Helping Hospitals Address Community Health Needs
The Pennsylvania Public Health Training Center (PAPHTC) is one of 37 training centers located in schools of public health and other academic institutions across the country. PAPHTC is based in the Center for Public Health Practice at the University of Pittsburgh Graduate School of Public Health and is operated in partnership with the Drexel University School of Public Health and the University of Pittsburgh at Bradford Center for Rural Health Practice. Funding is provided by the Health Resources and Services Administration.

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The Affordable Care Act and IRS 501r provide an historic opportunity to impact the health of our Nation from a population perspective. These legislative mandates align and integrate health care and public health. In doing so, existing resources can be refocused to identify community health needs and implement interventions proven to be effective in promoting health and preventing disease.

To introduce the value and dimension that public health expertise can add to the process of identifying and addressing community health needs, the Pennsylvania Public Health Training Center, a program of the Center for Public Health Practice based at the University of Pittsburgh Graduate School of Public Health, and its team of content experts produced a series of two webinars for hospital administrators, community outreach directors, and their consultants. The series presents a five-step model that is outlined below. Content experts from the Department of Community and Health Sciences describe each step and the ways in which public health experts add value and dimension to the process. This booklet of supplemental materials was developed to further support the efforts of the teams working to assess and address community health needs.

The University of Pittsburgh Graduate School of Public Health is committed to improving the health of Pennsylvanians. Our public health experts can help hospitals comply with the requirements of community health under the new federal tax laws and make a difference in the health status of their service populations. You and your team can learn how to align the new reporting requirements with your strategic goals and resources by utilizing our training opportunities, the resources provided in this packet, and our technical assistance services. Together, we can impact health outcomes in Pennsylvania by integrating health care and public health.
Addressing Community Health Needs: A Model Process

Assess the Need

- Identify community leaders, agencies, special interest groups and public health experts
- Find the right tools to conduct community health needs assessments

Align the Resources

- Build a strategic plan by aligning assessed community needs with hospitals’ financial resources, marketing potential and available expertise

Identify the Intervention

- Select interventions to address needs by using systematic reviews, research-based evidence and best-practice recommendations

Address the Need

- Implement targeted and tailored interventions: plan, staff, manage, monitor and report

Evaluate the Impact

- Measure progress toward meeting community health needs and ROI
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How Public Health Experts Can Help Hospitals Meet the Community Health Needs Assessment Requirements of the Affordable Care Act (ACA)

George A. Huber, JD, MSIE, MSSM

The Affordable Care Act added section 501(r) to the United States Internal Revenue Code which requires each tax-exempt hospital to conduct community health needs assessments (CHNA’s) every three years. These assessments must take into account input from persons with a broad range of interests in the communities the hospitals service including individuals with expertise in public health. These assessments are to the basis for each hospital’s planning for its community benefit program.

Some hospitals have already been doing variations of the CHNA requirements. However, most hospitals are primarily concerned about having the right services in place to address individual patient treatment needs. Most hospitals have been understandably cautious about venturing into the broad unreimbursable field of public health and, specifically, community health.

Health care is only one of the many determinants of the health of a population. Other determinants include individual behavior, social factors, physical environment, and genetics as they all relate to morbidity, mortality, quality of life, and health disparities. From many hospitals’ historical perspective, these have been fields better left to government and other community organizations to address.

However, hospitals have always been considered a relatively untapped resource available to enhance the health status of the community at large. The CHNA requirements of 501(r) provide an incentive for hospitals to get more involved in population-based health. Failure for a hospital to do so could result in a $50,000 penalty per year and possible loss of tax-exempt status at the federal and state levels. Additionally, the more hospital reimbursement becomes population and outcome dependent, the more hospitals will find it useful to understand the health risks of the population they serve and how they might realistically help to reduce them.

