while ignoring broader societal and environmental impacts. Some of the commonly cited community needs according to healthcare professionals are: child and domestic abuse, teen pregnancies, shortage of doctors or specialists, limited and expensive health insurance, and less drug and alcohol abuse (Bosworth, 2000). However when the community has the opportunity to voice their concerns, the results can be different. The Georgia Healthy Policy Center conducted a Health Assessment in Southwest Atlanta as part of the Environmental Protection Agency’s Area-wide Planning Program for brownfields. Concerns discovered using those processes included graduation rates, violence, overweight and obesity, bullying in schools and via the internet, birth outcomes, cancer, childhood lead poisoning, and physical neighborhood disorder (Rushing, 2012). Similarly, a health assessment in Dumbiedykes, Scotland revealed that rather than increased or improved health services as the physicians expected, residents wanted things like a bus that came into their estate, a supermarket nearby, and the creation of play areas and dog-free zones (Murray, 1999).

Other recommendations for overcoming the barriers to successful CHNAs were also identified such as the triangulation of data (verifying one source with other sources) (Murray, 1999) (Stevens, 1998). As a way to counter the feeling some communities have of being just “subjects” of research, Greenberg suggests building a portfolio of previous advantageous projects by the group conducting the assessment in the community prior to initial engagement for the assessment. This will prevent the community from feeling like separate entities from the university researchers and promote trust among both parties. (Greenberg, 2006).

CHNAs relationship to other health planning tools/methods

While no widely accepted CHNA methodology exists yet, it does have similarities with several other planning and public health tools. The relationship to public health is more obvious, given a hospital's role as the center of the healthcare community, but its relationship to the field of planning may be more obscure. According to the American Public Health Association, public health is “the practice of preventing disease and promoting good health within groups of people, from small communities to entire countries” (APHA). This disease prevention practice, has a clear connection to hospitals, as discussed earlier when defining health and healthcare. Urban and regional planning is a “dynamic profession that works to improve the welfare of people and their communities by creating more convenient, equitable, healthful, efficient, and attractive places for present and future generations” (APA, 2013). A hospital has a large impact on the urban fabric of a place in terms of employment, traffic patterns, and property taxes among other planning-related components of any physical environment. The work of hospitals, caring for the sick and improving the health of the communities, can be realized through place-based interventions that fall within the realm of city planning.

One tool that combines planning and public health and has gained popularity in recent years is **Health Impact Assessment (HIA)**. As of 2010, over 170 HIAs were in progress or completed in the country (Rutt & Avey, 2012). Whereas a CHNA produces an overall snapshot of community health and devises a large range of programs, an HIA looks at a proposed policy or project and its possible effects on health, both positive and negative. It is a structured process that uses scientific data, professional expertise, and stakeholder input to identify and evaluate public health consequences of these proposals and suggest actions to minimize adverse impacts and optimize beneficial ones (Rutt & Avey, 2012). The integration of both quantitative and qualitative data, involvement of key stakeholders, unique community engagement strategies and a focus on health outcomes makes a CHNA and an HIA very similar.

Another similar planning tool is **comprehensive planning**. In Georgia, comprehensive planning serves to show local governments the important relationships between community issues (Georgia Department of Community Affairs, 2012). Furthermore, the social determinants of health that are often raised as concerns by community members in health assessments, imply a relationship between the fields of city planning and public health. Social determinants of health are economic and social conditions that influence the health of people and communities and are mostly shaped by the amount of money, power, and resources that people have (CDC, 2012). A local comprehensive plan is a fact-based resource for local constituents that tracks implementation of community-based policies. Common elements are community goals, needs and opportunities, economic development, land use, transportation, and housing (Georgia Department of Community Affairs, 2012) - all of which have an effect on health. In the American Planning Association's (APA) 2012 report *Healthy Planning* identified six categories of public health related elements that can be found in Table 3 (Ricklin, 2012). The concept of a CHNA acting as both a resource and an evaluative measure over time links these two tools – HIA and comprehensive planning. The purpose of local planning requirements reflects the state interest of creating healthy vibrant cities and counties (Georgia Department of Community Affairs, 2012). APA's 2011 report, *Comprehensive Planning for Public Health* found that approximately 31%* (* figure based on survey respondents) of jurisdiction's draft or adopted comprehensive plan contained explicit goals, objectives, or policies that addressed public health (Hodgson, 2011).

NACCHO and CDC developed a “community-driven strategic planning tool for improving community health” called **Mobilizing for Action through Partnerships and Planning (MAPP)** (NACCHO, 2012). MAPP is a six-phase method to help communities prioritize community health issues; identify resources to address; and take action (Peake, 2009). The six phases are: 1. Organizing 2. Visioning 3. Assessments 4. Strategic Issues 5. Goals/Strategies, and 6. Action Cycle. It is an interactive process facilitated by public health officials that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems (NACCHO, 2011). The St. Clair County Health Department of Illinois adopted the MAPP framework to address community health concerns. They adapted a quality of life survey from the MAPP handbook, and distributed it in various locations. To account for under-represented groups in the survey results, they held two focus groups one for men and two for the elderly (urban and rural). Once goals were determined (increasing community connectedness and increasing collaboration among existing community agencies), they enlisted more people for brainstorming - a municipal planner and a clinical nursing student, adding to the existing members from the County Health Commission – to decide on a program that met their goals

(Boyd, 2009). MAPP, like the assessment portion of a CHNA, seeks to develop a system to collect, analyze and interpret data to prioritize and address community health issues; determine whether there are disturbing or unexpected trends; and identify health disparities (Peake, 2009). It centers on assessments of community wellness across nine health indicators including demographics, socio-economic status, health resource availability, behavioral risk factors, and more (Williams, 2009). MAPP tends to place a heavy emphasis on social determinants of health, tying it back to both HIA and comprehensive planning as well.

Table 3. Public health elements of comprehensive plans

ACTIVE LIVING	EMERGENCY PREPAREDNESS
General	Climate change
Active transport	Natural and human-caused disasters
Recreation	Infectious disease
Injury	
ENVIRONMENTAL EXPOSURES	FOOD & NUTRITION
General	Access to food and healthy food options
Air quality	Water
Water quality	Land use
Brownfields	
HEALTH & HUMAN SERVICES	SOCIAL COHESION & MENTAL HEALTH
General	General
Accessibility to health and human services	Housing quality
Aging	Green & open space
	Noise
	Public safety / security

CDC's National Center for Environmental Health also partnered with NACCHO to develop **PACE EH – Protocol for Assessing Community Excellence in Environmental Health**, a process that leads to actions affecting health and community needs. In this process, community collaboration occurs in identifying local environmental health issues, setting priorities for action, targeting populations most at risk, and addressing identified issues (CDC, 2013). Examples of top health issue ideas from the PACE EH process in Wabasso, Florida include:

- Safe and healthy housing;
- Community safety from violence and drug trafficking;
- Street lighting;
- Accessible areas for safe physical activity and recreation;
- Access to safe drinking water; and
- Solutions to septic system failures and access to a municipal wastewater system (CDC, 2013).

In response to these needs, several civic improvements occurred:

- Installation of streetlights, sidewalks, water lines, and a walking trail;
- Removal of abandoned homes;
- Improvements in septic systems; and
- Enhanced parks (CDC, 2013).

While the process contains many components similar to that of a CHNA, the results of this tool also place a high emphasis on the power of social determinants of health as not only factors on health but as areas for improving human health.

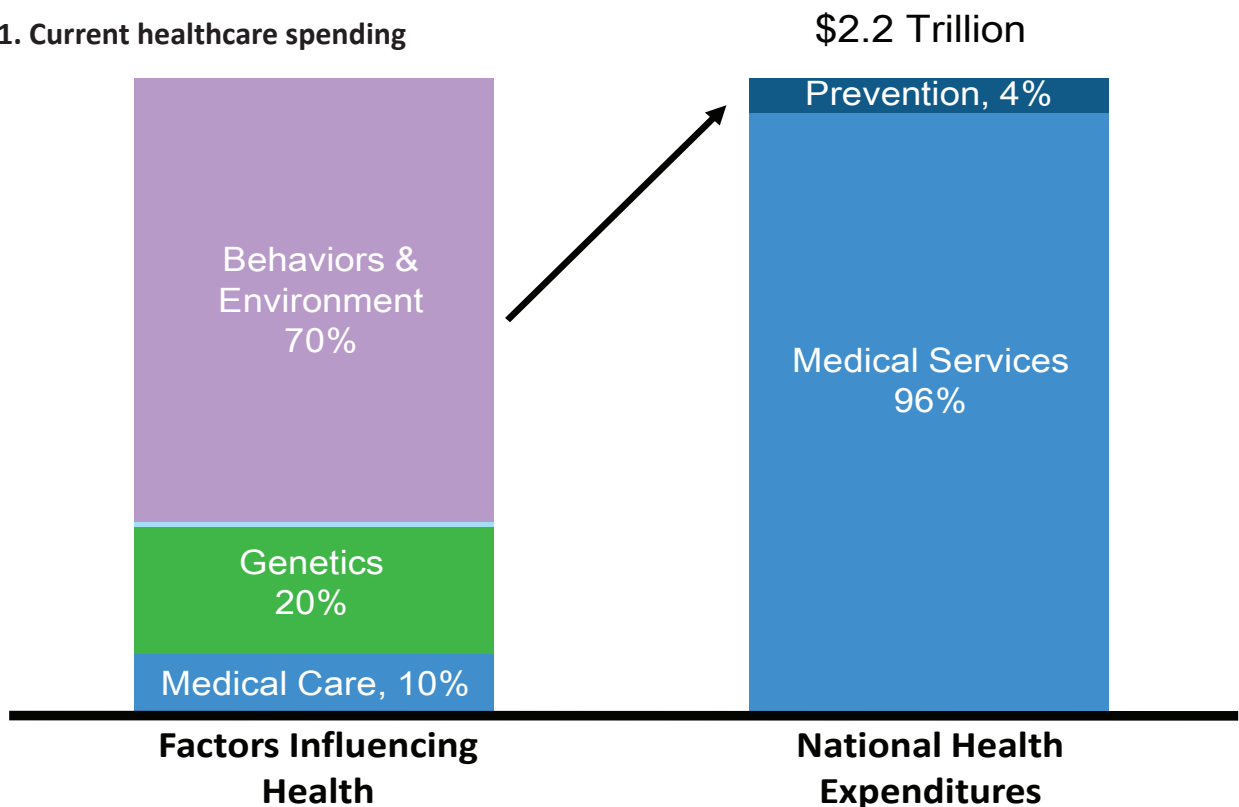
CDC's Healthy Communities Program offers the **CHANGE Tool (Community Health Assessment and Group Evaluation)** to help community teams develop a community action plan. It walks groups through assessments and defining and prioritizing possible areas of improvement (CDC, 2012). The tool "allows local stakeholders to work together in a collaborative process to survey their community; offers suggestions and examples of policy, systems, and environmental change strategies; and provides feedback to communities as they institute local-level change for healthy living" (CDC, 2012). One unique feature of the tool is its ability to track progress. By using a five-point scale, incremental changes can be noted (CDC, 2012).

