Trinity Health

Community Health Needs Assessment Guide

A guide for ministries to identify significant needs, inclusive of the physical, mental, and social influencers of health in their communities, with particular focus on racial equity and inclusion.

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Why we developed the Guide and how to use it

Community Health & Well-Being (CHWB) teams lead the development and implementation of the Community Health Needs Assessment (CHNA) and Implementation Strategy (IS) as part of our purpose to optimize health for people experiencing poverty and other vulnerabilities in our communities through connecting social and clinical care, addressing social needs, dismantling racism and reducing inequities. BIPOC communities have lived this reality for centuries and since the onset of COVID-19, it is undeniable that racism and racial inequities stand in the way of achieving our purpose.

This guide supports Trinity Health hospitals to develop their triennial CHNA. Trinity Health is focused intentionally on engaging communities and residents experiencing poverty and other vulnerabilities, with a particular emphasis placed on Black, Indigenous, and People of Color (BIPOC). The guide establishes minimum standards and recommends best-practices for hospitals as they conduct a *collaborative* and *inclusive* CHNA. This guide also outlines best practices on how to conduct a root cause analysis to identify and prioritize community needs—all while ensuring compliance with IRS Section 501(r)(3) requirements for CHNAs.

Similarly, the Implementation Strategy Guide will assist Trinity Health hospitals and partners develop collaborative implementation strategies – with explicit emphasis on applying racial equity principles on how we partner, develop and implement the strategies outlined in the IS. The Trinity Health Implementation Strategy guide, along with a four-part training series on *Community Engagement to Advance Racial Justice - Preparing for the Implementation Strategy,* are meant to serve as a foundation for our health ministry leaders to meaningfully engage communities to address the needs that matter most to the communities we serve. Both guides will continue to evolve as our health system and community partner together to improve health.

All Trinity Health hospitals are expected to use this CHNA guide, process and checklist (Appendix A), along with the subsequent Trinity Health Implementation Strategy Guide and Implementation Strategy template and to collaborate with community organizations, and other hospitals as you conduct the CHNA and develop the IS. Community members and communities most impacted by racism and other forms of discrimination that confront the greatest disparities and inequities in health outcomes should be inclusively engaged in all community health assessment and improvement efforts.

Community Health Needs Assessments and Implementation Strategies

What are they?

Together, the CHNA and IS foster collective action for the equitable allocation of resources from the hospital and other community sources, directed toward needs being addressed and for those most impacted.

A Community Health Needs Assessment (CHNA) uses quantitative and qualitative data, inclusive of community input from systemically oppressed populations, to identify and understand community assets, needs, and the relative health and social well-being of a community. The CHNA results in a prioritized list of needs.

The Implementation Strategy (IS) is a plan of the collective strategies that the hospital and its partners intend to implement in order to address the identified needs in a defined geographic area with the greatest inequities and expand upon the assets that were identified through the CHNA.

Why are hospitals required to conduct a CHNA?

Enacted in March of 2010, the Patient Protection and Affordable Care Act, Section 501(r) of the Internal Revenue Code requires each separately licensed 501(c)(3) tax-exempt hospital facility to conduct a CHNA at least once every three tax years, and to adopt an IS to meet the community health needs identified through the CHNA. The IRS requires hospitals to conduct a new CHNA—with all required components completed—before the end of the fiscal year in which it is due (June 30 for most TH hospitals, September 30 for Connecticut hospitals). The development of the CHNA should begin in the fiscal year before it is due. While the Implementation Strategy can follow the same timeline as the CHNA, the IRS gives hospitals up to 4.5 months after the end of the fiscal year in which the last CHNA is completed to develop the IS (November 15 for most TH hospitals, February 15 for Connecticut hospitals). 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 publicly available to regulators, press, community organizations and residents by the Trinity Health Tax Department.

While CHNAs and Implementation Strategies are required by the IRS, Trinity Health ministries have been conducting CHNAs and developing Implementation Strategies, long before the IRS required it, as a way to meaningfully engage our communities and deliver on our Community Health & Well-Being strategy. This guide places particular emphasis on how the CHNA can begin to identify and dismantle systemic racism and reduce inequities through engagement of Black, Indigenous, and People of Color (BIPOC) communities.

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. Hospitals and 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 be comprised of an aggregate of the service areas for participating hospitals and organizations.

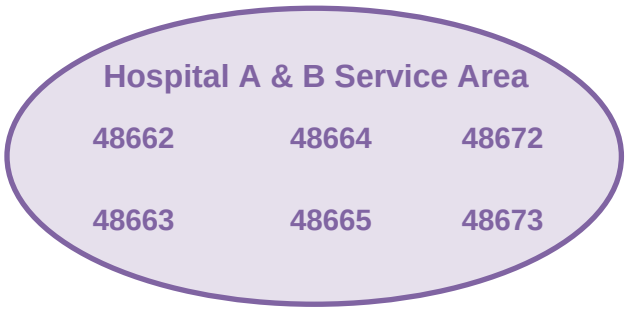
In conducting a joint CHNA process, the following must conditions must be met:

[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

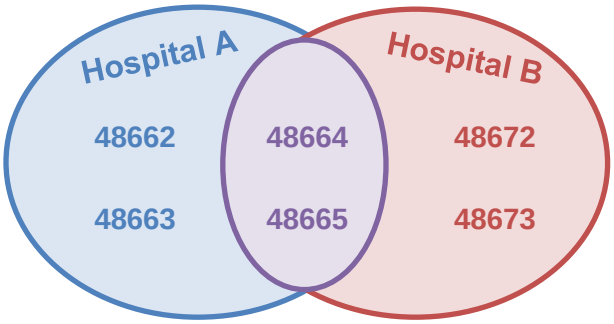
1. Like individual CHNAs, joint CHNA written reports must meet all required components for each hospital.
2. The joint CHNA written report is clearly identified as applying to each individual hospital and organization. *Take care to ensure each hospital is represented in each required component*.
3. All of the collaborating hospital facilities and organizations included in the joint CHNA process and written report define their community to be the same (scenario 1 below).

Example: Hospital A's primary service area includes zip codes 48662, 48663, Hospital B's primary service area includes zip codes 48672 and 48673, and they share zip codes 48664 and 48665.

Scenario 1 (right): Hospitals A and B declare an identical service area, for the purposes of this CHNA, which is comprised of all six zip codes. Hospital A and B can adopt a joint CHNA report, granted it meets the required components and includes all hospital-specific information for each hospital.



Scenario 2 (right): Hospital A and B do not declare an identical service area and choose to adopt individual CHNA reports. All collaboratives with 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.



Conducting the Community Health Needs Assessment

The following outlines the process that Trinity Health hospitals should follow while conducting their Community Health Needs Assessment. Each of these are described in detail below.

I. Questions to consider before getting started

The past CHNA 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 hospital's impact on the 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.**

II. Form and/or convene an Advisory Committee

Hospitals cannot (and should not) conduct the CHNA alone. The Advisory Committee should have at least 50% or more of its membership by made up of non-hospital participants and should convene at a frequency necessary to ensure the development of the CHNA in a timely manner. Convene community partners who are engaged in addressing and preventing community needs for those most impacted by the community needs should be engaged in the process of identifying and prioritizing community needs. The CHNA Advisory Committee drives the entire CHNA development process and ensures an inclusive and racially equitable approach. If the hospital is not already involved in a community collaborative, begin to identify and convene a committee of internal and external partners who will manage and/or inform all aspects of the CHNA process. Include within this committee people from various disciplines who will help identify root causes of unfavorable health issues, validate and produce quantitative and qualitative research, ensure voices are heard from the areas of greatest need, provide ideas and avenues for broader community engagement, and ensure an inclusive and thorough assessment process. At a minimum, ensure the following are included in the Advisory Committee, workgroups, and/or community focus groups:

- Those most impacted by community needs (ex. Social needs—are those experiencing social needs participating)
- Community members residing in the community/neighborhood most impacted by community needs
- Diverse representation, with particular emphasis on BIPOC led and/or BIPOC serving organizations

Offer volunteers and community members financial compensation, such as a $25-50 gift card for every 60-90 minutes (be mindful of State and Federal tax laws), for their contributions on the Advisory Committee and to the development of the CHNA. Ensure all capacities or skillsets of those listed below are included and/or consulted as part of the Advisory Committee, with particular emphasis on ensuring BIPOC representation.