We have identified some of the ways in which public health experts might help hospitals as well as their other advisors and consultants in satisfying the CHNA requirements in a useful fashion:

1. Identifying and using relevant data sources and methods to establish the hospital’s “community”, to determine realistic health profiles of the health status of community members, to develop appropriate population based health benchmarks, and to involve community stakeholders in identifying priorities for intervention. This includes methods for obtaining stakeholder input through such mechanisms as focus groups, town meetings, surveys, and concept mapping.
2. Recommending evidence-based programs to meet key community health needs. This should be followed by linking the current inventory of community programs to CHNA as well as identifying gaps and proposing alternatives to address the gaps.

3. Providing guidance in the evaluation of “community benefit” programs including what is needed for effective and reasonable evaluation, such as rigorous data collection, audit, analysis, and comparison to reasonable benchmarks.

4. Training of hospital staff, consultants, and advisors in all of the above areas. It should be noted that many universities and colleges have faculty with these types of unique expertise. See www.cphp.pitt.edu/communityhealth/

It is anticipated that hospitals, depending upon their locations and financial resources, will take various routes to satisfying CHNA requirements. However, improving community health has historically been a focus of most American hospitals. Consequently, the conceptual transition from general to specific programming should not be a problem for hospital leadership as they engage in the useful process described above in order to maximize benefits to the hospital and the community. Public health experts are here to help with that transition.

George A. Huber, JD, MSIE, MSSM, is Associate Dean of Public Health Policy at the University of Pittsburgh Graduate School of Public Health.
EXECUTIVE SUMMARY

Community health needs assessments (CHNA) and implementation strategies are newly required of tax-exempt hospitals as a result of the Patient Protection and Affordable Care Act. These assessments and strategies create an important opportunity to improve the health of communities. They ensure that hospitals have the information they need to provide community benefits that meet the needs of their communities. They also provide an opportunity to improve coordination of hospital community benefits with other efforts to improve community health. By statute, the CHNAs must take into account input from “persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.” As national organizations representing those with that special knowledge and expertise, we present here consensus recommendations about how hospitals can most effectively work with public health experts to maximize community benefits. We look forward to supporting collaboration between hospitals and governmental public health departments and public health experts to facilitate effective and cost-efficient hospital CHNAs.

**Recommendation 1: Persons with “special knowledge of or expertise in public health” should be persons with public health training or experience who possess technical community health needs assessment competencies.**

In developing their CHNAs and implementation strategies, hospitals should consult with public health experts in order to ensure that CHNAs draw on public health methodologies and standards. For the purposes of this process, public health experts should be defined as individuals with:

- Public health training or experience.
- The technical competencies needed to develop valid CHNAs and implementation strategies.
The table below provides detail on how to define and document this expertise:

<table>
<thead>
<tr>
<th>Definition</th>
<th>Documentation</th>
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<tbody>
<tr>
<td><strong>Public health training or experience</strong></td>
<td>• Diploma from Council on Education for Public Health-accredited public health program or school, or</td>
</tr>
<tr>
<td>• A degree from a Council on Education for Public Health-accredited public health program or school, or</td>
<td>• Credentialing document from National Board of Public Health Examiners, or</td>
</tr>
<tr>
<td>• Credential through the National Board of Public Health Examiners, or</td>
<td>• Resume or CV documenting prior public health work experience.</td>
</tr>
<tr>
<td>• Prior public health assessment-related work experience for at least two years in a public health organization (including but not limited to local, state, federal, or tribal governmental public health departments, public health institutes, and schools and programs of public health)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHNA and Implementation Strategy Competencies</th>
<th>Documentation that shows person played substantive role in prior community health needs assessments and implementation strategy development (e.g. authorship of prior assessments, letters of recommendation from previous clients, etc.).</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Methods and processes for collecting and analyzing community health needs and assets using qualitative and quantitative data</td>
<td></td>
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<tr>
<td>• Methods for effective community engagement</td>
<td></td>
</tr>
<tr>
<td>• Interpretation of community health data and prioritization of community health needs</td>
<td></td>
</tr>
<tr>
<td>• Knowledge of science-based health promotion and disease prevention interventions</td>
<td></td>
</tr>
<tr>
<td>• Implementation and evaluation of community health plans</td>
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</tbody>
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Recommendation 2: Hospitals should consult with both the state health department where the facility is licensed and the local health department where the facility is located.

