

TEMPLATE FOR COMMUNITY HEALTH NEEDS ASSESSMENT

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Prepared with Input and Advice from:

Community Health Needs Assessment National Advisory Team

December 2011

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TEMPLATE FOR COMMUNITY HEALTH NEEDS ASSESSMENT

I. Executive Overview

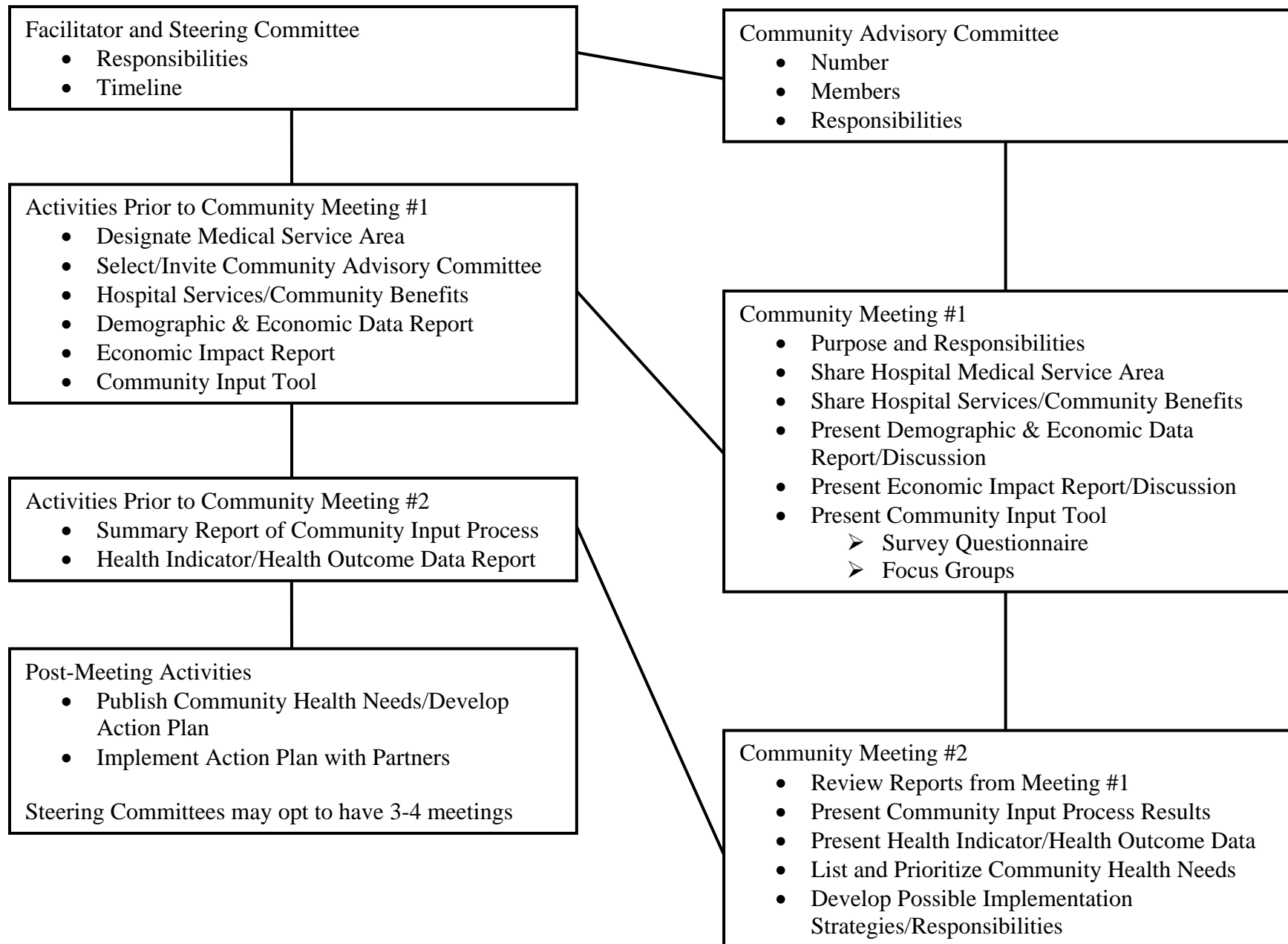
“The 2010 Affordable Care Act” requires that all 501(c)(3) hospitals conduct a community health needs assessment. The purpose of this template is to provide a relatively quick, non-intensive process to complete the requirement for rural hospitals. The template is designed for state level professionals such as state offices of rural health, state hospital associations, state cooperative extension agencies, health departments, or consultants to facilitate the process in rural hospitals at no or low cost to the hospitals. The template is also relatively easy to adopt if hospitals desire to conduct the assessment themselves. All data sources and materials for implementation are included, with additional assistance available from the National Center for Rural Health Works (www.ruralhealthworks.org).

The process can be designed over two to three meetings. Additional meetings can be held at the hospital or community’s discretion. Two meeting formats will be illustrated: the two-meeting process and the three-meeting process.

An overview of the two-meeting template is presented in **Figure 1**. The facilitator and steering committee will oversee the entire process. The facilitator could be a hospital employee or an outside professional from a state agency or a consultant. The steering committee is a small group (three to five members) that will oversee the process. The steering committee members would typically be the hospital administrator, hospital marketing personnel, health department representative, hospital board member, or others identified by the hospital administrator. The responsibilities of the steering committee include:

- Activities Prior to Community Meeting #1
 - Designate Medical Service Area
 - Select/Invite Community Advisory Committee
 - Hospital Services/Community Benefits
 - Demographic & Economic Data Report

Figure 1. Overview of Community Health Needs Assessment Template for a Two-Meeting Process



- Economic Impact Report
- Community Input Tool
- Activities Prior to Community Meeting #2
 - Summary Report of Community Input Process
 - Health Indicator/Health Outcome Data Report
- Post-Meeting Activities
 - Publish Community Health Needs/Develop Action plan
 - Implement Action Plan with Partners

The two-meeting process is illustrated in **Figure 1** and would generate four products and result in the community's assessment of health care needs and the community's proposed activities, actions, and responsibility parties to implement and resolve these health care needs.