- Health System: Community Health & Well-Being, Population Health, Advocacy, Diversity, Equity & Inclusion, Strategy, Marketing & Communications and Mission.
- Community Organizations and Institutions: public health, other area hospitals, physician groups or clinics, any local FQHCs, school districts and educational institutions (pre-k through postsecondary), public safety, and youth and adult social service groups, organizing, advocacy and CBOs that engage in activism.
- Community Members and Other Community Organizations that serve those who have lived experience and are most impacted by the community needs (ex. Food—someone experiencing food access issues), community members of the area/neighborhood most impacted by the needs, and technical experts in this area of needs (ex. Food—food policy council leader).
- Hospital/Regional Health Ministry Board of Directors: We recommend the board, or a representative of the board, is involved in the advisory committee and/or focus groups and are consulted throughout the CHNA process. The timing for the development and approval of the CHNA and Implementation Strategy will depend largely on the hospital board's involvement. Plan ahead and prepare for the board's desired involvement.

III. Develop a timeline and budget

Timeline

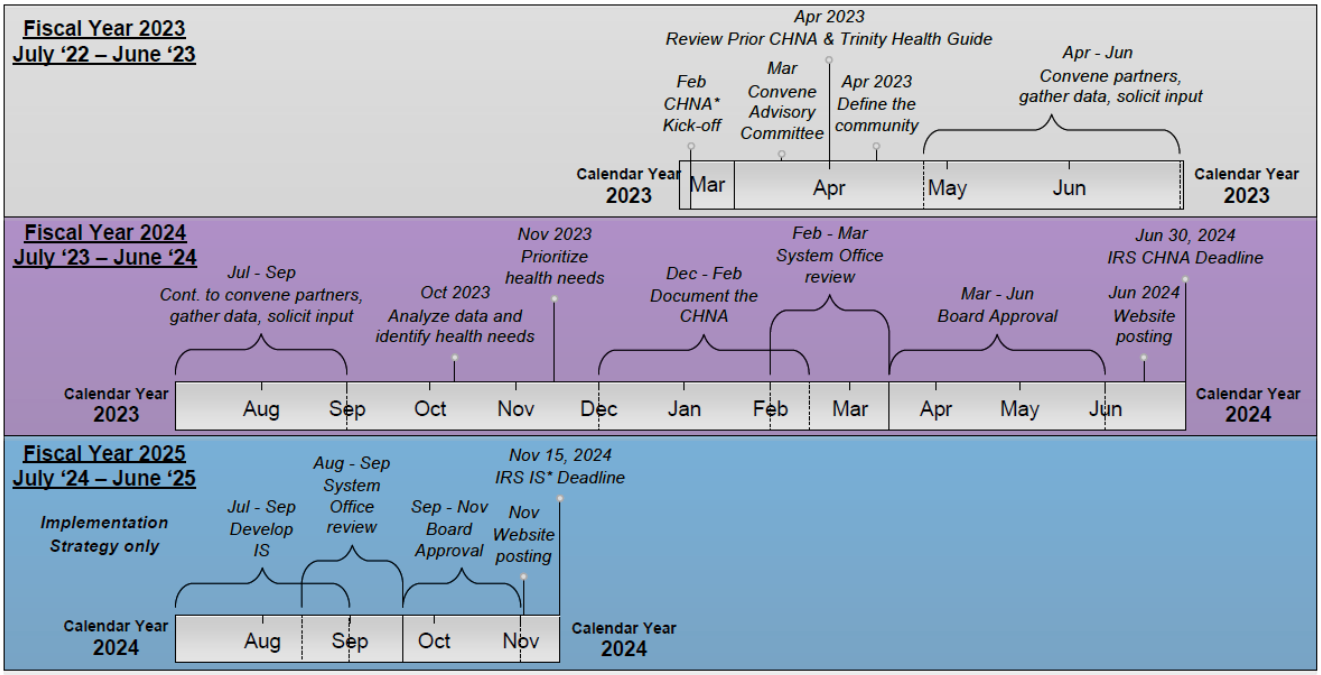
The Advisory Committee will need to develop a timeline that ensures all CHNA process requirements are completed before the deadline in which the IRS requires hospitals to publish the CHNA and Implementation Strategy. One date should be established so that all committee members are working toward the same deadline. Trinity Health recommends that the CHNA and Implementation Strategy are approved at separate board meetings, in order to give the hospital and partners adequate time to conduct the CHNA, in addition to gaining appropriate input from internal (executive leadership, Board of Directors, System Office) and external partners, (community members, grassroots organizations, and other partners).

When preparing the timeline, consider the following:

- Consider the scheduling needs of all stakeholders (i.e. hospital's Board meeting dates within the timeframe that is required for compliance, grassroots organization's fiscal years, public health department due dates, etc.). 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 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 for one or two extra board meetings at the back-end of the fiscal year, in case there are unforeseen circumstances that prevent the CHNA from being approved by the board in the expected timeframe.
- Keep in mind that community input, involvement and relationship building takes time, so build ample time into your schedule to account for the various voices that need to be heard while conducting the CHNA.
- 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, local Marketing & Communications formatting, 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 2024 CHNA and IS process. The hospital CHNA process should begin at least sixteen months before the conclusion of the fiscal year. Your hospitals timeline may be accelerated, however the key milestones indicated below must be met by these dates.

Example 16-month CHNA and 4.5-month Implementation Strategy Timeline
Fiscal Year 2024
June Year-end



CHNA – Community Health Needs Assessment
IS – Implementation Strategy

Budget

Prepare a budget of the anticipated costs for conducting the CHNA and ensure that these costs are included in the annual CHWB forecast, 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. These costs may include:

- Hiring consultants to facilitate focus groups or collect data
- Space, meeting materials and refreshments for all participants engaged in the planning sessions – as a reminder, all CHWB hosted meetings should provide healthy food and beverages per the Healthy Meeting Procedure
- Reimbursing community members to participate in the advisory committee, workgroups, or focus groups, or providing other incentives for participating in the process
- Evaluation costs (data collection, consultant, analysis tools, etc.)
- Estimated costs for addressing the needs in the implementation strategy and ongoing implementation, evaluation, etc.

IV. 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. If the community served used in the

CHNA differs from the local planning/strategy definition, the rationale must be supported and documented. Regardless, the community served must not exclude those who are medically underserved, low-income, uninsured, underinsured, or minority populations.

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.

V. Community engagement

Trinity Health defines *Community Engagement* as the activities and process of working collaboratively with and through community members, groups, and organizations who are from, led by, and/or who partner closely with the populations we seek to benefit and who are most impacted by health inequities.

Trinity Health expects all hospitals to conduct the CHNA and develop the IS in collaboration with community partners, with the goal of engaging communities and residents to identify the root causes of needs impacting those experiencing poverty and other vulnerabilities, with a particular emphasis placed on the BIPOC population.