In developing their CHNAs and implementation strategies, hospitals should consult with both the state health department where the facility is licensed and the local health department where the facility is located. This will help ensure access to existing data and knowledge of local needs and coordination with other existing needs assessment and health improvement efforts.
**Recommendation 3: Consultation with public health experts and public health departments should be documented.**

*Schedule H*

Hospitals should report on Schedule H whether they involved public health experts and state and local public health departments in the development of their CHNAs and implementation strategies.

**CHNA Reports**

CHNA reports and implementation strategies should describe:

1. The names, affiliations, and qualifications of the public health experts consulted.
2. The organizations, including the public health departments, that were consulted and the name of at least one individual in each organization.
3. How public health experts and public health departments were involved in the following components of the development of the CHNA and implementation strategy:
   - Collecting and analyzing quantitative and qualitative health data.
   - Coordinating efforts across hospital organizations and other entities engaged in health needs assessment.
   - Ensuring meaningful community engagement in the CHNA process.
   - Interpreting CHNA findings and prioritizing health needs.
   - Identifying appropriate interventions.
   - Developing short- and long-term goals and objectives.

**Recommendation 4: Hospitals should seek input from community representatives.**

We agree with the IRS’s intent to require that input be taken into account from “leaders, representatives, or members of medically underserved, low-income, and minority populations and populations with chronic disease needs, in the community served by the hospital facility.” Community member input is an essential component of effective community health needs assessment; therefore, we support a requirement for that input in hospital CHNAs. Governmental public health departments and public health experts have expertise in community engagement that can be useful in this process.

**Recommendation 5: CHNA and implementation strategy consultation and transparency requirements should be the same.**

Both the CHNA and the implementation strategy documents should ideally be developed using similar community input and engagement processes to ensure that both documents benefit from the expertise and insights of the relevant community representatives. Also, because both are activities that are at the core of public health practice, both would benefit from consultation with public health experts and governmental public health agencies.
Recommendation 6: The community served by a hospital facility should not be defined in a way that excludes medically underserved or low-income populations.

Community benefits should specifically address the need of medically underserved populations. Therefore, the community served by a hospital facility should include all individuals within political jurisdictions where the facility is an essential provider, and should not be defined in a way that excludes medically underserved or low-income populations.

Recommendation 7: Implementation strategies should address all the needs identified through the CHNA.

To ensure hospital community benefits address community health needs, we support the IRS’ intent to require that hospitals specify in their implementation strategy and on Schedule H how they are addressing all the needs identified in the needs assessment, or, if they are not addressing a particular need, why not.

Recommendation 8: Implementation strategies should include evaluation measures to facilitate assessment of the impact of hospitals’ community health improvement activities.

Implementation strategies should include measures and targets describing the impact the strategies are expected to have in order to facilitate assessment of the impact of hospitals’ community health improvement activities. This will help communicate the actual impacts that hospitals anticipate generating through their community benefit activities and facilitate accountability, transparency, and evaluation of effectiveness.

Recommendation 9: Include additional requirements to ensure the CHNA and implementation strategy are widely available to the public.

Hospitals should make the CHNA and implementation strategy widely available to the public by posting on a website as well as providing written copies upon request and by publicizing the availability of these documents on their websites and in their facilities. Additionally, the web address for the CHNA and implementation strategy should be reported on Schedule H.

Recommendation 10: Hospitals should be allowed to conduct CHNAs with others.

We strongly support the IRS’s intent to allow hospital organizations to conduct CHNAs in collaboration with other organizations, including other hospital organizations, for-profit and government hospitals, and state and local public health departments and other agencies. We agree that this will allow for more cost-effective and efficient identification of a community’s health needs and assets and a more fully informed perspective.
Recommendation 11: Hospitals should be allowed to include resources needed to support involvement of public health experts, governmental public health agencies, and community leaders and representatives as part of the reported community benefits operations.