The four products presented at the meetings include:

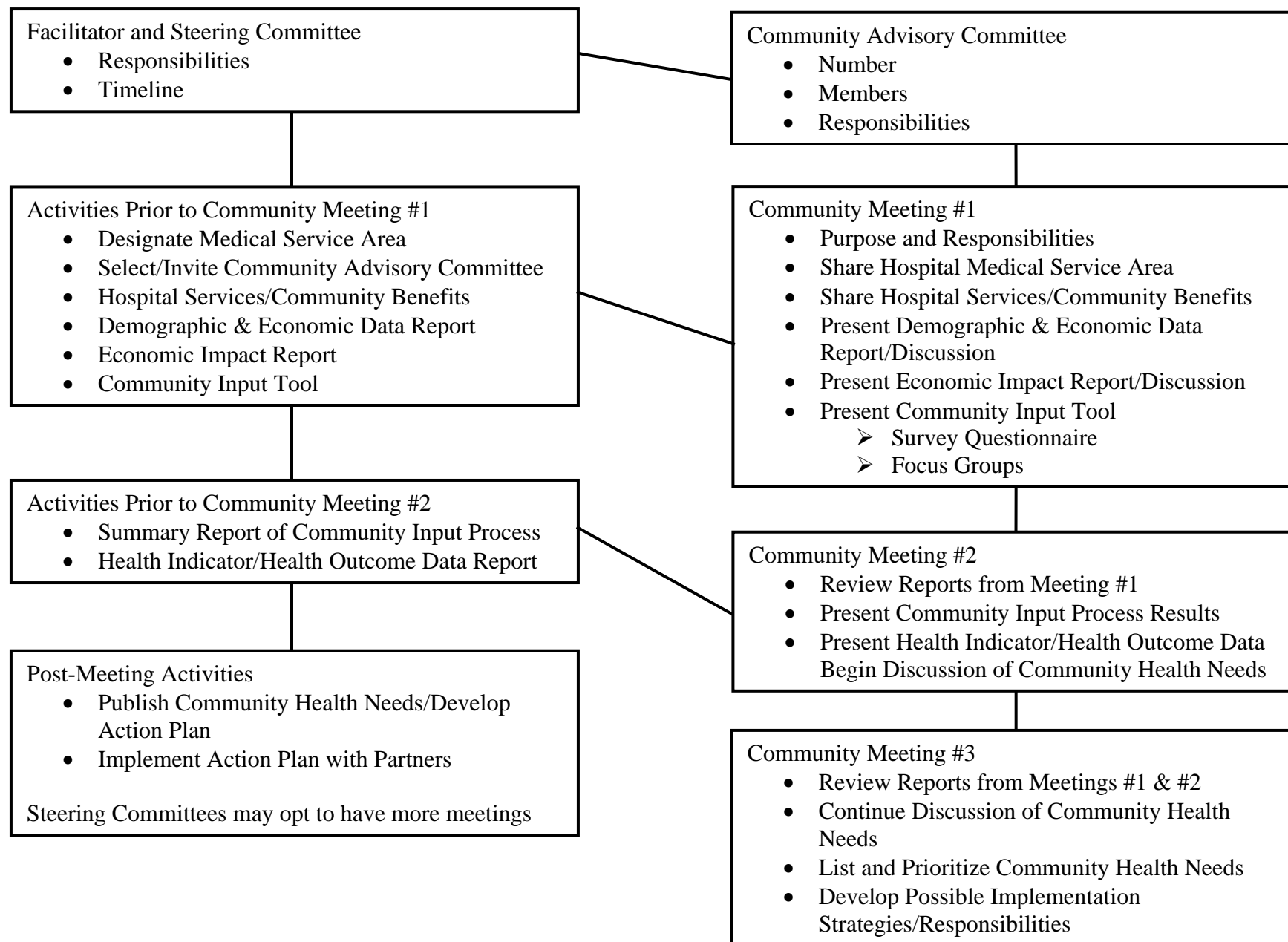
1. The Economic Impact of the Hospital
2. Demographic and Economic Data Report
3. Health Indicator/Health Outcome Data Report
4. Summary Results of Community Input Process

An overview of the three-meeting process is illustrated in **Figure 2**. The three-meeting process will perform the same functions and activities of the two-meeting process. The three-meeting process includes a third meeting for the community to have additional time to discuss the community's health care needs and the community's proposed activities, actions, and responsibility parties to implement and resolve these health care needs.

For both of these templates, the local hospital can decide to have additional meetings beyond the two- and three-meeting process. Additional meetings enable more time for discussion and input from the community advisory committee.

Community meetings work best when held over lunch with a light lunch provided. The community meetings should be held about one month apart to allow for preparation and

Figure 2. Overview of Community Health Needs Assessment Template for a Three-Meeting Process



evaluation of the products. The two- meeting process would take three to four months, where a three-meeting process would take about five months.

The complete template for either a two-meeting or three-meeting process will enable a facilitator and steering committee the ability to provide a community health needs assessment with relative ease. **All data sets are identified and example products are provided.**

For additional information on the template or any of the files or data sets, please contact the National Center for Rural Health Works:

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II. Introduction

Why?

The 2010 Affordable Care Act requires that all 501(c)(3) hospitals must conduct a community health needs assessment. The overarching view of the community assessment must be health needs from the perspective of the community, not the perspective of the health providers within the community. This is an important distinction because much of the discussion will be focused on health provider activities. Thus, the community orientation is critically important.

Duplication and/or Partnering

There are other community assessment processes available and potential users are encouraged to evaluate this template and the others and select the one which best fits their delivery style and their community needs. Two other community assessment processes that are readily available include the Catholic Healthcare Community Assessment Process and Association of Community Health Improvement. This template is intended to be very effective and efficient in achieving the legislative requirements, as well as being applied at a minimal cost to the hospital.

Duplication of community assessments in your community should be avoided if possible. Other organizations involved in community assessment may be open to collaborating in a combined community assessment. For instance, many, if not all, public health departments have long been hosting community assessment processes with various partners. If a public health department has recently completed a community assessment and the medical service areas of the public health department and the local hospital are basically the same, the results of the recently completed community assessment of the public health department could be utilized by the hospital governing board to determine which community issues the hospital can address. The

hospital governing board will review the community issues to determine resources available, develop appropriate work plans, determine who will provide the necessary components of the plans, plan any coordination and collaboration with other organizations and agencies, and propose timetables for implementation. The results of the community assessment from the public health department and the hospital governing board's plans on how to deal with the community issues will be reported to the Internal Revenue Service (IRS) to fulfill the requirements of community assessment.

Again, local organizations are encouraged to partner and work together to avoid duplication. This is especially important for future community assessments. Many public health departments conduct a community assessment every five years and the new legislation requires that hospitals conduct one every three years. This is the perfect opportunity for these two organizations to partner and conduct a comprehensive community assessment every five years with an updated shorter version in the middle, every 2 ½ years. This could avoid duplication and develop more cooperation and coordination between the hospital and public health department, while both organizations meet their reporting requirements.