The community members, groups, and organizations that are needed for meaningful community engagement can be defined in three categories:

- *Grassroots:* "Grassroots" often refers to community members who do not have a formal or professional role in public health, and who are not in leadership for a local agency or organization. Grassroots organizations are primarily made up of civilians advocating a cause to spur change at local, national, or international levels, these are often small organizations that operate with unpaid staff members. Some grassroots engagement techniques—specifically community organizing—focus on identifying, involving, and empowering the community members 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 community members or others who are recognized leaders in their neighborhoods or organizations due to their professional roles, public profiles, or positions of power and privilege. Grasstops leaders usually have access to, and can wield influence on, key decision-makers or segments of the *grassroots* community.
- *Partners:* Partners are people (and organizations) who are either impacted by a problem, either directly or indirectly, or who can have an effect on the outcome of a problem (often called "key partners"). Partners can refer to both grassroots and grasstops/tips.

Facilitating Power, a consulting company, developed the 'Spectrum of Community Engagement to Ownership' pathway model. The spectrum is designed to acknowledge marginalization, assert a clear vision, articulate a developmental process, and assess community participation efforts[2]. The developmental stages are pictured below. The spectrum can be a tool to identify where your community

[2] Facilitating Power; https://movementstrategy.org/wp-content/uploads/2021/08/The-Spectrum-of-Community-Engagement-to-Ownership.pdf

collaborative is on the engagement spectrum and set goals for collective practice that build on the culture of collaboration, which is essential to planning and achieving racial equity.

Identify and consult community partners and organizations

Community Engagement is expected throughout the CHNA process. Outside of the CHNA Advisory Committee, there are likely other partners or resources who can assist with data collection and act as sources for community input.

Engage with a variety of community-based organizations (CBOs) across sectors. Identify CBOs with intimate knowledge of community needs, especially those who are led by and/or serve people who face racism and other forms of oppression. Asset mapping, often utilized in the development of CHNAs and described in section VII, can help identify potential partners—who work with those who are most impacted by the community needs and possess lived experience—to solicit input on your ministry's behalf.

The following is a sample list of government organization and CBO's the workgroup may engage to help shed light on community health and social needs:

- Civic engagement organizations
- Local health departments
- Homeless shelters
- Area Agency on Aging
- Police and other law enforcement*
- Schools
- United Way
- YMCA/YWCA
- Salon/Barber shops
- LGBTQIA focused organizations
- Behavioral health/community mental health providers
- Food pantries
- Libraries
- CBO’s involved in community organizing and advocacy

*Before inviting law enforcement into a community partnership, there should be an assessment of how this impacts community members. BIPOC, immigrants, substance users, etc. may have mistrust of law enforcement and bringing that voice to the table may discourage others to participate.

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*.
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.

Barriers to Community Engagement
Some barriers that impede meaningful community engagement are listed below. Be mindful of these barriers and work to mitigate as early on as possible.

Barrier	Ways to mitigate barrier
Meeting hours that do not match community availability	Offer multiple meeting opportunities at varying times and locations
No childcare, food, or cultural considerations such as scheduling during high holidays	Provide free childcare and healthy culturally appropriate food offerings, be mindful of holidays and cultural community events
No compensation for community members for their time and knowledge	Pay community members for their time

Language barriers and lack of resources for those who do not speak English	Engage multilingual facilitators and/or translators, and translate any and all surveys as appropriate
Use of community organizations' name in grant applications without their knowledge or consent	Ensure all CBOs who are named are aware and fully supportive of grant applications, and understand their role, if grant is approved
Community mistrust of institutions and staff; failed projects are re-implemented and community feedback is not considered, addressed or implemented	Trust is hard to rebuild. Don't rush this process. Be open to having fair and honest conversation about the ministry's role in failed projects
Engaging community because it is a requirement without understanding why it is important.	Shift mindsets by exploring why community engagement is essential to equitable, effective community health improvement.
Expecting community members to understand and adapt to organizational norms and practices.	Provide training and support for community members as well as organizational partners in how to engage in planning together.
Including a single community member and asking them to represent a whole community or group.	Balanced representation between community members, CBOs, and hospital staff.

Community engagement activities

When face-to-face engagement is not possible, substitute with virtual technology. The following includes a list of community engagement activities that support conducting a CHNA:

- Facilitate focus groups and community listening sessions
- Host advisory committees, CBOs, community members, etc.
- Host open community forums with resident polling
- Conduct individual interviews with community leaders, individuals with expertise in public health, or other individuals within the community
- Collect community information from organizations participating in outreach, community organizing and advocacy and those the hospital/partners provide referrals to resources
- Resident surveys with validated questions– example survey questions available in appendix D.

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.

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.

Community engagement outlets and methods

The Social Care Community Engagement Workgroup identified recommended outlets and methods for community engagement during the COVID pandemic. This list is not all-inclusive, but is meant to be considered when planning your ministry's community engagement work within the CHNA process.

Outlets	**Methods**
Food distribution Food pantries Farmers markets Flea markets School pick-up sites	• Hard copy survey • Conversations • On-site polling • Post card with link and phone number to complete survey by phone
Youth engagement School events Boys and Girls Clubs Afterschool programs Drop-in centers Local parks and recreation College Campuses	• Hard copy survey • Conversations • On-site polling • Post card with link and phone number to complete survey by phone
Social Media	• Link to online survey • Phone number to complete survey by phone • Virtual data walks/discussions
Mobile services Grocery shuttle Mobile clinics COVID testing sites	• Hard copy survey • Conversations • Post card with link and phone number to complete survey by phone
Local businesses Corner stores Grocery stores Laundry Mats Salon/Barber shops	• Hard copy survey • Conversations • Post card with link and phone number to complete survey by phone
Senior Engagement Assisted living Nursing homes Area Agency on Aging	• Hard copy survey • Focus groups • Individual conversations • Post card with link and phone number to complete survey by phone
Local public transportation	• Ride along to complete surveys • Hard copy survey • Conversations • Post card with link and phone number to complete survey by phone
Patient Family Advisory Council	• Focus groups
Faith community partnerships	Faith leaders share message re: the importance of community input and steps how to complete survey

	• Hard copy survey • Post card with link and phone number to complete survey by phone
Engaging internal workforce, i.e. vulnerable people work at health system – work directly with operational leaders and managers to encourage feedback i.e. environmental services, food services, etc.	• Hard copy survey • Link to online survey • Focus groups
Libraries	• Hard copy survey • Conversations • Post card with link and phone number to complete survey by phone
Homeless shelters	• Hard copy survey • Conversations
Behavioral health / community mental health providers	• Hard copy survey • Conversations

VI. Quantitative data collection and analysis

Hospitals need to 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.

Trinity Health Data Hub

Use the Trinity Health Data Hub (password: CHWBdata) to create a CHNA report for the hospital's service area. The CHNA report is comprised of specific indicators that were selected by the CHWB council and are required for all Trinity Health ministries to include in their CHNA data analysis. The indicators available on the data hub replace the previously distributed list of required indicators. Instructions for creating a CHNA report, as well as making a map of your community, are located in Appendix E.

The data hub standard CHNA report includes the following categories of indicators:

- Health Outcomes and Behaviors
- Health and Healthcare
- Education
- Economic Stability
- Social Support and Community Context
- Neighborhood and Built Environment
- Demographics

Note: A data table that includes all of these indicators—and others you collect—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.

While the Trinity Health Data Hub CHNA report is required for all Trinity Health Hospitals, the following are other data sources and types of data that, when included in the CHNA data analysis, would result in a more thorough picture of the community's health and well-being.

Social Influencers of Health (SIoH). Additional SIoH data should be analyzed for the hospital's service area, including data related to poverty, education, built environment, access to employment, etc., as they contribute to the health of the community.

