CHAPTER 3

Assessing Population Health: Community Health Needs Assessments

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KEY TERMS

Community Benefit
Community Health Improvement Matrix
Community Health Improvement Plan (CHIP)
Community Health Needs Assessment (CHNA)
Community Health Assessment Toolkit
County Health Rankings and Roadmaps
Mobilizing for Action Through Planning and Partnership Model (MAPP)
Patient Protection and Affordable Care Act (PPACA)
PolicyMap
Social Determinants of Health

LEARNING OBJECTIVES

1. Explain the community benefit mandate and the emphasis on community engagement.
2. Assess the Patient Protection and Affordable Care Act (PPACA) of 2010's impact on the role of population health management (PHM) in the community.
3. Identify diverse interactive databases and mapping technologies appropriate for community health needs assessments (CHNAs).
4. Describe the CHNA process.
5. Compare CHNA models on their ease of use and potential outcomes.

Podcast 3.1. Why Does a Hospital Need to Demonstrate Community Benefit?
Podcast 3.2. Who Needs a Community Health Needs Assessment?

Access the podcast online at http://connect.springerpub.com/content/book/978-0-8261-4427-0/part/part01/chapter/ch03

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INTRODUCTION

Populations consist of people who live, work, and play in local communities (Carlson, 2020). Community healthscapes impact the health status and quality of life outcomes of every population-of-interest. For many communities, hospitals and health systems are the major or largest employers and serve as an anchor for local economies (Zuckerman, 2013). Each of these roles emphasizes the deep relationship between communities and the health sector. A primary goal, for population health managers, centers on ensuring the optimum health of their community. This chapter covers the hospitals and health system's efforts and activities to ensure community quality of life via CHNAs and community health improvement plans (CHIPs).

Initial Population Health and Community Alignments: Community Benefit

Maintaining a community's quality of life is an integrated priority in addition to PHM's twin goals of increasing health access and lowering cost. The Internal Revenue Service (IRS) established a community benefit standard in 1969 (James, 2016). **Community benefit** focuses on ensuring that nonprofit hospitals/healthcare systems serve the needs of their community to be eligible for tax exempt status and to operate as a 301c organization (Community Benefit Connect [CBC], 2020). Hospitals and health systems who meet the standards and criteria can be best described as a "public trust" initiative.

"Community benefits are clinical or nonclinical programs or activities providing treatment and/or promoting health and healing that are responsive to identified community needs, not provided for marketing purposes" (James, 2016). Common examples are health fairs with disease screening, mobile health vans, and community gardens all sponsored by the health system or hospital.

DID YOU KNOW?

What Is a Community Benefit?

Community benefit goes far beyond the brick walls of the local community hospital. This video provides multiple examples of hospital efforts to demonstrate community benefit.
https://www.youtube.com/watch?v=cRXDVTq69XY
Catholic Health Association (n.d.-b)

The Catholic Health Association (CHA) remains one of the premier leaders in defining, implementing, and assessing community benefit. Since 2008, tax-exempt hospitals have been required to report their community benefit and other information related to tax exemption on the IRS Form 990 Schedule H, and over the years, additional requirements have been added (CHA, n.d.-a).

TABLE 3.1 Community Benefit Objectives and Criteria

Community Benefit Objectives	Community Benefit Criteria
• Address community need • Improve access to health services • Enhance population health • Advance knowledge • Demonstrate charitable purpose	• Have a board made up of community members • Qualified physicians in the area must have medical privileges at the hospital • Have an emergency department • Admit all types of patients without discrimination and • Funding must be directed to benefit the patients served by the hospital

DID YOU KNOW?

IRS Form 990 Schedule H

Today, Schedule H serves as the primary reporting mechanism for community benefits. Click this link to view the form: www.irs.gov/pub/irs-pdf/f990sh.pdf.

As the primary goal of hospital/health system and community relationships is to improve the health of all residents, PH managers have a responsibility and accountability to meet and achieve all community health objectives. The community benefit standards are specific and detailed for all nonprofit hospitals, which must meet established criteria. Table 3.1 displays both community benefit objectives and criteria (IRS, 2020).

DID YOU KNOW?