Conducting rigorous and meaningful CHNAs with the input and involvement of public health experts, public health departments, and community representatives will require investment of hospital resources. Hospitals should be allowed to include those resources as part of community benefits operations.
Health is…

…a dynamic state of complete physical, mental, spiritual, and social well-being and not merely the absence of disease or infirmity.

(WHO, 1998)

Public health is…

…what we as a society do collectively to assure the conditions in which people can be healthy.

(IOM 1988)
The health status of individuals is aligned with a continuum that ranges from *healthy* to *at risk* to *chronic illness/disease* to *co-morbidity*. As individual health decreases, health care needs increase as does the cost of increasingly complex care. Public health seeks to contain health care costs by focusing on population-based prevention efforts and assuring conditions in which people can be healthy.
The Spectrum of Prevention

The Spectrum of Prevention is a framework that provides strategies designed to address complex, significant public health problems. These strategies take into account the multiple determinants of community health and can be used to develop a comprehensive approach to current public health issues. While many of these strategies are familiar to public health practitioners, when considered as parts of a single approach they become an effective framework for planning public health interventions and coordinating the activities of multiple programs or agencies.
Collaborating through Community Health Assessment to Improve the Public’s Health

Introduction

The National Association of County and City Health Officials (NACCHO) represents the nation’s 2,800 local health departments (LHDs), which have conducted community health assessments (CHAs) in the United States since the 19th century. In the early part of the 20th century, the public health community developed successive iterations of an appraisal form to be used as a self-assessment tool by local health officers. By 1945, the Emerson Report recommended six basic services, including the collection and interpretation of vital statistics. In 1974, Congress made an effort to organize a comprehensive national health planning system informed by assessment through PL 93-641, the National Health Planning and Resources Development Act. The Act, which created a complex network of local, regional, and state planning agencies with significant responsibility for assessment activities, was allowed to lapse in 1986. In a landmark report near the close of the century, the Institute of Medicine (IOM) recommended that:

Every public health agency regularly and systematically collect, assemble, analyze and make available information on the health of the community, including statistics on health status, community health needs, and epidemiologic and other studies of health problems. Not every agency is large enough to conduct these activities directly; intergovernmental and interagency cooperation is essential. Nevertheless each agency bears the responsibility for seeing that the assessment function is fulfilled. This basic function of public health cannot be delegated.¹

The IOM’s three core functions of public health (assessment, policy development, and assurance) were subsequently developed into 10 essential public health services. Two other recent developments have increased the interest in assessment activities. First, the 2010 Patient Protection and Affordable Care Act (ACA) requires nonprofit hospitals to conduct community health needs assessments (CHNAs) every three years and to adopt implementation strategies to meet the needs identified in the assessments. The law stipulates that CHNAs should consider the broad interests of the community, including those with special knowledge of, or expertise in, public health. Second, in 2011, a voluntary national accreditation program for LHDs was launched; among the accreditation standards is the requirement that LHDs participate in or conduct a collaborative process resulting in a comprehensive CHA and community health improvement plan.
This issue brief describes the current state of CHA activity across the country and encourages continued and expanded collaboration among LHDs, hospitals, and other partners. The report is divided into three sections: assessment, a systems-collaborative approach, and epidemiologic and community considerations. Resources for additional information are also provided.²

**Assessment**

LHDs have a broad range of knowledge and competencies required for CHA and community health improvement planning efforts, including community engagement and outreach, epidemiology, health equity, partnership and collaborative techniques, and assessment and planning methodologies. NACCHO’s 2010 National Profile of Local Health Departments study³ (Profile study) showed that 60 percent of LHDs had conducted a CHA in the last five years (Figure 1). An additional nine percent planned to conduct a CHA within the next year. Although down from the 2008 Profile study, which showed 63 percent having conducted a CHA in the last three years, this percentage is expected to increase with the recent launch of voluntary national accreditation of LHDs, which requires the completion of a CHA.