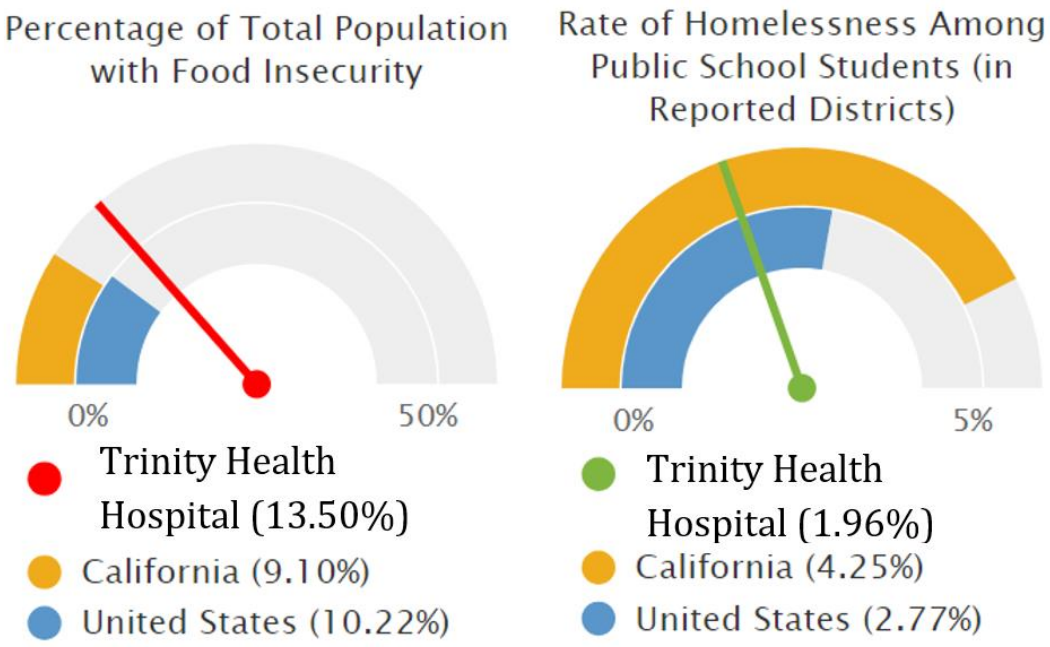
Demographic data. At a minimum, hospitals should collect demographic data on the community's population and population trends, distribution of age, gender, race, ethnicity, language, income, and poverty levels, as well as other pertinent information related to the community.

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.

When possible, more recent, localized data for the community should be pursued and included in the data analysis for the CHNA. Try to collect and analyze indicators at the lowest data point possible (census tract, zip, county, etc.). Appendix F 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.).

Benchmark analysis

The recommended method for analyzing quantitative data to determine whether an indicator is a potential need within the community is to perform a benchmark analysis. This involves comparing indicators against a benchmark, such as a state or county benchmark, Healthy People 2030 goals, or county health rankings top performers (10^{th} percentile). Indicators that do not meet the established benchmark, therefore unfavorable, could emerge as potential needs. Most indicators in the data hub have a speedometer graphic (below) that compares the indicator to the state benchmark and displays either as unfavorable (red) or favorable (green).



When the data is exported to Excel, you can use a formula to compare the service area data to the state or national benchmarks for each indicator:

=((service area – benchmark)/((service area + benchmark)/2))

	B	C	D	E	F	G	H
1	**Data Indicator**	**Indicator Attribute**	**Service Area**	**State**	**USA**	**Need Differential (State)**	**Need Differential (US)**
5	Access to Mental Health Providers	Estimated Population	191224	19989717	317105555		
6		Number of Mental Health Providers	353	53582	643219		
7		Ratio of Mental Health Providers to Population	446.9	1034.6	1000	=((D7-E7)/((D7+E7)/2))	
8		Mental Health Care Provider Rate (Per 100,000 Pop)	184.6	268	202.8	-36.85%	-9.40%
9	Access to Primary Care	Total Population (2017)	189886	9976447	325147121		
10		Primary Care Physicians (2017)	94	7800	249103		
11		Primary Care Physicians, Rate per 100,000 Pop.	49.5	78.2	76.6	-44.95%	-42.98%
16	Insurance - Uninsured Adults	Total Population Age 18 - 64	117991	5979307	195883847		
17		Population with Medical Insurance	111537	5520811	171496973		
18		Percent Population With Medical Insurance	94.53%	92.33%	87.55%	2.35%	7.67%
19		Population Without Medical Insurance	6454	458496	24386874		
20		Percent Population Without Medical Insurance	5.47%	7.67%	12.45%	-33.49%	-77.90%

The formula will help determine how significant the variance is between the service area and the benchmark. A percentage that is closer to zero (0), relative to other data indicators, means that the indicator differs from the benchmark at a lower degree. While a higher percentage, relative to other data indicators, means that the indicator differs from the benchmark at a higher degree. In other words, the greater the differential, the greater the difference between the service area and the benchmark is for a particular indicator. If the differential is a negative percent, the service area was less than the benchmark. If the differential is a positive percent, the service area was greater than the benchmark. Note that most indicators are worded so that a lower number or percentage is better, however there are

some indicators where a higher number or percentage is better (i.e. Primary Care Physicians per 100,000 population, Percent within 1/2 mile of a park, Population with Medical Insurance, etc.), and some are neutral (i.e. demographics).

VII. 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 and partners 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.)

Community intervention resources: initiatives and programs that are currently provided within the community (i.e. community benefit programs, food banks, youth programs, senior programs, etc.). The Community Resource Directory (CRD) is a great resource for free or reduced cost services such as medical care, food, job training, and more.

Cultural and Neighborhood Resources: faith-based organizations, advocacy and/or community organizing organizations, specific population organizations (BIPOC, LGBTQ+, etc.)

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.

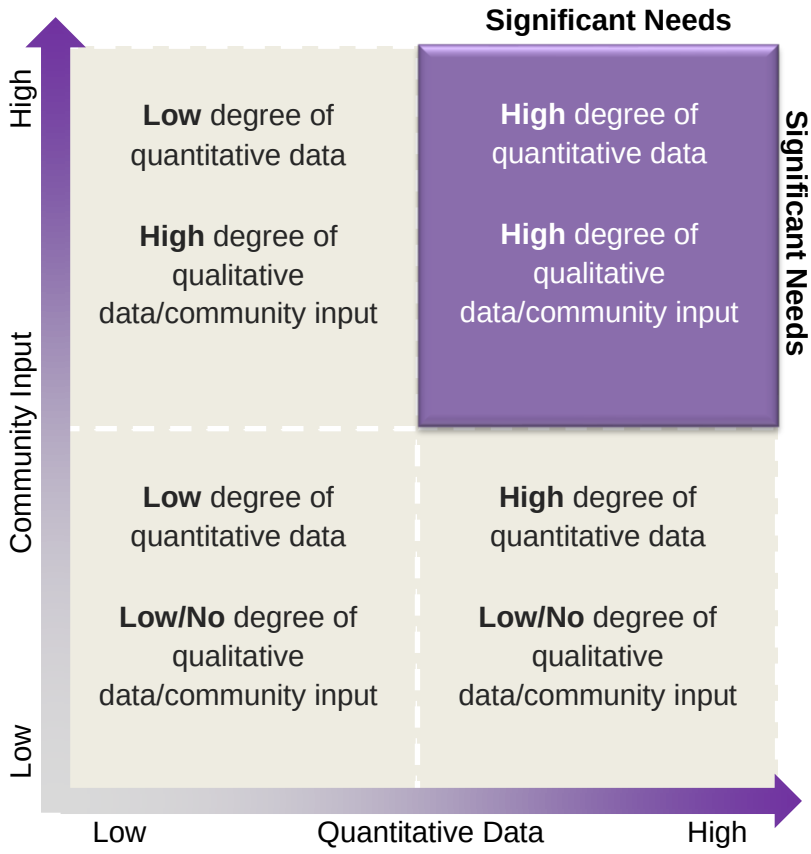
VIII. Identify the significant health needs

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
- Reducing inequities experienced by BIPOC communities
- Improvement or maintenance of the health status in the community at large

Within the Advisory Committee and with other collaborative partners, identify the significant health needs that surface as a result of the quantitative and qualitative data collection process.