Since the PPACA requires a final report that is widely available to the community, the ability to clearly summarize the process and results of a CHNA is essential for community comprehension. It is recommended that HIA reports: provide a succinct summary; document the process for each step; discuss evidence, data sources, and methods used for each health issue analyzed; include input from all stakeholders; and is accessible to multiple audiences (Rutt & Avey, 2012). HIA reports that followed these recommendations improved comprehension by decision-makers; empowered the community; and made the people involved with the project more aware of how health was affected by their work and decisions (Ross, 2012). Without a clear report, the community, as the gatekeeper, is limited in its ability to police the work proposed in a CHNA report.

Conclusion

The overarching concept of a CHNA is to look upstream to prevent downstream health crises (Bosworth, 2000). Seven of ten deaths in the United States are from chronic diseases such as heart attack, cancer, and stroke which are primarily related to four risk factors: 1. lack of physical activity, 2. poor nutrition, 3. tobacco use, and 4. excessive alcohol consumption. According to the CDC, Blue Sky Initiative, University of California at San Francisco, and Institute of the Future, behaviors and environment are responsible for 70% of the factors that influence our health, with genetics representing 20% and medical care 10% (Rutt & Avey, 2012). Implementing changes in these four major factors can reduce the prevalence of chronic diseases. Yet, current government spending is not reflective of these numbers. Only 4% of the national health expenditures in 2000 focused on prevention (Rutt & Avey, 2012), see Figure 1. By identifying what these needs are in a CHNA, a hospital has the knowledge to create an implementation strategy that could recalibrate the focus of their health initiatives to better align with health-influencing factors.

Figure 1. Current healthcare spending



Source: Centers for Disease Control and Prevention, Blue Sky Initiative, University of California at San Francisco, Institute of the Future, 2000

A successful CHNA could provide fact-based evidence for decision-makers to reallocate these resources to more accurately reflect the aforementioned factors on health as a means of achieving incidence and prevalence considerations, and creating healthier communities and a healthy America. To further this notion, a 2007 study commissioned by the Robert Wood Johnson Foundation revealed that the annual economic value that would accrue to disadvantaged Americans if their health and longevity improved to that of college-educated Americans is \$1.02 trillion (Schoeni, 2011). While this number does not account for the costs of policies and programs to raise educational attainment or otherwise eliminate health disparities seen between less- and more-educated Americans, it has the power to resonate with decision-makers on an economic level (Schoeni, 2011).

There is a certain danger associated with implementing a top-down approach to health and healthcare in which too much attention is paid to what a few people perceive as the needs of a community as opposed to what they objectively are (Murray, 1999). Ultimately, implementation of successful CHNA programs have the opportunity to lower healthcare costs - which are on a steady rise in developed countries and will continue given technological advances - by stopping health issues at the source (Murray, 1999).

In its response to congressional concerns about non-profit hospitals, the PPACA fails in some regard to adequately meet them. The vague CHNA requirements make it difficult to determine whether or not a hospital is in compliance, and it is therefore up to the individual organizations to complete a CHNA that sufficiently identifies the needs of its public, and prioritizes and fulfills them. Community needs differ significantly from one place to another, often based on the make-up of their vulnerable populations, offering state and local governments the opportunity to enact policies beyond what is mandated by PPACA to ensure that a CHNA is being used appropriately (Folkemer, 2011).

Next Steps

Study Methodology

In order to obtain a more comprehensive understanding of CHNAs and assist in filling the known gaps, I interviewed practitioners with “hands-on” CHNA experience. I conducted seven telephone interviews with professionals in various roles including advocacy, hospital administration, policy, and urban planning. I contacted 25 professionals via e-mail, received responses from 13 individuals, and of those 13, seven were willing to participate in an interview. Some responses bordered on annoyance and hostility, others were very amicable and eager to help, while others simply ignored my attempts at contact. Speculation for the lack of response or nature of these responses is that some organizations are simply not proud of how they are conducting their CHNA, that they do not feel confident in their knowledge of a CHNA, or that they are too overloaded already with the amount of work that comes with a CHNA. See Table 3 for a list of the phone interviews conducted and their respective titles and organizations. The list of interview questions is attached in Appendix B.

Table 4. Interviewees

Name	Title	Organization
Basak Alkan	Urban Designer	Perkins + Will
Chris Kochtitzky	Associate Director for Program Development	CDC's Division of Emergency & Environmental Health Services
Holly Lang	Director of Community Benefit	Piedmont Healthcare
Kim Milbrath	Senior Manager	ICF Macro
Bill Rencher	Director of Health Access Program	Georgia Watch
Whitney Robinson	Manager of Strategic Planning	Emory Healthcare
Martha Somerville	Director of Hospital Community Benefit Program	The Hilltop Institute

Intent of CHNA

Holly Lang, Director of Community Benefit at Piedmont Healthcare, argues that the CHNA requirement (and health reform in general) is intended to shift hospitals' foci towards community health, from fee-based to population-based. When asked if some hospitals intend to accept the \$50,000 excise tax rather than engage in the time-consuming CHNA process she wholeheartedly agreed. She put this penalty into simpler financial terms that made sense to hospitals: "Piedmont Healthcare operates 5 facilities. If all the facilities paid the excise tax it would only total \$250,000 which is essentially equivalent to one surgery for an uninsured patient" (Lang, personal communication, 2012). In order to make hospitals comply, another incentive may be needed.

As addressed earlier, a CHNA is an opportunity for a hospital to make a large difference in improving the health status of its community. It is a necessary tool that allows hospitals to hone in on specific needs that often get overlooked in traditional quantitative epidemiological data. Utilizing civic engagement techniques, community input will enhance the knowledge and understanding of qualitative data. Currently, a CHNA, per the PPACA, has a clear, but thinly laid out process. By acknowledging the foundations that a CHNA has in similar health and planning assessments, and using the existing frameworks and guidelines, a CHNA process can be easier to complete. Some specific gaps that have been identified are how to involve stakeholders – not just identify them; a range of acceptable practices; and methods to follow for each step.

The CHNA process is also troubled by misconceptions that discourage or discount the input of community members. Michael Wyland, in a 2013 article published in *Nonprofit Quarterly* lists four common misconceptions as:

1. Statistical data is sufficient
2. A CHNA is a marketing exercise
3. CHNAs are a structure for public health sector alignment
4. CHNAs aren't really that different or that important

Hospitals rushing to complete a CHNA to meet the first deadline are at risk of falling into these traps, particularly relying on strictly statistical reports with little community input. Such traps could move the hospital away from its stated mission (Wyland, 2013).

Local Examples

Two hospital systems within the Atlanta MSA that have already conducted their CHNA are Emory Healthcare and Piedmont Healthcare. While both systems operate multiple facilities and serve similar areas, they took different approaches to the CHNA. Emory Healthcare primarily relied on internal leaders and other resources whereas Piedmont involved several external groups.

Below is a brief overview of health and healthcare statistics regarding Atlanta, GA, in order to provide context on the hospitals and ideas discussed.

- 82% of Georgia's hospitals are nonprofit entities (Healthcare Georgia Foundation, 2011).
- The state does not have community benefit regulations in place (Healthcare Georgia Foundation, 2011).
- In 2009, Georgia hospitals spent more than \$524.4 million on indigent care and more than \$218.5 million on charity care (GHA, 2010).
- The top categories for community benefit spending in Georgia are: research, health professions education, subsidized health services, community health improvement services, cash and in-kind contributions, and community building activities (GHA, 2010).
- According to the *America's Health Rankings 2008* report, Georgia ranked 41st in health and health status (Georgia Health Policy Center, 2009).
- More than 794,000 people in Greater Atlanta do not have health insurance and 144,000 of those are children (UWGA, 2013).
- From 2004-2007, almost 20 percent of the cases diagnosed in Emergency Rooms (ERs) in the Atlanta MSA could have been treated in an outpatient setting (Georgia Health Policy Center, 2009).
- 75% of the counties in the Atlanta MSA are designated as Medically Underserved Areas (Georgia Health Policy Center, 2009).
- The 30318 zip code (but particularly along Donald Lee Hollowell Parkway) is the most challenging in terms of health status (Lang, 2012), likely associated with the high rates of poverty.

Emory Healthcare's Model

Emory Healthcare operates eight facilities with a focus on the tripartite mission of academic hospitals: research, education and teaching, and clinical care (Robinson, p.c. 2013).

The group responsible for conducting a CHNA at Emory Healthcare is the Internal Consulting office made up of 10 people who largely have a healthcare administration background or education. This office is also tasked with facilitating the annual planning cycle, activities in the hospital marketplace, searching for partnerships and acquisitions, among other responsibilities. Emory Healthcare had already begun community benefit reporting and conducting a CHNA was the natural next phase (Robinson, p.c. 2013). However, they are not familiar with creating reports under IRS guidelines, for community comprehension, and informative to individual facilities.

In the summer of 2011, the office began researching and developing the approach they would take based on proposals they received from consultants. They opted to perform the CHNA in-house after receiving astronomically high quotes and viewed the undertaking as a learning opportunity. As of February 2013, all data collection was complete, priority needs were identified, and each of the hospitals were developing their own implementation strategies (Robinson, p.c. 2013).

One-on-one interviews with 20 different people satisfied the community engagement requirement. They also used a steering committee with people across the Emory system in different roles, including patient family advisors who acted as community members. The internal governing body responsible for approving the assessment and strategy act as the stamp of community approval because several community leaders sit on it (Robinson, p.c. 2013).

Piedmont Healthcare's Model

Piedmont Healthcare can be looked to as a seasoned leader in both community benefit and health assessment. Prior to PPACA legislation, they had a program in place with Kaiser Permanente to reduce admissions (Rencher, p.c. 2012). They have worked on similar health related assessments through organizations such as Atlanta BeltLine on their HIA, the City of Atlanta on sidewalk and park improvement issues, and Fulton County (Lang, p.c. 2012). In March of 2012, Piedmont Healthcare hired Holly Lang as the Director of Community Benefit to lead community benefit and external affairs efforts along with another staff member. She was the former Director of Health Access Program Hospital Accountability Project through Georgia Watch, the state's leading consumer advocacy organization (Lang, p.c. 2012).

Piedmont Healthcare operates five hospitals. The smallest is Jasper, with only 42 beds. It is very community based, with strong and positive leadership. They maintain a great reputation with the volunteer clinic seeing a high amount of Medicaid and uninsured patients. Major problems in Jasper's community are cancer and tobacco, mental health issues, and a lack of organization within the community. Coweta and Fayette despite being only 10 miles apart in physical distance serve very different populations. Fayette sees a mostly white, middle-upper class and overall healthier population with active community participation. Coweta sees a large portion of Medicaid and Medicare patients with a mix of concerns, affected by social determinants of health. Henry is newer to the system, opening in 2011 and serves a community that is eager to hear about the health system and has been involved in coalition-based work. Atlanta serves a lower income population facing major health disparities even though the hospital itself is located in a wealthy neighborhood (Lang, p.c. 2012). Operating hospitals with such different populations makes it difficult to create a singular process considering the concerns between rural and urban communities are often varied and sometimes opposing.