Background

In response to the hospital community health needs assessment requirement, the National Center for Rural Health Works formed a national advisory team to assist with development of a template which rural hospital administrators and personnel from state hospital associations, state offices of rural health, and others can use to meet the new requirements. Members of the national advisory team are included in **Appendix A**. The national advisory team met in Kansas City on November 23, 2010 to share ideas and to begin development of the template. The U. S. Department of Health and Human Resources, Federal Office of Rural Health Policy, provided financial support for the meeting.

The national advisory team recommended that the proposed template be tested in several communities. The template was tested and revised based on pilot applications with Labette Health in Parsons, KS, Oswego Community Hospital in Oswego, KS, and Battle Mountain General Hospital in Battle Mountain, NV. Products created for these three pilot hospitals, as well as resulting reports, will be utilized to illustrate the proposed template.

Legislative Requirements

Before discussing each of these points, the new requirements for Section 501(c)(3) Status hospitals for the community health needs assessment will be shown.

Community Health Needs Assessment Requirements

- i. The organization must conduct a “community health needs assessment” not less frequently than every three years and adopt an implementation strategy to meet the community health needs identified through the assessment.
- ii. A “community health needs assessment” must include input from persons “represent[ing] the broad interests of the community served by the hospital facility,” including those “with special knowledge of or expertise in public health.”
- iii. The assessment must be made widely available to the public.

Even though the requirements state that the organization must conduct a needs assessment and adopt an implementation strategy, the organization does not have to include an implementation strategy for each need. It may not be economically feasible to implement every suggested strategy. The strategy must only address what can be completed and what actions are to be implemented. The requirements state that the first needs assessment must be completed during the first tax year following March 2011. After that, the assessment must be completed every three years.

The Act also requires hospitals to have financial and billing and collection policies in place and available to the public. Example policies and procedures may be available from the

American Hospital Association (AHA); please check with AHA directly. Hospital boards should review their policies and procedures and modify them to reflect the requirements. Below are the new requirements for Section 501(c)(3) Status hospitals for the financial assistance and billing and collections:

Financial Assistance Policy Requirements

- i. The organization must establish a financial assistance policy that –
 - 1. Is in writing.
 - 2. Includes the eligibility criteria for financial assistance and specifies whether such assistance includes free or discounted care.
 - 3. States the method for applying for financial assistance.
 - 4. Includes a description of the actions the hospital may take in the event of non-payment where the organization does not have a separate billing and collections policy.
 - 5. Includes measures to widely publicize the policy within the community served by the organization.
- ii. The organization must establish an emergency medical care policy that –
 - 1. Is in writing.
 - 2. Requires the organization to provide non-discriminatory emergency medical care to an individual, regardless of that individual's eligibility under the financial assistance policy required above.

Requirements Regarding Charges

- i. Charges for emergency or other medically necessary care provided to persons who are eligible for assistance under the financial assistance policy described above cannot exceed “the amounts generally billed to individuals who have insurance covering such care.”
- ii. The use of gross charges is prohibited.

Billing and Collection Requirements

- i. The organization cannot engage in “extraordinary collection efforts” before it has made a reasonable effort to determine whether the individual is eligible for assistance under the organization's financial assistance policy.

This template does not include any other information on the financial assistance requirements, requirements regarding charges, or billing and collection requirements. This template is designed to assist with the community health needs assessment requirements only.

III. Facilitator and Steering Committee

Prior to the first community meeting, the local hospital administrator will select a facilitator to lead the process. This facilitator could be the local hospital administrator, a representative from the state office of rural health (SORH), a representative from the state hospital association, a consultant, or other community, region, or state leader. A list of the state offices of rural health (**Appendix B**) and the state hospital associations (**Appendix C**) are included. The local hospital administrator will select a small group of local leaders as the steering committee to guide the process. The steering committee needs to identify the medical service area of the hospital, select members for the community advisory committee, prepare materials (or have them prepared) for the community meetings, and assist in facilitating the meetings. The designated professional will be the lead facilitator for the meetings.

Possible members for the steering committee include director of local health department, hospital management team or marketing director, local government representative, social service agency representative, and/or other knowledgeable community members. The suggested size of the steering committee is three to five members.

IV. Activities Prior to Community Meeting #1

The facilitator and steering committee will need to complete the following tasks prior the Community Meeting #1. These include:

- Identify medical service area;
- Select and invite community advisory committee;
- Overview of hospital services/community benefits;
- Demographic and economic data report
- Community input tool
- Economic impact report (OPTIONAL)

Medical Service Area

The steering committee will work closely with the hospital administrator and hospital data to determine the medical service area of the hospital. Every effort should be made to avoid duplication of medical service areas. Many other groups already have designated medical service areas, such as the health department. The medical service area of the hospital has to be realistic in terms of neighboring hospitals. One method to determine the medical service area would be to base the area on the home address locations of a percent (i.e., 75 to 85 percent) of the hospital admissions. The hospital administrator may want to analyze the data closely to determine the appropriate percentage. The key is to designate an area which clearly defines where the majority of the patients using the hospital services live. It may be necessary to designate both a primary and secondary medical service area.

The medical service area should be identified along county or zip code area boundaries. The boundaries are necessary to provide medical service area demographics. The advantage of a county boundary is that much more data are available at the county level. Some county level data sources include:

- U. S. Census Bureau <www.census.gov>;
- U. S. Census Bureau County Business Patterns

<<http://www.census.gov/epcd/cbp/index.html>>;

- U. S. Department of Commerce, Bureau of Economic Analysis <www.bea.gov>; and
- U. S. Department of Labor, Bureau of Labor Statistics <www.bls.gov>.

At the zip code level, only minimal demographic data are available in non-Census years. The source of non-Census year data is Community Sourcebook of Zip Code Demographics, 23rd Edition, 2009, ESRI. The new 2010 Census zip code data will be available in late 2011.

Community Advisory Committee

The next responsibility of the steering committee is to identify community leaders that would be willing to serve on the community advisory committee. The size of the committee will be determined by the population of the medical service area. It is suggested that a smaller rural hospital service area might need 15 to 25 members and a larger rural hospital service area from 20 to 35 members. The requirements clearly state:

‘A “community health needs assessment” must include input from persons “represent[ing] the broad interests of the community served by the hospital facility,” including those “with special knowledge of or expertise in public health.”’

A listing of potential membership on the community advisory committee is included in **Table 1**.