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.



Root Causes

When identifying the health needs of the community, be specific and think of the root causes. The Trinity Health Implementation Strategy Guide describes the importance of identifying and addressing the root causes of needs and provides the steps for conducting a problem analysis, which asks “why?” a particular problem is prevalent and “why here?” and uses this technique to surface root causes of problems experienced within the community, particularly within populations disproportionally affected, such as the BIPOC population. This section is provided in Appendix G of this guide. A problem analysis should be conducted while identifying needs in order to ensure the root causes are called out, as opposed to broad categories that encompass several needs (i.e. Social Influencers of Health, Health Outcomes, etc.).

IX. 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 the collaborative partners and other 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 the 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, and the social influencers of health
- Known to affect those most impacted by health inequities and the BIPOC population
- 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 measurable 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 H. 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.

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.

X. 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 publicly available, and reported on the IRS 990 Schedule H. All hospitals participating in a collaborative effort should perform a gap analysis of the CHNA process and the collaborative (or joint) 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. Ideally though, the hospital-specific information would be included in the collaborative report (even if as an appendix).

Trinity Health does not have a required template for the written CHNA report. However, an outline is provided in Appendix I of this guide with recommended headers, sub-headers, and content suggestions.

XI. Final Approvals and Published Report

CHWB System Office CHNA Review Process

All CHNAs, along with the checklist (in toolkit and Appendix A), must be submitted to the Trinity Health System Office (SO) for review and approval no later than six weeks prior to your hospital's Board of Directors meeting to approve the CHNA written report (or four weeks prior to the board materials due

date). 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.

After System Office approves your CHNA, work with your local Marketing & Communications teams to finalize the report with local branding.

Formally Gain Board Approval and Publish
It is necessary that the final CHNA written report (not a draft or a summary) is formally approved by your hospital's Board of Directors on or before the last day of the fiscal year in which the CHNA is due to be completed (June 30 for most TH hospitals and September 30 for Connecticut hospitals).

The IRS regulations allow for the Board to appoint an authorized person or committee to adopt the CHNA and Implementation Strategies (this needs to be documented in board meeting minutes, if applicable). 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 that 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 must be approved by all hospitals' board of directors.

The two most recent final and approved CHNA written reports and implementation strategies 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. The CHNA 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. The IS must be posted by November 15 for most Trinity Health ministries and February 15 for Connecticut ministries. For a record, save a screenshot of the posted CHNA and IS by their respective due dates.
- Available - upon request - at the hospital facility, free of charge.

Developing the Implementation Strategy and Next Steps

The development of the IS should begin while finishing the final written CHNA. The IRS gives hospitals up to 4.5 months after the end of the fiscal year in which the last CHNA is completed to complete the IS (November 15 for most TH hospitals, February 15 for CT hospitals). Trinity Health expects all of its hospitals to develop the IS in collaboration with community partners and evaluated over the subsequent three years. The goal while developing the IS should be to have a positive impact on the community needs that are selected to be addressed and to successfully reach those most affected by the need, and to make meaningful, measurable progress toward reducing the inequities that were identified as the root cause of the prioritized need.

Appendix A – Community Health Needs Assessment Checklist (Found in 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 4 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		
3	**Process and methods used**		
	The data used, including sources		
	Data table of quantitative data used, including sources (appendix)		
	Data table of CARES data (Trinity Health Data Hub) for service area (appendix)		
	Methods used to collect and analyze the data		
	Collaborative partners		
	Description of any parties collaborated with or contracted/hired for data assistance		
	List and description of community partners		
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		

Requirements for the CHNA	Page Number	Notes
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		
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		

5	**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.		

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

7	**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		

8	**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.		

9	**Documentation - must be kept <u>internally</u> 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 Health & Well-Being Executive

Reporting level above CHWB Executive (enter title)

_____ _____

Date

Date

Appendix B – IRS Requirements and Compliance

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 IS 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).[3]

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

[3] 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

Appendix C – Glossary of Terms and Acronyms

ACA – Affordable Care Act

CBISA – Community benefit reporting database from Lyon Software

CHNA – Community Health Needs Assessment

Community Engagement - the activities and process of working collaboratively with and through community residents, groups, and organizations who are from, led by, and/or who partner closely with the populations we seek to benefit and who are most impacted by health inequities.

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.

Minority populations – The IRS uses this term, we expand it to mean Black, Indigenous, and People of Color (BIPOC), persons with disabilities, the LGBTQIA+ community, and those who are systemically oppressed.

Root Causes – the underlying, and sometimes long-standing, reasons that there is poor health in a community. Poor health outcomes—like high rates of asthma, heart disease, and cancer—are often symptoms of root causes.

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

Workgroups – A group dedicated to developing the strategy to address a single need, comprised of at minimum: someone most impacted by the need, a representative or grassroots organization located in an area most impacted by the need, and a subject-matter expert.

Appendix D - Example Resident/Consumer Survey Questions

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

Demographics

- Which 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).
- 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:** "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)*

COVID-19 Specific Questions

The Social Care Community Engagement Workgroup identified example questions around the current COVID-19 pandemic that are recommended for use in the CHNA consumer survey. These questions (1-5), along with other questions used by Trinity Health ministries in their CHNA process, are below:

1) During COVID-19, have you had trouble getting or accessing any of the following? (check all that apply). **Response options:** General healthcare/doctor; Groceries; Exercise; Spiritual support; Prescriptions; Time with family/friends; Other (please specify)
2) During COVID-19, have you or your family found you needed help getting enough food, paying bills, rent or mortgage, finding child care, or meeting with primary care providers? **Response options:** Yes/ No; If YES, how often? (All of the time; Most of the time; About half the time; Less than half the time
3) Since COVID-19 began, have you felt an increase of depression, anxiety, isolation, or other issues? **Response options:** All of the time; Most of the time; About half the time; Less than half the time; Not at all
4) Were you or anyone in your household tested for COVID-19? **Response options:** Yes/ No; If YES, why? (Had COVID-19 symptoms; Pre-surgery or procedure test; Exposure to someone positive at home; Exposure to someone positive at work; Other (please specify)

Questions Regarding Discrimination (racial and other...)

1) Have you ever felt discriminated against in any of the following ways because of your race, ethnicity, gender, age, religion, physical appearance, sexual orientation, or other characteristics? (check all that apply) **Response options:** I was discouraged by a teacher or advisor from seeking higher education; I was denied a scholarship; I was not hired for a job; I was not given a promotion; I was fired; I was prevented from renting or buying a home in the neighborhood you wanted; I was prevented from remaining in a neighborhood because neighbors made life so uncomfortable; I was hassled by the police; I was denied a bank loan; I was denied or provided inferior medical care; I was denied or provided inferior service by a plumber, care mechanic, or other service provider

2) We'd like to understand how you feel you're treated by others. For each of the following statements, please say whether the statement applies to you often, sometimes, rarely or never.

	Often	Sometimes	Rarely	Never
I am treated with less courtesy than other people.				
I receive poorer service than other people at restaurants or stores.				
People act as if they think I am not smart.				
People act as if they are afraid of me.				

People act as if they think I am dishonest.				
People act as if they think I am not as good as they are.				
I am called names or insulted.				
I feel threatened or harassed.				

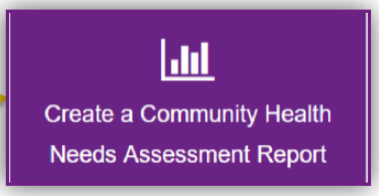
Sources: Discrimination Questions 1&2: Perceived Discrimination Scale\. Williams, D. R., YU, Y., Jackson, J. S., & Anderson, N. B. (1997). Racial differences in physical and mental health: Socioeconomic status, stress and discrimination. Journal of Health Psychology, 2, 335-351.)