Broader than a CHNA, a CHA is based not only on needs but also on identifying priority community health and quality of life issues. As described in the Mobilizing for Action through Planning and Partnerships (MAPP)⁴ guidance, a robust CHA can include an assessment of community health status, an assessment of community strengths and assets, an assessment of the contextual concerns or forces of change, and an assessment of the local public health system (see sidebar on page 3).

LHDs and hospitals use CHAs in many ways, including using the data from CHAs to inform strategic plans and community improvement plans.⁵ They also use CHAs to strengthen grant applications and secure resources, justify health initiatives, prioritize health issues and the efforts to address them, support the work of partners, advocate for policy changes, and monitor health trends in the community.

**A Systems-Collaborative Approach**

NACCHO’s 2008 Profile study showed two important facts related to collaboration. First, the LHD was frequently part of a broader coalition in the development of the local CHA, with about six in 10 LHDs (among those that had conducted a CHA) having participated with a local coalition in its development. Second, LHDs are collaborating with many organizations in the community. Almost all LHDs (97%) already partner with their local hospitals in some capacity, with 90 percent reporting information exchange, 53 percent reporting regular meetings, 40 percent reporting shared personnel or resources, and 39 percent reporting an existing written agreement.

In a CHA process, each partner brings unique experiences, resources, and expertise. LHDs are uniquely positioned to conceptualize the challenges and the assets a community brings to achieving improved population health. LHDs have expertise particularly with collecting and analyzing public health data, leading strategic planning processes to improve community health, and understanding the process of using data to develop priorities and action plans for
community health improvement. They also work directly with members of the community and offer skills such as organizing coalitions and facilitating focus group discussions, which are important to successful assessment processes. LHDs also have an ability to engage non-traditional partners, such as community-based and grassroots organizations, which may not be typical partners for hospitals.

Hospitals provide financial resources and manpower to the CHA process, particularly during a time when LHDs across the country are facing severe budget cuts and staffing issues. Hospitals not only offer financial resources for the assessment itself but also commit resources to the initiatives that arise from the process. Hospitals often have access to unique datasets that can inform assessments, particularly specialty hospitals (e.g., military hospitals or Indian Health Service hospitals). Hospitals are able to engage other members of the medical community that LHDs may not typically have access to, such as specialty providers. Hospitals are very powerful within a local community. As prestigious and credible stakeholders, they can gain attention from the media and bring population health more readily to the public eye.

Factors leading to successful LHD and hospital CHA collaboration often include the following:

- Previous collaboration on other types of initiatives, such as preparedness planning;
- Friendly, professional relationships between hospital and LHD leaders;
- Recognizing common goals between the agencies and establishing a common vision;
- Having an established forum for leadership to discuss population health issues;
- Maintaining a credible intermediary, such as a health planning council, advisory group, or formal network board with key stakeholders and experts from the health community;
- Recognizing the strengths of each other’s agency—for example, that the hospital considers the LHD the expert in population health issues;
- A mutual understanding of political and financial environments, which can be driven by the health officer and CEO;
- A formal memorandum of understanding, which can set the foundation and be a precedent for collaboration across a range of activities, regardless of changes in leadership; and
- Being clear about roles, responsibilities, and expectations of collaborators and partners.

Epidemiologic and Community Considerations

CHAs are based in the science of public health: epidemiology. Although shrinking economic resources have meant more sharing of epidemiologists among LHDs, LHDs still have access to a broad range of epidemiologic information pertinent to a CHA. The 2008 Profile study noted that data sources related to vital statistics and disease outbreak investigation were available to over 80 percent of LHDs.

Centralized state databases with county-level data collection, comprehensive hospital inpatient databases searchable by zip code and by patient, qualitative data from the field, community health surveys and focus groups, data from non-traditional partners, such as law enforcement
databases, Healthy People benchmarks, County Health Rankings, and vital statistics are examples of data sources that are valuable both to LHDs and hospitals.

One particular epidemiologic concern is defining the geographic boundaries of the community. Many different approaches to defining community for purposes of conducting CHAs exist; the most important consideration seems to be not the specific method of defining the geographical boundaries but rather the assurance that all partners agree on the definition.