The community advisory committee should have a diversified membership representing the medical service area and the membership should be broad-based including not only health care providers but also representation from the other groups listed in **Table 1**. It is strongly suggested that members of the steering committee phone the potential members and personally invite them to be part of the community advisory committee. During the invitational call, the member of the steering committee can provide a short overview of the community assessment process, the responsibilities of the community advisory committee members, the number and duration of the meetings, and the date, time, and location of the first meeting. If the potential member agrees to

Table 1
Potential Community Advisory Committee Members

City government(s); city manager, mayor, city council members
County government(s); county commissioners, county officers
State government; human services, health department, state legislators
Tribal government(s); tribal leaders, health care coordinator, local IHS representative
Health care providers
Hospital administrator and other key hospital personnel
Hospital board members
Physicians
Dentists
Optometrists
Chiropractors
Clinics or community health centers
Mental health professionals—i.e., psychiatrist, psychologist, counselors
Nurse practitioners
Physician assistants
Therapists—physical, massage, speech, rehabilitation, occupational
Pharmacists
Medical equipment suppliers
Home health providers
Hospice
Nursing homes, assisted living facilities, and adult day services
School health
Others
Emergency medical services (ambulance services)
Local public health officials
Chamber(s) of commerce
Economic development groups; coalitions, councils of government, sub-state planning districts
Industry/business; manufacturing, banks, phone companies, retail sales (Main St. businesses), groceries, realtors, insurance, fishing, farming, forestry, mining, petroleum, etc.
Public education; superintendent, principals, school nurse
Technology education (formerly vo-tech)
Higher education
Private education
Volunteer organizations; local food banks, soup kitchens
Religious leaders; ministerial alliance, ministers
Minority or disparate population groups or group leaders
Service organizations; Kiwanis, Lions, Rotary, Toastmasters, etc.
Social service organizations
Other community leaders

participate as a community advisory committee member, a letter outlining the process should then be sent to the committee member. An example of an invitational letter is included in **Appendix D.**

The hospital administrator, steering committee, and facilitator will determine the number of community meetings. For the template, the number of meetings will be a minimum of two. With two meetings, the local hospital (1) will obtain useful information from the identified community needs for both short- and long-term planning, (2) will be able to meet the IRS requirements, and (3) will have invested a minimum amount of their limited time and resources in fulfilling the new requirements. However, some hospital administrators, in conjunction with their steering committee and facilitator, may desire to have more than two meetings.

Overview of Hospital Services/Community Benefits

Many residents may not be aware of all of the services and community benefits provided by the hospital. It is suggested that the hospital administrator prepare a one- or two-page summary of the hospital services and community benefits. The pilot project material prepared and presented by the hospital administrator of the Oswego Community Hospital is provided in **Appendix E.**

Demographic and Economic Data Report

Since health care usage is a function of the demographics of the medical service area, it is crucial to have demographic data. Furthermore, the elderly are extremely high users of health services and thus the number of elderly in the medical service area should be clearly identified. The demographic and economic data prepared and presented for the pilot project at Labette Health are presented in **Appendix F.** The report contains nine tables of demographic and economic data. The main sources of the data are:

- U. S. Census Bureau, <www.census.gov>;

- U. S. Census Bureau, County Business Patterns, <<http://www.census.gov/epcd/cbp/index.html>>;
- U. S. Department of Commerce, Bureau of Economic Analysis, <www.bea.gov>;
- U. S. Department of Labor, Bureau of Labor Statistics, <www.bls.gov>.

At the zip code level, only minimal demographic data are available in non-Census years. The source of non-Census year data is Community Sourcebook of Zip Code Demographics, 23rd Edition, 2009, ESRI. The new 2010 Census zip code data (<www.census.gov>) will be available in late 2011.

Community Input Tools

The steering committee will have to determine how they will obtain community input prior to the Community Meeting #1. Community input is mandatory in the requirements. Several options are available:

1. Conduct a community survey questionnaire through the members of the community advisory committee. A questionnaire will be prepared, personalized to the hospital community and medical service area (example available in **Appendix G**). At Community Meeting #1, each member of the community advisory committee will be asked to complete a survey at Community Meeting #1 and then to obtain five completed questionnaires from the community group(s) they are representing. The completed questionnaires would be returned to a designated person from the steering committee (typically, mailed to the hospital administrator) by a designated deadline. An instruction sheet will be provided with the health survey questionnaire to provide this information to the community advisory committee members. A spreadsheet has been designed such that the steering committee (or designated hospital personnel) will be able to enter the data from the completed questionnaires and the results will be automatically generated. The summary of the survey results will then be printed for presentation at Community Meeting #2.

This is not a completely random survey example; however, if the members of the community advisory committee truly represent a cross-section of the community, the survey will provide adequate community input from a somewhat random example. This method would be an easy way to get input from over 100 local residents. For example, if the community advisory committee has 20 active members and each member completes a questionnaire and obtains five additional completed questionnaires, then the survey would have 120 completed responses.

2. Conduct a focus group discussion with subgroups of the community advisory committee. Focus group questions would be prepared and available for the community advisory committee to utilize (**Appendix H**). The community advisory committee would be divided into small groups (no more than ten per group and optimum group size is five to six per group). Members of the steering committee would facilitate the small focus groups. Each focus group facilitator will conduct a small focus group session, take extensive notes, and prepare the results for consolidation with the other focus group sessions. A final consolidated focus group report would be prepared by the steering committee or hospital personnel. The summary focus group report would be presented at Community Meeting #2.
3. Other Community Input Options
 - i. **Phone Survey.** If a community has access to funds, a professional survey company could be contracted to conduct a random phone survey. These surveys are quite expensive. See the National Rural Health Works website <www.ruralhealthworks.org> for an example.
 - ii. **Computer Survey.** A computer survey instrument could be designed and community residents could respond to the online survey. The advantage is that the process is cost efficient but not random. Many elderly residents who are heavy users of medical services would not have an opportunity to participate because of lack of computer knowledge or availability.
 - iii. **Patient Survey.** Many hospitals conduct surveys from patients who use their services. This information can be utilized as input, but again, it is not inclusive of the community as whole because this information is only gained from residents that have actually used hospital services.

Economic Impact Study (Optional)

The economic impact of the hospital is proposed as an OPTIONAL study. While this is listed as an OPTION, the economic contribution of the hospital on the local economy is tremendous. This is not part of the community assessment requirements from the IRS; however, the hospital is often the cornerstone of the healthcare delivery system. Without a hospital, other health services such as physicians and pharmacies soon disappear. The national advisory team recognizes the importance and usefulness of the economic impact study.

This community benefit should not be overlooked. For example, the hospital is often the second largest employer in a rural community, typically second only to schools. The national advisory group views this as extremely important to provide information showing the economic

importance of the hospital and the health sector to the local economy. Three alternatives are presented to assist the steering committee in providing this:

- I. Contact state offices of rural health (**Appendix B**) or state hospital associations (**Appendix C**) to see if economic impact studies for hospitals are available. Some states have professionals that can quickly compile an economic impact study and others have tools to develop them. For example, see Wisconsin's website <http://www.wha.org/financeanddata/healthyhospitals.aspx>.