The Importance of Hospitals' Benefit to the Community

A recent free eBook is available with the latest information and review of the impact of community benefit. The eBook titled *Hospitals' Benefit to the Community: Research, Policy and Evaluation,* a collection of recently published, peer-reviewed papers, is now available as a free eBook from *Frontiers in Public Health.* The link is here: https://www.frontiersin.org/research-topics/9723/hospitals-benefit-to-the-community-research-policy-and-evaluation.

As the healthcare sector transitions and enters nontraditional entrepreneurial types of partnerships and business relationships, various community stakeholders have questioned if local hospitals provide an appropriate amount of community benefit to their constituents in need (Ofri, 2020). Do hospitals consistently and systematically address the most appropriate healthcare needs of their communities? Are there any missed opportunities for alignment?

Health Policy Implications for Community and Population Health Alignment

The U.S. health sector is one of the most regulated industries in the world, and health policy greatly impacts the parameters of health sector/community relationships. In 2010, the **Patient Protection and Affordable Care Act (PPACA)** (HealthCare.gov., 2010) became one of the most far-reaching policy mandates since the beginnings of Medicare and Medicaid in the 1960s (Goldstein et al., 2016).

DID YOU KNOW?

The PPACA—Past and Present

The PPACA can be considered one of the major catalysts for population health. This legislation's impact list includes many major innovations, some of which have flourished such as the Accountable Care Organization model for value-based care. Other ideas have yet to be fully accepted or integrated into the healthcare sector. The impact list can be categorized into three major areas: health promotion, delivery of care, and value-based initiatives.

Health Promotion Policy

- National Prevention, Health Promotion, and Public Health Council
- Prevention and Health Fund
- **Community Health Needs Assessment Mandate**

Access and Delivery of Care Initiatives

- Health insurance marketplace (public exchange)
- Coverage of preventive health services
- Coverage for annual Medicare wellness visit
- Expanded Medicaid options for states

Value-Based Models

- Accountable care organizations
- Medicare Shared Savings Programs

The PPACA's primary goal targeted universal health coverage for Americans. A review of the Act's impact 10 years later suggests a significant reduction in the number of uninsured people and an increase in access to healthcare services, especially for low-income and people of color (Blumenthal et al., 2020).

The PPACA has transformed the delivery of healthcare, and a prime example is the support for innovation and program waivers. The ACA established the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS) (CMS, 2020). Soon states began integrating population health approaches, such as disease management programs, in high-cost populations such as Medicaid and Medicare recipients. State health departments also began implementing chronic disease self-management programs (SMPs) as an effective PHM strategy.

DID YOU KNOW?

State Health Promotion Example

One public example of a population health initiative is the adoption of general health promotion initiatives tailored to seniors. New Jersey's Department of Human Services, Division of Aging Services publishes a monthly e-newsletter available to the public—"HealthEASE." Provided in the following is a sample list of health promotion–inspired SMPs, which were transferred to virtual formats due to the COVID pandemic.

HealthEASE

A Matter of Balance–
Move Today–

Project Healthy Bones–
Stress Busters for Family Caregivers–
Tai Ji Quan: Moving for Better Balance–
Take Control of Your Health–
The various CMMI demonstration programs and other delivery models align with PHM goals that emphasize access, quality initiatives, and value-based initiatives (Shepard et al., 2021).

Community Health Needs Assessments: Population Health Alignment

The PPACA also introduced the requirement for CHNAs, which focuses on accessing and meeting each community's needs to maintain nonprofit status. This expansive policy, under the IRS jurisdiction, also establishes protocols detailing a hospital's financial assistance and emergency medical policy, limitations of charges and billing, and collection procedures.

Over the years, community benefit criteria had established the necessity of addressing community need but lacked a systematic process, plan, and assessment framework. Local health departments regularly complete mandated community health assessments (CHAs) of their constituents based on geographic location, as directed by state and federal guidelines, but this was not the case with community hospitals. Note the terms CHNA and CHAs are often used interchangeably (Public Health Accreditation Board [PHAB], 2011).