July of 2012 saw the beginning of their community engagement process through focus groups and interviews. Their key stakeholders were identified as the public health departments, social service agencies, and community leaders. Other important people that were involved were Georgia Power - a major employer; plants that employed shift workers – since these employees tend to experience more health issues; employers that did not provide health insurance; Boards of Education – for insight on nutrition and education; the YMCAs; and local representatives of fitness – since obesity is an issue across the board. They also worked with Morehouse School of Public Health to discuss the 30318 zip code, identified as the most vulnerable population. Lang stated that Piedmont is willing to share the data that they have collected through this CHNA process with other hospitals and organizations that would benefit from it (Lang, p.c. 2012).

Town hall meetings were held for each of their hospitals to reveal the results of the CHNA in February and March of 2013. They advertised these in the local newspapers and radio stations and by placing flyers on cars in the Wal-Mart parking lot servicing their more vulnerable populations – their target audience (Lang, p.c. 2012). The next step from the assessment is the implementation strategy and each individual hospital is responsible for producing a tailored one.

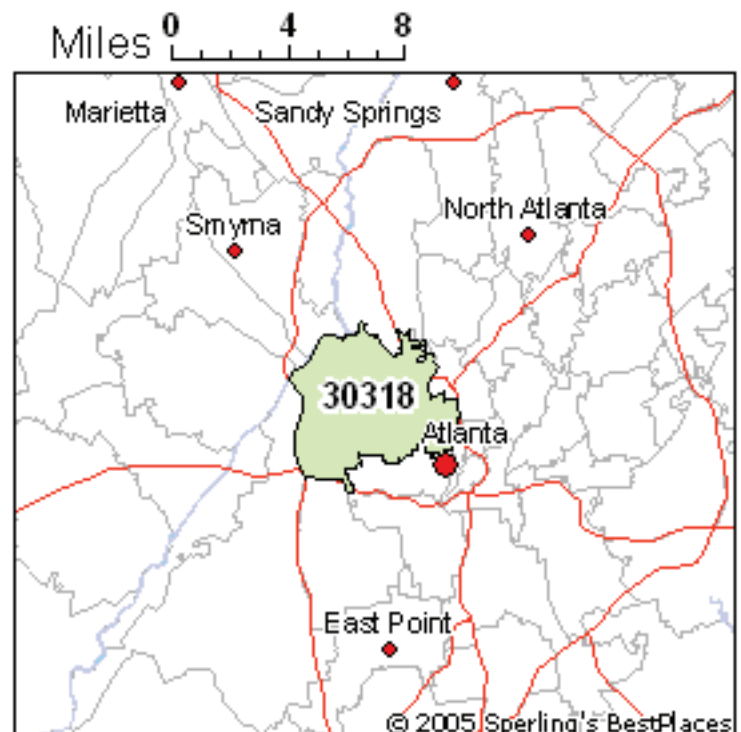


Figure 2. 30318 zip code
Source: bestplaces.net

Case Studies

Gwinnett Medical Center

Gwinnett Medical Center is a 553 bed healthcare system with two acute care hospitals located ten miles apart in Duluth and Lawrenceville both serving the residents of Gwinnett County (Gwinnett Medical Center, 2012). 80% of Gwinnett Medical Center-Lawrenceville’s patients reside in Gwinnett County. Their chosen “community” is the county which may not be the best representation considering that the Duluth hospital is close to the border of Fulton County and probably serves a large portion of Fulton County residents. See Figure 5. This is an example of how politically-drawn geographic boundaries are not the most accurate description of the hospital’s actual community. The report did not address how many Gwinnett-county residents the Duluth facility serves.

Figure 3. Gwinnett County, GA
Source: Gwinnett Medical Center, 2012

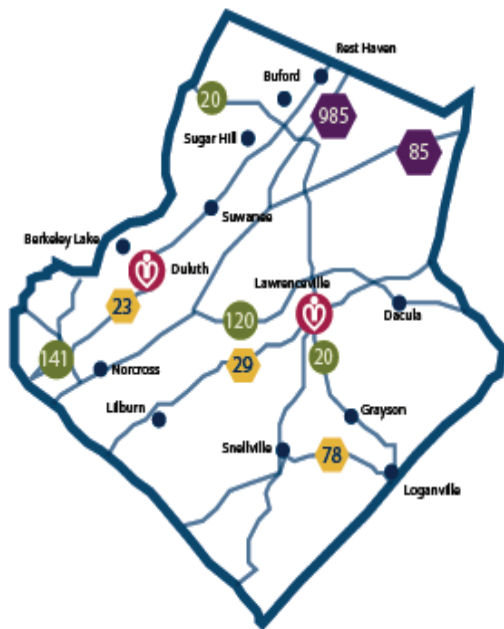


Figure 4. Atlanta Metropolitan Area
Source: Gwinnett Medical Center, 2012



Gwinnett Medical Center had hearty community involvement and data collection processes. They conducted eight focus groups over a two-month period that featured 100 “community representatives of different ages, races and interests” (Gwinnett Medical Center, 2012). They also held two town hall meetings, advertised through e-mail blasts and social media posts, with 88 representatives from various Gwinnett County agencies that helped to identify and prioritize community needs. A representative from the Gwinnett County Health Department conducted key informant interviews with community leaders. 2011 call data from the Gwinnett County Coalition for Health and Human Services community Helpline was also incorporated, as were responses from the 2010 Gwinnett County Youth Survey (Gwinnett Medical Center, 2012). Statistical data was taken from the 2006-2007 Gwinnett County Health Status Report, current data from OASIS, and the U.S. Census Bureau’s Quick Facts. The top priorities ended up being:

- Manage Health Conditions and Chronic Disease Treatments
- Improve Access to Care
- Prevent Chronic Diseases and Increase Wellness (Gwinnett Medical Center, 2012)

The full 98-page report is available for download on their website or by contacting the hospital administration offices. The report is succinctly summarized in 7 pages with attachments explaining descriptions and processes in more detail. They plan to utilize the Healthy Communities Institute system as they create an implementation strategy. Representatives from the needs assessment team, hospital administration, and the Board of Directors will oversee this process (Gwinnett Medical Center, 2012).

Phoebe Putney Health System

Located in Albany, GA, the 4th poorest city in the nation according to *Forbes*, Phoebe Putney is an example of a rural hospital successfully completing a CHNA within their means. Albany residents are impacted by poverty, teen pregnancy, low literacy rates and a general lack of access to needed health services. While there are several existing non-profits, the fragmentation of them leads to piecemeal delivery of services. While no report can yet be found online, they did purchase the HCI software and make it publicly available on their website to aid non-profits and their local health department. For their efforts, they received one of the Healthy Community Institute's "Healthy Communities 2013 Achievement Awards", that recognized system users exhibiting meaningful, creative, and innovative ways to advance health in their community (HCI, 2013).

Atlanta MSA

The Georgia Health Policy Center conducted a health needs assessment of the Atlanta region for Kaiser Foundation Health Plan of Georgia Inc. in 2009. The plan has an extensive list of data sources that includes:

- BRFSS
- OASIS
- US Census Bureau
- Georgia County Guide
- Current Population Survey
- Georgia Hospital Association Discharge Data
- Georgia Department of Community Health (Georgia Health Policy Center, 2009)

While its scope prevents it from being easily comparable to other CHNAs, it remains a good resource for data collection sources, indicators, and corresponding best practices. The indicators used in this report are broken into four categories and listed in Table 5.

Table 5. Atlanta MSA report categories of indicators
Data from: Georgia Health Policy Center, 2009

Social Determinants of Health	Health Risks and Behaviors	Health Outcomes	Health Care
Population	Obesity	Years of Potential Life Lost (YPLL)	Insurance Status
Income	Physical Activity	Cardiovascular Disease	ER use by the uninsured
Education	Cigarette smoking	Cancer	Ambulatory care
	Mammograms	Injury	Sensitive Conditions
	PAP Smears	Infant Mortality	Workforce
	Sigmoidoscopes	Diabetes	
	Prenatal Care	Hypertension	
		Asthma	
		HIV/AIDS	
		Mental Illness	
		Low birth weight	
		Mortality	

Common CHNA Challenges

The three most common challenges were finding applicable data at the correct scale, lack of IRS instructions, and a multitude of communication issues. See the list below for the challenges raised by interviewees, and a survey of gray literature, commentaries, and webinars.

A. Lack of Experience

1. Lack of health knowledge on behalf of the IRS
2. Lack of understanding of community organization tactics
3. Hospitals inexperienced in community engagement processes
4. Lack of direction and guidance from the IRS
5. Lack of understanding about social determinants of health on behalf of the healthcare community

B. Communication Issues

6. Communicating across professions and across education levels (bridging the technical language barrier)
7. Communicating the value proposition of participating in a CHNA to external entities (what are they getting in return for their staff time and knowledge)
8. The need to be politically savvy
9. Communicating the importance of a CHNA to hospital leadership and Board of Directors

C. Community Engagement

10. Determining the community served (see the section title “Language of the Legislation” for more on this)
11. Determining boundaries or possible relationships with other hospitals or organizations doing this work.
12. Finding an entity to hold hospitals accountable
13. The difficulty in involving people in an urban setting