OR

- II. A *generic* PowerPoint presentation showing the "Economic Impact of a Rural Hospital on a Local Economy" could be presented to the community advisory committee. The National Center for Rural Health Works has prepared this 18-slide PowerPoint presentation from its rural hospital research in several states (**Appendix I**).

OR

- III. An *actual* short, three-page economic impact study could be prepared using local multipliers. The National Center for Rural Health Works could derive the multipliers. This service is available to those hospitals that do not have the IMPLAN multipliers available from any organizations in their states (as in the first alternative above). The National Center for Rural Health Works has limited staffing and funding and would have to charge a fee of \$250 plus the cost of the IMPLAN data to derive the multipliers for a hospital. To determine the cost of the IMPLAN data, the medical service area of the hospital must be designated. An example short economic impact study for Labette Health is presented in **Appendix J**.

V. Community Meeting #1

Past community planning experience indicates that a lunch meeting works well in getting optimum participation of community advisory committee members. If a local organization can provide a simple, light lunch in a timely and efficient manner, the community advisory committee members will be able to participate and minimize their time away from their regular business activities. If funds are not available for lunch, find a local restaurant with a separate meeting room and have each individual pay for their lunch. The length of the meeting should be kept to a reasonable time; typically about 1 to 2 hours. In some cases, meetings in the early morning or in the evenings will be necessary. The steering committee will need to be flexible and decide on the best day and time for their community meetings. A suggested agenda for Community Meeting #1 is presented in **Table 2** below.

Table 2
Suggested Agenda for Community Meeting #1

I.	Introductions (led by hospital administrator)	8 minutes
II.	Overview of community assessment process (facilitator)	10 minutes
III.	Medical service area (hospital administrator)	2 minutes
IV.	Hospital services/community benefits (hospital administrator)	8 minutes
V.	Demographic and economic data (facilitator)	10 minutes
VI.	Community input tool (facilitator)	30 minutes
VII.	Economic impact of hospital (facilitator)	8 minutes
VIII.	Questions (facilitator and other participants)	10 minutes
IX.	Time and date of next community meeting (facilitator)	2 minutes

The community meeting should start on time with the hospital administrator welcoming the community advisory committee. At this meeting it is generally helpful to have members introduce themselves and indicate who they are in a short manner (i.e. Joe Brown, County Commissioner). Then it is important to have the facilitator give a brief overview of the community health needs assessment process. This includes the purpose and responsibilities of

the community advisory group. A sample PowerPoint providing an overview of the community health needs assessment process is provided in **Appendix K**.

Following the overview, the medical service area should be delineated and the remaining reports presented. After each report, the community advisory committee should be encouraged to comment or ask questions. At the end of the meeting, a time, date and location of the next meeting should be announced. Community Meeting #2 should be a month to 6 weeks after Community Meeting #1 to allow time for preparation of data and reports.

VI. Activities Prior to Community Meeting #2

The facilitator and steering committee will have two additional reports to prepare prior to Community Meeting #2:

- Health Indicator/Health Outcome Data Report
- Community Input Summary report

Health Indicator/Health Outcome Data Report

The community health indicator data/health outcome data are available from the following sources:

- 1) County health rankings <www.countyhealthranking.org>;
- 2) U. S. Department of Health and Human Services, Community Health Status Indicators <www.communityhealth.hhs.gov/>; and
- 3) State health departments (vital statistics) from individual state websites.

The steering committee will determine which data to report to the community advisory committee. The Labette County Health Indicator/Health Outcome Data Report contains eight tables and is presented in **Appendix L**. The data are typically only available at the county level and may reflect behavior habits, health indicators, or health outcomes and may include comparisons between county and state data.

Community Input Summary Report

The steering committee will prepare summary results from the community input methodology, based on which methodology was utilized. Whatever tool is used to collect local community input, the results need to be tallied, summarized, and presented back to the community advisory committee. This is the most difficult report to complete in the community assessment template. The steering committee should allow sufficient time between the two

community meetings to prepare the results. The community input summary report will assist the community advisory committee in identifying community health needs.

Community Health Survey Questionnaire Methodology

If the community health survey questionnaire methodology is utilized, the community advisory committee will complete the health survey questionnaire at Community Meeting #1. After the meeting, each community advisory committee member will obtain an additional five completed health survey questionnaires to be submitted to a pre-designated local person by a specific date. A cover sheet will be included with the survey questionnaire with the deadline and name and address of the person to whom completed questionnaires will be submitted.

A spreadsheet has been designed to enable a local person to enter the data from the completed questionnaires and the results are automatically generated in report form for presentation at Community Meeting #2. An example health survey questionnaire (**Appendix G**) and health survey results (**Appendix M**) are presented for Labette Health.

Focus Group Methodology

If the focus group methodology is utilized, the facilitators of each focus group will take extensive notes and prepare preliminary results to be aggregated with the other focus group summary results. A final aggregated group report would be prepared by the steering committee or hospital personnel to be presented at Community Meeting #2.

Other Community Input Methodologies

Phone Survey. If a community has access to funds, a professional survey company could be contracted to conduct a random phone survey. This methodology may be expensive.

Computer Survey. A computer survey instrument could be designed and community residents could respond to the online survey. This methodology may be more cost effective but

will not be random. Many elderly residents who are heavy users of medical services may not have an opportunity to participate because of lack of computer knowledge or availability.

Patient Survey. Many hospitals conduct surveys from patients who use their services. This information can be utilized as input, but again, it is not inclusive of the community as whole because this information is only gained from residents that have actually used hospital services.

VII. Community Meeting #2

A suggested agenda for Community Meeting #2 is presented in **Table 3**. The meeting will begin with introductions by the hospital's administrator. The facilitator will provide a brief review of activities from Community Meeting #1, including a review of the demographic and economic data report and the economic impact study (Optional). The community health indicator/health outcome data report and community input summary report will then be presented by the facilitator.

Table 3
Suggested Agenda for Meeting #2

I.	Introductions (hospital administrator)	5 minutes
II.	Review of demographic and economic data report	3 minutes
III.	Review of economic impact of hospital (optional)	2 minutes
IV.	Presentation of health indicator/health outcome data report	10-15 minutes
V.	Presentation of community input summary report	10-20 minutes
VI.	Discuss community health needs/issues	45-60 minutes
	a. Identify and prioritize community health needs	
	b. Determine possible implementation strategies	
	c. Summarize community recommendations	
VII.	Response and final comments (hospital administrator)	10-15 minutes

After all reports have been reviewed and presented, the community advisory committee will list community health needs or issues. The next step will be to prioritize the community health needs. The committee will propose implementation strategies for each health need with suggested deadlines and suggested responsible organizations or persons. **Table 4** is provided as a possible format to summarize and illustrate the community advisory committee's suggested implementation strategies to meet the top community health needs. A summary of the community health needs from the Labette Health needs assessment process is presented in **Appendix N**.