The PPACA of 2010 required hospitals to conduct, every 3 years, CHNAs in partnership with other stakeholder community agencies, such as the local health departments. The purpose was twofold—(1) to assess the current population's health status (CHNA) and (2) to develop an appropriate community implementation plan, commonly known as a CHIP (IRS, 2020). Figure 3.1 presents the specific CHNA requirements in outline form.

Completion of a CHNA is a complex and detailed process, involves many hours of data collection, analysis, and interpretation, and begins usually more than a year in advance. After the CHNA is completed, the CHIP development process requires input and collaboration with diverse and representative community stakeholders. The PPACA stipulates a financial penalty tax of $50,000 per hospital for noncompliance, and the IRS can revoke hospital tax-exempt status.

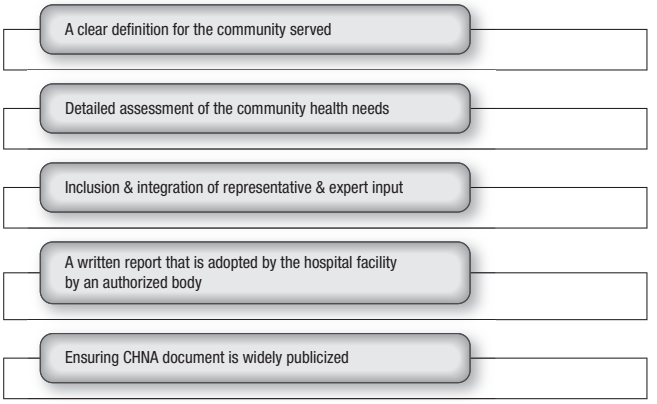

FIGURE 3.1 Outline of Core CHNA Requirements

CHNA, community health needs assessment.

Step-by-Step Community Alignment

Given the CHNA mandate to work with all community stakeholders, population health managers should strongly align with their local public health department or office. Assessment is one of public health's three core functions, and local public health departments have completed CHAs regularly for many years. The professional organization National Association of County and City Health Officials (NACCHO) provides supporting models and materials applicable for completing a CHA process (NACCHO, n.d.-a). Public health professionals often follow the **Mobilizing for Action through Planning and Partnerships (MAPP) model**, which is a recently revised multiphase model based on a community-driven strategic planning process (NACCHO, n.d.-c). In Exhibit 3.1, the original six MAPP phases are presented. As a strategic planning processes, there are multiple activities and deliverables associated with each of these six outlined stages of the community framework.

To support local community hospitals, the American Hospital Association (AHA) sponsored the Association for Community Health Improvement's (ACHI's) **Community Health Assessment Toolkit** (ACHI, 2020).

EXHIBIT 3.1 Mobilizing for Action Through Planning and Partnership Model

Source: Adapted from National Association of County and City Health Officials. (2020). *Mobilizing for action through planning and partnerships (MAPP)*. https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

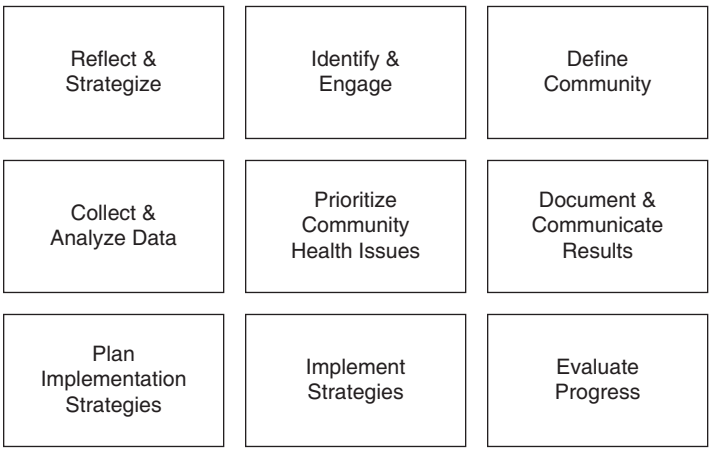

EXHIBIT 3.2 Nine Phases of Community Health Assessment Toolkit

Source: Adapted from AHA Community Health Improvement—Community Health Improvement. (2020). *Community health assessment toolkit.* https://www.healthycommunities.org/resources/community-health-assessment-toolkit

This detailed Toolkit provides a nine-step process to successfully complete a CHNA. Each of the nine phases reflects a community oriented, transparent process to improve community health outcomes (see Exhibit 3.2).

