Trinity Health
Community Health Needs Assessment Guide

A guide to assessing all needs, inclusive of the physical, mental, and social influencers of health, within our communities

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Community Health Needs Assessments and Implementation Strategies

What are they?

Community Health Needs Assessments (CHNAs) use data and community input to measure the relative health and social well-being of a community. The community assets and needs identified through the CHNA will be used to develop an implementation strategy, which outlines the hospital's strategies for addressing the identified needs and expanding upon the assets. The findings should inspire collective action and ensure meaningful, effective allocation of resources, both within the hospital and in the community.

Who is required to conduct a CHNA?

The Patient Protection and Affordable Care Act (ACA), enacted March of 2010, added Section 501(r) to the Internal Revenue Code, which effects charitable hospital organizations that are 501(c)(3) tax-exempt. Section 501(r)(3) of the Code requires each separately licensed hospital facility to conduct a CHNA at least once every three tax years, beginning in 2011, and to adopt an implementation strategy to meet the community health needs identified through the CHNA. A Notice of Final Rule was published December 2014 and provides the requirements for tax-exempt hospitals to conduct the CHNA and prepare Implementation Strategies, as well as the consequences for failing to comply with Section 501(r).[1]

Tax-exempt hospitals are required to report on the most recently conducted CHNA and implementation strategy on the annual IRS Form 990, Schedule H, which is made publically available to regulators, press, community organizations and residents by the Trinity Health Tax Department.

[1] Notice of Final Rule - https://www.federalregister.gov/documents/2014/12/31/2014-30525/additional-requirements-for-charitable-hospitals-community-health-needs-assessments-for-charitable

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Trinity Health Standards

This guide establishes minimum standards and recommends best-practices for Trinity Health hospitals as they conduct a CHNA and develop an Implementation Strategy and to ensure compliance with Section 501(r)(3). A survey regarding CHNAs and Implementation Strategies, completed by both internal and external subject matter experts, as well as research into best-practices, informed many of the revisions to this Trinity Health CHNA guide. All Trinity Health hospitals are expected to use this guide, including all procedures, tools, and checklists. The common tools and procedures will allow greater collaboration among Trinity Health hospitals and inform future organization-wide strategies.

Joint CHNAs and Implementation Strategies

The IRS describes joint CHNAs and Implementation Strategies as the shared report that is produced by multiple collaborating hospital facilities. Collaboration, with community organizations and other hospitals, is expected and should be the norm for Trinity Health hospitals. Collaborative organizations that, for the purposes of the assessment, define their service area to be the same can produce a "joint CHNA" and a "joint Implementation Strategy". The service area defined in the joint CHNA should comprise an aggregate of the service areas for participating hospitals and organizations.
Like individual CHNAs, this joint CHNA report would need to specifically identify each participating hospital and organization, and meet all required components.

> **Example 1:** Hospital A's primary service area includes zip codes 48662, 48663, 48664, and 48665. Hospital B's primary service area includes zip codes 48662, 48663, 48664, 48672, and 48673. Hospitals A and B each declare an identical service area, for the purposes of this CHNA, which is comprised of zip codes: 48662, 48663, 48664, 48665, 48672, and 48673.
>
> **Example 2:** All other collaborative organizations who have overlapping communities and do not adopt an identical service area can, and should, share as much of the CHNA process as possible and adopt "substantively identical" reports that differ enough to reflect any material differences in the communities served by participating hospital facilities and community organizations.

See the table below, which outlines these two scenarios.

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Example 1: Adopting the same service area	Example 2: Not adopting the same service area
Hospital A & B's shared service area: 48662, 48663, 48664, 48665, 48672, and 48673	Hospital A's service area: 48662, 48663, 48664, and 48665 Hospital B's service area: 48662, 48663, 48664, 48672, and 48673
Can produce a "joint CHNA" written report. See additional guidance for joint CHNAs and joint implementation strategies below.	Must produce separate CHNA written reports. They may however be substantively identical and differ from each other to reflect the differences in the community served by the respective hospitals. In this example, hospitals A and B could share data sections of the CHNA pertaining to zip codes 48662, 48663, and 48664. Hospital A would need to gather data and input for zip code 48665 and include this zip code in the CHNA process and written report. Hospital B would need to gather data and input for zip codes 48672 and 48673 and include these zip codes in the CHNA process and written report.

Collaborators who adopted a joint CHNA can also adopt a joint Implementation Strategy. Like individual Implementation Strategies, joint Implementation Strategies must meet all required components, in addition to all of the following:

- Clearly identify the document as applying to each participating hospital facility and community organization.
- Clearly identify each individual participating hospital facility and community organization's particular role and responsibilities in taking the actions described in the implementation strategy and the resources each participant hospital facility plans to commit to such actions.
- Include a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relate to each participating hospital facility and community organization.

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Before Beginning a CHNA

Review the Past CHNA Process

The past community health needs assessment should be reviewed prior to starting the new CHNA. Though a complete CHNA must be conducted every three years, CHNAs should build upon one another. Additionally, monitoring and evaluation of the prior implementation strategy should be conducted annually. These data will also be used to inform the new CHNA—specifically when disclosing the impact the hospital has made on community health needs since the last CHNA was conducted and any written comments that the hospital received for the last CHNA and implementation strategy.

Consider the following questions:

- What methodology was used to conduct the CHNA in the past? Was it a designated best practice? Was it useful? What changes could be made to the process?
- Did the hospital receive any comments on the previous CHNA or implementation strategy? **Note: all comments that are received need to inform the new CHNA cycle, and be described in the final CHNA written report.**
- What priorities were identified in the previous CHNA, and were there any emergent needs that developed in the community in the years since the prior CHNA was conducted?
- What other organizations or partners participated in the previous CHNA? Will they participate again this cycle? Are there more that should be included this cycle?
- Were the three required input sources (health department, minority populations/representatives, and written comments) effectively included to identify and prioritize the health needs? How could they be more involved and included earlier in the process?
- What outcomes and successes resulted from the prior CHNA and implementation strategy? Was there improvement in the addressed community need? **Note: the impact (i.e. % or # improved) of actions—not simply a description of the actions—taken since the previous CHNA must be included in the final CHNA written report.**

Identify Internal & External Personnel Resources and Their Involvement

The Board of Director's Desired Involvement

The timing for the development and approval of the CHNA and Implementation Strategy will depend largely on the hospital board's involvement. Trinity Health recommends that the CHNA and

Implementation Strategy are approved at separate board meetings, in order to give the board an opportunity to contribute to the development of the implementation strategy. We also recommend the board, or a representative of the board, is involved in the advisory committee and/or focus groups. Plan ahead and prepare for the board's desired involvement.

Managing the CHNA Process (Advisory Committee)

If the hospital is not already involved in a collaborative process, begin to identify and convene a committee of internal and external stakeholders who will manage and/or inform aspects of the CHNA process. Include within this committee people from various disciplines who will help identify root causes of unfavorable health indicators and validate quantitative and qualitative research, as well as offer volunteers, expertise, financial assistance, ideas for community initiatives, and assistance with widening the reach of the assessment. If the hospital is already involved in a partnership, it may be useful to ensure all capacities or skillsets from the list below are included in the advisory committee.

- Internal: planning and strategy, mission, advocacy, finance, communications, clinical, community health and well-being, and affiliates (clinics, home health, hospice, skilled nursing, foundations, pharmacy, physician groups, etc.)
- External: other area hospitals, physician groups or clinics, any local FQHCs, school districts and educational institutions (pre-k through postsecondary), public safety, youth and adult social service groups, public health, community residents and other community organizations that serve vulnerable populations, etc.

Prepare a Schedule and Budget

A common theme that surfaced in the CHNA survey that preceded the revision to this Trinity Health guide was to start conducting the CHNA earlier, specifically the community input and involvement sections. When preparing the schedule, identify the hospital's board meeting dates within the fiscal year that the CHNA is due. Choose one date to work toward, taking into account:

- An allowance of one or two extra meetings at the back-end in case there are unforeseen circumstances that prevent the CHNA from being approved by the board in the expected timeframe.
- The schedules and timelines of stakeholders, partner organizations, and internal staff. Likewise, ensure the hospital's timeline is taken into account if the CHNA is conducted within a collaborative. Per IRS regulations, the CHNA must be completed by the end of the hospital's fiscal year. Therefore, even if other partners have additional time, know the

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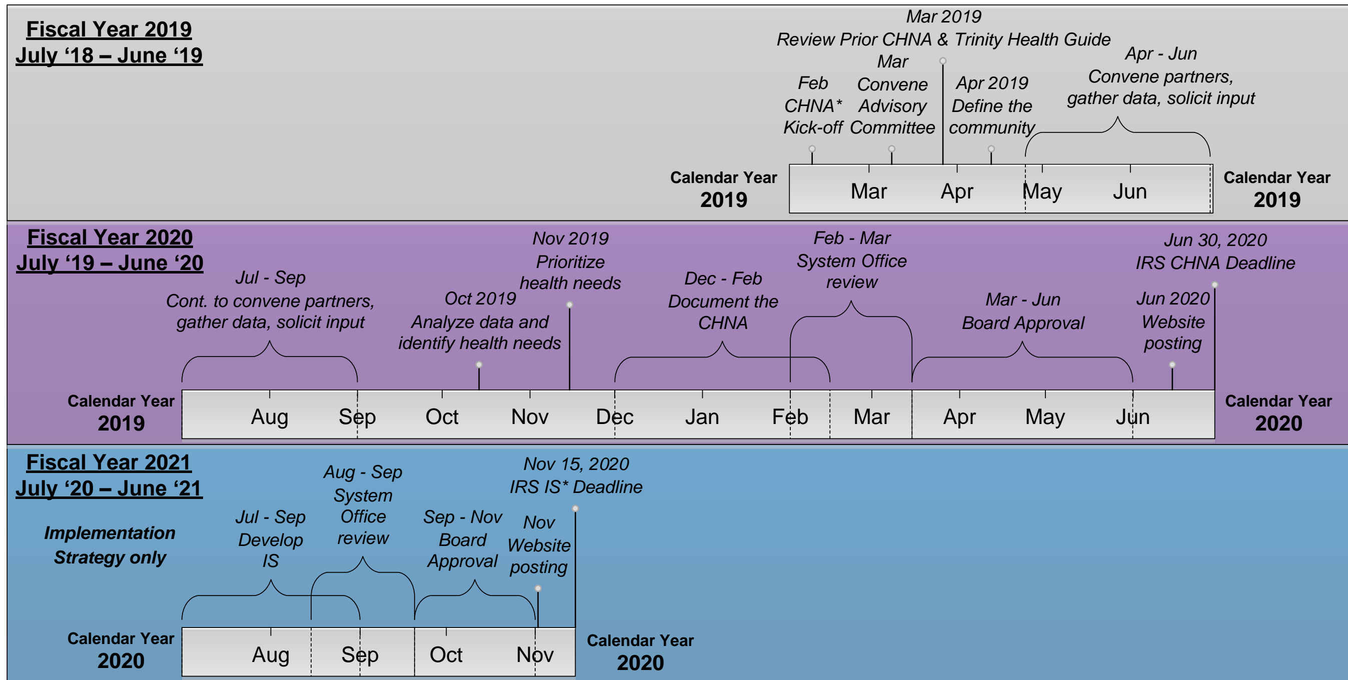
CHNA must be finalized, approved by the hospital's board and posted on the hospital's website by June 30 (September 30 for CT hospitals).

- Allow 12-18 months to adequately conduct the CHNA, including required input and community participation, preparing the written report, gaining appropriate approvals (internal leadership, system office CHWB review, and final board approval), as well as making the document widely available via the hospital's website and at the hospital facility.

Below is an example timeline for the fiscal year 2020 CHNA and implementation strategy process, which includes target progression dates, System Office deliverable due dates and IRS deadlines. The hospital CHNA process should begin at least sixteen months before the conclusion of the fiscal year, or the targeted board meeting at which the CHNA will be adopted. Your hospitals timeline may be accelerated, however the key milestones indicated below must be met by these dates. A printable timeline is located in Appendix B.

Example 16-month CHNA and 4.5-month Implementation Strategy Timeline
Fiscal Year 2020
June Year-end



CHNA – Community Health Needs Assessment
IS – Implementation Strategy

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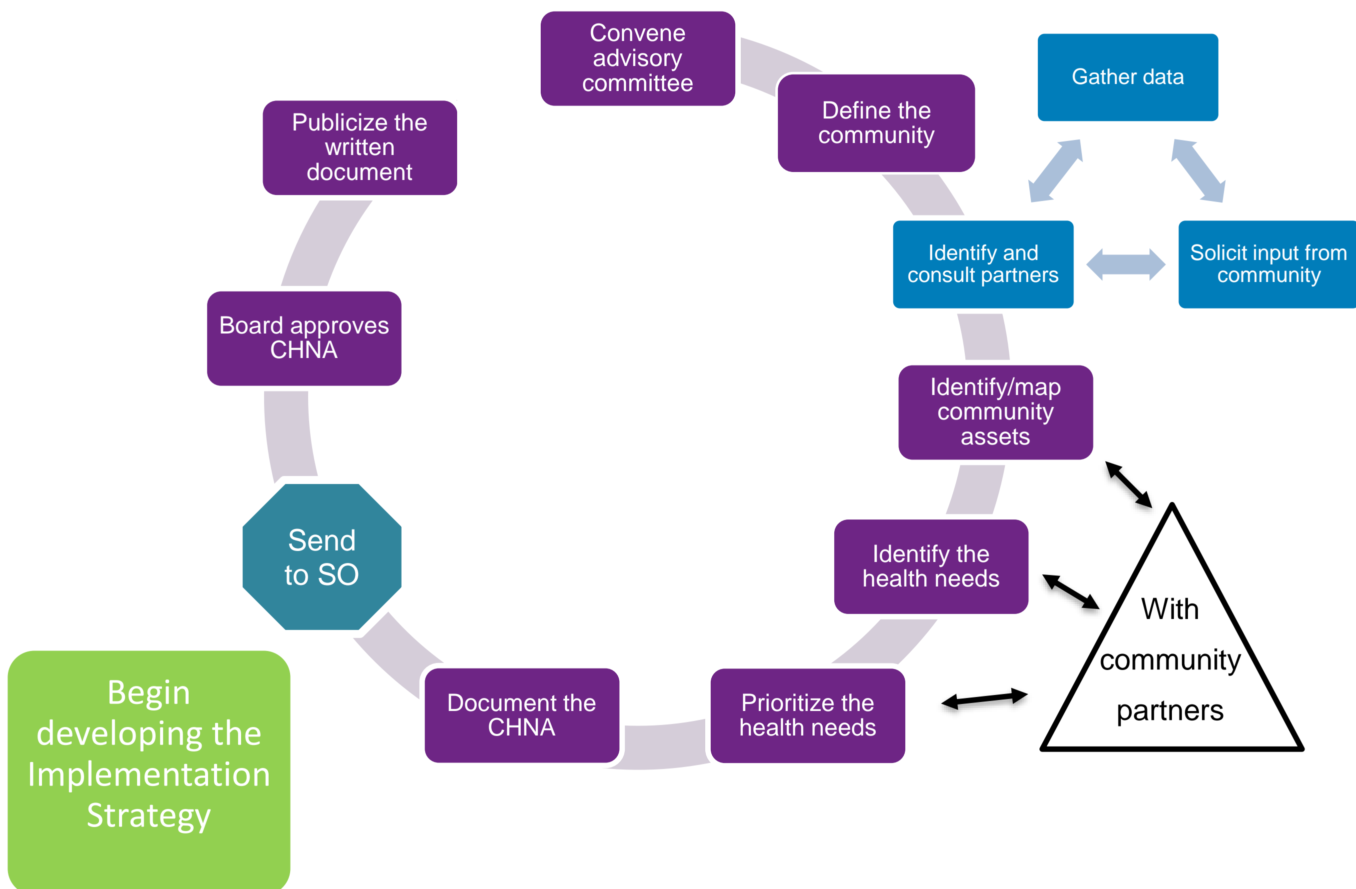
Prepare a budget of the anticipated costs for conducting the CHNA and ensure that these costs are included in the annual CHWB budget, which is submitted to the System Office each Spring. Keep in mind that all costs associated with conducting the CHNA "count" as Community Benefit and should be reported in category G2—Community Health Needs/Implementation Strategy in CBISA. For each hospital, take the following into account while preparing a budget:

- The size of the hospital's service area
- Type and frequency of community input methods
  - For in-person meetings, account for the costs of space, food and other incentives
- Partners and external resources available to assist with the CHNA and their ability to contribute personnel and/or financial support
- Required timeframe for completing the CHNA (a longer timeframe may reduce costs, while a tighter timeframe may increase costs)
- Use of paid consultants and/or unpaid interns for data collection and/or other aspects of conducting the CHNA
- Evaluation costs (data collection, consultant, analysis tools, etc.)
- Estimated costs for addressing the needs in the implementation strategy and ongoing implementation, evaluation, etc.