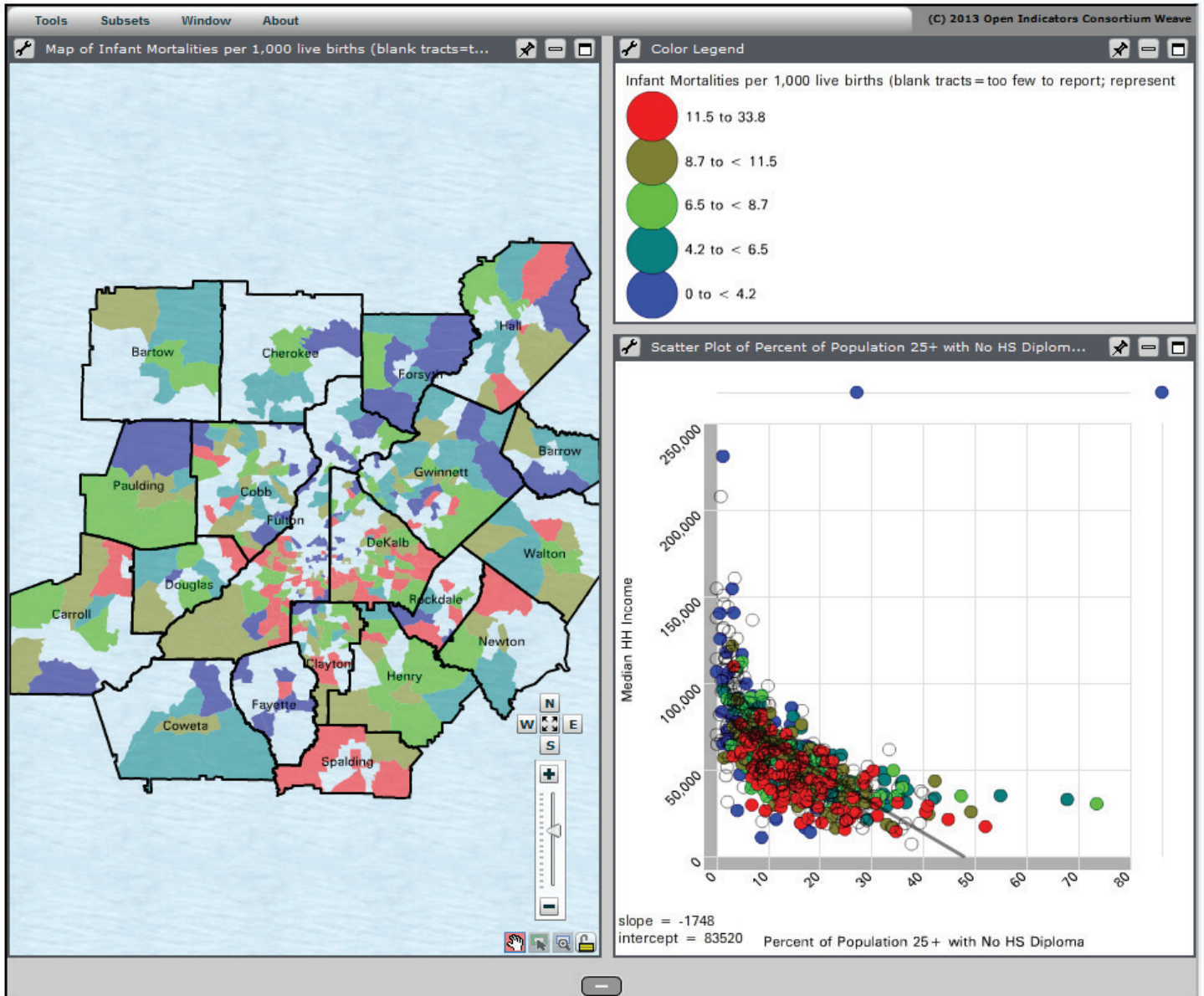
D. Resources

14. Preparing the marketing and public relations staff (usually the group that becomes responsible for completion) to conduct a CHNA
15. Working within small staffs and limited budgets
16. The time intensive and hands-on nature of the process
17. Developing an approach that meets IRS requirements while remaining feasible within the hospitals limitations
18. Finding data at the local level to make projects and programs feasible and applicable

Quantitative health data is extremely difficult to extract below county level, making qualitative data that much more useful when conducting a CHNA. An example of county and Metropolitan/Micropolitan Area (MMSA) level data is the Behavioral Risk Factor Surveillance System (BRFSS), which is the “nation’s premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services” (CDC, 2013). For more localized and aggregated data, the Georgia Department of Public Health operates the Online Analytical Statistical Information System (OASIS). OASIS is a “suite of interactive tools used to access the department’s health data repository” which is “currently populated with Vital Statistics (births, deaths, fetal deaths, induced terminations, and pregnancies), Hospital Discharge, Emergency Room Visit, Arboviral Surveillance, Youth Risk Behavior Survey (YRBS), Behavioral Risk Factor Surveillance Survey (BRFSS), STD, Motor Vehicle Crash, and Population data” (OASIS, 2013). The Atlanta Regional Commission maintains a regional information system called Neighborhood Nexus providing data as a catalyst to create opportunity for all of the region’s citizens. While the tool offers visual representation of a variety of criterion at the census tract level, the only health-related statistic is “Infant Mortalities per 1,000 live births” (Neighborhood Nexus, 2012). See Figure 5. While these options do not address obtaining data below the county level, they are a start to getting quantitative health data in Georgia.

Communication regarding a CHNA is difficult in both the internal and external processes. The group responsible for conducting a CHNA needs to be able to use health language, economic language, and political language when working with hospital leadership. There needs to be conversation between the group and other professionals: city planners, elected officials, public health professionals, and others. Staff members also need to be able to step out of their role and speak to community members at a “person-to-person” level. Parties responsible for the community engagement processes are required to be proficient in several “languages”. Once the process is finished, the group is then tasked with creating a report that is acceptable by the IRS, understandable by the public at large, and informative for the individual facilities to use in the development of an Implementation Strategy. These ‘asks’ are mostly new for the people responding to them.

Figure 5. Screenshot of Atlanta Regional Commission's WEAVE tool, using the health variable.
Source: Neighborhood Nexus, 2013



Language of the Legislation and Proposed Changes

Several interviewees cited the vague language of the CHNA legislation and lack of guidance as a barrier to successful completion. Bill Rencher, Director of the Health Access Program for Georgia Watch – the states leading consumer advocacy organization - when asked what the barriers to conducting a CHNA were, remarked that defining a hospital’s community will pose the biggest challenge. For instance, since Piedmont Healthcare services a 20 county region that spans both urban and rural. He was most concerned with tailoring an assessment that encompasses that area (Rencher, 2012). IRS Notice 2011-52, addresses some of these concerns. For instance, in reference to defining the “community served”, it gives hospitals the flexibility to define the scope of the CHNA as appropriate for them. The Treasury and the IRS generally expect a community to be defined in terms of a geographic location such as city, county, or metropolitan boundaries. However, in some cases a community can be defined as target populations such as children or the elderly, or principal functions like a hospital’s specialty or targeted disease (IRS, 2011). In the Best Practices Forum, Jeff Spade, Vice President of the North Carolina Hospital Association when discussing the drawbacks of county designations in rural settings, cited a North Carolina case saying that “They are the number one healthcare provider in the next county over. And for them to totally discount that they have an impact on the health of the county next to them simply because they weren’t located there is, to me, is missing the point. They have a huge impact on the health of that community” (Barnett, 2012). This comment addresses that geographic boundaries according to zip codes or county lines, have little effect on who the hospital actually impacts.

On April 5th, 2013, the IRS issued a Notice of Proposed Rulemaking for Community Health Needs Assessments for Charitable Hospitals, as a response to the comments they previously received on Notice 2011-52. This new document allows hospitals to determine their population based on their own “facts and circumstances” so long as they do not exclude the medically underserved, low-income, or minority populations in the area they serve. Medically underserved populations are those that experience health disparities or at risk of not receiving adequate medical care as a result of being underinsured or due to geographic, language, financial, or other barriers (Federal Register, 2013). This proposed new rule also allows hospitals to choose which needs are considered “significant” and therefore need to be prioritized and assessed based on their “facts and circumstances”.

The vague language worked to the benefit of Emory Healthcare when conducting their CHNA, as Notice 2011-52, allows for one person or group in the input process to serve as the input from multiple pieces of the requirement for:

1. Persons with specialized knowledge or expertise in public health;
2. Agencies with current data regarding the community; and
3. Representatives or leaders of low-income and minority populations served by the hospital facility. (Lunder, 2011).

The notice states that interviewing a government official with an expertise in public health could satisfy criteria 1 and 2 (IRS, 2011). Emory Healthcare chose to use an internal steering committee that was able to satisfy these criterion (Robinson, 2012). Under the new proposal, the three requirements of the input process would be:

1. At least one state, local, tribal , or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community;
2. members of medically underserved, low-income, and minority populations in the community, 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 (Federal Register, 2013).

These changes could either enhance or hinder the true intent of the CHNA process in hospitals. Explicitly including public health departments in the requirements promotes collaboration with departments seeking PHAB accreditation (see section titled: Groups in Place to Assist), but it may also make the bare minimum – a level we see some hospitals satisfied with attaining - to stop the engagement process at only one stakeholder or collaborator. This would drastically reduce the amount of external participation and outsider perspective that the hospital needs, as demonstrated in the literature review. Making leaders or representatives optional, and moving towards simply “members” of the community potentially omits a large segment of the population. The benefits of getting feedback from leaders is that they generally interact with a broad section of the community, and can speak for several people at once. A community member that is not in tune with these broader issues is more likely to have a narrow perception or understanding of the community needs and is

at risk of being a misrepresentation of the true needs. However, by integrating written comments, the requirements could expand the participation. Written comments, if done right and properly advertised, has the benefit of including input from people who otherwise would have been excluded. For instance, a single mother working two jobs would not have the free time to participate in a focus group, but she could still submit her feedback on the hospital's process, results, or strategy if she had the time. Written comments often will not indicate the demographics of responses, allowing for one population to be either over- or under-represented. This is where advertising, particularly the saturation and effectiveness of advertising within certain audiences, and facilitating opportunity to comment at a variety of community events becomes paramount.

Additionally, the proposal suggests changes to the report by including descriptions of:

1. how the community was determined;
2. prioritized health needs identified (as opposed to all needs);
3. the process and criteria used in identifying those needs as significant; and
4. subsequently prioritizing them; and potential measures and resources identified through the CHNA to address the significant health needs (Federal Register, 2013).

Comments on the proposed new rule must be received by July 5, 2013 and can be submitted here: http://www.regulations.gov/#!submitComment;D=IRS_FRDOC_0001-1048.

Groups in Place to Assist

There are several possible organizations that hospitals can collaborate with either during the assessment process or the development of an implementation strategy.

ICF International is an example of group that could help with the implementation strategy. They are experts on public health policy change and can gauge the environment of a community to decide if it is ready to pass new policy. While the organization is skilled in several other fields, health is one of their market offerings. In the past, they have given technological assistance and training to CDC's REACH Communities (Racial and Ethnic Approaches to Community Health) (Milbrath, p.c. 2012).

Public health departments are an ideal partner for hospitals in this process. The Public Health Accreditation Board (PHAB) launched their national public health department accreditation in September 2011, the requirements for voluntary accreditation relevant to the IRS requirements is a community health assessment (CHA), community health improvement plan (CHIP), and an agency strategic plan (PHAB, 2012). In Oregon, to address this accreditation and the IRS non-profit hospital requirements, they formed the Four-County Community Health Needs Assessment Group (FCCHNA). It is a large, self-organized, public-private collaborative that "represents fourteen hospitals and four Local Public Health Authorities in Clackamas, Multnomah, Washington Counties (Oregon) and Clark County (Washington)" (Shirley et. al., 2013). Collaborations such as these:

- increase assessment quality;
- reduce overall costs borne by all partners and the community at large;
- lead to shared accountability for outcomes;
- promote trust and relationship building among hospitals, local health departments and the community at large;
- eliminate duplicate efforts;
- lead to prioritization of needs; and
- enable joint efforts for implementing and tracking improvement activities (Shirley et. al., 2013).

The Catholic Health Association of the United States is a national leader in community benefit planning and reporting that has supported the Catholic health ministry's commitment to improve health and provide compassionate quality care since its foundation in 1915 (Catholic Health Association, 2012). CHA provided draft documents to assist non-profit hospitals through the new PPACA requirements and while they are not to be considered legal or tax advice, they offer helpful headings and examples of content that could be found in a report. Based on their work, the needs analysis should include: maps, how it was funded, how any community meetings were analyzed, who made up the assessment team, summaries of community engagement events (dates, locations, participant names and affiliations), how results were coded (the agreed upon criteria for determining needs), any trends in data, and whether the needs were broad or site-specific. Further, it recommends that the Implementation Strategy also include target areas and populations; how the strategy was developed; how needs and priorities were established; description of what the hospital will do to address the community needs; an action plan with numerable steps; any excluded priorities; and proof of plan approval from hospital or other authority (The Catholic Health Association, 2012). Their most recent report *Assessing and Addressing Community Health Needs* offers step-by-step instructions and recommendations for hospitals seeking guidance on the entire process, both the assessment and the implementation strategy. It directs readers to online resources and tools where applicable and touts the benefits of community partnerships (Catholic Health Association, 2012).