DID YOU KNOW?

Models of Community Health Needs Assessment

Take the time to read in-depth about each of the two models that are briefly discussed—MAPP and the CHNA Toolkit (NACCHO, n.d.-b); https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp; (ACHI, 2020) https://www.healthycommunities.org/resources/community-health-assessment-toolkit.

Since the passage of the PPACA, both local public health departments and community hospitals have aligned to coproduce CHNAs that are valuable and useful to each partner. In fact, these relationships have led to better data collection and sharing processes (Stoto et al., 2019).

Although differences exist between these two CHA models, each approach produces clearly identified goals to be used for developing a CHIP. As a community is made of many members with diverse agendas, these recognized priorities provide a framework for action and the potential for creating community coalitions focused on similar health priorities. There is no other way to get a complete and comprehensive picture of the health status of the community. As healthcare needs continue to increase, reducing delivery redundancies and addressing the community's health needs is the only way to improve the health of any population.

Community Health Needs Assessments Tools and Applications

Frequently, hospital and health system personnel rely on electronic medical records, also known as electronic health records, and clinical, usage, or claims data for planning purposes. Primary sources, such as the AHA, Medicare, and the Dartmouth Atlas of Health Care (Dartmouth Atlas Project, 2020), provide detailed hospital specific information. Other types of data available include the International Classification of Diseases (ICD) data and specific disease registry information, such as the Surveillance, Epidemiology and End Results Program (SEER) sponsored by the National Cancer Institute (SEER, 2020). As technology capabilities enable greater access to diverse health indicators resulting in new data, industry information and marketing statistics will become available. For instance, access to over-the-counter medications information can serve as complementary data source for a community (Das et al., 2005).

Population and public health researchers, planning, and policy experts regularly access national databases for basic population health information including standard federal and state data on vital statistics (morbidity, mortality, births, deaths, etc.) and the American Community Survey based on U.S. Census data. CDC Wonder, an interactive web-based tool, sponsored by the CDC provides public use data and information (CDC WONDER, 2020). Another valuable CDC resource, the Behavioral Risk Factor Surveillance Survey (BRFSS) analyzes population's health risk behaviors, health conditions and status, and use of preventive services with an emphasis on documenting actual behaviors (Centers for Disease and Health Prevention, 2020).

Each state annually has the option to add specific questions-of-interest targeting emerging health issues. This information helps enhance and provide a more detailed snapshot of a population's health status.

County Health Rankings and Roadmap *and PolicyMap*

Two important community databases and CHNA tools are the RWJ Foundation's sponsored **County Health Rankings and Roadmap** (CHRR) (CHRR, 2020a), and **PolicyMap** (PolicyMap, 2020). Both interactive digital platforms provide supplemental data that permit population health planners to access and manipulate easily. Often state and local public health agencies lack comprehensive, representative, or up-to-date health statistics at a county level or municipal level. Using a four-category system (clinical care, health behaviors, social and economic factors, and physical environment), CHRR ranks the health of nearly every county in the nation and demonstrates ways location affects how well and long we live. Key findings, summarized each year, provide useful comparison metrics that encourage benchmarking analysis to state standards and other top performing county peers (CHRR, 2020b) (https://www.countyhealthrankings.org/reports/2019-county-health-rankings-key-findings-report).

While the CHRR provides user-friendly integration of available county health data, PolicyMap, an online mapping tool, offers a vast assortment of data from multiple databases to describe a population at a defined and specific geographic location (PolicyMap, 2020). PolicyMap, an example of a geographical information system (GIS), is an interactive, visual resource that aligns multiple determinants of health metrics with pinpointed locations. Another PolicyMap benefit is the opportunity to layer personalized data or other relevant information onto a three-layer map. With this level of analysis, health planners and programmers have access to valuable visual evidence to target the most vulnerable communities.

DID YOU KNOW?

What Happens When a Community Is Ignored?

Understanding a community and the population requires trust, patience, and listening. You only need to listen to the first 3½ minutes of this humorous TEDx video (Ernesto Sirolli: Want to help someone? Shut up and listen!) to understand the importance of valuing the community's voice: https://www.youtube.com/watch?v=chXsLtHqfdM.