Conducting a Community Health Needs Assessment

The process that Trinity Health ministries should follow while conducting a CHNA is illustrated below. Be sure to document the entire process, as each hospital will be required to include a summary and description of its process in the final CHNA written report, which is reported on the IRS 990 Schedule H. The required steps to conducting the CHNA are as followed: convening the CHNA advisory committee, defining the community served, then identifying and consulting partners, soliciting input from the community residents and organizations, and gathering data—all of which should be completed concurrently. An inventory of the current assets within the community should be identified. Using the input that is gained from the community and through partners, identify the significant health needs. Then, those significant health needs will need to be prioritized—with community involvement. Document the process and results of the CHNA in a written CHNA report, then send to the System Office for review. Once the written CHNA is reviewed and any necessary edits are made, the final CHNA can go to the board for their approval. As a last step to the CHNA process, the final CHNA written report must be publicized.



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Convene Advisory Committee

The advisory committee should consist of both internal and external representatives. See page 7 of this guide for additional information about selecting individuals to participate in the advisory committee. The advisory committee drives the entire CHNA process and ensures a collaborative and inclusive approach to conducting the CHNA. Another important role of the advisory committee is to be aware of regulatory and Trinity Health standards and ensure that the CHNA and Implementation Strategy process and final written reports are compliant.

Define the Community Served

The community served can be defined as a geographic area, or target population. In general, the primary and secondary service areas for the hospital, as established by the planning or strategy department, should be used to define the community served. Regardless, the community served must not exclude those who are medically underserved, low-income, uninsured, underinsured, or minority populations. Note that if the community served used in the CHNA differs from the local planning/strategy definition, the rationale must be supported and documented.

As mentioned previously, hospitals who conduct a "joint-CHNA", as defined by the IRS, must adopt an identical definition of the community served for purposes of the CHNA. See pages 4-5 of this guide.

Identify and Consult Community Partners, Solicit Input from the Community, and Gather Data

Identify and Consult Community Partners

Outside of the internal and external CHNA advisory committee, there are likely other partners or resources who can assist with data collection and act as sources for community input. Organizations that regularly compile data and information from the community include: United Way, local foundations, educational institutions, city/county government, health department, and other local hospitals or healthcare providers. Community Engagement is expected throughout the development of the CHNA and the Implementation Strategy.

Community and stakeholder engagement are broad terms with multiple interpretations. Community Catalyst—one of the national technical assistance providers for the Transforming Communities Initiative (TCI)—has developed the following definitions to guide the approach to community engagement and to provide a common framework.

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Within the community health context, “community engagement” is frequently defined as the activities and process used to work collaboratively with and through community residents, groups, and organizations who are impacted by a particular problem to win meaningful change. Terminology and concepts can vary slightly in other sectors.

Coalition Building: A coalition is an alliance or partnership among different organizations that represent a broad range of interests and bring different assets, missions, perspectives, constituencies, relationships and strategies to work collaboratively toward a common goal. Coalition building is not the same as community engagement. Coalitions may seek to bolster their competence and capacity for community engagement by forming deliberate partnerships with other organizations, such as those that organize or work with grassroots community residents. However, organizing organizations is not the same as organizing individuals.

Community Engagement: The activities and process each site uses to work collaboratively with and through community residents, groups, and organizations who are from, led by, and/or partner closely with the populations included in the CHNA. Community engagement may involve outreach to grassroots or grasstops individuals, and may consist of a wide range of activities, from seeking input on a proposal to shared decision-making.

Grassroots: “Grassroots” often refers to “ordinary people” who do not have a formal or professional role in public life, and who are not in leadership of a local agency or organization. Some grassroots engagement techniques—specifically community organizing—focus on identifying, involving, and empowering the community residents who are most impacted by a problem to act on their own behalf and win change. Grassroots is also used as shorthand to describe strategies that involve reaching out to large segments of the public, such as door-knocking or open meetings.

Grasstops or Grasstips: Generally used to describe residents or other community members who are recognized leaders in their neighborhoods or organizations due to their professional roles, public profiles, or positions of power. Grasstops leaders usually have access to, and can wield influence on, key decision-makers or segments of the *grassroots* community.

Stakeholders: Stakeholders are people (and organizations) who are either impacted by a problem or a site, either directly or indirectly, or who can have an effect on the outcome of a site (often called “key stakeholders”).

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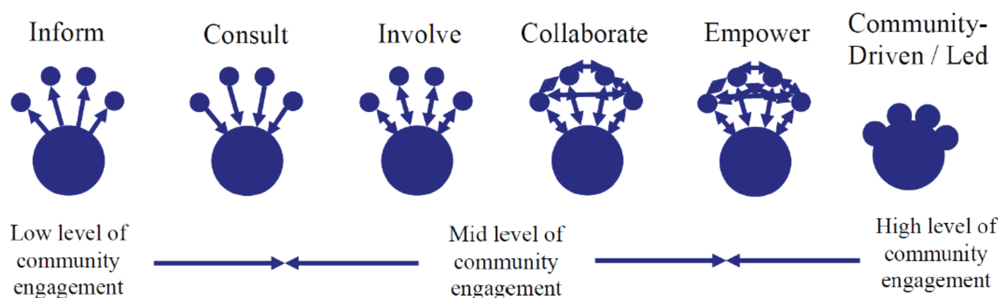
Techniques to build community engagement range across levels of those engaged (grassroots, grasstops, grasstips) and across a spectrum of engagement stages. The ladder of engagement includes building awareness, interest, participation or action, commitment, or leadership/decision-making capacity. Strategies therefore range from informing or consulting with community members, to involving and collaborating with community members, to placing final decision-making authority with community members.

Community Engagement Spectrum. The community engagement spectrum below depicts a continuum of community engagement ranging from low (informing the community) to high (having a community-driven and led process). The larger blue circle in the depiction represents the hospital. Hospitals are encouraged to engage their communities at the highest level within every step of the development of the CHNA and implementation strategy. Additional community engagement information is available at the website referenced in footnote 2 below.



Source: International Association of Public Participation and adapted by DPH[2]

Solicit Input from the Community

Required input sources. The IRS Final Rule requires that hospitals obtain input from those who represent the broad interests of the community and use this information to both identify and prioritize the community health needs. To fulfill this requirement, input must be solicited from all of the following groups with knowledge or expertise in public health and the community:

1. At least one public health department (state, local, tribal, regional government, or equivalent) or a State Office of Rural Health. It is Trinity Health's expectation that every hospital demonstrates in their CHNA that a representative of the health department participated on the advisory committee.

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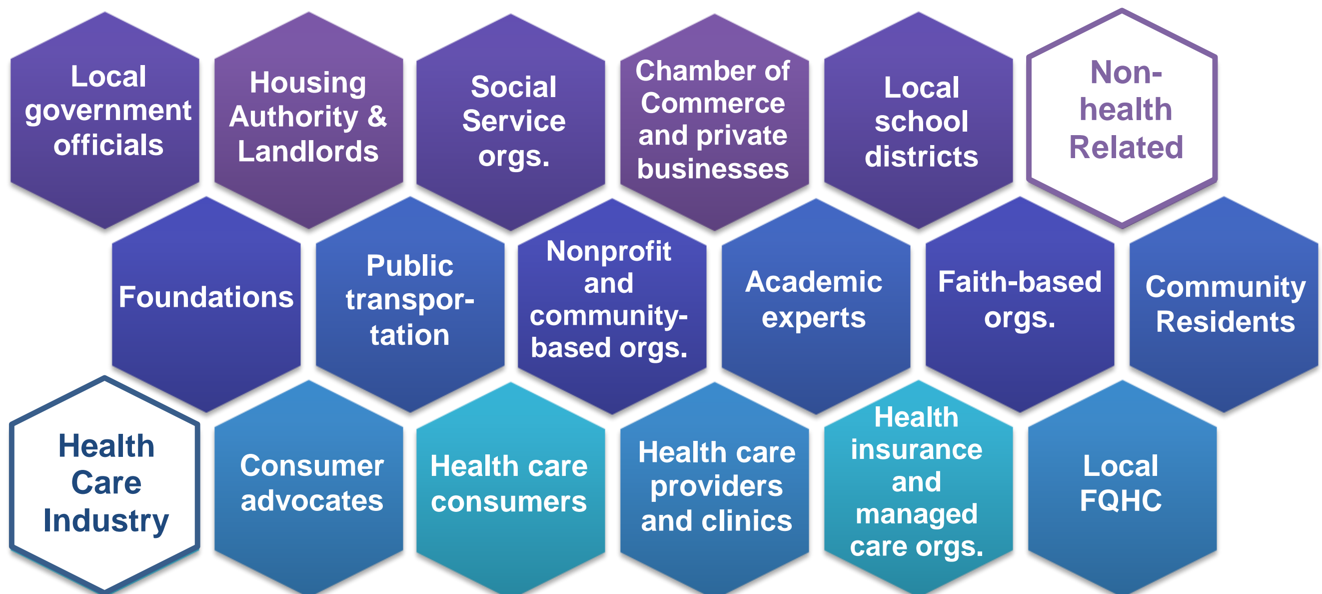
[2] "Community Engagement Standards for Community Health Planning Guideline," Massachusetts Department of Public Health, available at: http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf.

2. Members of the medically underserved, low-income, and minority populations in the community, or individuals/organizations serving/representing the interest of such populations.
3. Through written comments received for the hospital's previous CHNA and Implementation Strategy.

The hospital must describe in the final written CHNA report and in the IRS 990 Schedule H how the input was solicited from each of these groups and how it was taken into account to identify and prioritize the health needs of the community. The names of the organizations from which input was provided, the approximate timeframe for such input, and a summary of the nature and extent of their input must be included in the description. If input is solicited but not collected from any one of these groups, the hospital must describe the reasonable efforts it took to gain input.

Additional input sources. In addition to the previous three groups whose input is required by the IRS, hospitals are expected to seek input from other sources. Consider soliciting input from a broad range of persons or organizations located in or serving the community including those listed below:



Input methods. According to the survey regarding CHNAs, which was conducted by the CHWB department in May 2018, the most commonly used community input methods included: consumer surveys and focus groups or forums, also called community feedback sessions and townhall meetings.

Several respondents provided examples of their consumer survey questions used to solicit community input. A compilation of these questions and additional questions sourced from other resources can be found in Appendix C. When the survey is being built for the CHNA process, be sure to use validated questions to ensure that the answers received will be useful for analysis. The verbiage used in the survey questions listed in Appendix C are validated, however the way in which the question and the response options are provided on the survey are equally important.

The formats of focus groups and community feedback sessions can vary. For example, a hospital/collaborative may hold a focus group or forum and invite members of the community. Consider holding the meeting in a central location, off hospital grounds, offering incentives to participants, setting expectations and distributing an agenda well in advance of the session, and offering various ways for community members to provide input. Additionally, hospitals should collaborate with partners, grantees, or other organizations representing or serving the community by attending regularly scheduled meetings to discuss the health and social needs of those they serve. This can serve to gain input from the health department, representatives of those who are minority or underserved, and the general community. Be sure to record the dates, location, the organizations and populations represented (names of individuals are not necessary), and a brief summary of the meeting to include in the CHNA written report, all of which are required components of the CHNA. In order to reach special populations and those who are most vulnerable, it is best practice to convene in smaller groups, particularly in settings where these populations gather (i.e. a youth center, senior center or retirement facility, substance use addiction treatment clinic, homeless shelter, etc.).

Another method that is used to solicit input is conducting individual interviews with community leaders, individuals with expertise in public health, or other individuals within the community.

Regardless of which method, or methods, are selected for the CHNA process, be sure to include an accurate representation of the community served, including minority populations. For

example, surveys should be offered in both paper and electronic format and distributed at public events and businesses (laundry-mats, food banks, farmer's markets, senior centers, etc.). Trinity Health recommends that community surveys are translated into other languages if the community served has a significant non-English speaking population.

Gather Data

Hospitals should take into account both quantitative and qualitative data when analyzing the needs of the community. Both qualitative and quantitative data can be sourced from the community through the community input methods described above. Quantitative data should also be pulled from internal patient utilization data (both acute and physician networks). Correlations can be drawn between patient data and community data and if the hospital's patient sample is representative of the community, it can be used as a proxy for more frequent, timely data for the CHNA and evaluation measures.

Additional quantitative data should be sourced for the community. Community Commons and County Health Rankings & Roadmaps are two sources that provide data and analysis for the nation at a county level from a broad range of health, social, environmental, and economic indicators. Click on the icons at the right to be directed to their website. When possible, more recent, localized data for the community should be pursued and included in the data analysis for the CHNA. Appendix A comprises a list of data sources that may be useful to some hospitals, depending on the location of the community served and the desired topics of data (i.e. education, economics, environmental, violence, etc.).