In addition to the requirement in the ACA that nonprofit hospitals assess community health needs, the law also requires non-profit hospitals to provide a description of how the organization is addressing the needs identified in each community health needs assessment conducted under Section 501(r)(3) and a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed.\(^6\)

LHDs have significant expertise implementing solutions to issues identified through an assessment process, including experience in addressing the root causes of health inequities and the social determinants of health.

The 2008 Profile study collected information on the percent of LHDs conducting activities to reduce health disparities and the type of activities that were conducted. Among LHDs serving larger (and usually more urban) populations, over 80 percent reported supporting community efforts and using data to describe disparate health outcomes by marginalized population groups.

Both LHDs and hospitals are cognizant of the unequal burden of health problems on marginalized populations. Both have experience in serving these groups, and each have data on the health problems that exist in communities where the marginalized reside. These data provide the basis for CHAs, which is a springboard for developing actions that address health inequities.

**Conclusion**

By collaborating in a CHA process, LHDs, nonprofit hospitals, and other community stakeholders can describe the current health of the community they serve and provide an organizing framework for improving the public’s health. Moreover, a collaborative effort can work to align efforts, avoid duplication, and increase efficiencies. When collaboration occurs, CHAs are more likely to be developed according to a process that meets the ACA’s explicit requirement to take into consideration the broad needs of the community. Although a collaborative approach to CHA may appear more time-consuming, communities that engage in such a model will be the most likely to reach their public health goals.

**References**


2. The Community Health Assessment/Community Health Improvement (CHA/CHIP) Planning Resource Center provides an online and publicly accessible venue to LHDs and related
partners for information on practical, customizable tools, key source material, examples from the field, and upcoming webinar trainings on CHA/CHIP topics at www.naccho.org/chachipgeneral.

3. The Profile study includes data on LHD jurisdictions, governance, budget, staffing, activity levels, and other topics. First conducted in 1989, the most recent Profile study was the sixth in the series. It was fielded in the summer of 2010 and yielded a response rate of 82 percent. The 2008 Profile study had a similarly high response rate and included detailed information on community health assessment and planning.

4. MAPP is a framework for developing, implementing, and evaluating collaborative community health improvement plans, which are informed by robust CHA data.

5. In summer 2011, NACCHO conducted two focus groups with 16 LHD top executives or their representatives on CHA as related to the community benefit provisions in the ACA.


7. The Centers for Disease Control and Prevention (CDC) National Public Health Performance Standards Program (NPHPSP) supports a national partnership initiative that has developed National Public Health Performance Standards for state and local public health systems and for public health governing bodies. The mission of the NPHPSP is to improve the quality of public health practice and performance of public health systems.

8. More information on the National Public Health Performance Standards Respondent Information Form report is available through the Public Health Foundation.

Acknowledgments

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Problem Identification and Prioritization Cycle

www.nap.edu/openbook.php?isbn=0309055342
Data Sources to Inform a Community Health Needs Assessment

There are several sources that can be used to inform a community health needs assessment.