The Impact of Recent Community Health Needs Assessment Findings

The first CHNA results became available in 2013, and policy-makers were interested in whether hospitals would adopt the process and integrate outcomes into their strategic plans and programs. An initial study reported substantial variation among hospitals in respect to meeting implementation progress as outlined by the federal CHNA requirements (Cramer et al., 2017). Early research identified the top rural health community needs in two categories: (a) community concerns—alcohol/substance abuse, cancer, and obesity and (b) healthy community issues—access to healthcare, good jobs and a healthy economy, and healthy behaviors and lifestyle (Barnett, 2012).

Later research on a rural area, the Appalachian Ohio region, suggested that hospitals formalize their processes, focus on developing an evidence base, cultivate local partnerships, and reflect on the role of the hospital in public health (Franz, Skinner, & Kelleher, 2017).

Other reports focused on single issues such as a study noting that in U.S. cities with the highest violent crime rates, 74% of CHNAs mentioned violence-related terms, but only 32% designated violence prevention as a priority need (Fischer, 2018). Another targeted CHNA review of Florida hospitals that provided pediatric services revealed that the top four mentioned community health priorities were access to care, nutrition/exercise/obesity, mental health, and health education (Gruber et al., 2019). Researchers also report hospitals predominantly identified health needs related to access to care, insurance coverage, and costs, but dental care, behavioral health, substance abuse, social factors, and healthcare and prescription drugs were infrequently targeted for strategic action (Powell et al., 2018). Results from a significant national analysis using a random sample of 496 U.S. nonprofit hospitals found mental health, access to care, obesity, substance abuse, diabetes, cancer, and the social determinants of health were the most identified needs. However, the rate at which hospitals chose to address each of these needs in their implementation strategies varied considerably, ranging from 56% (cancer) to 85% (obesity) (Franz, Cronin, & Singh, 2021). In addition to chronic care diseases, social determinants of health began to appear as a category of need.

DID YOU KNOW?

Social Determinants of Health

There are many types of determinants of health including physical, genetics, personal (genetics, gender), and external influencers such as education, social status (income), relationships (social support networks), health services (access and availability of care), and even the physical environment (Caron, 2017). Today, social and economic factors are believed to contribute up to 40% of an individual's health status (CHRR, 2020a).

Social determinants of health are defined as "conditions in which people are born, grow, live, work, and age, these circumstances are shaped by the distribution of money, power, and resources at the global, national, and local levels" (World Health Organization [WHO], 2008). Although these were acknowledged several years ago, today's data show their extremely significant impact on health status and quality of life. The WHO definition further describes SDOH as "circumstances are shaped by the distribution of money, power, and resources at the global, national, and local levels."

The PPACA's increased emphasis on mandating healthcare system alignment with community health needs resulted in a greater recognition of SDOH's role in the health of every American. Community and location (place-based) issues gained prominence as risk factors for positive health outcomes.

Concerned with the importance of social determinants of health as reported in CHA and CHNAs, NACCHO released a 2014 report assessing SDOH activities described in local health department CHIPS and nonprofit hospitals strategic implementation plans (NACCHO, 2014). After an extensive

review and analysis, the findings suggested that assessing the alignment between SDOH identification (CHNA, CHA) and the resulting strategy or activity (CHIP) required a bivariate analysis on two levels—the level of prevention and the amount or intensity of intervention. The **Community Health Improvement Matrix** presents a visual depiction of an SDOH goal achievement (see Table 3.2).