COMMUNITY COMMONS

The following categories of data are required for all Trinity Health ministries to include in their CHNA processes:

Social Influencers of Health (SIoH). Review data for the hospital's service area related to poverty, education, built environment, access to employment, etc. that contribute to the health of the community.

Demographic data. At a minimum, hospitals should collect demographic data on the community's population and population trends, distribution of age, gender, race, ethnicity, language, income, and poverty levels, as well as other pertinent information related to the community.

Data from prior CHNA and Implementation Strategy. Data should be collected from the evaluations of activities and programs that the hospital and community partners engaged in for the prior Implementation Strategy.

Required data indicators. All ministries are required to collect and analyze a set of indicators at the lowest data point possible (census tract, zip, county, etc.). The data set and the sources can be found in Appendix F. A tool to collect these indicators is forthcoming from the System Office in the Spring of 2019.

Note: A data table that includes all of these indicators will need to be included as a separate appendix in the hospital's final CHNA written report, even if data was referenced elsewhere within the report.

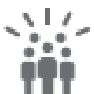
Identify Community Assets

Asset "mapping" is the process of identifying existing community strengths, both related to physical structures and capacity, which support the health of the community. Asset maps can be a simple list of community assets, an illustrated "map", or a geographical map. By focusing on community assets, additional stakeholders and collaborative partners may be revealed. Also, with knowledge of the current assets, hospitals may place greater emphasis on enhancing, expanding, and connecting existing resources and associations while making decisions about the community needs and developing the implementation strategy. Assets that should be considered include:

Human resources: the skills and capacity of local residents, organizations, governing bodies, existing programs, and associations (i.e. individuals, philanthropic institutions, business owners, local leaders, activists, volunteers, etc.)

Physical resources: public spaces that are available to community members for meeting space and recreation (i.e. library, community center, gardens, parks, farmer's markets, etc.)

Informational resources: associations and memberships, both formal and informal, available for networking, communication, and support (i.e. faith-based organizations, civic groups, etc.)



Political/governmental resources: elected officials and public and private institutions that currently advocate for resources and policy change within the community (i.e. advocacy groups, law enforcement, public health department, social services, colleges/universities, school district, pre-k/childcare, etc.)

Existing intervention resources: initiatives and programs that are currently provided within the community (i.e. community benefit programs, food banks, youth programs,

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senior programs, etc.). Auntbertha.com is a great resource for free or reduced cost services such as medical care, food, job training, and more.

Additional information about asset mapping and ways of leveraging these strengths to improve community health, including a toolkit developed by the Association for Community Health Improvement, can be found here: http://www.healthycommunities.org/Resources/Toolkit/files/step2-identify-engage-stakeholders.shtml#.W1tWQJ9KjIU, http://www.hpoe.org/images/asset-mapping-for-chna.pdf, https://resources.depaul.edu/abcd-institute/resources/Pages/default.aspx

Identify the Significant Health Needs

The significant health needs identified within the CHNA must include the community input, data analysis, and social influencers and other contributing factors to the health of the community. Health needs can generally include:

- Financial and other barriers to accessing care
- Preventing illness
- Ensuring adequate nutrition
- Social, behavioral, and environmental factors that influence health
- Improvement or maintenance of the health status in both the community at large and in particular parts of the community (such as neighborhoods or populations experiencing disparities)

Quantitative Data Analysis

The recommended method for analyzing quantitative data to determine whether an indicator is a "significant" need within the community is to perform a benchmark analysis. This involves comparing indicators against a benchmark, such as Healthy People 2020 goals, county health rankings top performers (10th percentile), or a state or county benchmark. Indicators that do not meet the established benchmark, therefore unfavorable, will emerge as needs. Next, calculate the need differential, which is the difference between the community's performance and the established benchmark:

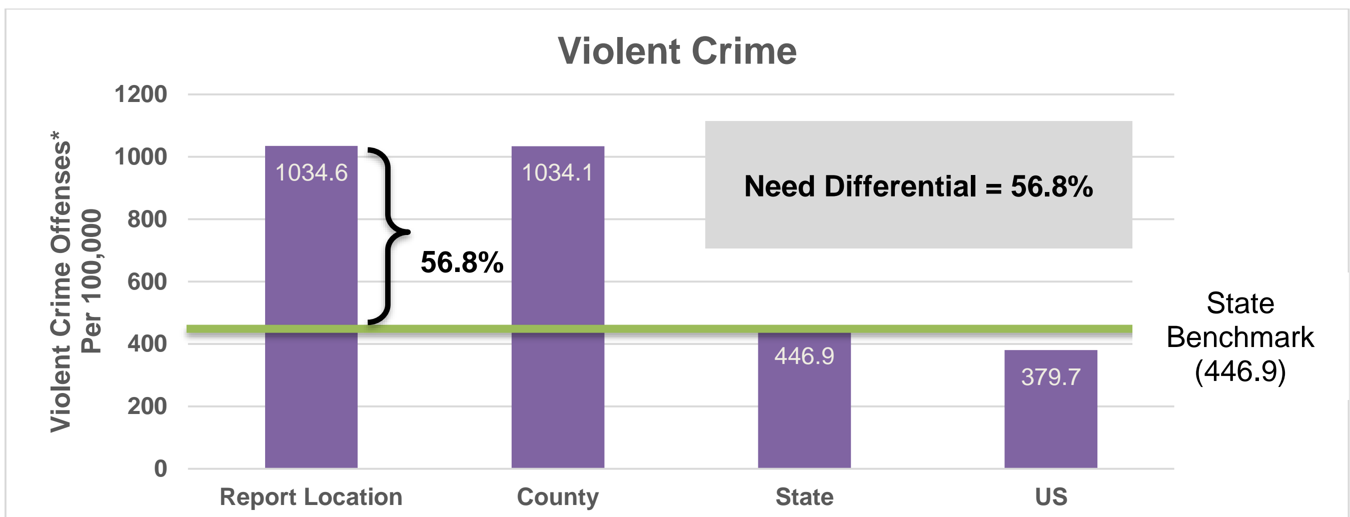
((current rate – benchmark) / current rate) x 100 = Need Differential

A smaller percentage, relative to other needs, means that a need is unfavorable compared to the benchmark at a <u>lower</u> degree. While a larger percentage, relative to other needs, means that a need is

unfavorable compared to the benchmark at a higher degree. In other words, the greater the differential, the greater the need is for a particular indictor.

In the Violent Crime example below, the current rate for the reporting location is 1,034.6 per 100,000. The state benchmark is 446.9 per 100,000.

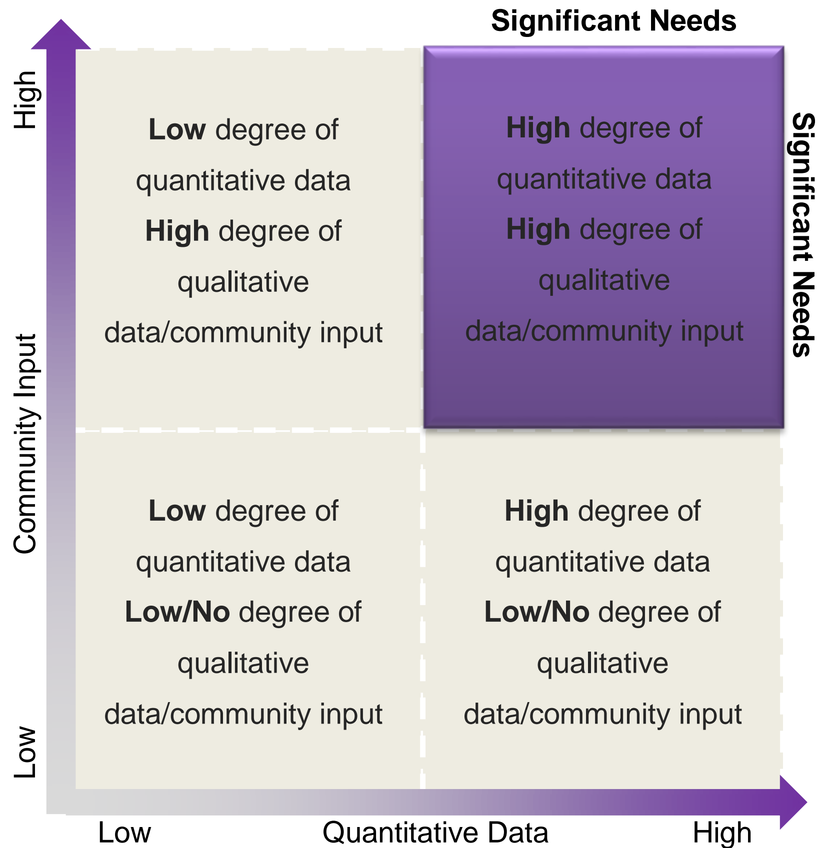
$$((1{,}034.6 - 446.9) / 1{,}034.6) \times 100 = 56.8\%$$



Qualitative Data Analysis

Next consider the needs identified through the qualitative data gathered through focus groups, surveys, interviews, and other sources for community input. Separate the indicators that were a common theme among community input from those that were less common.

Arrange the needs in the matrix according to the description in each quadrant, pictured at right. The top right quadrant of the matrix holds the community's "significant health needs", which were both identified through community input *and* performed unfavorably when compared to the established benchmarks, at a higher degree than other needs. The significant health needs listed in the top right quadrant, shown in purple, are those that will go through the prioritization process.



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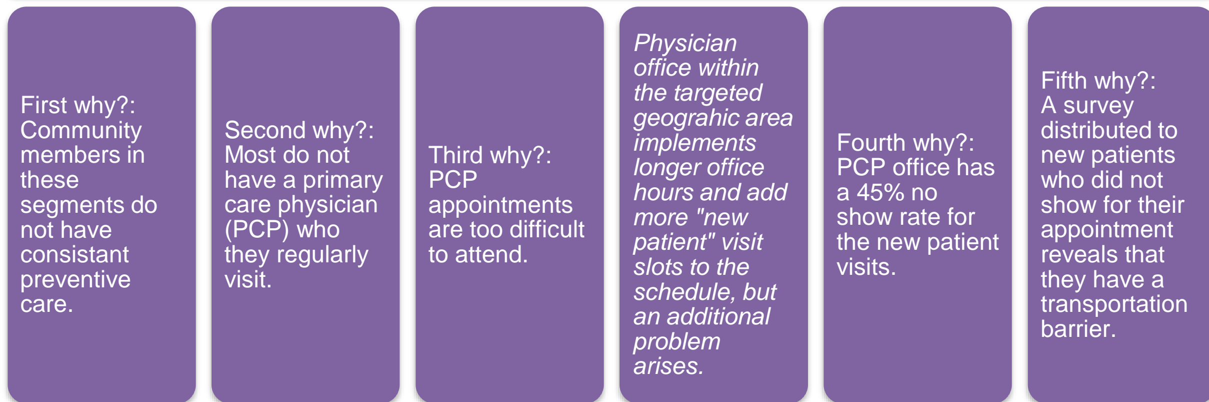
Root Cause (Five-whys)

When identifying the health needs of the community, be sure to be specific and think of the root causes. Utilize the "five whys", a process of asking "why?" five times to identify the underlying issues that caused the need to develop within the community.

Example: a hospital partners with other health care providers and they identify *Community Wellness* as a community health need.



As a result of asking for additional information—the series of "whys"—rather than the broad need of *Community Wellness*, the hospital instead identifies *Transportation* as a community need that influences health. The hospital goes on to address the need within their implementation strategy through beginning to screen for transportation barriers in the acute setting, connecting patients with existing community resources, including free taxi and bus vouchers, and working with public transportation to add additional bus stops to existing routes and modify business practices for improved timeliness.

Resources to Address the Significant Health Needs

Resources that are identified through the CHNA process that address the community's significant health needs must be listed in the written CHNA report. Keep a running list of these resources as they surface.

Prioritize the Significant Health Needs

All identified health needs that are deemed "significant" in the previous step go through a prioritization process, where the hospital and/or collaborating partners numerically rank the needs using one of

many methods available. The purpose of prioritizing the significant health needs is to allow for community organizations to easily pinpoint which needs have been deemed most critical and practical to direct resources, time, and energy toward. Keep in mind that the priorities given to the significant health needs are reflective of the community's priorities, not whether the hospital itself can or will address the need. The hospital is not obligated to directly address each prioritized significant health need and can choose which needs will and will not be addressed in their implementation strategy.

The hospital and partners can select any method and criteria for prioritizing the health needs. The methods selected must be documented in the written CHNA report, along with a description of how community input was used in the prioritization process. The initial steps to prioritization is to identify the method(s) and criteria by which the needs will be ranked.

Criteria

The criteria for prioritization may include any of the following, plus others as determined by the CHNA stakeholders:

- The severity, magnitude, or urgency for addressing the need
- The feasibility and effectiveness of possible interventions
- How are existing community resource and assets addressing, or not addressing, the need
- Potential impact on the greatest number of people, identified disparities, or the social influencers of health
- The consequences of inaction (i.e. the burden placed on the community, loss of life or quality of life, potential worsening of the problem, or the financial losses).
- Potential for outcomes which are measureable and achievable within a three year period.

Methods

There are several prioritization methods that can be used to numerically prioritize the health needs, once they have been identified. Summaries for select methods are offered below and detailed step-by-step instructions, along with a comparison chart are located in Appendix E. Choose the method that works best for your group size, meeting format (i.e. virtual or in person, separate meetings with individual partners or one prioritization session, etc.), preference, and number of identified needs. Any of the methods can be tailored and customized to meet the needs of your prioritization group.

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Criteria Weighting Method – Using a set of criteria, such as those listed above, needs are ranked through a mathematical process. Each criterion is given a weight by which each need is ranked (i.e. -8 to +8, 1-10) according to. Scores for each need are then averaged and fall into a numerical rank by significance. The needs with the highest number are given the highest priority. This is the Trinity Health preferred prioritization method due to its objective, mathematical basis.

Simplex Method – Assists the prioritization group to prioritize needs through group perceptions, which are obtained via a questionnaire. Each need should have the same number of questions and the questions should be comparable to each other. Questions can be weighted, which would give the particular question more importance than others. Answers to the questionnaire are then scored and ranked numerically. The needs with the highest scores are given the highest priority.

Nominal Group Planning – Through group discussion and information exchange, needs of greatest concern are prioritized. Group members individually, then as a group, list ideas and recommendations for needs. Individually, group members then rank the options, which get aggregated. Group members form a list of decision-making criteria, such as equity, proportion of community affected, and cost of intervention, which is used at the end to finalize prioritization.

Quick and Colorful Approach – Using a quick, easy, and interactive approach, group members vote on the priority of needs. Voting can be secret (using ballots and a box or basket per need) or open (using flip charts and colored stickers). Determine ahead of time what each color or symbol will correspond to which rank (i.e. red indicates high priority, yellow indicates medium priority, and green indicates low priority, etc.). Group members cast their votes by distributing their ballots or stickers and results are aggregated.