A variety of consultants are eager to assist hospitals with their process and filing. While, this option was not taken by Piedmont or Emory, it is a possibility for hospitals who have not yet met their requirements. Cohn Reznick LLP, an accounting and assurance, tax, and business advisory firm advertised their services on the social media network Twitter for any hospitals needing assistance complying with the CHNA requirements and reported obligations (CohnReznick LLP, 2013). Crescendo Consulting Group LLC, a firm experienced in CHNAs and strategic planning, communications, and marketing also advertised their services on Twitter and views consultants as a way to help hospitals best utilize their budgets and resources to implement programs that can "kill two birds with one stone" (Good, 2012).

Helpful Tools

Since the IRS requirements were released, several organizations have designed and developed tools to assist hospitals and organizations through the process. The tools mentioned below are by no means an exhaustive list, but a snapshot of available resources. Neither Emory Healthcare nor Piedmont Healthcare indicated that they were utilizing such systems.

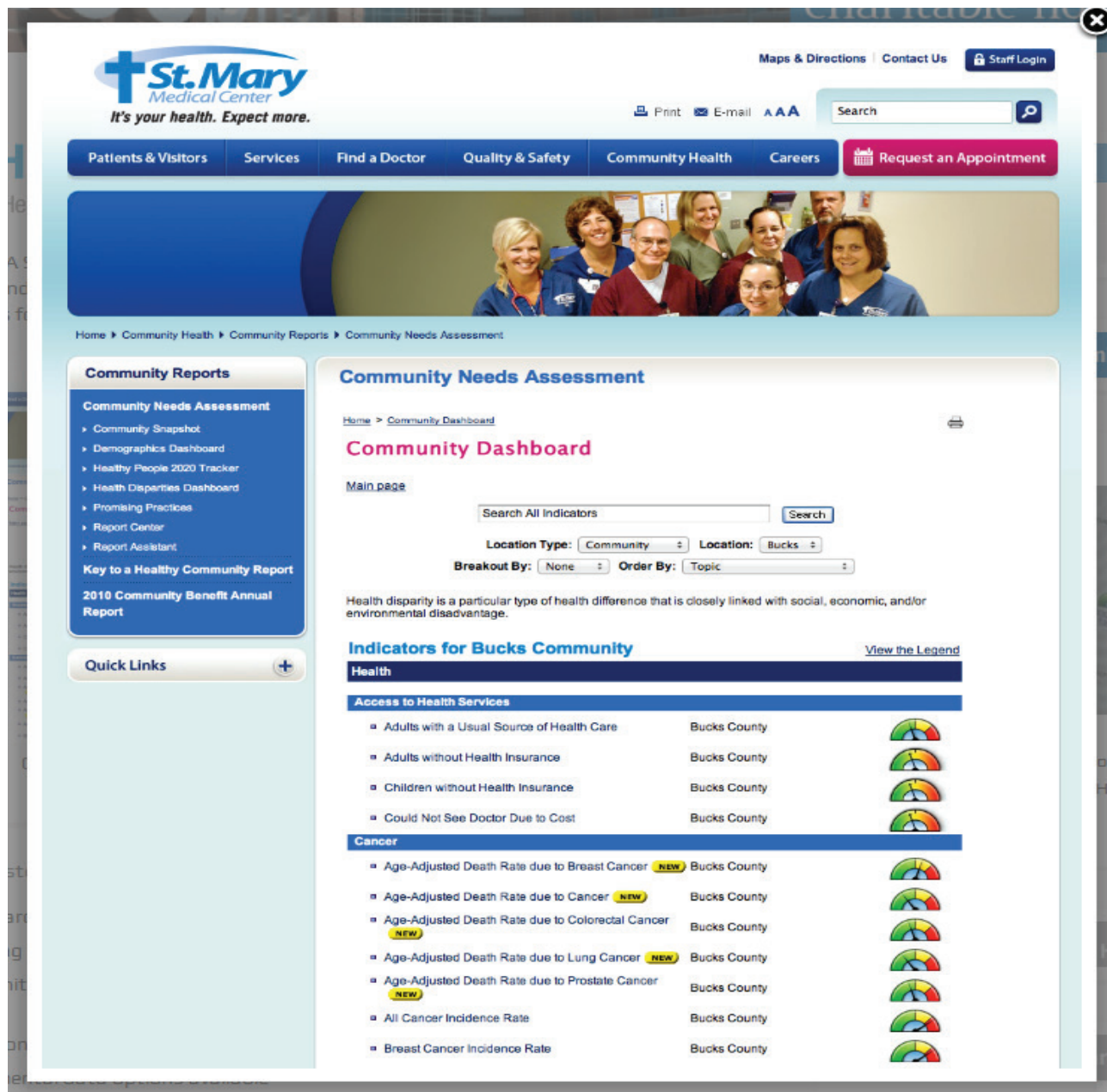
The Healthy Communities Institute's CHNA System, shown in Figure 6, is a customizable web-based information system that provides data, tools, and best practices. It is designed to give stakeholders access to high-quality data, improved indicator tracking, best practice sharing, and community development tools that function together. The system is embedded within a hospital or health system's existing website and provides a dashboard of indicators to drive the assessment.

Features include:

- dashboard of at least 75 Health and Quality of Life Indicators;
- database of over 1,800 proven programs;
- community engagement features such as event calendars and polls; and
- evaluation and tracking through Healthy People 2020 and a customizable local tracker (Healthy Communities Institute, 2013).

Georgia Regents University uses the HCI system to provide publicly accessible data for Aiken, SC, Columbia, GA and Richmond, GA. The Augusta area has benefitted from CHNA's over the years that were produced over the years by the Kroc Center, ACHIEVE Augusta, Good Samaritan House Free Community Health Center, Federally Qualified Health Centers (FQHC), and Greater Augusta Healthcare Network (GAHN) (Georgia Regents University, 2013).

Figure 6. Screenshot of HCI Tracker
Source: HCI, 2013



The Association for Community Health Improvement (ACHI) provides a CHA toolkit as a guide for “planning, leading and using community health needs assessments to better understand - and ultimately improve - the health of communities” (hospitalconnect.com, 2007). The toolkit is provided to paid members of the following groups:

- Association for Community Health Improvement (ACHI)
- American Hospital Association (AHA)
- Society for Healthcare Strategy and market Development (SHSMD)
- American Organization of Nurse Executives (AONE)
- Other AHA Personal Membership Groups (hospitalconnect.com, 2007)

It includes:

- detailed guidance on six core steps of a suggested assessment framework, including but not limited to data collection;
- step summaries containing task checklists, budget and timeline guides, and the skills useful for conducting an assessment;
- case examples with a quick reference table to help you find the most appropriate one to your situation;
- resource links to additional guides, tools and templates at every step; and
- answers to frequently asked questions and access to a peer discussion forum (hospitalconnect.com, 2007).

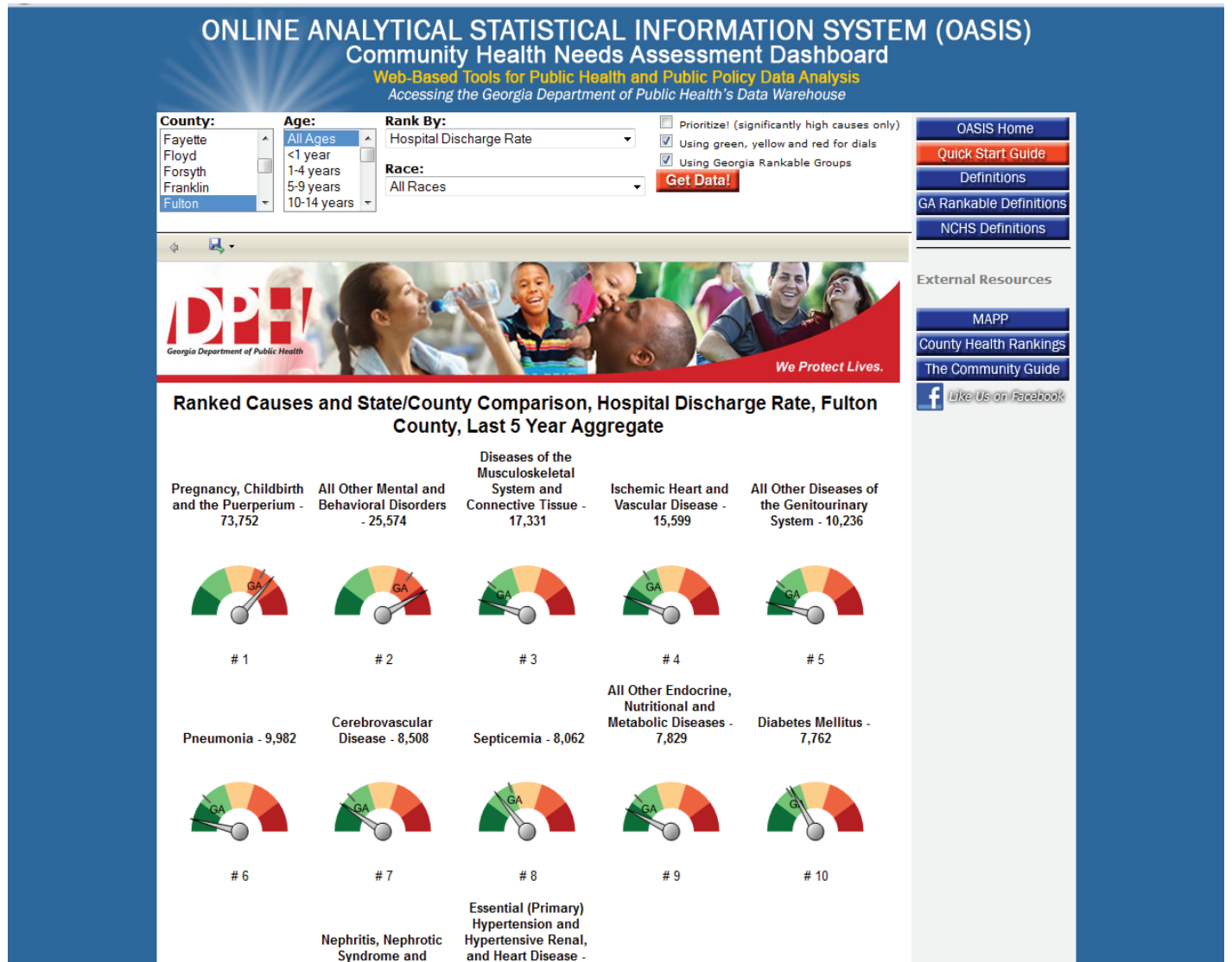
NACCHO's CHA/CHIP process can be used as an example, their resource website offers archived webinars and handouts on:

- quality improvement and quality planning;
- social determinants of health;
- health equity;
- engaging local public health system partners and community members;
- facilitating meetings with diverse groups of people;
- indicators;
- county health rankings;
- collecting and analyzing quantitative and qualitative data;
- asset mapping; and more (NACCHO, 2013).

Georgia's OASIS website boasts that the querying tools can:

- Develop profiles and report cards for counties or districts
- Assess community health needs, prioritize health problems, and evaluate programs
- Assemble data for grant writing, health analysis, special projects or state legislative reporting
- Examine data by census tract to identify high risk populations, and allocate resources
- Identify areas that contribute a disproportionate share of a health issue
- Target problem areas to analyze specific health problems and outcomes
- Create a basis for health communications or health advocacy
- Apply GIS to analyze varied environmental risks focused on disease process, economic status and other environmental variables that influence health outcomes
- Map several geographic areas to compare varied health outcomes (OASIS, n.d.).