Table 4
Community Needs and Implementation Strategy with Responsibilities

Community Need	Implementation Strategy	Responsible Org. or Person
1. _____ _____ _____	_____ _____ _____	_____ _____ _____
2. _____ _____ _____	_____ _____ _____	_____ _____ _____
3. _____ _____ _____	_____ _____ _____	_____ _____ _____
4. _____ _____ _____	_____ _____ _____	_____ _____ _____

The community advisory committee will submit the identified community health needs with suggested implementation strategies and suggested responsible organizations or persons to the hospital administrator. The hospital administrator will respond and give comments to the community advisory committee. The community advisory committee is *only* advisory and decisions concerning hospital commitments can only be made by the hospital board.

After the hospital administrator presents the identified community health needs and suggested implementation strategies and suggested responsibility organizations or persons to the hospital board, the hospital board will decide which community recommendations the hospital will address and/or implement. The hospital board will make the final decision; only the hospital board has the authority to obligate the hospital to provide programs or activities. The final community health plan developed by the hospital board will be shared with the local community.

The hospital may need to partner and/or collaborate with other organizations to meet certain community health needs. Resources available to accomplish the community needs must be considered by the hospital board as the final community health plan is developed. If resources

are unavailable to meet a community health need, this should be indicated in the final report to the IRS.

VIII. Additional Community Meetings (Optional)

The template proposes the two-meeting or three-meeting process. The only difference is that a third meeting is added to the two-meeting process to allow for additional discussion time for the community advisory committee. Additional meetings beyond the two and three meetings could be added if the hospital would like more time for community input. A three to four meeting process would enable more time for discussion and input from the community advisory committee. Community meetings work best when held over lunch with a light lunch provided. The community meetings should be held about one month apart to allow for preparation and evaluation of the materials. The two- meeting process would take three to four months, where a three-meeting process would take about five months. A four-meeting process would take about six months.

The two-meeting process is illustrated in **Figure 1** and would generate four products and a community needs assessment report. The three-meeting process is illustrated in **Figure 2** and would also generate four products and a community needs assessment report. The four products are:

1. The Economic Impact of the Hospital
2. Demographic and Economic Data Report
3. Health Indicator/Health Outcome Data Report
4. Summary Results of Community Input Process

The complete template will enable a facilitator and steering committee the ability to provide a community health needs assessment with relative ease. All data sets are identified and example products are provided.

Figure 1. Overview of Community Health Needs Assessment Template for a Two-Meeting Process

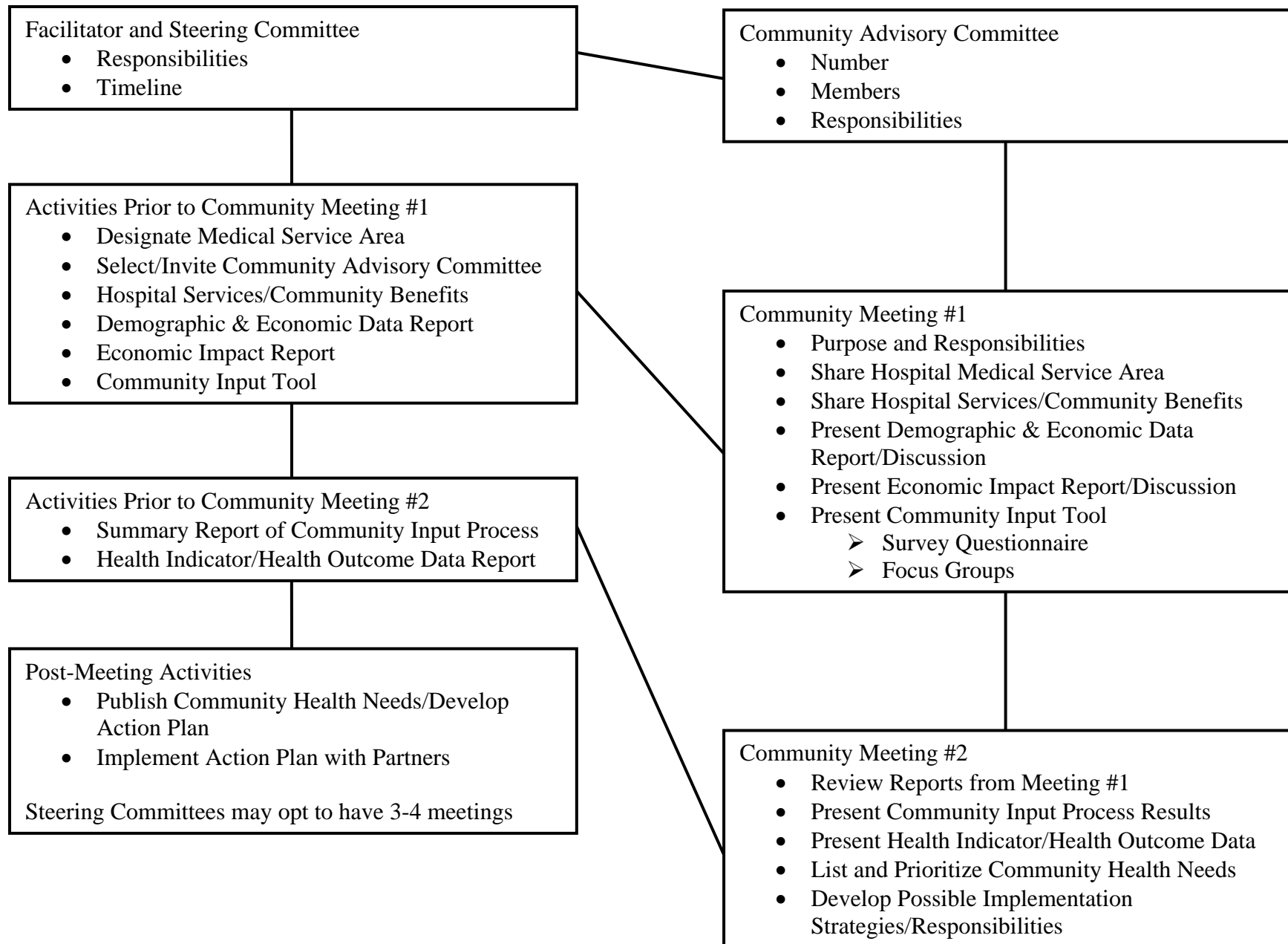
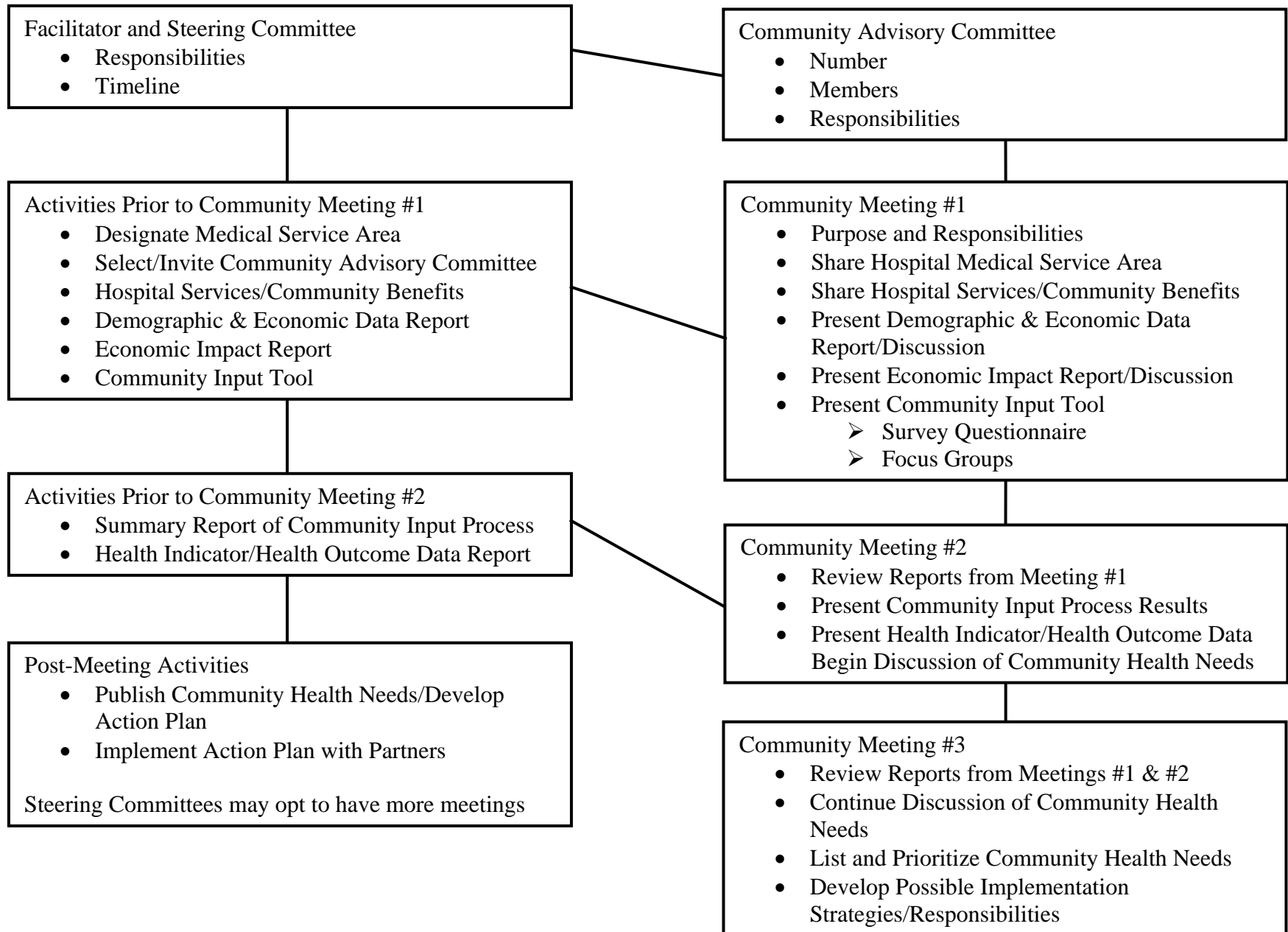