TABLE 3.2 Community Health Improvement Matrix—Asthma Reduction Example

Objective: Decrease Asthma in Children						
PREVENTION	*TERTIARY*	*Pediatric Clinic*		School-Asthma Trained Nurses		
	SECONDARY	*Peer Support Groups*		School Screenings		
	PRIMARY	Action Plan/ Prescription Access Programs	Family Support Groups	Home Weatherization Program		
	PRIMORDAL	Safe Play Areas	Clean and Safe Homes	Home Visits	Clear Air Regulations/ No Smoking Zones	Environmental and Pollution Policy
		Individual	Interpersonal	Organizational	Community	Public Policy
INTERVENTION LEVEL						

Source: Adapted from National Association of County and City Health Officials. (2014). *Addressing the social determinants of health through the community health improvement matrix. Research brief*. https://www.health.state.mn.us/communities/practice/resources/equitylibrary/docs/AddressingtheSocialDeterminantsofHealthCommHealthMatrix.pdf

Frameworks for assessing population health outcomes highlight the importance and role of CHA as an expected competency for both PH managers and their organizations. In July 2020, the AHA and other health-related professional organizations requested the Secretary of Treasury provide an extension of the next CHNA due date because of the extraordinary burden placed on hospitals due to the COVID-19 challenge (Heath, 2020). The next series of CHAs and CHNA reports will undoubtedly show greater community health needs especially for vulnerable American subpopulations.

SUMMARY

Hospitals continue to maintain their role and position as a community's primary hub and safety net for the populations served. National policies, including the recent PPACA of 2010, hold hospitals accountable for positive population health outcomes. Data informed decision-making based on analysis of multiple health databases and interactive GIS platforms require competencies in both CHNAs and development of community health implementation plans. Future community collaborations will need to focus on the social determinants of health to attain an equitable level of health for all Americans.

DISCUSSION QUESTIONS

1. What is the primary role of the hospital/healthcare system in the community?
2. List and explain at least three major PHM innovations from the PPACA of 2010?
3. Compare the community benefit and CHNAs commonalities and differences.
4. Identify the CHI Toolbox model and describe which of the various 9 steps might pose the largest management challenge.
5. Describe primary benefits for both the CHRR and PolicyMap.
6. Which datasets and which metrics would you select to create a community dashboard?

Toolkit Competency Application—Mini-Case Study: Designing a CHNA Process

ABC Health System: Community Health Needs Assessment

Compliance with IRS guidelines for CHNAs requires the input of the community in the creation of the CHNA. Organizations can employ a broad array of methods to collect, analyze, and ultimately build actionable reasoned insights from community input data derived relative to health issues faced by the population.

The ABC Health System (ABC-HS) consists of six acute care hospitals. The ABC-HS, through its hospitals, ambulatory sites, physician practices, and other partner organizations serves about a million area residents annually, with many in multiple care settings. The health system's geographic footprint ranges from urban to rural setting and from the most to the least

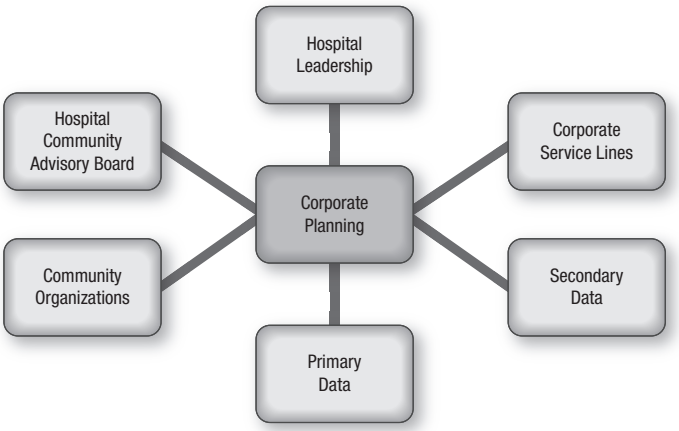

FIGURE 3.2 Necessary Stakeholders and Components for a CHNA

densely populated portions of the state. Building a network of care that provides access to health care services for such a diverse population is informed by the CHNA process, which the ABC-HS developed beginning in 2010 and continues to refine and enhance with each iteration of its CHNA.

Part of any successful CHNA is a clear definition of the contribution that each participant, group, or data set brings to the process. Figure 3.2 depicts the stakeholders and components necessary for a CHNA.

Corporate Planning

In the model employed by the System, corporate planning functions act as the responsible party for completion of the CHNA in accordance with Federal guidelines and timeframes. Planning also serves to identify constituencies and data sources that will inform the process as well as providing substantial support to each constituency as they review secondary data, process findings from primary research and distill qualitative and quantitative elements down to substantive and reasonable targets for community health improvement efforts based on identified needs or disparities in the populations served by the System. Ultimately, planning produces a publicly available report of the CHNA that is approved and adopted by hospital Community Advisory Boards (CABs).