Figure 7. Screenshot of OASIS Sampling
 Source: OASIS, 2013



OASIS also offers a CHNA dashboard for the state, by aggregating the last five years (with 2009 being the most recent year as of March, 2013). The tool can query by county, age, rates, and race. The result is a series of dials with rankings and aggregate numbers and a comparison to the state level (OASIS, n.d.). See Figure 7 for an example.

Community Health Needs Assessment beta 2.0 found at CHNA.org and powered by IP3 provides “easy and efficient access” to quantitative data freeing up more time for analysis and taking action (Community Commons, 2012). The three options available are to:

1. Generate a CHNA report
2. Find target areas
3. Explore Map Gallery

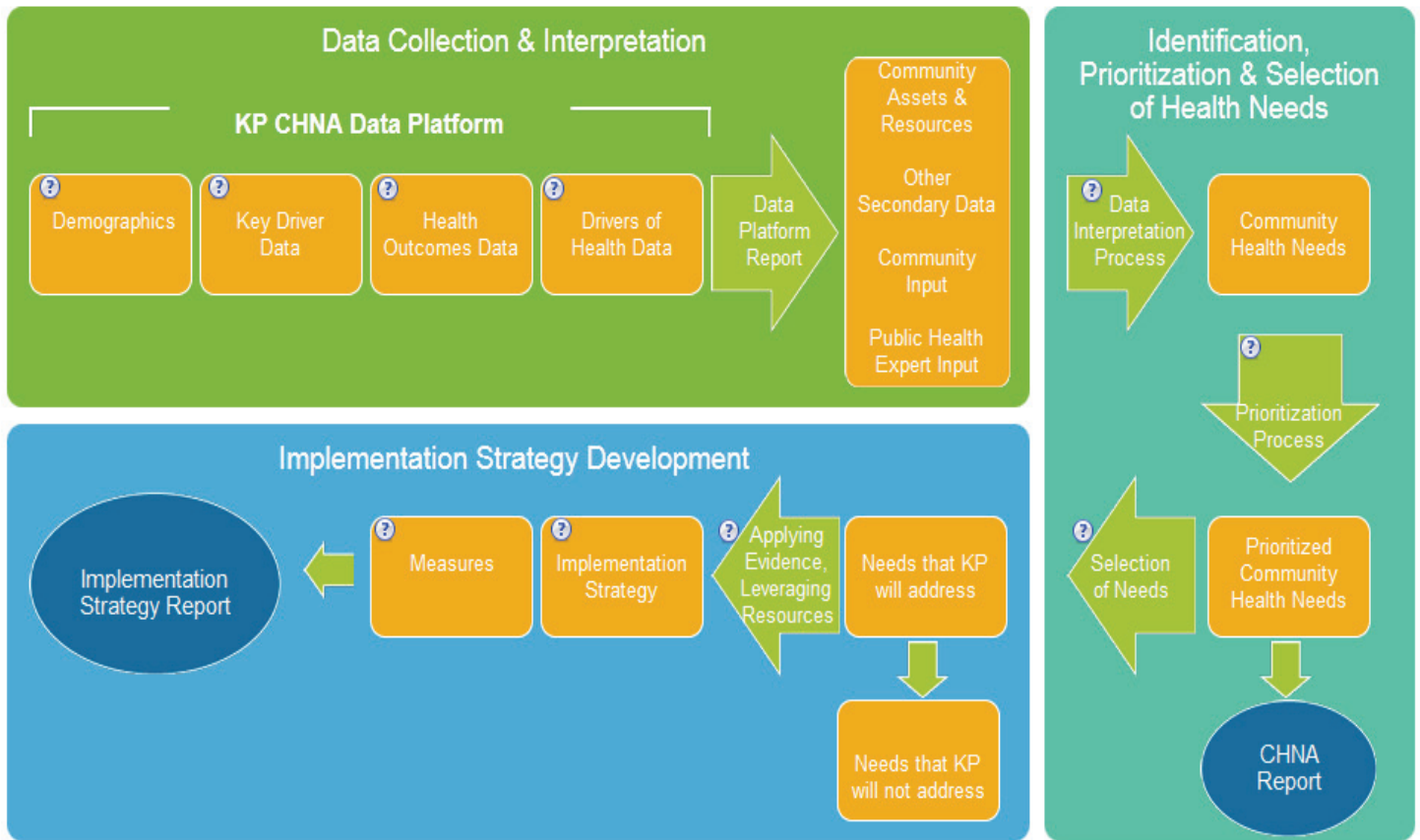
The report function hosts 80 different indicators of health status and produces tables, charts, and graphs. The Target Areas Assessment allows a look into target areas via an interactive map with “Poverty Level” and “Educational Attainment” as variables and adjust the thresholds as necessary. These preset indicators can begin to show areas experiencing disparities that should be targeted (Community Commons, 2012).

In August of 2012, Kaiser Permanente’s Community Benefits Programs produced a 60 page “Community Health Needs Assessment Toolkit” accessible via the web. The program has been conducting CHNAs for “many years as a way of informing how we allocate our resources” (Kaiser Permanente Community Benefit, 2012). The report explains the legislation, a possible timeline, and tips for data collection and analysis. The process map is shown in Figure 8.

They are a host of other similar organizations or processes that can be drawn from when a hospital is determining how to plan for, conduct, analyze, and evaluate their own CHNA processes. A sample of these are:

- Healthy Carolinians Community Health Assessment Guide Book
- NCCDPHP CHANGE Action Guide
- NCCDPHP Planned Approach to Community Health (PATCH) Process
- New York State Community Health Assessment Development Process
- MAP-IT: A Guide to Using Healthy 2020 in Your Community
- SAMHSA Community Needs Assessment Guide
- Missouri Information for Community Assessment (MICA) Health Needs Assessment
- Environmental Law Institute’s Community Environmental Health Assessment Workbook
- University of Wisconsin-Madison Population Health Institute’s Mobilizing Action Toward Community Healthy (MATCH) logic model

Figure 8. Kaiser Permanente CHNA Process Map
 Source: Kaiser Permanente, 2012



What a Successful CHNA Contains

When conducting a CHNA and developing an Implementation Strategy, a hospital should strive to follow the “Principles to Guide Community Health Improvement” as published in George Washington University’s *The Affordable Care Act’s Community Health Needs Assessment Reforms: Guiding Principles for Successful Community Health Improvement*.

1. Community health improvement is most effective when it is based on multi-sector collaborations that support the goal of shared ownership of all phases of community health improvement, from assessment through investment, implementation and evaluation.
2. Proactive, broad and diverse community engagement to improve results and create the strongest possible sense of ownership.
3. A flexible definition of community that is both broad enough to consider policy solutions and sufficiently targeted to address disparities and areas of significant need
4. Community health improvement utilizes maximum transparency in order to improve community engagement and accountability
5. Community health improvement investments foster innovation, while resting on evidence-based interventions linked to measurable results.
6. Community health improvement efforts incorporate continuous improvement through ongoing evaluation.
7. Community health improvement rests on the highest quality data pooled from, and shared among, diverse public and private sources (Rosenbaum, 2012).

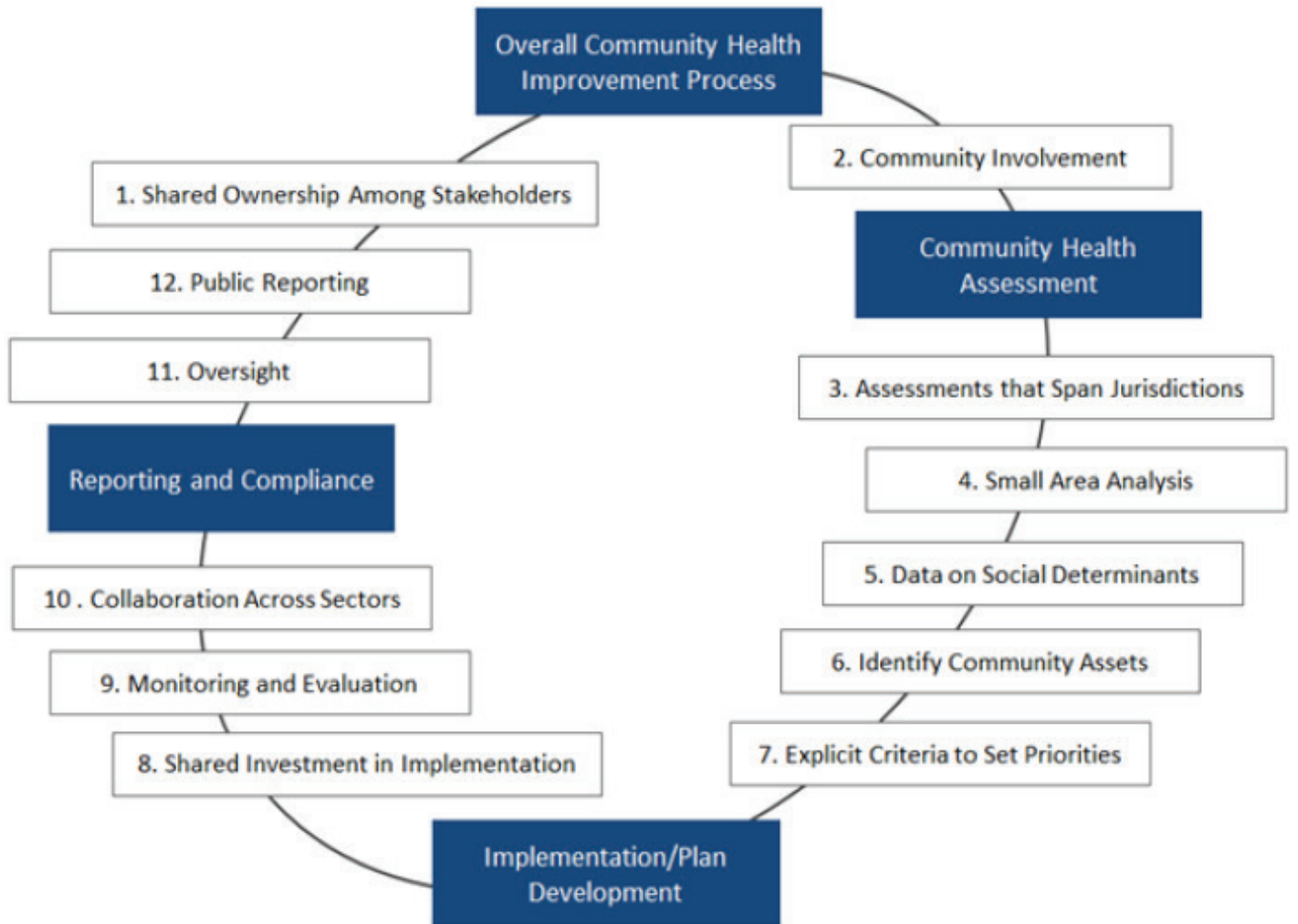
Stephen Fawcett, Christina Holt, and Jerry Schultz in Some Recommended Practice Areas for Enhancing Community Health Improvement use a different set of seven principles for guiding principles:

1. Have a common agenda
2. Enhance collaboration across sectors and levels
3. Assure community participation
4. Use comprehensive approaches to improving population health/equity
5. Use evidence-based approaches
6. Address social determinants of health
7. Use performance monitoring (Fawcett, Holt & Schultz)

These principles then guide the cyclical “Overall Community Health Improvement Process shown in Figure 9. This cycle and the 12 components within note the need for ongoing health improvement and evaluation of improvement methodologies. It factors in the need for transparency, the importance of social determinants of health as well as localized data.