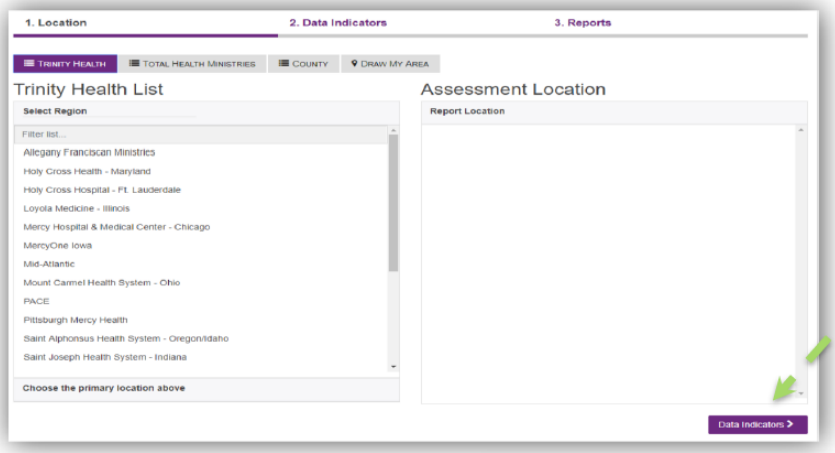
Additional questions can be found at the following site:

Social Interventions Research & Evaluation Network (SIREN)
Survey Monkey Demographic Template
Survey Monkey Question Bank

How to Create a Community Health Needs Assessment Report

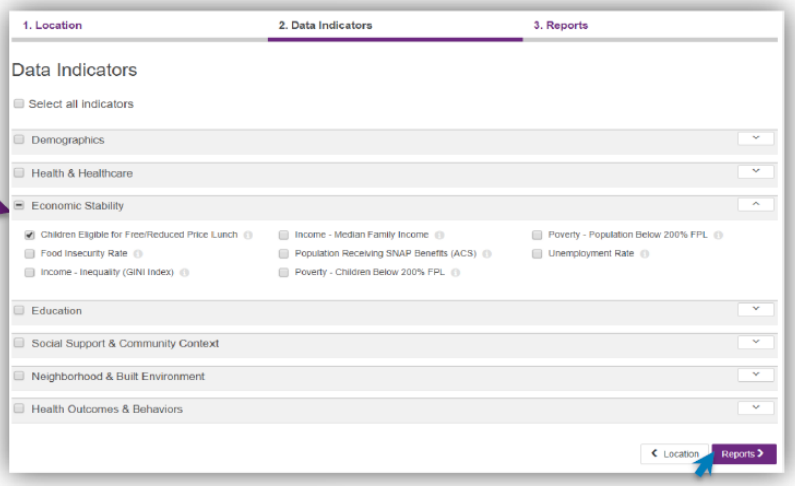
1. From the homepage, click the "Create a Community Health Needs Assessment Report" button.



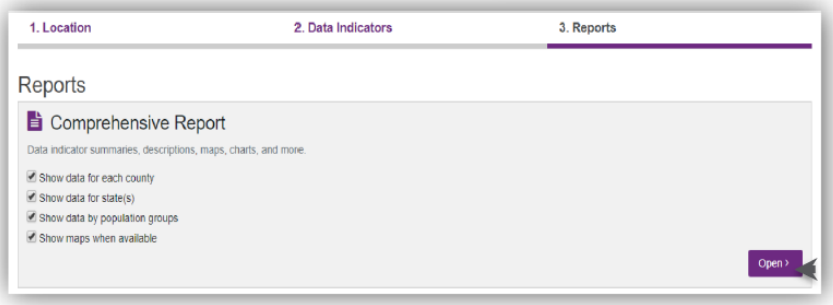


2. Next, select a Region, and your Service Area. You can also select a Ministry under the Total Health Ministries tab. Once you've selected your report area, click the "Data Indicators" button.

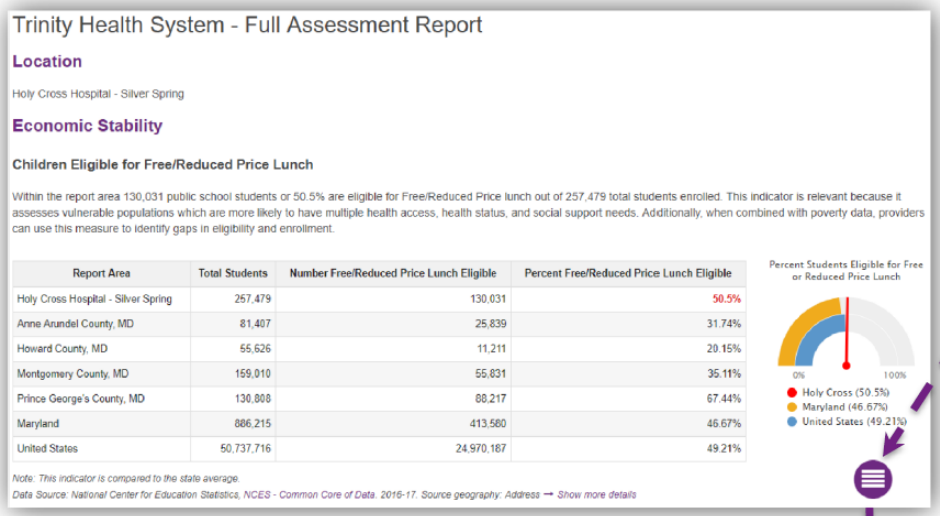
3. Select indicators to include in the report by clicking the check box next to the data category or individual indicator.



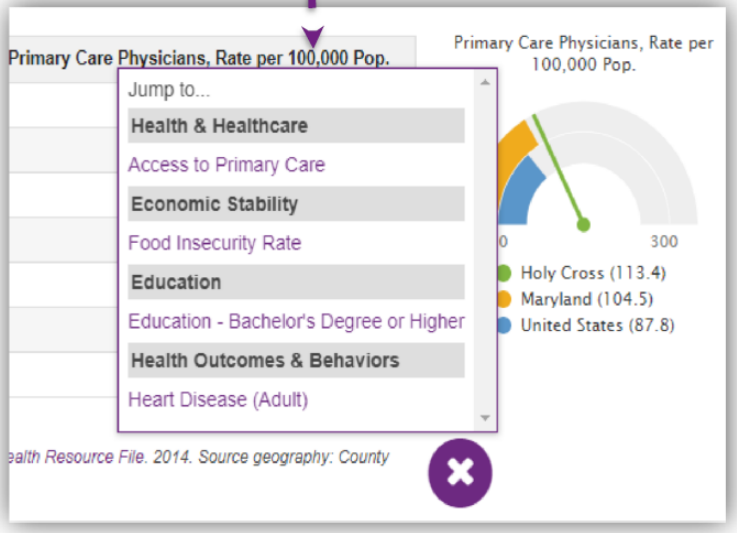
4. Click the "Reports" button to select your report type.



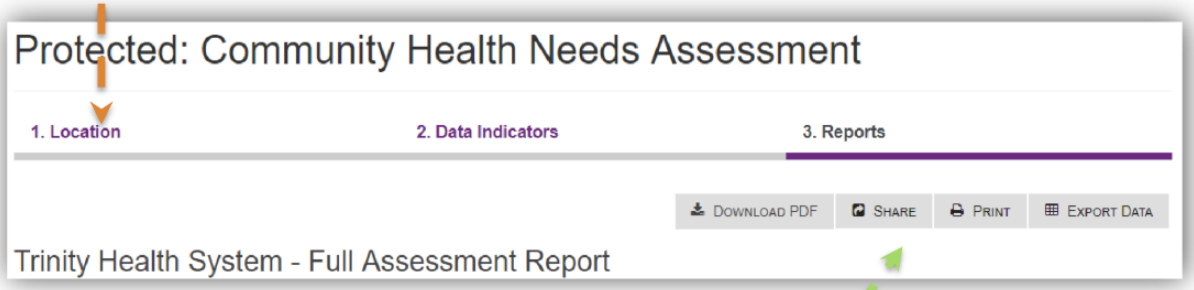
5. Select a report type by clicking the "Open" button.