Document the CHNA

The entire CHNA process must be documented into a written report that will be approved by the hospital's board of directors, made publically available, and reported on the IRS 990 Schedule H. Hospitals participating in a collaborative effort should perform a gap analysis of the CHNA process and the written report to determine what additional steps may be necessary to meet the hospital-specific requirements for the CHNA, as outlined in section 501(r)(3) of the Internal Revenue Code. For

example, the CHNA produced by the collaborative may lack a description of the specific impact the hospital made on the health needs identified in the prior CHNA or it may not have solicited input from the local health department or other required sources. In either case, the hospital can use relevant sections from the collaborative CHNA for the hospital's final written CHNA report, but would need to supplement these sections and produce a CHNA that conforms to Trinity Health's CHNA Guide and includes all IRS required hospital-specific information.

Below is an example outline for the final written report which consists of recommended headers and sub-headers. Additional content suggestions and requirements are also included for some sub-headers, denoted as roman numerals. Copy and paste the outline into a new document to begin drafting the final written report.

Title/cover page

a. Hospital name
    i. The title page must clearly identify the hospital facility or facilities for which the CHNA applies to. Unless a hospital is adopting a "joint CHNA" report with other hospitals (*see pages 4-5 of this guide for criteria*), each hospital facility should have its own cover page.
b. CHNA Date "This CHNA was adopted by X board on XX/XX/XXXX, for FY21-23"
c. Credits and collaborative partners (or inside cover page)

Table of contents

Executive Summary (2-3 pages)

a. Summary of CHNA process (community served, collaborative partners, methods used to identify and prioritize significant health needs, and community input).
b. List of all "significant" health needs identified (not just those the hospital plans to address)
c. Date the CHNA was adopted by the authorized body

Introduction (3-5 pages)

a. Hospital description
    i. Mission statement
    ii. Services provided by the hospital
    iii. Health facilities owned/operated by the hospital
b. Description of advisory committee

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c. List/logo compilation of collaborative partners

d. Review of prior CHNA

i. A summary of the prior CHNA, including needs that were identified at that time

d. Evaluation of the impact since the previous CHNA

i. Include the evaluation and results of any actions that were taken since the hospital facility finished conducting the previous CHNA, to address the significant health needs identified in that CHNA (*see page 27 of this guide for standards*)

Community description (2-4 pages) *See page 11 of this guide for standards*

a. Geographic area served

i. including a map of the area, with the hospital(s) and zip codes labeled

b. How the community served was identified (service area, population served, etc.)

c. Demographics of population

i. tables and charts are preferred over text

d. Community assets

Process and methods used to conduct CHNA (3-5 pages)

a. Methods used to collect and analyze the data (*see pages 11-21 of this guide for standards*)

b. Data collected, including sources (*see pages 14-15 of this guide for standards*)

c. Description of any parties collaborated with or contracted/hired for assistance

Community input received from required sources (8-10 pages) *See pages 11-13 of this guide for standards*

Required sources:

1. State, local, regional or other health department
2. Members or representatives of those who are medically underserved, low-income, or in minority populations
3. Written comments received on the prior CHNA and Implementation Strategy

For each of the required sources listed above, include in the description of community input the following:

i. Methods used to solicit input (focus groups, public forums, consumer health surveys, and other methods for collecting input)

ii. How the hospital took into account input, including **identifying and prioritizing** significant needs

iii. A summary of the input received (including the needs that were surfaced by source)
iv. The approximate date or time period input was provided
v. If no input was received from these sources, hospitals are required to describe how they solicited input and provide a brief explanation that the input was not received (ex: Hospitals are required to include any written comments received on their most recent CHNA and implementation strategy. The prior CHNA and implementation strategy were made available for public review and comment on the hospital's website. To date, no comments have been received by the hospital.)

Significant Community Health needs (3-5 pages)

a. Process and criteria for identifying and prioritizing these significant needs (*see pages 16-21 of this guide for standards*)
    i. Include how the community input was used (Ex: insert the materiality matrix from p. 18).
    ii. Include the criteria and methods for identifying the significant health needs
    iii. Include a description of the prioritization process, if separate from the identification of the health needs.
b. Significant Health Needs (*see pages 16-19 of this guide for standards*)
    i. List in priority order
    ii. Include a detailed description and analysis of all the "significant" health needs identified through the CHNA (i.e. disparity data, explanation of barriers and gaps, etc.)

Community Resources and Assets (1-2 pages)

a. Potential resources to address significant health needs, only if known or identified through in the course of the CHNA process
b. List and description of community assets

Conclusion (1 paragraph)

a. Acknowledge that an implementation strategy will be developed and available in a separate document
b. Instructions for how to obtain copies (physical and web address)
c. Contact information to solicit comments regarding this CHNA for the future CHNA cycle
d. The fiscal year that the next CHNA is due

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Appendices (as many as needed)

a. Table of community, health, social, and environmental data that was collected for use in the CHNA **(required)**
b. Table of community assets **(required)**
c. Data compiled from other sources
d. Consumer health and business surveys
e. Additional supportive documentation referenced in the written report

Note:

- The lengths of individual sections may vary; however the main content of the Final Report should not exceed 50 pages, plus relevant appendices.
- Consider using the executive summary (or a version of the summary) to distribute to as a mailer, handout, or to be published in the newspaper to further publicize the CHNA. The full-length document must be posted online.

System Office Approval Process

All CHNAs written reports and Implementation Strategies must be submitted to the Trinity Health System Office (SO), along with the checklist, for review and approval prior to the documents being approved by the hospital's Board of Directors. Please allow at least four weeks turnaround time and additional time to make edits, if necessary, prior to submitting the documents for the board packets. We will also accept and encourage drafts for review prior to the finalized written report submission.

Formally Gain Board Approval

It is necessary that the final complete CHNA written report (not a draft or a summary) is formally approved by the hospital's Board of Directors prior to the end of the fiscal year, June 30 for most Trinity Health ministries and September 30 for Connecticut ministries. The IRS regulations allow for the board to appoint an authorized person or committee to adopt the CHNA and Implementation Strategies.
If due to timing it may be problematic to have the final report ready by the last board meeting of the fiscal year, provide a draft or summary report to the board at their next meeting and request that the board appoint an authorized person or committee to adopt the final report before June 30 (September 30 for CT). The adoption, which can be done via email or in person, must be documented in writing. This documentation is required to be retained for the two most recent CHNAs conducted. Maintain the

minutes from the board meeting which describes the action taken on the CHNA written report and the date on which it was approved.

If a joint CHNA was conducted for two or more hospitals, the CHNA written report must be approved by all hospitals' board of directors.

Publicize the Written CHNA Document

The two most recent final and approved CHNA written reports must be publicized via the following means:

- Conspicuously posted on the hospital's website, 1 or 2 clicks from the hospital-specific homepage. If a ministry does not have a Community Benefit or Community Health & Well-Being landing page, please post these documents to the "About Us" page. These documents must be posted to the website by June 30 for most Trinity Health ministries and September 30 for Connecticut ministries, and must remain posted through two CHNA cycles. For a record, save a screenshot of the posted CHNA by June 30 (September 30 for CT ministries).
- Made available upon request at the hospital facility, free of charge.

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Developing the Implementation Strategy

It is recommended that the development of the Implementation Strategy begins while finishing the final written CHNA. The IRS gives hospitals an additional 4.5 months to complete the Implementation Strategy, in order to specifically focus and devote enough time to the development of the implementation strategy (November 15 for most TH hospitals, February 15 for CT hospitals). This will result in a plan that the hospital will implement and evaluate over the subsequent three years, with the goal of making a positive impact on the community needs that the hospital chooses to address.

Trinity Health has adopted a standard implementation strategy template that all member hospitals must use for publication. The template is concise and understandable for public review, and ensures that the 501(r)(3) requirements are met. An evaluation of the actions taken by the hospital is necessary and is a critical component of the CHNA written report. For this reason, the standard template stresses the importance of having evaluation measures in place from the beginning, and will help hospitals evaluate their effectiveness for reporting in the future CHNA cycle and the upcoming IRS Form 990 Schedule H. Addtionally, the standard template allows Trinity Health ministries to compare "apple to apples" when reviewing and benchmarking strategies across the system, as well as sharing best practices.

The Importance of Implementation Strategies

Assure **intentional and strategic** investment of limited charitable resources

Communities benefit most from **effective** interventions directed at **priority** needs

Implementation strategy development **encourages collaboration** around shared goals

Implementation strategies are **required** for 501(r) compliance

Using the Implementation Strategy Template

Accessible via a separate Microsoft Word document, the implementation strategy template features fillable tags within the body of the document for descriptions of the hospital, community served, demographics, mission statement, etc. There is a section in the Implementation Strategy template to input a list and description of the prioritized significant health needs that were identified in the CHNA, shown below. This list must match what was reported in the CHNA written report.

Health Needs of the Community

The CHNA conducted on 5/5/2019 identified the significant health needs within the Trinity Health System community. Those needs were then prioritized based on magnitude of persons affected, impact on quality of life, feasibility of reasonable impact, and the consequences of inaction. The significant health needs identified, in order of priority include:

Need	Description
1) Mental Health	– 25% of survey respondents cited Mental Health as their biggest health concern – Lack of mental health providers in Oakland and Wayne counties
2) Obesity	– 45% of Wayne and 35% of Oakland residents are considered to be obese – 60% of survey respondents are not meeting physical activity guidelines to maintain a healthy weight – 45% of survey respondents are not consuming the appropriate daily servings of fruit and vegetables
3) Tobacco	– Click or tap here to enter description of need. – Click or tap here to enter description of need.
4) Violence	– Click or tap here to enter description of need. – Click or tap here to enter description of need.
5) Transportation	– Click or tap here to enter description of need. – Click or tap here to enter description of need.

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The significant health needs that were identified are then broken down in the implementation strategy between those that the hospital will address, and those in which it will not. Determination for which needs will and won't be addressed is made by the hospital, and partners, based on all available facts and circumstances. Involve partners early on and throughout the development of the strategy. Limiting the needs that are selected for intervention to no more than three to five health needs is recommended, to ensure sufficient focus and resources are allocated to effectively address a need.

For the significant health needs that will not be addressed, the hospital must include in the implementation strategy a brief explanation. Example reasons for inaction could include:

- To avoid duplication of efforts because other facilities and organizations are addressing the need
- Resource constraints
- Competing priorities
- Relative lack of expertise or competency to effectively address the need
- The need being relatively low priority

For the significant health needs that the hospital selected to address, an individual strategy tool must be completed. Even if conducted jointly with partner organizations, each hospital must complete the tool for the hospital-specific actions and committed resources. The tool is described in greater detail below:

CHNA IMPLEMENTATION STRATEGY
FISCAL YEARS Click or tap here to enter year range.

Hospital facility:	Click or tap here to enter text.		
CHNA significant health need:	Click or tap here to enter name of need.		
CHNA reference page:	Click or tap here to enter text.	**Prioritization #:**	Click or tap here to enter prioritization # .

Brief description of need:
Click or tap here to enter text.

Goal: Click or tap here to enter text.

SMART Objective:
Click or tap here to enter text.

Actions the hospital facility intends to take to address the health need:

Strategies	Timeline			Committed Resources		Potential Partners
	Y1	Y2	Y3	Hospital	Other Sources	

Anticipated impact of these actions:

CHNA Impact Measures	CHNA Baseline	Target

Plan to evaluate the impact:
Click or tap here to enter text.

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Hospital and Significant Health Need Information

The title of a significant health need should match exactly to what it was called in the CHNA written document. Include the page of the CHNA written document where reference to this need can be located and numerical priority of the need. The brief description of the need can be copied from the CHNA written document and should tell readers why that particular need was identified and prioritized.

Goals and Objectives

The goal is the broad intent for addressing the need, which should be long-term and visionary. A goal describe who will be affected and what will change (one per significant health need).

Objectives describe the specific change(s) expected to occur as a direct result of the activities and support the attainment of the goal (1-3 per significant health need.) They should be SMART, and achievable within the three-year timeframe of the implementation strategy

Actions taken to address the need

Think of measurable, evidence-based policy, systems, and environmental change strategies that the hospital will implement in order to achieve the objective and address the selected need. In the timeline section, check which years (one, two, and/or three) each strategy will take place. List the committed resources, both financial and in-kind, that the hospital and partners are committing to address the need. Also list the potential, or known, partners that will participate to implement the strategy. For Joint Implementation Strategies, this table meets the specific requirement to clearly differentiate the hospital's particular role, responsibilities, and allocated resources, from the roles, responsibilities, and resources of potential community partners.

Community Health & Well-Being

As a part of Trinity Health's vision to create a People Centered Health System, Community Health & Well-Being's (CHWB) goal is to improve the health and wellbeing of all individuals and communities we serve. This is accomplished by addressing individual's needs as well as improving community conditions.

CHWB strategy encompass three key focus areas:

- Ensuring that care delivery models at our ministries assess and address the social needs of vulnerable patients
- Expand the availability of community based services and ensure that patients are linked to and can utilize these services
- Transform communities through policy, system and environmental change

For our efforts to be fruitful in improving conditions where people live, work, play and pray, we have to identify needs and address them in an impactful way while considering all three key focus areas.

Evidence-based strategies

Evidence-based strategies are programs and interventions that have been proven through research and evaluation to have made an impact. We strongly recommend that hospitals select from these strategies to address the significant community health needs within the Implementation Strategy. Appendix D compiles several sources for evidence-based strategies and interventions.

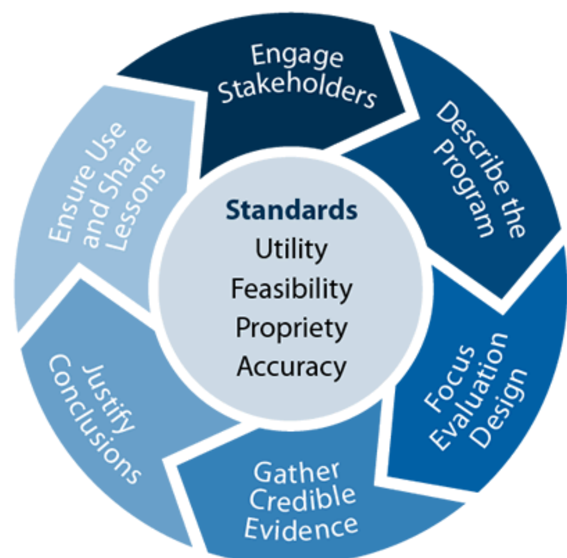
Anticipated Impact

The anticipated impact needs to directly align with the objectives. The program theory describes the anticipated impact(s) and the desired outcomes for a program or intervention, which can be identified by using an "if-then" statement. **If** a program is provided (the actions), **then** what changes are anticipated for participants (impact)? For example: **If** we advocate for local school districts to designate one hour each day to physical activity, **then** the school systems will put greater emphasis on student's health and the obesity rate of 15% among students will reduce by 10%. The "then" portion of the statement is the impact measure, while the "if" portion is the actions the hospital takes to address the need. For each impact measure, record the current baseline and the target. For example, the current childhood obesity rate would be the baseline of 15%, and a target of 13.5% would reflect the 10% improvement.