Figure 2. Overview of Community Health Needs Assessment Template for a Three-Meeting Process



IX. Reporting

Each hospital facility is required to make the assessment widely available to community members. To accomplish this, the hospital needs to prepare a summary report of the community assessment process and share the results with the community, including the resulting community needs to be addressed, the implementation strategy for each community need, and the responsible person(s) or agency(ies). This could be shared through the hospital's website or another organization's website, newspaper articles, articles in the hospital newsletter, at local group meetings, etc.

The hospital will also have to submit documentation or proof to the Internal Revenue Service (IRS) that a community health needs assessment process was completed. For convenience, a suggested outline of a final summary report is presented in **Table 5** to assist in completing the IRS reporting forms. The final report needs to include information pertaining to:

- Community Members;
- Medical Service Area;
- Community Meetings;
- Community Needs and Implementation Strategies;
- Hospital Final Implementation Plan; and
- Community Awareness of Assessment

The report is intended to include crucial data and not be all inclusive. If the IRS desires more data, they can request documents that were included in the community health needs assessment process, such the demographic and economic data report, community input summary report, etc.

The summary report will include a listing of all **community members** involved in the assessment, including the hospital administrator, the steering committee or leadership group, the

Table 5
Summary Report Outline
Community Health Needs Assessment

Community Members

Need to include name, organization and contact information for:

- Hospital Administrator
- Steering Committee or Leadership Group
- Facilitator
- Community Advisory Committee Members

Medical Service Area

- Describe by county or zip code areas
- Include populations and projected populations of medical service area
- Include demographics of population of medical service area

Community Meeting #1

- Date
- Agenda
- List reports presented with short summary of each

Community Meeting #2

- Date
- Agenda
- List reports presented with short summary of each

Community Needs and Implementation Strategies

- Include community needs and implementation strategies with responsibilities from community group

Hospital Final Implementation Plan

- Include which needs hospital can address and the implementation strategies
- Include which needs hospital cannot address and reason(s) why

Community Awareness of Assessment

- Describe methodology for making assessment widely available to the community

facilitator, and the Community Advisory Committee members. The **medical service area** of the hospital has been identified and is readily available, as well as population and demographic information of the medical service area and/or county. A summary of the dates, agendas, and reports prepared and presented for all **community meetings** should be provided. A short summary of each report presented at the community meetings would be beneficial. A summary report of the **community needs and suggested implementation strategies** from the Community Advisory Committee needs to be prepared; either utilizing **Table 4** shown previously in this document or a similar summary report. The **hospital final implementation plan** adopted by the hospital should also be included. This report should indicate which community health needs the hospital will address and the implementation strategy planned for each. If all identified community health needs or issues are not addressed, then the reason why an identified need/issue is not being addressed must be included in the report (e.g., lack of finances or human resources). Each hospital facility is required to make the **assessment widely available to the community members**. The local newspaper reporters are typically available to write articles to share the community health needs assessment with the general public.