6. Explore your report by clicking the hamburger menu at the bottom right of the report. Click a category or indicator name to jump to another section.



7. Edit your report area, indicator selection, or report type by clicking the tabs at the top of the report.



8. To download, share, print, or export your report, click the buttons at the top right.

Appendix F – 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

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 G – Root Cause Analysis from TH Implementation Strategy Guide

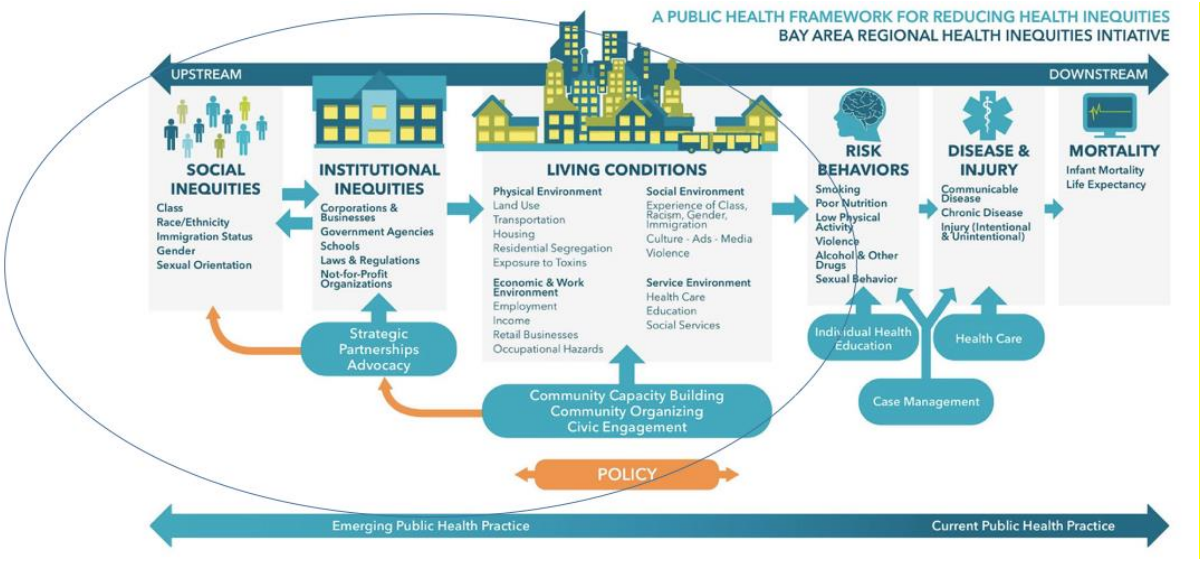
Determine how the significant health needs will be addressed – Workgroups
Workgroups need to be formed around each of the needs that the Advisory Committee selected to address in the IS. Workgroups are responsible for developing and recommending the actions/strategies to address the need, who the strategies will be directed toward, where the strategies will be offered/delivered, and who will implement the strategies with what resources. Workgroups should include:

- Community members of the area/neighborhood most impacted by the needs – these members may need assistance directly from the hospital and those needs should be considered when the individuals are engaged.
- Community organizations that serve those who have lived experience and are most impacted by the community needs (ex. Food Insecurity—someone experiencing food access issues),
- Technical experts in this area of need (ex. Food—food policy council leader).

It is also useful to ensure the following capacities or skillsets of the following areas within the health ministry are included in the workgroups to help develop the strategies that will address the community needs: Strategy, DEI, Mission, Advocacy, Finance, Population Health (clinics, home health, hospice, skilled nursing, foundations, pharmacy, physician groups, etc.). Inclusion of these health system leaders will further integrate CHWB across the health ministry and utilize healthcare expertise in developing the strategies within the IS.

Workgroups need to review qualitative and quantitative data that pertains to their need. The CHNA is a good starting place for such information, including indicator data, focus group summaries, survey responses, etc. The Trinity Health Data Hub (password: CHWBdata) CHNA Report and map room can provide additional quantitative data.

Workgroups then conduct a problem analysis for the “problem” or need that they are working to address. The Bay Area Regional Health Inequities Initiative (BARHII) developed a conceptual framework that illustrates the connection between social inequalities and health. It illustrates how deep inequities underlie the living conditions that ultimately impact health and health inequities. By addressing upstream root causes, implementation strategies can drive prevention at a population level. This framework has been used widely as a guide to health systems and health departments working to address health inequities.



One strategy for identifying the root causes of a particular area of need is the technique described in the [Community Anti-Drug Coalitions of America (CADCA) 'Assessment Primer: Describing Your Community, Collecting Data, Analyzing the Issues and Establishing a Road Map for Change'](). [4] CADCA's method not only asks "why?" a particular problem is prevalent, but also, "why here?" and uses this technique to achieve the following:

- Surface root causes of problems experienced within the community, particularly within populations disproportionally affected,
- Challenge the perceptions and assumptions about the root causes of a problem, while taking into consideration the community's data, unique experience, and scientific evidence,
- Help the collaborative build consensus around problem solving and prioritize actions that will have the greatest impact on those directly affected by a need,
- Create a framework that is easily translated to a logic model, which builds support for the actions that are eventually outlined in the IS and implemented by the collaborative to collectively address the need.

To embed an equity lens in this process, workgroups are asked to assess the following:

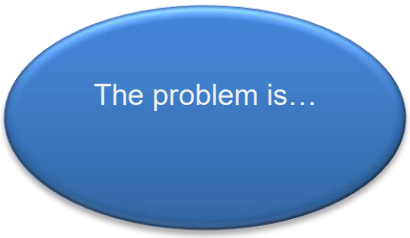
- Who is participating in this problem analysis?
- Are those who are most impacted by the need represented here? If not, how will they be recruited and retained?
- How is the BIPOC population, specifically, affected by this?
- How are other populations affected by this need (high/priority zip code community members, people who are systemically oppressed, people with disabilities, etc.)?
- What are the institutional barriers that communities have when trying to provide input and feedback?
- Is the health system set up to receive this input from community and how?

[4] Assessment Primer: Describing Your Community, Collecting Data, Analyzing the Issues and Establishing a Road Map for Change | CADCA

- What would the health equity impact be of not addressing the specified need?

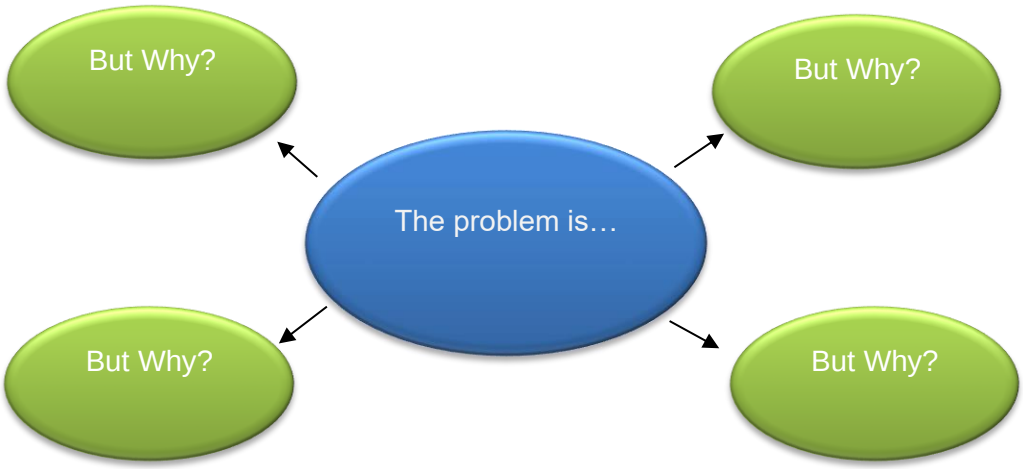
Conduct the Problem Analysis

Step 1 – the workgroup describes the problem (need) in a brief statement and place in center circle (this can be done on a large piece of paper, whiteboard, or electronically with Word or PowerPoint).