Plan to Evaluate

Develop plans to evaluate the impact of actions upon selection of intervention. The evaluation plan should include the specific measures that will be evaluated, sources for the data, and the measurement period (one, two, three years, etc.) and frequency (monthly, quarterly, annually, etc.) for collecting and analyzing the data.

Evaluation is important to the CHNA process as it ensures that the significant health needs are targeted and addressed with programs or policy, systems or environmental change efforts that will have the greatest impact on the health of the community. Ongoing evaluation of the implementation strategy will help to identify opportunities for improvement within the program or the community health and well-being activities. At the end of the implementation strategy cycle, the results of the evaluation will help hospitals document in their next CHNA written report what impact they have made since this CHNA and Implementation Strategy cycle.



Centers for Disease Control and Prevention. Framework for program evaluation in public health. MMWR 1999;48 (No. RR-11)

Catholic Health Association's (CHA) guide, 'Evaluating Your Community Benefit Impact', describes evaluation using the CDC's six-step framework: engagement stakeholders, describe the program, focus the evaluation design, gather credible evidence, justify conclusions, and ensure use and share lessons learned. CHA's evaluation guide, along with additional resources found on the Community Health & Well-Being SharePoint site, will help hospitals develop plans for evaluating their activities and interventions.

The timeline below shows how evaluation fits within the CHNA and Implementation Strategy process. The Implementation Strategy and Program Planning includes planned actions, resources and partners, and the anticipated impact of actions taken to address the needs identified within the CHNA. These strategies and programs are then implemented and evaluated for both, implementation and impact findings. The results of the evaluations are then summarized to describe the hospital's impact in the subsequent CHNA report.

COMMUNITY HEALTH NEEDS ASSESSMENT	IMPLEMENTATION STRATEGY & PROGRAM PLANNING			IMPLEMENT & EVALUATE PROGRAMS		COMMUNITY HEALTH NEEDS ASSESSMENT
Needs	**Planned Actions**	**Resources, Partners**	**Anticipated Impact**	**Implementation Evaluation Findings**	**Impact Evaluation Findings**	**Impact of Actions**
Identify and prioritize significant community health needs.	Describe actions (programs) to address needs identified in the CHNA.	Identify resources and partnerships that will address needs.	Describe anticipated impact of the actions to address needs (also known as goals and objectives).	Determine how actions (programs) are being implemented.	Measure results or changes resulting from actions.	Describe impact of actions taken since previous CHNA report.
▸ CHNA report.	▸ Implementation strategy and program planning documentation (e.g., logic model).			▸ Evaluation reports.		▸ Subsequent CHNA report.

CHA 'Evaluating Your Community Benefit Impact', 2015

Implementation Evaluation

Implementation evaluation assesses how a program or policy, system or environmental change (PSE) is carried out in order to improve the flow of activities or make better use of resources. Questions to ask while evaluating program/PSE implementation are:

- Was the program/PSE implemented as planned?
- Did the program/PSE reach the target group?
- What as the cost per person?
- What problems were encountered?
- Was the intervention strong enough to make a difference?

Plan-Do-Study-Act (PDSA) is one method for conducting an implementation evaluation. Developed by the Institute for Healthcare Improvement (IHI), PDSA is a tool for testing a program in a real setting following these four steps:

1.) planning to test the intervention
2.) carrying out the intervention on a small scale
3.) studying the results or impacts
4.) acting on the lessons learned.

Impact Evaluation

Impact evaluation measures the **changes** or **outcomes** that result from the program or intervention. These outcomes can be short-term, intermediate, or long-term.

Short-term Outcomes	Intermediate Outcomes	Long-term Outcomes
The observable effects or changes in knowledge, attitude, or skill.	The medium-term effects on participants' actions or behaviors and should link the short-term results with the long-term results.	The ultimate goals for the program or intervention. Long-term goals should be realistic for the program and timeframe.

Questions to ask while evaluating program/PSE impact and effectiveness are:

- Did the program/PSE reach the intended population?
- Did the program/PSE change the participants knowledge, attitude, or skill?
- Is there improvement in the data indicators from benchmark as a result of the program/PSE?
- Did the program/PSE change the participants actions and behaviors?
- Were the ultimate goals/objectives for the program/PSE met?

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Appendix A – Additional Data Sources

211 Counts – offers searchable, 211 utilization data and heat maps for select states at the zip and county level. 211 call centers allow residents to receive help and community-specific information for basic needs, such as food, shelter, and emergency services.

American Community Survey Data Profiles – social, economic, housing, and demographic data at the county level

Centers for Disease Control and Prevention (CDC) – includes several data sets on categories ranging from vaccinations, injury and violence, motor vehicle, smoking and tobacco use, and other health and community related metrics

Behavioral Risk Factor Surveillance System (BRFSS)

Youth Risk Behavior Surveillance System (YRFSS)

City Health Dashboard – demographic, socioeconomic, and health status data from 500 of the largest U.S. cities

Federal Bureau of Investigation – The Uniform Crime Reporting Statistics tool provides data for crime and violence

National Housing Preservation Database – Provides the availability of publically supported housing property inventory and profiles used to educate lawmakers and community leaders about affordable housing and preservation funds

National Low Income Housing Coalition – Contains a resource library that has several tools and approaches to advocacy, a housing research repository, and various other research and reports containing data related to housing

Robert Wood Johnson Foundation – United States Small Area Life Expectancy Estimate Project (USALEEP) provides life expectancy rates at the census tract level for nearly every community in the United States.

United States Department of Agriculture – Their Economic Research Service provides state fact sheets for food security, income, poverty, and other agriculture related data sets. Data products also include a wide range of topics including crops, food and nutrition assistance, food choices and health, food safety, and natural resources/environment

United States Department of Housing and Urban Development – HUD includes several topic areas including, housing research and data sets. Data sets available include: State of the Nation's Housing Reports, housing market profiles and indicators, creation and maintenance of affordable housing, and community development

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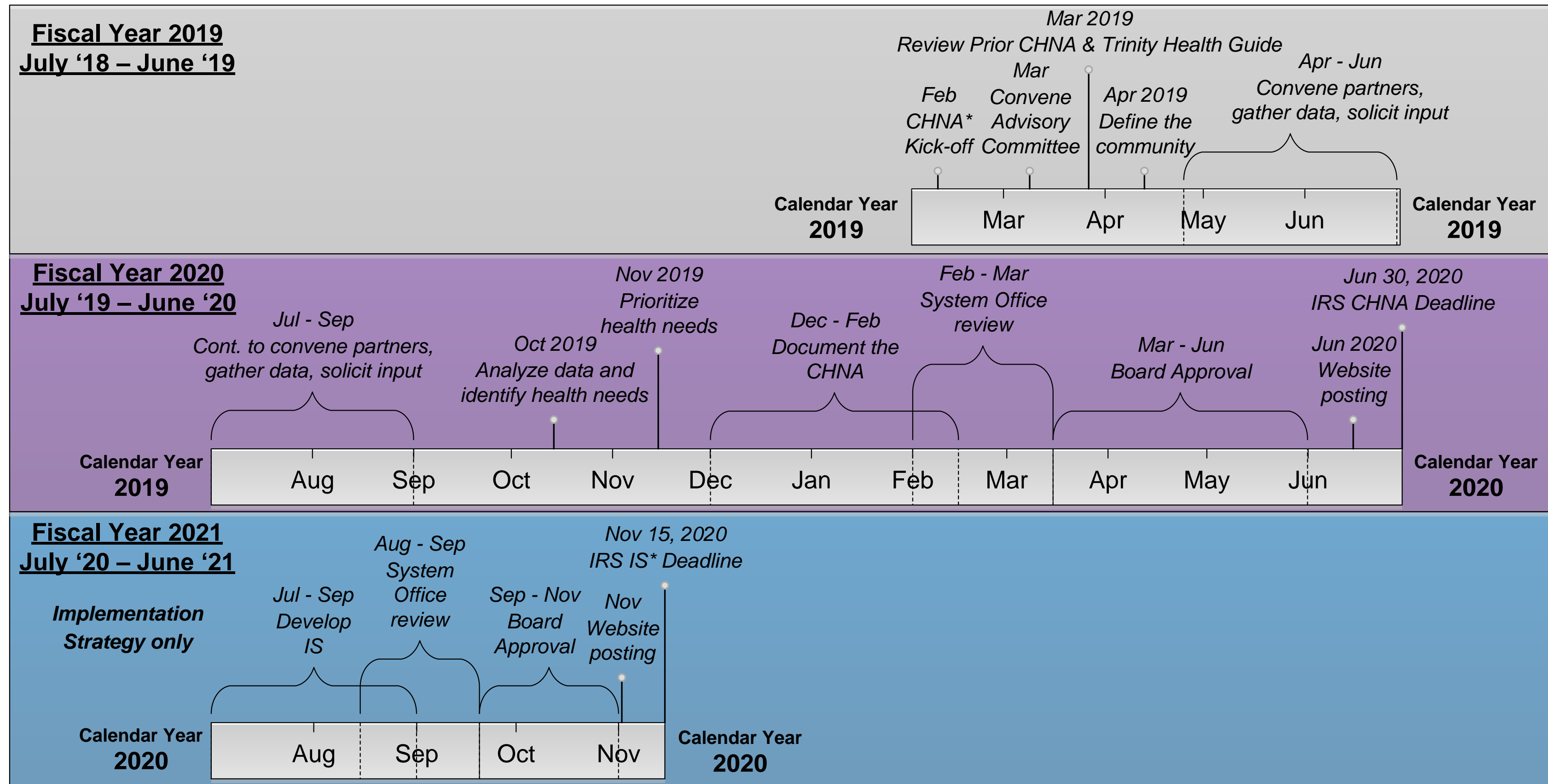
United States Department of Labor – The Bureau of Labor Statistics offers data sets and tools for national labor, economics, and employment.

United States Environmental Protection Agency – MyEnvironment includes a dashboard for in-depth data regarding air and water quality, energy use, toxic pollutant risk, the climate, and other environmental related indicators for cities, counties, and bodies of water

University of Washington Institute for Health Metrics and Evaluation (IHME) – offers national, state, and county level health data and infographics for several topics including, health equity, global disease burden, trends and patterns for various diseases.

Appendix B – CHNA & Implementation Strategy Timeline



CHNA – Community Health Needs Assessment
IS – Implementation Strategy

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Appendix C – Example Consumer Survey Questions

Sources are provided, when available, for your reference only and should not be included in the survey.

Demographics

- What County (or zip) do you live in? **Response options:** drop-down menu of service area counties/zips.
- Select your age from the ranges within the drop-down menu. **Response options:** drop-down menu: 17 or younger; 18-24; 25-34; 35-44; 45-54; 55-64; 65+. *(source: Community Commons)*
- What is your gender? Multiple choice response options: Male; Female; other (please specify). (*source: Survey Monkey*)
- Are you of Hispanic, Latino, or Spanish origin? **Response options:** No, not of Hispanic, Latino, or Spanish origin; Yes, Mexican, Mexican American, Chicano; Yes, Puerto Rican; Yes, Cuban; Yes, other Hispanic, Latino, or Spanish origin (please specify). *(source: U.S. Census)*
- What is your race? (check all that apply). **Response options:** White; Black or African American; American Indian or Alaska Native; Asian Indian; Chinese; Filipino; Japanese; Korean; Vietnamese; Other Asian (please specify); Native Hawaiian; Guamanian or Chamorro; Samoan; other Pacific Islander (please specify); some other race (please specify); blank comment box for "other". *(source: U.S. Census)*
- What is your current marital status? **Response options:** married; widowed, divorced; separated; never married (*source: Survey Monkey)*
- Do you speak a language other than English at home? **Response options:** yes/no (*source: Centers for Medicare and Medicaid Services)*

Access to Health Care

- What kind of healthcare coverage do you have? (check all that apply) **Response options:** through employer; privately purchased; Medicare; Medicaid or other state program; TRICARE, VA, or Military; Alaska Native, Indian Health Service, Tribal Health Services; Dental; Vision; I do not have healthcare coverage; other (please specify). (*source: modified from the 2018 Behavioral Risk Factor Surveillance System (BRFSS) survey)*
- Do you have any of the following barriers that make it difficult to access healthcare services or get medication? (check all that apply). **Response options:** expensive healthcare or medication costs; lack of transportation; distance to nearest healthcare facility or pharmacy; making time for healthcare appointments; other (please specify other barriers you face to accessing healthcare or medication).