IRS Reporting Forms

The hospital is required through the new legislation to disclose any community health needs assessment activities in its annual information report to the Internal Revenue Service (IRS). **IRS Form 990** is required to be completed by all organizations exempt from income tax. When completing **IRS Form 990**, additional schedules may be required. Hospitals are required to complete Schedule H. See page 3 of *IRS Form 990, Part IV, Checklist of Required Schedules, Question 20a, 'Did the organization operate one or more hospitals? If "Yes," complete Schedule H.'*

Part IV Checklist of Required Schedules

	Yes	No
1 Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? If "Yes," complete Schedule A	1	
20 a Did the organization operate one or more hospitals? If "Yes," complete Schedule H	20a	
b If "Yes" to line 20a, did the organization attach its audited financial statements to this return? Note. Some Form 990 filers that operate one or more hospitals must attach audited financial statements (see instructions)	20b	

Form **990** (2010)

Attached in **Appendix O** are both of these IRS reporting forms (**Form 990** and **SCHEDULE H**).

IRS SCHEDULE H (Form 990) is required to be completed by any tax-exempt organization that operates one or more hospitals. **SCHEDULE H** is broken into six major parts with subsections for **Part V**:

PART I - Financial Assistance and Certain Other Community Benefits at Cost

PART II - Community Building Activities

PART III - Bad Debt, Medicare, & Collection Practices

PART IV - Management Companies and Joint Ventures

PART V - Facility Information

Section A. Hospital Facilities

Section B. Facility Policies and Procedures (Complete a separate Part V, Section B, for each of the hospital facilities listed in Part V, Section A.)

Community Health Needs Assessment (Optional for 2010)

Financial Assistance Policy

Billing and Collections

Policy Relating to Emergency Medical Cater

Charges for Medical Care

Section C. Other Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility

PART VI - Supplemental Information

SCHEDULE H, Part V (Sections A and B) and **Part VI** address the community health needs assessment process. **Part V, Section A**, requires a listing of all hospital facilities in order of size from largest to smallest, measured by total revenue per facility.

Schedule H (Form 990) 2010

Page **3**

Part V Facility Information

Section A. Hospital Facilities

(list in order of size, measured by total revenue per facility, from largest to smallest)

How many hospital facilities did the organization operate during the tax year? _____

Name and address

	Licensed hospital	General medical & surgical	Children's hospital	Teaching hospital	Critical access hospital	Research facility	ER-24 hours	ER-other	Other (describe)
1									
2									

Part V, Section B, is required to be completed for each facility listed in **Section A**. **Section B** is divided into four subsections. The first subsection, **Community Health Needs Assessment (Optional for 2010)**, is the section that deals with community health needs assessment.

Schedule H (Form 990) 2010

Page **4**

Part V Facility Information (continued)

Section B. Facility Policies and Practices

(Complete a separate Section B for each of the hospital facilities listed in Part V, Section A)

Name of Hospital Facility: _____

Line Number of Hospital Facility (from Schedule H, Part V, Section A): _____

Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)

1 During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8

	Yes	No
1		

There are seven questions relating to Community Health Needs Assessment shown below. Some questions may require additional information; i.e., **Questions 1j, 3, 4, 5c, 6i, and 7**.

		Yes	No
Community Health Needs Assessment (Lines 1 through 7 are optional for 2010)			
1	During the tax year or any prior tax year, did the hospital facility conduct a community health needs assessment (Needs Assessment)? If "No," skip to line 8	1	
If "Yes," indicate what the Needs Assessment describes (check all that apply):			
a	<input type="checkbox"/> A definition of the community served by the hospital facility		
b	<input type="checkbox"/> Demographics of the community		
c	<input type="checkbox"/> Existing health care facilities and resources within the community that are available to respond to the health needs of the community		
d	<input type="checkbox"/> How data was obtained		
e	<input type="checkbox"/> The health needs of the community		
f	<input type="checkbox"/> Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups		
g	<input type="checkbox"/> The process for identifying and prioritizing community health needs and services to meet the community health needs		
h	<input type="checkbox"/> The process for consulting with persons representing the community's interests		
i	<input type="checkbox"/> Information gaps that limit the hospital facility's ability to assess all of the community's health needs		
j	<input type="checkbox"/> Other (describe in Part VI)		
2	Indicate the tax year the hospital facility last conducted a Needs Assessment: 20__		
3	In conducting its most recent Needs Assessment, did the hospital facility take into account input from persons who represent the community served by the hospital facility? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted	3	
4	Was the hospital facility's Needs Assessment conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI	4	
5	Did the hospital facility make its Needs Assessment widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply):	5	
a	<input type="checkbox"/> Hospital facility's website		
b	<input type="checkbox"/> Available upon request from the hospital facility		
c	<input type="checkbox"/> Other (describe in Part VI)		
6	If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):		
a	<input type="checkbox"/> Adoption of an implementation strategy to address the health needs of the hospital facility's community		
b	<input type="checkbox"/> Execution of the implementation strategy		
c	<input type="checkbox"/> Participation in the development of a community-wide community benefit plan		
d	<input type="checkbox"/> Participation in the execution of a community-wide community benefit plan		
e	<input type="checkbox"/> Inclusion of a community benefit section in operational plans		
f	<input type="checkbox"/> Adoption of a budget for provision of services that address the needs identified in the Needs Assessment		
g	<input type="checkbox"/> Prioritization of health needs in its community		
h	<input type="checkbox"/> Prioritization of services that the hospital facility will undertake to meet health needs in its community		
i	<input type="checkbox"/> Other (describe in Part VI)		
7	Did the hospital facility address all of the needs identified in its most recently conducted Needs Assessment? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs	7	

The supplemental information for these questions (for each separate facility) will need to be included in **Part VI, Supplemental Information, Question 1, Required descriptions.**

Part VI Supplemental Information

Complete this part to provide the following information.

- Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II, Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6l, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.

Part VI, Supplemental Information, has six additional questions that must be answered. Some of these questions are related to community health needs assessment:

- **Question 2, Needs assessment.**
- **Question 4. Community information.**
- **Question 5. Promotion of community health.**

The other questions will need answered but may not directly pertain to community health needs assessment.

Part VI Supplemental Information

Complete this part to provide the following information.

- 1 Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II; Part III, lines 4, 8, and 9b; and Part V, Section B, lines 1j, 3, 4, 5c, 6i, 7, 11h, 13g, 15e, 16e, 17e, 18d, 19d, 20, and 21.
- 2 Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any needs assessments reported in Part V, Section B.
- 3 Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.
- 4 Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.
- 5 Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).
- 6 Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.
- 7 State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

For additional information on IRS reporting requirements, consult your tax professional.