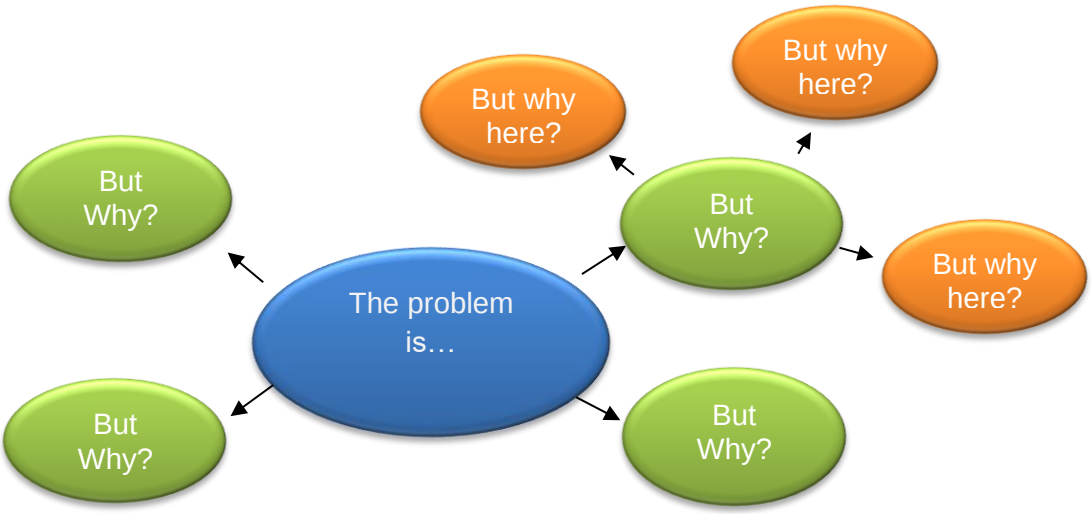


Step 2 – the workgroup brainstorms and hears from those who are impacted reasons the problem exists, using data and evidence, by asking “but why?”. Focusing on the living conditions and social determinants of health identified in the BARHII model could any of these determinants contribute to into the problem?

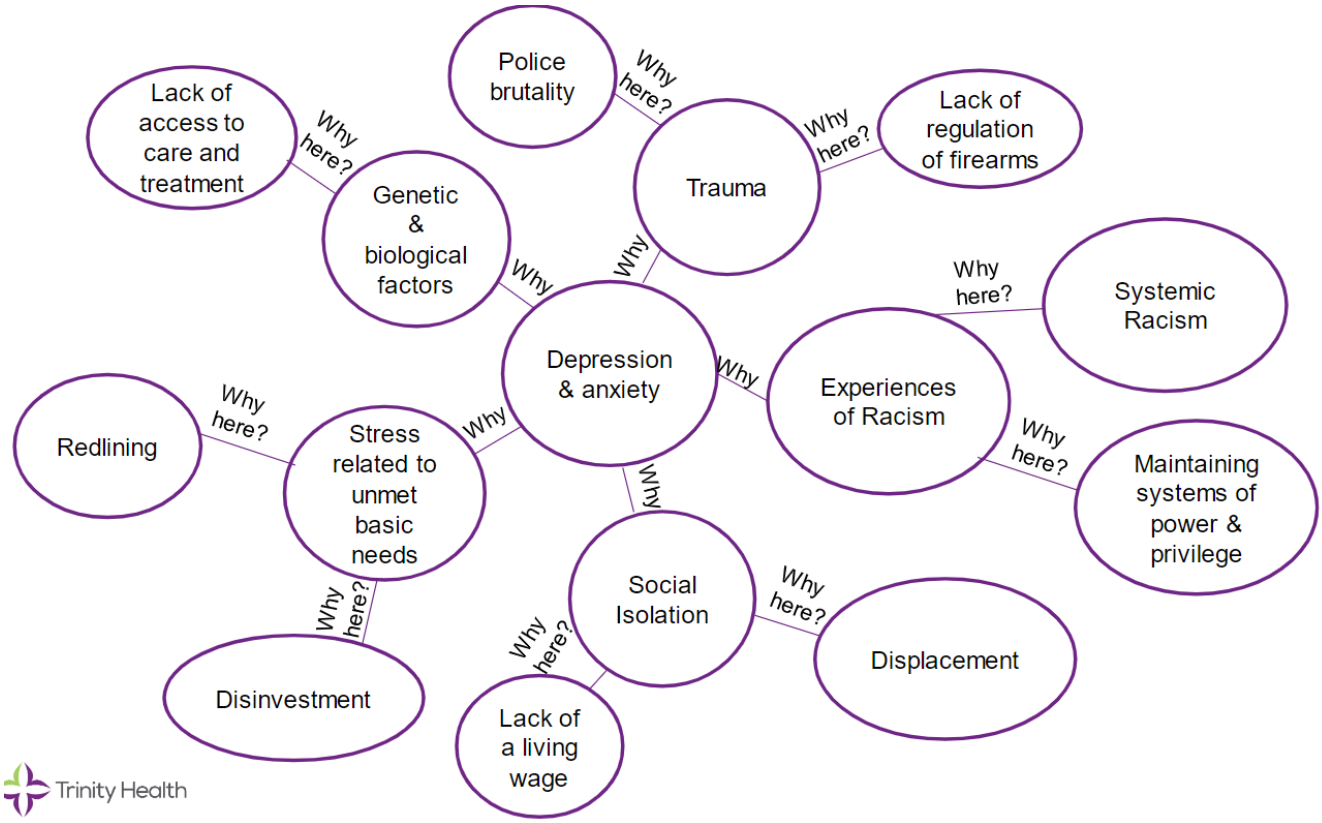
Arrange the answers to this question around the problem statement.



Step 3 – to focus in on the priority community and go deeper, the workgroup brainstorms reasons these conditions problems exist locally, by asking “but why here?”. At this point, the workgroup should consider the social and institutional inequities in the BARHII framework that created and perpetuate the conditions in the community. To further focus the problem analysis on the populations most impacted by a need, use the defined high priority/priority zip codes in your service area as the location to answer the ”but why here” tier. The high priority and priority zip codes for each community are listed in the CHWB Ministry-Wide folder in Teams. These zip codes were identified as meeting either federal poverty guidelines or racial demographic criteria (priority), or both (high priority). Areas of need may be more granular and concentrated to a particular block or neighborhood, or a particular demographic (such as persons of a certain race or age, or persons with a disability). Arrange the answers to this question around the “but why” tier. These responses should be locally tailored and draw from data and input gleaned from the CHNA process, as well as the focus groups convened for the development



The following example shows how to progress through the problem analysis to describe how the root causes and local conditions were defined, using the systemic, structural, and social determinants of health, for the problem statement of depression and anxiety.



Appendix H – 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.

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.

<u>Ideas for Customizing Criteria Weighting</u>:

- 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.

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 Planning	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.) Allows for many ideas in a short period of time Stimulates creative thinking and dialogue. Uses a democratic process.	Vocal and persuasive group members can affect others. A biased or strong-minded facilitator can affect the process Can be difficult with larger groups (more than 20-25). May be overlap of ideas due to unclear wording or inadequate discussion.	10-15 (larger groups can be broken down into subgroups.) Not <6.
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	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 I – Example CHNA Outline

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 FY24-26"
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
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

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.