Both sets of principles emphasize the need for high quality quantitative and qualitative data from a variety of sources, transparency for community members to act as gatekeepers of the process and implementation strategy, broad and multi-sectoral community participation, and continuous evaluation to ensure the optimal health improvement practices are in place. These four overlapping principles coincide with the previously identified categories of CHNA challenges: lack of experience, communication issues, community engagement, and resources. By ensuring that these main four principles are kept in mind, using either of these models for extra guidance, the challenges should be easily overcome.

Figure 9. Recommended Areas of Health Improvement
 Source: Fawcett, et. al



Relationship to City Planning

There is a growing realization of the relationship between city layouts and the health status of American citizens. In the 19th century, city planning and public health officials worked together to tackle epidemics such as cholera and tuberculosis by providing access to clean water, sanitation and green spaces. Today, chronic diseases such as heart disease, cancer and diabetes have replaced infectious ones as the leading causes of death and disability in America (Alkan, 2012). Studies such as the one published by the Nashville Area Metropolitan Planning Organization show a correlation between obesity and vehicle miles traveled further prove the relationship shown in Figure 10 (Rutt & Avey, 2012). We see real-life examples of city planning tactics improving health, such as residents of Charlotte, NC losing, on average, six pounds per person after light rail was installed. (R. Jackson, p.c. 2012) Dr. Jose Camacho, Executive Director/General Counsel of Texas Association of Community Health Centers claims that attention to social determinants of health is of central importance, citing limited employment options being tied to a lack of insurance coverage, support services needed for single parent households, and the impact of lack of high school education and limited English proficiency on health behaviors (Barnett, 2012). The example previously discussed in the health assessment of Dumbiedykes shows that residents think of transit and greenspace being tied to their overall health and well-being.

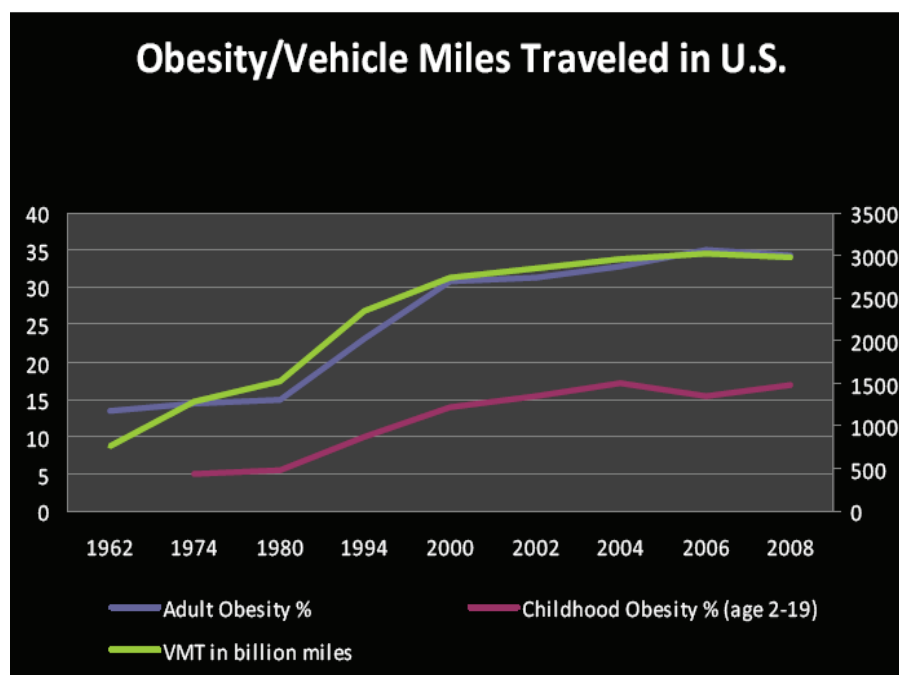


Figure 10. Obesity and VMT
Source: Nashville Area Metropolitan Planning Organization

The report generated on the health needs of the Atlanta MSA by Georgia Health Policy Center showed a pattern that counties with “a higher proportion of affluent, highly educated residents have better health outcomes, while those with a higher proportion of residents in poverty, with lower levels of education, have poorer health outcomes” (Georgia Health Policy Center, 2009). This report, among other best practices, makes special note that “programs targeting the social determinants of health equity (SDOHE) have potential to significantly improve health disparities because such interventions focus on the root causes of unjust social conditions” (Georgia Health Policy Center, 2009). Ideal recommendations will target social and environmental conditions, “the CDC’s Task Force on Community Preventive Services identified over 200 community-based interventions that show promise for promoting health enhancing environments”, the most frequently mentioned ones are listed in Table 6 below:

Table 6. Common community determinants of health
Source: Georgia Health Policy Center, 2009

Social Environment	Physical Environment	Economic Environment	Service Environment
Social Cohesion and Trust	Housing and Neighborhood Conditions	Employment	Health and Human Services
Collective Efficacy	Transportation	Home Ownership	Public Safety and Emergency Services
Civic Engagement	HEAL Promoting Structures	Local Business Development	Education
Cultural Characteristics and Norms	Natural Resource Quality	Product Availability	Community-based Organizations
	Aesthetics		Cultural/Artistic Opportunities

The proposed new rule from the IRS places emphasis on the social determinants of health, recognizing the “need to improve access to care by removing financial barriers” as a possible significant health need (Federal Register, 2013). Per IRS standards, community-building activities within hospital community benefit programs can include:

- physical improvements and housing;
- economic development;
- community support;
- environmental improvements;
- leadership development and training for community members;
- coalition building;
- community health improvement advocacy; and
- workforce development (Healthcare Georgia Foundation, 2011).

The above list serves as evidence that the IRS indirectly recognizes the need for city planning knowledge to be included into implementation strategy planning.

Basak Alkan, an Urban Designer with the firm Perkins + Will and a member of the Congress for the New Urbanism Health Districts Initiative Team, has worked on several hospital campus plans. In her work, she has recognized that hospitals are often reluctant to share any expansion plans for fear of public outcry. Hospitals aren’t used to working with city planners, but medical planners. They often fail to realize the impact their own campus has on the health of their neighborhood. Hospitals tend to be large physical structures (often, several structures) with plenty of parking lots and decks that take up space within a community and often alter the urban fabric. They affect traffic issues (Johns Hopkins in Baltimore has 80,000 visits per week), noise and light pollution, and pedestrian challenges. While hospitals often get excited about projects such as improving energy efficiency which can have an economic impact of job increases, they are much less likely to get excited about external projects. They tend to think within the walls of their building rather than within the block they reside. They chose parking lots over parks to purposely keep neighbors out. Alkan suggests creating pedestrian paths that can connect the neighborhood, invite people in, and integrate the hospital as a part of the urban fabric (Alkan, p.c. 2013).

Hospitals have grown in size and scale throughout the twentieth century in response to requirements for safety, security, and efficiency (CNU, 2011). They often use about 3,000 square feet to treat each inpatient. Some urban designers refer to them as “spaceships in parking lots” and compare them to suburban shopping malls, as they take up huge swaths of land, mostly for parking. The Health Districts Initiative seeks to formulate implementable solutions that “remove the barriers between neighborhoods and health systems and encourage collaboration among the professions of urban design and healthcare planning and architecture” (CNU, 2011).

Figure 11. Florida Hospital Memorial Medical Center in Daytona Beach

Source: http://southeast.construction.com/features/2009/1101_HealthyAdditions.asp



The Institute of Medicine cited enhancing the built environment as the number one strategy to reduce obesity (Institute of Medicine, 2009). The growing realization of the relationship between these two is evidence in publications such as New York City’s *Active Design Guidelines* and Richard Jackson’s *Designing Healthy Communities*. Through CHNAs, health systems are offered a strategic opportunity to build healthier, lifelong communities in their neighborhoods (CNU, 2011).

Several institutions are already leading the way on improving the health and well-being of their communities through city planning and urban design tactics. Kaiser Permanente, a managed care consortium, hosts 30 farmers markets at KP hospitals in nine states. Physicians at the Heart Clinic of Arkansas raised funds to create “The Medical Mile”, a trail through downtown Little Rock along the Arkansas River and included other physicians and practices, local hospitals, and the Arkansas Department of Health (CNU, 2011).

Design and programmatic factors aside, city planners can provide assistance in a CHNA process with their knowledge of how to “do” community engagement and their data and spatial analysis skills. Within their professional capacity, they hold workshops, public meetings, can analyze city dynamics and possess problem-solving skills. They can assist in creating a long-term vision for the implementation strategy, since hospitals tend to be more pragmatic and less visionary (Alkan, p.c. 2013). The proposed new rule would require only a general summary of the input received as opposed to specific dates of meetings, lists of attendees, or minutes, (Federal Register, 2013) potentially requiring less effort from hospitals in the community engagement process. It would, though, require a list of the organizations providing input, and which medically underserved, low-income, or minority populations they represent (Federal Register, 2013). Currently, and with the proposed new regulations, city planners are not listed as a group that should be included in the CHNA process but they would be a valuable asset.

Examples of Good Implementation Strategies

One of the biggest challenges hospitals are facing is what to do with the information they have collected over the course of the assessment. City planners and public health professionals, that are often responsible for healthy planning and programming can offer a wealth of information regarding the brainstorming and implementation process that may require “outside the box” type thinking. In Georgia, some examples are:

- St. Joseph’s hospital in Savannah “provides housing rehabilitation, GED testing preparation, and tax preparation for low-income members of its community” (Healthcare Georgia Foundation, 2011).
- Redmond Regional Medical Center provides an annual complementary Thanksgiving meal to more than 3,000 less fortunate community members (GHA, 2010).
- The Columbus Regional Healthcare System partners with a local elementary school to provide programming and recognition to increase educational enrichment for students (GHA, 2010).

Suggestions for CHNA Improvements

In order to overcome some of the challenges associated with the CHNA process, interviewees were able to provide suggestions for future endeavors. Selected suggestions are:

A. Lack of Experience

1. Reaching out to consultants, boards of health, and any universities or centers (such as the Georgia Health Policy Center, Georgia Tech's School of City and Regional Planning, Emory's Rollins School of Public Health, Morehouse School of Medicine, etc.) for community evaluations and surveying of health issues

B. Community Engagement

1. Identifying any bad history between certain groups before engaging them in any process
2. Inviting non-traditional people into the engagement process. Cited examples are community banks, private health plans, free and low cost clinics, church congregations, major employers, city planners, and community based professional associations
 - i. Avoiding the "usual suspects" and the internet as the sole source of data
3. Providing a forum for community members to interact with one another throughout the process
4. Conducting successful community engagement processes by: holding key informant interviews, building the trust of the leaders, providing incentives for attending, equipping people with health knowledge, having convenient meeting times, understanding motives for attending
5. Recognizing that outsiders offer a fresh perspective from those that are entrenched in the daily burdens and internal politics of the institution

C. Resources

1. Preparing the staff to spend a large amount of time relationship-building and subsequently feeling like no work is getting accomplished

Hospital Accountability

It is evident that one purpose of the CHNA requirement is to hold hospitals accountable for their responsibility to the community in exchange for received tax breaks. However, the lack of medical, health, or city planning knowledge at the IRS, makes it difficult to ensure that the implementation strategies accurately meet the needs identified in the CHNA process. While consumer advocacy groups do exist, such as Georgia Watch or Community Catalyst, there is still a further need to allow community members the power to oversee and provide insight to the process. The new language suggested as of April 5th addresses some of these concerns by calling for online comments and website postings. This could be taken a step further if the IRS were to create an online clearinghouse for all CHNAs. If this were to be created, not only would the IRS have all community comments and concerns in one place but the public at large would have one easy resource to go to. It would also allow the public to view more than multiple hospital approaches at once, and compare and contrast their hospital to others near and far. The idea of comparison is important since in the identification of needs, local health statistics are often compared to those of both the state and nation.