Hospital Community Advisory Board

The System's hospitals all operate a CAB. One of the many functions of this board is to provide leadership of the CHNA process for each hospital and to adopt the CHNA for that cycle. As part of the "kickoff" of the CHNA process, corporate planning provides the CAB an in-depth review and assessment of health factors and behaviors in their community. In most instances, this review serves to inform the CAB with baseline knowledge and often generates questions or inquiries from CAB members about sub-populations the hospital serves. As the CHNA moves through the remaining process steps, the CAB is periodically informed of progress and preliminary findings. Ultimately a numerically prioritized list of health indicators, having been informed by

community input, vetted through hospital leadership and relevant service line leads, is presented to the CAB for their final prioritization and adoption.

Data Sources: Secondary Data Options

The basis for any successful CHNA is in the data. Since the inception of the CHNA process, secondary data sources have evolved from extremely limited county or national indicators to extremely granular census tract or block group data sets that allow for identification of disparities and health needs at a hyper-local level.

The first CHNA's were largely informed by aggregated data from state health departments or national estimates from the Centers for Disease Control or the U.S. Department of Health and Human Services. These initial data sets, while informative to hospitals and community organizations seeking to identify opportunities for health improvement, were woefully inadequate at the local level and ultimately became relegated to informing the CHNA process at a remarkably high level.

To make CHNA's more actionable at a local level, forward thinking organizations began mining their own de-identified organizational data. What better way could there be to identify specific clinical and geographic opportunities for health improvement than to look inward to the very individuals the System treated daily. The aggregation of this type of data allowed for much more targeted analyses and sharing of more actionable insights with the community and local public health departments.

Today, there have been tremendous strides made by large data collectives (national, commercial, and local) that allow the System to provide a wide-ranging secondary data analysis of health factors and behaviors in the communities the System serves. This analysis and findings are shared with constituencies in the next process step.

Primary Data and the Role of Community Organizations

Given the limitations of secondary data analyses and driven by blind spots created by a relevant lack of granularity and/or general absence of available data, it is critical that some level of primary research be used to inform the CHNA process. The ABD-HS engages community partners in this process, rather than develop widely distributed public survey instruments. Time and iteration have shown that identifying a core group of community representatives (public health officials, clinical partners, clergy, grass-roots community organizations, etc.) to respond to survey instruments reveals similar substantive community health concerns as would a public survey data collection methodology. Participating organizations and groups are recommended or selected by CAB (CAB members, hospital administrative and clinical leads, and other community organizations with strong ties to populations served by the hospital. The results of this primary data are integrated into findings from secondary data sources, which are weighted by frequency and ultimately form the prioritized list of health factors and behaviors presented to the CAB.

Hospital Leadership and Corporate Service Lines

Administrative and clinical leads at the hospitals play a crucial role in informing the CHNA process. Ultimately, the individual hospitals will carry

the responsibility of developing an annual CHIP that is based on the health priorities adopted in the CHNA. Ensuring that hospital leadership and service line leads are informed of health disparities in their communities, can provide insight and direction on how the hospital is currently/not currently addressing a particular health factor or behavior. Corporate service line leads can best deploy resources across a large population and geographic region where similar disparities exist. Their engagement and participation will ultimately create a CHNA that is actionable, measurable, and successful in its goal of improving the health of the communities served by the System.

CASE STUDY SUMMARY

The key organizational element that must be present for a CHNA to be useful, transformative, and to provide a sustainable process is a commitment to substantive and ongoing communication between the community and hospital about how partnerships and resources can best be identified and utilized to alter the direction of identified health disparities.

CASE STUDY QUESTIONS

1. Assess the alignment of ABC-HS's CHNA process with the nine phases of the Community Health Assessment Toolkit.
2. Identify the strengths and weaknesses of the ABC-HS's approach as represented in the Figure 3.2.
3. Describe the multiple roles of the Community Advisory Board in this model.
4. What data sources would you recommend for ABC-HS to help address their healthscape needs for both rural and urban areas?

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