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- In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? **Response options:** Yes/ No (*source: Accountable Health Communities Health-Related Social Needs Screening Tool)*
- How long has it been since you last visited a dentist or a dental clinic for any reason? **Response options:** within the past 12 months; within the past two years (longer than 12 months, but less than 2 years ago); within the past 5 years (longer than 2 years, but less than 5 years ago); 5 or more years ago (*source: 2018 Behavioral Risk Factor Surveillance System (BRFSS) survey)*
- Do you have access to the internet using any of the following? (check all that apply). **Response options:** cellular data plan for a smartphone or other mobile device; broadband (high-speed) internet services such as cable, fiber optic, or DSL service; satellite internet service; dial-up internet service; other (please specify). *(source: U.S. Census)*

Healthcare Behaviors and Outcomes

- Examples of moderate-intensity activity include brisk walking, tennis, or raking the yard and examples of vigorous-intensity activity include jogging, running, carrying heavy items upstairs, shoveling snow, or participating in a strenuous fitness class. In a usual week, which category best describes your level of physical activity? **Response options:** Inactive (not getting any moderate- or vigorous-intensity physical activity beyond basic movement from daily life activities); Insufficiently active (doing some, but less than 150 minutes per week of moderate-intensity physical activity, or doing some, but less than 75 minutes per week of vigorous-intensity physical activity, or a combination); Active (doing 150 to 300 minutes per week of moderate-intensity physical activity; Highly active (doing more than 300 minutes per week of moderate-intensity physical activity. (*source: Physical Activity Guidelines for Americans, 2nd Edition*)
- In a usual week, how many days do you eat at least 2 to 3 servings of vegetables **and** at least 2 servings of fruit in a day? **Drop-down menu response options**: 0, 1, 2, 3, 4, 5, 6, 7. (*source: based on 2015-2020 Dietary Guidelines*)
- What is your biggest health concern? (textbox) *(source: Ministry CHNA Survey)*
- Has a doctor, nurse, or other health professional ever told you that you had, or are at risk for, any of the following? (check all that apply). **Response options**: heart attack; coronary heart disease; stroke; asthma; cancer; chronic obstructive pulmonary disease (C.O.P.D.), emphysema, or chronic bronchitis; arthritis; depression; kidney disease; diabetes; high blood

pressure; obesity [add others as necessary] (*source: modified from the 2018 Behavioral Risk Factor Surveillance System (BRFSS) survey)*

Socioeconomic Factors

- What is the highest grade or level of education/schooling that you have completed? **Response options**: some high school, but did not graduate; high school graduate or a GED; some college or vocational courses; Associates Degree; Bachelor's Degree; Graduate/Master's Degree or higher. (*source: modified from Kaiser Permanente's 'Your Current Life Situation Survey')*
- What is your current employment status or working situation? **Response options**: full-time employment; part-time employment; temporary or contracted employment; laid-off; unemployed and seeking work; otherwise unemployed, but not seeking work (ex: volunteering, disabled, unpaid primary care-giver, student, retired, etc.). (*source: modified from PRAPARE)*
- What is your annual household income? **Response options**: less than $25,000; $25,000 – $49,999; $50,000 – $99,999; $100,000 – $149,999; $150,000 – $199,999; $200,000 or more. *(source: Survey Monkey)*
- Within the past 12 months, have you or anyone in your household have trouble paying for any of the following? (check all that apply). **Response options:** childcare, transportation, food, housing, medical care, medication, utilities, none of these. *(source: PRAPARE)*
- "Within the past 12 months, we worried whether our food would run out before we got more money to buy more" **Response options:** "often true", "sometimes true", "never true". *(source: American Academy of Pediatrics)*
- "Within the past 12 months, the food we bought just didn't last and we didn't have enough money to get more" **Response options:** "often true", "sometimes true", "never true". *(source: American Academy of Pediatrics)*

Social Environment

- What strengths and resources are available in your community that help residents maintain or improve their overall health? (*source, ministry CHNA survey*)
- Are there any additional services or resources that you think should be available to your community to help residents maintain or improve their overall health? (*source, ministry CHNA survey*)
- Are you a primary caregiver for a child under the age of 18 or for someone who is frail, chronically ill, or has a physical or mental disability? (check all that apply). **Response options:**

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"Yes, one or more children", "yes, someone who is frail, ill, or has a disability", "no". *(source: Kaiser Permanente)*

- How often do you see or talk to people that you care about and feel close to? (For example, talking to friends on the phone, visiting friends and family, going to church or club meetings) **Response options:** Less than once a week, 1-2 days a week, 3-4 days a week, 5 or more days a week) *(source: Kaiser Permanente)*

Physical Environment

- What is your current living situation? **Response options:** I have a steady place to live; I have a place to live today, but I am worried about losing it in the future; I do not have a steady place to live (I am temporarily staying with others, I am staying in a shelter, living outside, in a car, in an abandoned building, bus or train station, or in a park). *(source: Accountable Health Communities Health-Related Social Needs Screening Tool)*
- Are you worried that in the next two months, you may not have stable housing? **Response options:** yes/no. *(source: Health Leads)*
- Are you experiencing any of the following issues with your current living arrangement? (check all that apply). **Response options:** Bugs (e.g. roaches) or rodents; general cleanliness; landlord disputes; lead paint; unsafe drinking water; nonfunctioning appliances (stove, oven, refrigerator); unreliable utilities (e.g. electricity, gas, heat); leaks; medical condition that makes it difficult to live in current home; mold or dampness; overcrowding; threat of eviction; violence/safety concerns; other (please specify). *(source: modified from the Medical-Legal Partnership IHELLP)*

Additional questions can be found at the following site:

Social Interventions Research & Evaluation Network (SIREN)

Survey Monkey Demographic Template

Survey Monkey Question Bank

Appendix D – Resources for Evidence-based Strategies and Interventions

Agency for Healthcare Research and Quality (AHRQ) – Offers practical, research-based tools and other resources to help a variety of health care organizations, providers, and others make care safer in all health care settings.

CDC 6|18 Initiative – The CDC prioritized six common and costly health conditions and identified proven interventions within each condition.

CDC Community Health Improvement Navigator – The navigator includes interventions within four action areas: socioeconomic factors, physical environment, health behaviors, and clinical care.

CDC High Impact in 5 Years (HI-5) – Shares community-wide approaches, targeted at the Social Determinants of Health (SDoH), that are evidence-based to have positive health impacts, results within 5 years and are cost effective or produce a cost-savings.

County Health Rankings and Roadmaps – They offer a menu of evidence-informed policies and programs for a wide variety of topic areas.

Substance Abuse and Mental Health Services Administration (SAMHSA) – This new Evidence-Based Practices Resource Center aims to provide communities, clinicians, policy-makers and others in the field with the information and tools they need to incorporate evidence-based practices into their communities or clinical settings

The Community Guide – The guide contains a collection of evidence-based findings for several "topics". Topics include both clinical and social interventions.

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Appendix E – Prioritization Methods

Prioritization

Introduction

A critical component of the Part I and Part II APEX*PH* processes occurs at the point where identified issues are prioritized. Prioritizing issues allows the health department and community to direct resources, time, and energy to those issues that are deemed most critical and practical to address.

The APEX*PH* workbook mentions several different methods of prioritizing and many have found those methods highly useful. The APEX*PH* workbook particularly describes how the Hanlon method can be used in both Part I and Part II (pp. 23-24 and Appendix E). Techniques, such as the Nominal Group Planning Method, the Simplex Method, and the Criteria Weighting Method, are mentioned but not described in detail. This section is designed to describe these methods in greater detail and also offers additional options.

Background

Before delving into the "how to," we will address some basic issues concerning prioritization:

What is prioritization? Prioritization is a process whereby an individual or group places a number of items in rank order based on their perceived or measured importance or significance. In conducting APEX*PH*, prioritization is generally a group process whereby organizational or health issues are ordered by perceived significance or importance. Prioritizing issues is an important process, in that it assists an organization in identifying the issues on which it should focus its limited resources.

Who is doing the prioritizing? All participants usually have input into the prioritization process. Members of the prioritizing group need to be mindful that their own perceptions may be different from those around them. Often there is no clear right or wrong order to prioritizing, thus creating more difficulty in the prioritization process. This is especially true when trying to prioritize options that are unrelated or whose solutions are very different.

Which method should be used? This section describes prioritization methods and the strengths and weaknesses of each. Some methods rely heavily on group participation, whereas other methods are less participatory and are more focused on baseline data for the health issues. It is important to

remember that no one method is best all of the time. Moreover, each method can be adapted to suit the particular needs of a given community or group.

Examples of Prioritization Techniques and How They May be Implemented

Several prioritization methods are described in the following pages. A step-by-step process for implementing each is described, as well as ideas for customizing each method. They are displayed in no certain order. A chart near the end of this section summarizes the strengths, weaknesses, and optimal group size for each process.

Simplex Method

With the Simplex Method, group perceptions are obtained by the use of questionnaires. The method assists a decision-making group to analyze problems more efficiently. The answers to the questionnaires are scored and ranked and the issues with the highest scores are given the highest priority.

An added feature of the Simplex method is that particular problems can be given more weight, thus raising its priority level. However, this method relies heavily on the way in which the questionnaire presents the problems and questions. A customized exercise using the Simplex method follows this section.

Step-by-Step for Simplex:

1. Develop a simplex questionnaire. The questionnaire should have a series of questions about each particular option being prioritized. Closed-ended questions should be used rather than open-ended, due to the ease in comparing responses to closed-ended questions. The answer to each question should have a corresponding score with the higher scores reflecting a higher priority. While the questionnaire can ask as many questions as desired, fewer questions permit quicker responses and diminish the chance that questions overlap each other or cause other distortions. For example, questions such as the following could be asked for each health issues being prioritized:

    1. This health issue affects:

        a) very few people
        b) less than half of the people
        c) half the people
        d) a majority
        e) everybody

2. The pain, discomfort, and/or inconvenience caused by this health issue is: a) none
    b) little
    c) appreciable
    d) serious
    e) very serious

Each issue being prioritized needs its own set of questions, and in order to compare the responses and place the answers in rank order, the questions need to be comparable for each health issue. At a minimum, each problem needs to have the same number of possible answers.

2. Before the questionnaire is distributed, respondents need to understand the issues being presented, its impact, other information and data related to the problem, and potential interventions.

3. Respondents then fill out the questionnaire.

4. Answers to the questions relating to each issue are averaged. The issues are then ranked in order, from most important to least important.

5. The issues, having been placed in rank order, can be selected in one of two ways: priority issues can be all those above a cutoff point (e.g., those with scores ≥ 60); or a specified number of the top issues can be selected (e.g., the top six issues).

Ideas for Customizing Simplex:

- Groups may choose to place additional weights to certain questions if they are deemed particularly important.

Nominal Group Planning

Nominal Group Planning was developed for situations where individual judgments must be tapped and combined to arrive at decisions which cannot be determined by one person. This strategy is best used for problem exploration, knowledge exploration, priority development, program development, and program evaluation.

In the APEX*PH* process, nominal group planning can be used to:

- determine what community issues are of greatest concern;
- decide on a strategy for dealing with the identified issues; and
- design improved community services or programs.

The model is used in basically the same way for each application. This method involves little math and is based more on group discussion and information exchange.

Group members generate a list of ideas or concerns surrounding the topic being discussed. This list becomes decision-making criteria and the prioritization is the ultimate result of consensus and a vote to rank order the criteria.

Step-by-Step for Nominal Group Technique:

1. First, it is important to establish the group structure. Decide whether or not the group should be broken down into subgroups. A more complicated problem is often better handled by being broken down into components that can be addressed by smaller subgroups. The minimum suggested size for the process is 6 to 10. This method often works well for larger groups, and consensus can be reached with as many as 15 to 20 participants.

2. The group should then determine the leader or facilitator. The leader explains the process and question being considered.

3. Before initiating discussion, the participants should silently write down all of their ideas and recommendations. There is no discussion at this stage. This stage should take approximately four to eight minutes.

4. The group leader works with the group to list items from each group member in a roundrobin fashion. Each member is asked to briefly state one item on his or her list until all ideas have been presented. The group leader records these items, using the members' own words, on a flip chart in full view of the group. Members should state their items in a phrase or brief sentence. This step may be lengthy, especially in large groups, but may be shortened by limiting each member to a specific number of items.

5. Once a list has been compiled, the group then reviews, organizes, clarifies, and simplifies the material. Some items may be combined or grouped logically. Each item is read aloud in sequence. No discussion, except for clarification, is allowed at this point. This stage should generally take approximately two minutes per item, but may be shortened by allowing less time per item.

6. Each member of the group then individually places all the options at hand in rank order from one to ten on a notecard (a community may choose to alter this number from ten). The group members' rankings are collected and tallied.

7. By tallying the rankings, each item is given a total score. The results are posted on a flipchart or through some other means whereby the group can see the results. The group leader then works with the group to discuss the preliminary results. At this point, criteria for evaluation, such as equity, proportion of the community affected, and cost of intervention, can be discussed for each item.

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8. After the discussion, the group may re-rank their choices. The process is then re-done and the new ranking is the final product.

Ideas for Customizing Nominal Group Technique:

- Criteria used in the discussion of the issue ranking can be selected by the community.
- Subgroups can be used to discuss issues (i.e., a subgroup can prioritize all of the environmental health issues, to come up with the priority issue to be addressed).

Criteria Weighting Method

The criteria weighting method is a mathematical process whereby participants establish a relevant set of criteria and assign a priority ranking to issues based on how they measure against the criteria. The calculated values do not necessarily dictate the final policy decision, but offer a means by which choices can be ordered. An example exercise which follows this section, entitled “Priority Setting Exercise,” is a customized version of this method.

Step-by-Step for Criteria Weighting Method:

1. The group first needs to start with criteria to consider about each issue. Criteria could include the following:
    - Magnitude of the problem: How much of a burden is placed on the community, in terms of financial losses, years of potential life lost, potential worsening of the problem, etc.?
    - Seriousness of the consequences of the problem: What benefits would accrue from correcting the problem? Would other problems be reduced in magnitude if the problem were corrected?
    - Feasibility of correcting the problem: Can the problem be addressed with existing technology, knowledge, and resources? How resource-intensive are the interventions?

    Other criteria might include whether the problem is perceived as serious by the community and whether incentives exist to intervene. The criteria can be derived through a variety of means, but the nominal group technique (described above) is particularly suited to help in this process.

2. The group then has the task of determining the relative significance of each criteria. This is done through these steps:
    a) The criteria are discussed to assure that the group understands each criteria and its appropriateness and validity.
    b) Each group member places a value on each criteria, such as 1 to 5.
    c) These values are averaged and these averages become the weights that will be used in the final ranking process.

3. Next, members of the group individually rank each issue according to the criteria. A scoring system of -10 to +10 permits a more acute measure of individual issues. For example, if an issue is nearly

impossible to address with current resources, it could be assigned a -8 in “feasibility of correcting the problem”, but may receive a score of +8 in “magnitude of the problem.” Once each member scores the issues, the scores are then averaged.

4. Then, determine the significance levels of the criteria by multiplying each issue rating by the criteria weight. The product of this is the “significance level.”

5. The significance level scores for each issue are then summed and divided by the number of criteria. The totals are then placed in rank order with the issues with the highest number being of the highest priority.

6. Once the issues are then ranked, the group can then make final decisions about prioritization.

Ideas for Customizing Criteria Weighting:

- Some groups may want to leave the issues in the order in which they are calculated—others may want to make the final prioritization decision based on discussion using the results as a starting place.
- Each community needs to determine their own criteria- this allows for consideration of many factors in the community.

A "Quick and Colorful" Approach

Some health departments and communities may want to adopt a quick, easy, and perhaps more entertaining approach to prioritizing. The technique uses a means whereby individual group members vote to prioritize each health problem. A secret ballot method or open method can be used.

Step-by-Step for a "Quick and Colorful" Approach:

1. Determine if the vote should be open or by secret ballot. If it is by secret ballot, set up labeled ballot boxes for each problem to be prioritized. The boxes should be constructed so that “voters” cannot see the ballot placed by the previous voter. If it is open, place flip charts around the room with the health issues written on them.

2. All members of the group should be provided with tokens with which to vote. These can be colored poker chips or pieces of cardboard, numbered pieces of paper, or a similar item that indicates a relative rank (i.e., red indicates top rating, yellow-medium, green- low). If the process is by open voting, colored stickers can be used. The number of ranks can be chosen by the group, but five or fewer simplifies the process.

3. Group members are given an overview of each of the health issues, and are instructed to consider all of the issues and to prioritize these by voting their relative rank.

4. Members place one token in each box, if by secret ballot, or place a colored sticker next to the written health issue on the flip chart, if by open voting.

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5. Votes are tallied for each health issue and the overall scores are then rank ordered.

6. At this point, the group can accept the prioritizing that resulted from the rank order or choose to discuss the order and re-rank the health issues. Before the process begins, it is often a good idea to decide what will be done after the result of the first vote and if it is decided to vote again following a discussion, it is a good idea to decide how many times this will be done.