Creation of a CHNA Report Card

The need for technical assistance is also evident among hospitals that are not accustomed to this type of process. While online tools, guidebooks, and other organizations are available, some hospitals still attempt to complete the process in-house, as we have seen in the case of Emory Healthcare. The reporting process is another aspect in which city planners and public health professionals can assist, given their fluency in producing comprehensive multi-faceted reports and plans.

I propose that a report card be created and made available to hospitals. A common comparable report card would be the LEED Rating Systems (Leadership in Energy and Environmental Design). It is a “market-driven program that provides third-party verification” (U.S. Green Building Council, 2013). In order to achieve LEED certification, projects earn a number of points within certain categories to determine the level of their certification, either Certified, Silver, Gold, and Platinum. LEED credit categories include things like sustainable sites, water efficiency, and indoor environmental quality (U.S. Green Building Council, 2013). Points are awarded in the form of a checklist, see Figure 12.

A CHNA checklist would identify a minimum standard of procedures for hospitals to meet. Examples could include the number of statistical data sources queried, the type and amount of community engagement, the breadth of stakeholders brought into the process, etc. This self-evaluation would take place throughout the core process steps:

- Organization and Planning
- Defining the Vision
- Partnership Building
- Data Collection and Analysis
- Prioritization
- Implementation Strategy
- Monitoring & Evaluation

Figure 12. LEED-ND Report Card
 Source: U.S. Green Building Council, 2013

LEED 2009 for Neighborhood Development Project Scorecard		Project Name: _____	
		Date: _____	
Smart Location and Linkage 27 Points Possible Y N H 0 0 0		Green Infrastructure and Buildings, Continued	
Y	Prereq 1 Smart Location Required		Credit 1 Certified Green Buildings 5
Y	Prereq 2 Impaired Species and Ecological Communities Required		Credit 2 Building Energy Efficiency 2
Y	Prereq 3 Wetland and Water Body Conservation Required		Credit 3 Building Water Efficiency 1
Y	Prereq 4 Agricultural Land Conservation Required		Credit 4 Water-Efficient Landscaping 1
Y	Prereq 5 Floodplain Avoidance Required		Credit 5 Existing Building Use 1
	Credit 1 Preferred Locations 10		Credit 6 Historic Resource Preservation and Adaptive Reuse 1
	Credit 2 Brownfield Redevelopment 2		Credit 7 Minimized Site Disturbance in Design and Construction 1
	Credit 3 Locations with Reduced Automobile Dependence 7		Credit 8 Stormwater Management 4
	Credit 4 Bicycle Network and Storage 1		Credit 9 Heat Island Reduction 1
	Credit 5 Housing and Jobs Proximity 3		Credit 10 Solar Orientation 1
	Credit 6 Steep Slope Protection 1		Credit 11 On-Site Renewable Energy Sources 3
	Credit 7 Site Design for Habitat or Wetland and Water Body Conserva 1		Credit 12 District Heating and Cooling 2
	Credit 8 Restoration of Habitat or Wetlands and Water Bodies 1		Credit 13 Infrastructure Energy Efficiency 1
	Credit 9 Long-Term Conservation Management of Habitat or Wetland 1		Credit 14 Wastewater Management 2
Neighborhood Pattern and Design 44 Points Possible Y N H 0 0 0		Innovation and Design Process 6 Points Y N H 0 0 0	
Y	Prereq 1 Walkable Streets Required		Credit 1.1 Innovation and Exemplary Performance: Provide Specific Title 1
Y	Prereq 2 Compact Development Required		Credit 1.2 Innovation and Exemplary Performance: Provide Specific Title 1
Y	Prereq 3 Connected and Open Community Required		Credit 1.3 Innovation and Exemplary Performance: Provide Specific Title 1
	Credit 1 Walkable Streets 12		Credit 1.4 Innovation and Exemplary Performance: Provide Specific Title 1
	Credit 2 Compact Development 6		Credit 1.5 Innovation and Exemplary Performance: Provide Specific Title 1
	Credit 3 Mixed-Use Neighborhood Centers 4		Credit 2 LEED* Accredited Professional 1
	Credit 4 Mixed-Income Diverse Communities 7		
	Credit 5 Reduced Parking Footprint 1		
	Credit 6 Street Network 2		
	Credit 7 Transit Facilities 1		
	Credit 8 Transportation Demand Management 2		
	Credit 9 Access to Civic and Public Spaces 1		
	Credit 10 Access to Recreation Facilities 1		
Regional Priority Credit 4 Points Y N H 0 0 0		Credit 1.1 Regional Priority Credit: Region Defined 1	

The plethora of case studies, guides, online tools, and similar processes provide good starting points for identifying the proper indicators and thresholds to be incorporated into a CHNA checklist. Such a checklist would allow a hospital to self-evaluate as they move through the process and see how well they are doing on a scale. The scale could range from the bare minimum to meet IRS standards to those procedures that would indicate going above and beyond. Similar to how LEED is market-driven, this scale would allow community members to better understand how their hospital is performing in terms of identifying and meeting local health needs. This checklist could also hold hospitals accountable to their own mission.

A successful checklist could be integrated into the Schedule H should it prove successful or useful for hospitals and therefore it would give the IRS a benchmark for hospitals that are consistently over- or under-performing.

When discussing this proposal to interviewees they provided several thoughts on the advantages of such a report card. They agree that such a procedure will:

- make CHNAs more comparable across institutions;
- require more structure and more thought from the hospital side;
- require more rationale in the selection of tools and data;
- help push the IRS to adopt a uniform guideline that addresses how compliance is handled or measured;
- allow the community to put pressure on a hospital system to implement their strategies;
- enhance quality improvement by helping people understand best practices and evidence-based strategies;
- provide transparency to the consumer;
- provide a method for the IRS to measure the benefit to consumers;
- help create similar engagement methods across institutions; and
- assist in the realization among healthcare professional who the drivers in the healthcare system are in terms of cost.

Not all feedback was positive however. Several respondents, those who participated via telephone or briefly via e-mail, were concerned that the creation of such a tool would be redundant. They thought that there are already several CHNA-related tools in existence with more being created all the time, and they are not all necessarily helpful. They commented that it is important that this tool, be distinctly different from existing tools and resources.

The goal of this procedure is to make all CHNAs more successful based on the criteria noted by interviewees. This means that ideally it would:

1. ensure that the entire community is invested in the overall health and well-being of the community;
2. ensure that the community is interested in continuing to work together throughout the implementation of the strategies and in the long-term;
3. increase the likelihood of regional plans that create a sense of movement and change in a more comprehensive way;
4. connect the hospital back to the community; and
5. create overall community health improvements.

This report card will assist in the evaluation of a CHNA, which makes it very different from the existing tools previously discussed. While other tools such as the HCI Tracker, the NACCHO CHA resources, or the OASIS dashboard guide a hospital through the process, they do not offer follow-up guidance. The similar tool that implicitly lays out a method for monitoring and evaluation is CDC's CHANGE tool. The report card is intended to be used after the assessment and implementation strategies have been completed and offer insight to the institution and community on how the next CHNA can be improved. It will assist in the building of an engagement portfolio as suggested previously by Greenberg.

Conclusion

The CHNA environment remains a volatile one, especially as the IRS continues to adjust the language of the PPACA legislation, PHAB accreditation becomes more popular, city planners take an interest, and consultants and hospitals gain more experience. The review of literature and previous assessments, interviews with experts, and critical look at the existing tools, show that a CHNA report card would still be a valuable asset in this process. I recommend that it be created and made widely available before the next round of reporting deadlines approach along with the nation-wide clearinghouse for the reports and strategies.

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Appendix A

**SCHEDULE H
(Form 990)**

Hospitals

OMB No. 1545-0047

2012

**Open to Public
Inspection**

▶ **Complete if the organization answered "Yes" to Form 990, Part IV, question 20.**
▶ **Attach to Form 990.** ▶ **See separate instructions.**

Department of the Treasury
Internal Revenue Service

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		
1b 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. <input type="checkbox"/> Applied uniformly to all hospital facilities <input type="checkbox"/> Applied uniformly to most hospital facilities <input type="checkbox"/> 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 <i>free care</i> ? If "Yes," indicate which of the following was the FPG family income limit for eligibility for free care: <input type="checkbox"/> 100% <input type="checkbox"/> 150% <input type="checkbox"/> 200% <input type="checkbox"/> Other _____%		
b Did the organization use FPG as a factor in determining eligibility for providing <i>discounted care</i> ? If "Yes," indicate which of the following was the family income limit for eligibility for discounted care: <input type="checkbox"/> 200% <input type="checkbox"/> 250% <input type="checkbox"/> 300% <input type="checkbox"/> 350% <input type="checkbox"/> 400% <input type="checkbox"/> Other _____%		
c If the organization used factors other than FPG in determining eligibility, describe in Part VI the income based criteria 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?		
5b If "Yes," did the organization's financial assistance expenses exceed the budgeted amount?		
5c 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?		
6b 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						

Appendix B

Appendix A: Interview Questions

1. Has this institution ever conducted a Community Health Needs Assessment (CHNA)?
 - a. A similar assessment such as HIA, comprehensive planning, or others?
2. Have you ever been involved in a CHNA?
3. Have you begun your (CHNA) for the new Form 990 and Schedule H requirements?
4. Do you have dedicated staff members to work on it?
5. Do you feel prepared enough to work on it?
6. How many administrators do you plan on involving in the process? Health professionals? (Doctors, nurses, etc.) Patients?
7. Do you plan on utilizing or creating any partnerships or business relationships to complete it?
 - a. With who?
 - b. Are you open to working with local health departments? City planning offices? Private consulting firms? Other non-profit organizations? Schools? Faith-based organizations? Politicians and other decision-making bodies? Other area hospitals?
 - c. How would you go about contacting them or starting the process?
8. What are your primary concerns with successfully completing a CHNA?
9. What are barriers that you have already encountered or plan to encounter in the process?
10. How knowledgeable is the staff about what a CHNA is? The benefits? The possible outcomes?
11. What resources does this institution plan on utilizing to conduct a CHNA?
12. What sources will data be collected from?
13. What methods of public engagement will be employed?
 - a. How long will it last?
 - b. How many populations will be targeted and why?
14. How beneficial would a CHNA framework be to this institution?
15. What does a successful CHNA look like?
16. Is there anything else about CHNA that would like to share?