Ideas for Customizing a "Quick and Colorful" Approach:

- The group can decide to place weights on particular problems if they are deemed more important.
- The number of colored tokens or stickers that each member receives can be controlled (e.g., distribute only two red stickers).

Comparison of Prioritization Techniques

Given the many different techniques for prioritization, health planners may wonder how to determine which method to use. Different techniques are suited to different types of decisions, groups, and data. Perhaps most importantly, most of these methods permit individual tailoring so that it can best meet the needs of a particular community. The chart below provides a summary of the techniques described here and the strengths and weaknesses of each.

SUMMARY OF PRIORITIZATION TECHNIQUES

	Strengths	Weaknesses	Optimal size of group
Simplex	Efficient and quick to use, once questionnaire is constructed. Can be used with any size group. Allows for weighting of problems.	Requires the development of a questionnaire. Relies heavily on how questions are asked.	Any size.
Nominal Group	Motivates and gets all participants involved. Can be used to identify areas for further discussion and can be used as part of other techniques (e.g., to help develop a Simplex questionnaire.)	Vocal and persuasive group members can affect others. A biased or strong-minded facilitator can affect the process.	10-15 (larger groups can be broken down into subgroups.) Not <6.
Planning	Allows for many ideas in a short period of time Stimulates creative thinking and dialogue. Uses a democratic process.	Can be difficult with larger groups (more than 20-25) May be overlap of ideas due to unclear wording or inadequate discussion.	

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Criteria Weighting	Offers numerical criteria with which to prioritize. Mathematical process (this is a weakness for some.) Objective; may be best in situations where this is competition among the issues. Allows group to weight criteria differently.	Can become complicated. Requires predetermining criteria.	Any size.
Hanlon (described in the APEX*PH* Workbook, pp 23-24 and Appendix E)	PEARL component can be a useful feature. Offers relatively quantitative answers that are appealing for many. Baseline data for issues can be used for parts; this can be appealing due to the objectivity of the data.	The process offers the lowest priorities for those issues where solution requires additional resources or legal changes which may be problematic. Very complicated.	Any size.
A "Quick and Colorful" Approach	Simple. Well-suited to customizing. Blinded responses prevent individuals influencing others. Less time intensive.	Less sophisticated (may be a benefit for some groups). Doesn't offer the ability to eliminate options that may be difficult to address given current laws and resources. If open voting is used, participants may be influenced by others' votes.	Any size.

Conclusion

There are many different techniques, which local health departments, community health committees, and others can use to identify and prioritize issues. By using formalized techniques, such as those described here, groups have a structured mechanism that can facilitate an orderly process. Such a process also offers a common starting point that groups can alter to suit their own specific needs. Whatever technique is used, it is important to keep in mind that the reason prioritization is undertaken is to include input from all interest groups. Therefore, it is vitally important to include the community when defining criteria.

Appendix F – Required Data Indictors

HP2020 SDoH	Data Category	Subcategory	Data Indicator	Source(s)	Lowest level of data
Economic Stability	Social Determinants of Health	Economic Factors	Children Eligible for Free Lunch (Alone) by Year	2015-2016 National Center for Education Statistics Common Core Data	Address
Economic Stability	Social Determinants of Health	Economic Factors	Children Eligible for Free/Reduced Price Lunch	2015-2016 National Center for Education Statistics Common Core Data	Address
Economic Stability	Social Determinants of Health	Economic Factors	Income - Families Earning Over $75,000	2012-2016 US Census	Tract
Economic Stability	Social Determinants of Health	Economic Factors	Income - Inequality (GINI Index)	2012-2016 US Census	Tract
Economic Stability	Social Determinants of Health	Economic Factors	Income - Median Family Income	2012-2016 US Census	Tract
Economic Stability	Social Determinants of Health	Economic Factors	Income - Per Capita Income	2012-2016 US Census	Tract
Economic Stability	Social Determinants of Health	Economic Factors	Income - Public Assistance Income	2012-2016 US Census	Tract
Economic Stability	Social Determinants of Health	Economic Factors	Poverty - Children Below 100% FPL	2012-2016 US Census	Tract
Economic Stability	Social Determinants of Health	Economic Factors	Poverty - Children Below 200% FPL	2012-2016 US Census	Tract
Economic Stability	Social Determinants of Health	Economic Factors	Poverty - Population Below 100% FPL	2012-2016 US Census	Tract
Economic Stability	Social Determinants of Health	Economic Factors	Poverty - Population Below 200% FPL	2012-2016 US Census	Tract
Economic Stability	Social Determinants of Health	Economic Factors	Unemployment Rate	2018 March Bureau of Labor Statistics	County

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Education	Social Determinants of Health	Education	Head Start	2018 Administration for Children and Families	Address
Education	Social Determinants of Health	Education	High School Graduation Rate	2015-2016 EDFacts	School District
Education	Social Determinants of Health	Education	Population with Associate's Level Degree or Higher	2012-2016 US Census	Tract
Education	Social Determinants of Health	Education	Population with Bachelor's Degree or Higher	2012-2016 US Census	Tract
Education	Social Determinants of Health	Education	Population with No High School Diploma	2012-2016 US Census	Tract
Education	Social Determinants of Health	Education	Student Reading Proficiency (4th Grade)	2014-2015 EDFacts	School District
Health & Health Care	Access to Care	Access to Care	Facilities Designated as Health Professional Shortage Areas	2016 HRSA	Address
Health & Health Care	Access to Care	Access to Care	Federally Qualified Health Centers	2018 CMS, 2010 Census	Address
Health & Health Care	Access to Care	Access to Care	Population Living in a Health Professional Shortage Area (HPSA)	2016 April Health Resources Services Administration	HPSA
Health & Health Care	Access to Care	Insurance	Insurance - Population Receiving Medicaid	2012-2016 US Census	Tract
Health & Health Care	Access to Care	Insurance	Insurance - Uninsured Adults	2016 Small Area Health Insurance Estimates	County
Health & Health Care	Access to Care	Insurance	Insurance - Uninsured Children	2016 Small Area Health Insurance Estimates	County
Health & Health Care	Access to Care	Insurance	Insurance - Uninsured Population	2012-2016 US Census	Tract
Health & Health Care	Access to Care	Mental Health	Ratio of population to mental health providers	2017 CMS National Provider Identification	County
Health & Health Care	Access to Care	Oral Health	Access to Dentists	2015 Area Health Resource File	County

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Health & Health Care	Access to Care	Primary Care	Access to Primary Care	2014 Area Health Resource File	County
Health & Health Care	Access to Care	Primary Care	Lack of a Consistent Source of Primary Care	2011-2012 BRFSS	County
Health & Health Care	Access to Care	Primary Care	Preventable Hospital Events	2014 Dartmouth Atlas CMS	County
Health & Health Care	Access to Care	Primary Care	Recent Primary Care Visit	2015 BRFSS, 500 Cities Data Portal	City
Health & Health Care	Maternal/Child Health	Maternal/Child Health	Lack of Prenatal Care	2007-2010 CDC from birth certificate	County
Health Outcomes & Behaviors	Cancer	Incidence	Cancer Incidence - Breast	2010-2014 State Cancer Profiles, CDC	County
Health Outcomes & Behaviors	Cancer	Incidence	Cancer Incidence - Cervical	2009-2013 State Cancer Profiles, CDC	County
Health Outcomes & Behaviors	Cancer	Incidence	Cancer Incidence - Colon and Rectum	2010-2014 State Cancer Profiles, CDC	County
Health Outcomes & Behaviors	Cancer	Incidence	Cancer Incidence - Lung	2010-2014 State Cancer Profiles, CDC	County
Health Outcomes & Behaviors	Cancer	Incidence	Cancer Incidence - Prostate	2010-2014 State Cancer Profiles, CDC	County
Health Outcomes & Behaviors	Cancer	Mortality	Mortality - Cancer	2012-2016 ICD-10 Codes, National Vital Statistics System	County
Health Outcomes & Behaviors	Cancer	Preventive/ Screening	Cancer Screening - Mammogram	2014 Dartmouth Atlas CMS	County
Health Outcomes & Behaviors	Cancer	Preventive/ Screening	Cancer Screening - Pap Test	2006-2012 BRFSS, Health Indicators Warehouse	County
Health Outcomes & Behaviors	Cancer	Preventive/ Screening	Cancer Screening - Sigmoidoscopy or Colonoscopy	2006-2012 BRFSS, Health Indicators Warehouse	County
Health Outcomes & Behaviors	Chronic Conditions	Cardiovascular/ Stroke	Heart Disease (Adult)	2011-2012 BRFSS	County

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Health Outcomes & Behaviors	Chronic Conditions	Cardiovascular/ Stroke	Heart Disease (Medicare Population)	2007-2015 CMS Chronic Conditions Warehouse	County
Health Outcomes & Behaviors	Chronic Conditions	Cardiovascular/ Stroke	High Blood Pressure (Adult)	2006-2012 BRFSS, Health Indicators Warehouse	County
Health Outcomes & Behaviors	Chronic Conditions	Cardiovascular/ Stroke	High Blood Pressure (Medicare Population)	2007-2015 CMS Chronic Conditions Warehouse	County
Health Outcomes & Behaviors	Chronic Conditions	Cardiovascular/ Stroke	High Blood Pressure Management	2006-2012 BRFSS, Health Indicators Warehouse	County
Health Outcomes & Behaviors	Chronic Conditions	Cardiovascular/ Stroke	High Cholesterol (Adult)	2011-2012 BRFSS	County
Health Outcomes & Behaviors	Chronic Conditions	Cardiovascular/ Stroke	High Cholesterol (Medicare Population)	2007-2015 CMS Chronic Conditions Warehouse	County
Health Outcomes & Behaviors	Chronic Conditions	Diabetes	Diabetes (Adult)	2013 CDC - National Diabetes Surveillance System	County
Health Outcomes & Behaviors	Chronic Conditions	Diabetes	Diabetes (Medicare Population)	2007-2015 CMS Chronic Conditions Warehouse	County
Health Outcomes & Behaviors	Chronic Conditions	Diabetes	Diabetes Management - Hemoglobin A1c Test	2014 Dartmouth Atlas CMS	County
Health Outcomes & Behaviors	Health Behaviors	Nutrition	Fruit/Vegetable Consumption	2005-2009 BRFSS, Health Indicators Warehouse	County
Health Outcomes & Behaviors	Health Behaviors	Nutrition	Fruit/Vegetable Expenditures	2014 Nielsen; 2005-2009 Bureau Labor Statistics' Consumer Expenditure Survey	Tract

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Health Outcomes & Behaviors	Health Behaviors	Nutrition	Soda Expenditures	2014 Nielsen; 2005-2009 Bureau Labor Statistics' Consumer Expenditure Survey	Tract
Health Outcomes & Behaviors	Health Behaviors	Physical Activity	Physical Inactivity	2013 CDC	County
Health Outcomes & Behaviors	Health Behaviors	Physical Activity	Walking or Biking to Work	2012-2016 US Census	Tract
Health Outcomes & Behaviors	Health Behaviors	Substance Access/Abuse	Alcohol Consumption	2006-2012 BRFSS, Health Indicators Warehouse	County
Health Outcomes & Behaviors	Health Behaviors	Substance Access/Abuse	Alcohol Expenditures	2014 Nielsen; 2005-2009 Bureau Labor Statistics' Consumer Expenditure Survey	Tract
Health Outcomes & Behaviors	Health Behaviors	Substance Access/Abuse	Alcohol-impaired driving deaths	2012-2016 Fatality Analysis Reporting System	County
Health Outcomes & Behaviors	Health Behaviors	Substance Access/Abuse	Drug overdose deaths	2014-2016 CDC Compressed Mortality File	County
Health Outcomes & Behaviors	Health Behaviors	Substance Access/Abuse	Liquor Store Access	2012 County Business Patterns, 2010 US Census	ZCTA (modified zip)
Health Outcomes & Behaviors	Health Behaviors	Substance Access/Abuse	Tobacco Expenditures	2014 Nielsen; 2005-2009 Bureau Labor Statistics' Consumer Expenditure Survey	Tract
Health Outcomes & Behaviors	Health Behaviors	Substance Access/Abuse	Tobacco Usage - Current Smokers	2006-2012 BRFSS, Health Indicators Warehouse	County
Health Outcomes & Behaviors	Health Behaviors	Substance Access/Abuse	Tobacco Usage - Former or Current Smokers	2011-2012 BRFSS	County

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Health Outcomes & Behaviors	Health Behaviors	Substance Access/Abuse	Tobacco Usage - Quit Attempt	2011-2012 BRFSS	County
Health Outcomes & Behaviors	Infectious Diseases	Incidence	STI - Chlamydia Incidence	2014 CDC Health Indicators Warehouse	County
Health Outcomes & Behaviors	Infectious Diseases	Incidence	STI - Gonorrhea Incidence	2014 CDC Health Indicators Warehouse	County
Health Outcomes & Behaviors	Infectious Diseases	Incidence	STI - HIV Prevalence	2013 CDC Health Indicators Warehouse	County
Health Outcomes & Behaviors	Infectious Diseases	Preventive/ Screening	HIV Screenings	2011-2012 BRFSS	County
Health Outcomes & Behaviors	Maternal/Child Health	Maternal/Child Health	Low Birth Weight	2006-2012 CDC, 2003-2009 birth certificate data	County
Health Outcomes & Behaviors	Maternal/Child Health	Maternal/Child Health	Teen Births	2007-2011 CDC from birth certificate data	County
Health Outcomes & Behaviors	Maternal/Child Health	Mortality	Infant Mortality	2006-2010 HRSA, 2014-2015 Area Health Resource File	County
Health Outcomes & Behaviors	Mental Health	Mental Health	Depression (Medicare Population)	2007-2015 CMS Chronic Conditions Warehouse	County
Health Outcomes & Behaviors	Mental Health	Mental Health	Frequent Mental Distress	2014 BRFSS	County
Health Outcomes & Behaviors	Mental Health	Mental Health	Poor Mental Health Days	2014 BRFSS	County
Health Outcomes & Behaviors	Morbidity		Poor General Health	2006-2012 BRFSS, Health Indicators Warehouse	County
Health Outcomes & Behaviors	Mortality	Cardiovascular/ Stroke	Mortality - Coronary Heart Disease	2012-2016 ICD-10 Codes, National Vital Statistics System	County

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Health Outcomes & Behaviors	Mortality	Cardiovascular/ Stroke	Mortality - Heart Disease	2012-2016 ICD-10 Codes, National Vital Statistics System	County
Health Outcomes & Behaviors	Mortality	Cardiovascular/ Stroke	Mortality - Stroke	2012-2016 ICD-10 Codes, National Vital Statistics System	County
Health Outcomes & Behaviors	Mortality	Mortality	Length of Life	2014-2016 National Center for Health Statistics - Mortality Files	County
Health Outcomes & Behaviors	Mortality	Mortality	Mortality - Unintentional Injury	2012-2016 ICD-10 Codes, National Vital Statistics System	County
Health Outcomes & Behaviors	Mortality	Motor/Vehicle	Mortality - Motor Vehicle Crash	2012-2016 ICD-10 Codes, National Vital Statistics System	County
Health Outcomes & Behaviors	Mortality	Motor/Vehicle	Mortality - Pedestrian Motor Vehicle Crash	2011-2015 US Department of Transportation - Fatality Analysis Reporting System	County
Health Outcomes & Behaviors	Mortality	Premature	Mortality - Premature Death	2014-2016 National Vital Statistics System	County
Health Outcomes & Behaviors	Mortality	Social Support	Mortality - Suicide	2012-2016 ICD-10 Codes, National Vital Statistics System	County
Health Outcomes & Behaviors	Oral Health	Oral Health	Dental Care Utilization	2006-2012 BRFSS, Health Indicators Warehouse	County
Health Outcomes & Behaviors	Oral Health	Oral Health	Poor Dental Health	2006-2012 BRFSS, Health Indicators Warehouse	County

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Health Outcomes & Behaviors	Overweight/Obesity	Overweight/ Obesity	Obesity	2013 CDC - National Diabetes Surveillance System	County
Health Outcomes & Behaviors	Overweight/Obesity	Overweight/ Obesity	Overweight	2011-2012 BRFSS	County
Health Outcomes & Behaviors	Respiratory Health	Mortality	Mortality - Lung Disease	2012-2016 US Census	Tract
Health Outcomes & Behaviors	Respiratory Health	Respiratory Health	Asthma Prevalence	2011-2012 BRFSS	County
Health Outcomes & Behaviors	Vaccine/Immunization	Vaccine/ Immunization	Pneumonia Vaccination	2006-2012 BRFSS, Health Indicators Warehouse	County
Health Outcomes & Behaviors		Substance Access/Abuse	Mortality - Drug Poisoning	2012-2016 ICD-10 Codes, National Vital Statistics System	County
Neighborhood & Built Environment	Environment	Air Quality	Air Quality - Ozone	2012 CDC National Environmental Public Health Tracking Network	Tract
Neighborhood & Built Environment	Environment	Air Quality	Air Quality - Particulate Matter 2.5	2012 CDC National Environmental Public Health Tracking Network	Tract
Neighborhood & Built Environment	Environment	Air Quality	Driving alone to work	2012-2016 US Census	County
Neighborhood & Built Environment	Environment	Air Quality	Long commute-driving alone	2012-2016 US Census	County
Neighborhood & Built Environment	Environment	Climate	Climate Health - Drought Severity	2012-2014 US Drought Monitor	County

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Neighborhood & Built Environment	Environment	Climate	Climate Health - High Heat Index Days	2014 National Oceanic and Atmospheric Administration, North America Land Data Assimilation System, CDC Wonder	County
Neighborhood & Built Environment	Environment	Water Quality	Drinking water violations	2016 EPA Safe Drinking Water Information System	County
Neighborhood & Built Environment	Health Behaviors	Physical Activity	Recreation and Fitness Facility Access	2012 County Business Patterns, 2010 US Census	County
Neighborhood & Built Environment	Physical Environment	Housing	Housing - Assisted Housing	2016 US Department of Housing & Urban Development	County
Neighborhood & Built Environment	Physical Environment	Housing	Housing - Housing Unit Age	2012-2016 US Census	Tract
Neighborhood & Built Environment	Physical Environment	Housing	Housing - Low Income Housing Tax Credit	2014 US Department of Housing & Urban Development	County
Neighborhood & Built Environment	Physical Environment	Housing	Housing - Mortgage Lending	2014 Federal Financial Institutions Examination Council	Tract
Neighborhood & Built Environment	Physical Environment	Housing	Housing - Overcrowded Housing	2012-2016 US Census	Tract
Neighborhood & Built Environment	Physical Environment	Housing	Housing - Substandard Housing	2012-2016 US Census	Tract
Neighborhood & Built Environment	Physical Environment	Housing	Housing - Vacancy Rate	2012-2016 US Census	Tract
Neighborhood & Built Environment	Physical Environment	Housing	Housing Cost Burden (30%)	2012-2016 US Census	Tract

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Neighborhood & Built Environment	Social Determinants of Health	Food Insecurity	Food Access - Fast Food Restaurants	2012 County Business Patterns, 2010 US Census	County
Neighborhood & Built Environment	Social Determinants of Health	Food Insecurity	Food Access - Food Desert Census Tracts	2015 USDA Food Access Research Atlas: 2015 STARS, SNAP Directory, 2010 US Census, 2010-2014 American Community Survey	Tract
Neighborhood & Built Environment	Social Determinants of Health	Food Insecurity	Food Access - Grocery Stores	2012 County Business Patterns, 2010 US Census	County
Neighborhood & Built Environment	Social Determinants of Health	Food Insecurity	Food Access - Low Food Access	2015 USDA Food Access Research Atlas: 2015 STARS, SNAP Directory, 2010 US Census, 2010-2014 American Community Survey	Tract
Neighborhood & Built Environment	Social Determinants of Health	Food Insecurity	Food Access - Low Income Low Food Access	2015 USDA Food Access Research Atlas: 2015 STARS, SNAP Directory, 2010 US Census, 2010-2014 American Community Survey	Tract
Neighborhood & Built Environment	Social Determinants of Health	Food Insecurity	Food Access - Modified Retail Food Environment Index	2011 CDC MRFEI: Division of Nutrition, Physical Activity, and Obesity	Tract
Neighborhood & Built Environment	Social Determinants of Health	Food Insecurity	Food Access - SNAP-Authorized Food Stores	2016 USDA Food & Nutrition Service, 2010 Census	Tract
Neighborhood & Built Environment	Social Determinants of Health	Food Insecurity	Food Access - WIC-Authorized Food Stores	2011 USDA Food Environment Atlas, Economic Research Service, 2010 Census	County

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Neighborhood & Built Environment	Social Determinants of Health	Food Insecurity	Food Insecurity - Food Insecure Children	2014 Feeding America	County
Neighborhood & Built Environment	Social Determinants of Health	Food Insecurity	Food Insecurity - Food Insecure Population Ineligible for Assistance	2014 Feeding America	County
Neighborhood & Built Environment	Social Determinants of Health	Food Insecurity	Food Insecurity Rate	2014 Feeding America	County
Social Support & Community Context	Social Determinants of Health	Social Support	Children in single-parent households	2012-2016 US Census	County
Social Support & Community Context	Social Determinants of Health	Social Support	Disconnected Youth	2010-2014 Measure of America	County
Social Support & Community Context	Social Determinants of Health	Social Support	Households headed by a single parent	2012-2016 US Census	County
Social Support & Community Context	Social Determinants of Health	Social Support	Lack of Social or Emotional Support	2006-2012 BRFSS, Health Indicators Warehouse	County
Social Support & Community Context	Social Determinants of Health	Social Support	Population Receiving SNAP Benefits	2012-2016 US Census	Tract
Social Support & Community Context	Social Determinants of Health	Social Support	Residential segregation - black/white	2012-2016 US Census	Tract
Social Support & Community Context	Social Determinants of Health	Social Support	Residential segregation - non-white/white	2012-2016 US Census	County
Social Support & Community Context	Social Determinants of Health	Social Support	Social Associations	2015 County Business Patterns	County
Social Support & Community Context	Social Determinants of Health	Transportation	Households with No Motor Vehicle	2012-2016 US Census	Tract

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Social Support & Community Context	Social Determinants of Health	Transportation	Use of Public Transportation	2012-2016 US Census	Tract
Social Support & Community Context	Violence/Injury Prevention	Mortality	Firearm fatalities	2012-2016 CDC Compressed Mortality File	County
Social Support & Community Context	Violence/Injury Prevention	Mortality	Mortality - Homicide	2012-2016 ICD-10 Codes, National Vital Statistics System	County
Social Support & Community Context	Violence/Injury Prevention	Violence/Injury Prevention	Violent Crime	2012-2014 FBI Uniform Crime Reports	County
	Demographics	By Age Groups	Median Age	2012-2016 US Census	Tract
	Demographics	By Age Groups	Population Age 0-4	2012-2016 US Census	Tract
	Demographics	By Age Groups	Population Age 18-24	2012-2016 US Census	Tract
	Demographics	By Age Groups	Population Age 18-64	2012-2016 US Census	Tract
	Demographics	By Age Groups	Population Age 25-34	2012-2016 US Census	Tract
	Demographics	By Age Groups	Population Age 35-44	2012-2016 US Census	Tract
	Demographics	By Age Groups	Population Age 45-54	2012-2016 US Census	Tract
	Demographics	By Age Groups	Population Age 5-17	2012-2016 US Census	Tract
	Demographics	By Age Groups	Population Age 55-64	2012-2016 US Census	Tract
	Demographics	By Age Groups	Population Age 65	2012-2016 US Census	Tract
	Demographics	By Age Groups	Population Under Age 18	2012-2016 US Census	Tract
	Demographics	By Ethnicity	Hispanic Population	2012-2016 US Census	Tract
	Demographics	By Ethnicity	Population by Ethnicity	2000-2010 US Census	Tract
	Demographics	By Gender	Female Population	2012-2016 US Census	Tract
	Demographics	By Gender	Male Population	2012-2016 US Census	Tract
	Demographics	By Race	Population by Race	2000-2010 US Census	Tract
	Demographics	Population	Change in Total Population	2000-2010 US Census	Tract
	Demographics	Population	Families with Children	2012-2016 US Census	Tract
	Demographics	Population	Foreign-Born Population	2012-2016 US Census	Tract
	Demographics	Population	Population Geographic Mobility	2012-2016 US Census	Tract

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	Demographics	Population	Population in Limited English Households	2012-2016 US Census	Tract
	Demographics	Population	Population with Any Disability	2012-2016 US Census	Tract
	Demographics	Population	Population with Limited English Proficiency	2012-2016 US Census	Tract
	Demographics	Population	Total Population	2012-2016 US Census	Tract
	Demographics	Population	Urban and Rural Population	2000-2010 US Census	Tract
	Demographics	Population	Veteran Population	2012-2016 US Census	Tract

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Appendix G – CHNA Checklist (Found in CHNA Toolkit)

RHM Name:

CHNA Checklist Instructions:

Complete and submit this checklist at the time a draft is submitted to the System Office for review, and when the final version of the CHNA is submitted to the System Office for our records.

**Final drafts must be submitted 3 weeks prior to the date in which materials are due for inclusion in the board's meeting packet.*

1.) Enter the page number for where the item resides within the CHNA in the purple section below for questions 1-6. - *draft and final versions*

2.) Answer yes or no for questions 7-9 in the purple section. - *draft and final versions*

3.) Enter the date adopted by the Board and complete the Signature Certification. - *final version only*

4.) Submit this form and the draft or final CHNA to Rachael Telfer (rachael.telfer@trinity-health.org) - *draft and final versions*

	Requirements for the CHNA	Page Number	Notes
1	**Cover, introduction, and executive summary**		
	Individual cover page for each hospital, with logo		
	Mission statement		
	Summary of the previous CHNA		
	Executive summary, including significant health needs identified		
	Date CHNA was adopted by Board		
2	**Community served description**		
	Geographic area served, including a map		
	How the population served was identified		
	Demographics of population		
	Health facilities owned/operated by RHM		
	Services provided		

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3

Process and methods used		
The data used, including sources		
Data table of quantitative data used, including sources (appendix)		
Data table of County Health Rankings for service area (appendix)		
Collaborative Partners		
Methods used to collect and analyze the data		
Description of any parties collaborated with or contracted/hired for data assistance		

4

Community input		
State, local, tribal, regional or other health department (provide organization name)		
Method used to solicit input		
How the hospital took into account input, including **identifying and prioritizing** significant health needs		
A summary of the input received		
Approximate date or time period input was provided		
Members or representatives of medically underserved, low-income, and minority populations and who they represent (provide organization name - if applicable)		
Method used to solicit input		
How the hospital took into account input, including **identifying and prioritizing** significant health needs		
A summary of the input received		
Approximate date or time period input was provided		
Other persons who represent the broad interests of the community		
Method used to solicit input		
How the hospital took into account input, including **identifying and prioritizing** significant health needs		

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A summary of the input received		
Approximate date or time period input was provided		
Written comments received on prior CHNA & Implementation Strategy		
Method used to solicit input		
How the hospital took into account input, including **identifying and prioritizing** significant health needs		
A summary of the input received		
Approximate date or time period input was provided		

6

Significant community health needs		
Prioritized description of all the significant health needs identified through the CHNA.		
Process and criteria for identifying and prioritizing these significant needs		
Potential resources to address significant health needs, only if known or identified in the course of the CHNA process.		
Evaluation of the impact of any actions taken to address significant health needs identified in prior CHNA.		

7

Solicit written comments		
Contact information (address, email, etc.) to solicit public feedback on this CHNA		

8

Authorized body adoption		
If a single CHNA was conducted for more than one RHM facility, an authorized body from EACH facility must adopt the CHNA		

9

Made widely available to public		
Posted on hospital facility's website and remain there through 2 subsequent CHNA cycles (Provide the URL in notes)		
Paper copies available at hospital facility.		

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10	**Documentation - must be kept internally through two cycles**		
	Meeting minutes of Board or authorized body from EACH facility, as evidence that the board adopted the CHNA, including date.		
	Screenshots of CHNA posting on website, as evidence that the documents were made widely available to the public by June 30 (or September 30 for CT hospitals).		

Note: these requirements are from the Final IRS regulations published in December 2014.

Enter date adopted by the governing Board or body authorized by the governing body.

We certify that the Community Health Needs Assessment was prepared in accordance with the December 2014 final regulations under IRC Section 501(r)(3) and is complete and accurate to the best of our knowledge:

Community Benefit Ministry Officer (CBMO)

Reporting level above CBMO (enter title)

Date

Date

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Glossary of Terms and Acronyms

ACA – Affordable Care Act

CHNA – Community Health Needs Assessment

Community Served – Used interchangeably with service area. This area is defined as the geographic boundaries of a hospital's patient service area or market.

FQHC – Federally Qualified Health Centers

Health – Throughout the guide, health is used as a comprehensive term to include the social influencers of health

IRS – Internal Revenue Service

Ministry – Refers to one Mission Health Ministry, National Health Ministry, or a Regional Health Ministry. In this guide, it is used to describe an individual hospital.

Significant Health Needs – The "significant health needs" include both social influencers of health and the physical and mental health needs that surface as significant through a community-driven need identification process

SO – System Office

Social Influencers of Health (SIoH) – Also known as Social Determinants of Health, are the conditions in which people are born, grow, live, work and age (WHO). Examples include education, neighborhood and built environment, social context, economic stability, and health care access.

Qualitative Data – Data that described the qualities or characteristics

Quantitative Data – Data that can be counted or compared on a numeric scale

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