<table>
<thead>
<tr>
<th>Source</th>
<th>Description</th>
<th>Website</th>
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<tbody>
<tr>
<td>County Health Rankings</td>
<td>Health outcomes data is presented to show how healthy each county is: how long people live (mortality) and how healthy people feel (morbidity). These outcomes are shaped by many factors (health behaviors, clinical care, social and economic factors, physical environment) that, in turn, can be influenced by policies and programs.</td>
<td><a href="http://www.countyhealthrankings.org/#app">www.countyhealthrankings.org/#app</a></td>
</tr>
</tbody>
</table>
| American Fact Finder | Population, housing, economic, and geographic information is captured annually through over 100 surveys and censuses conducted by the Bureau.  
- Decennial Census  
- American Community Survey  
- Economic Census  
- Population Estimates Program  
| Medically Underserved Areas/Populations Health Professions Shortage Areas |  
- Medically Underserved Areas may be a whole county or group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services.  
- Medically Underserved populations may include groups of persons who face economic, cultural or linguistic barriers to health.  
- Health Professional Shortage Areas are designated as having a shortage of primary medical care, dental or mental health providers. They may be urban or rural areas, population groups, or medical or other public facilities | [http://bhrp.hrsa.gov/shortage](http://bhrp.hrsa.gov/shortage) |
| Epidemiological Query and Mapping System | EpiQMS is an interactive health statistics web tool that can be used to create customized data tables, charts, maps, and county assessments / profiles for the following datasets:  
- Behavioral Risk Factor Surveillance System (BRFSS)  
- Births  
- Cancer incidence  
- Communicable diseases  
- Deaths | [www.portal.state.pa.us/portal/server.pt?open=514&objID=596553&mode=2](http://www.portal.state.pa.us/portal/server.pt?open=514&objID=596553&mode=2) |
| Local health data | Philadelphia County
Local health departments in the Commonwealth may provide data on a more detailed local level.
- The Philadelphia Department of Public Health collects and/or analyzes a variety of data to describe the health of Philadelphia’s residents and its communities.
- The Allegheny County Health Department monitors the health status and helps identify public health problems within Allegheny County. Periodically, the ACHD Biostatistics office prepares a Community Profile Series, which compiles some of the data necessary to evaluate a community's health.

| Allegheny County

www.phila.gov/health/commissioner/DataResearch.html

| Hospital Data | www.achd.net/biostats/biostats.html

| | Philadelphia County

www.achd.net/biostats/biostats.html

| Hospital Data | • Inpatient discharge surveys provide a description of payor types by service lines of those admitted to the hospital
• Emergency department data

Once the quantitative data has been reviewed and community has helped identifying health topics, health indicators need to be identified.

1. There are several criteria for a “good” health indicator (IOM, 1997):
   A. Validity and reliability
   B. Evidence-based link between performance and health improvement
   C. Responsibility and accountability for performance
   D. Robustness and responsiveness to change in health system performance, particularly in targeted populations
   E. Availability of data in a timely manner at a reasonable cost
   F. Inclusion in other indicator set

2. Healthy People 2020
   A. Starting point to identify the health topics of national importance and also as a way to begin identifying the indicators used to capture health needs of a community.
   B. The Healthy People 2020 includes over 600 health indicators across 42 health topic areas (see Appendix B) and
   C. Sets benchmarks for the nation’s health by 2020
Nominal Group Process

The Nominal Group Process is an efficient tool that ensures balanced participation. It requires participants to first think about the question and write down their thoughts. After a suitable time, the facilitator uses a round robin approach in which each participant is asked to nominate, or submit, a concept or statement that is most critical to them. Only one nomination is given by each participant. Each statement is written on the flip chart so that all can see the nominations. During this time the only person talking is the person nominating a statement; all others are requested to think about the statement to see if it stimulates an idea that they had not had before. This process continues until there are no more nominations, at which time the facilitator guides the group in a discussion of each nomination to clarify, discuss, edit, and remove redundancies. The discussion may uncover more events, which are then be posted on the flip chart.

Concept Mapping

Concept mapping is a structured conceptualization process. It is a participatory qualitative research method that yields a conceptual framework for how a group views a particular topic or aspect of a topic. It uses inductive and structured group data collection processes, which allow for the collection of a wide range of participant-generated ideas and application of quantitative analytical tools (i.e., multidimensional scaling and hierarchical cluster analysis). Results from the quantitative analysis are used to produce illustrative cluster maps depicting relationships of ideas in the form of clusters.

A concept map is a diagram that illustrates the relationships between ideas, just as a sentence diagram illustrates the grammar of a sentence. Concept maps are used to stimulate the generation of ideas. Although they are often personalized and idiosyncratic, concept maps can be used to communicate complex ideas. Because they can communicate complex ideas and arguments, concept maps can be used to facilitate the creation of shared vision and shared understanding within a team or organization.
Example: Concept Map – five clusters of fifty items
Example: Rating Comparison

Health Problem A
Health Problem B
Health Problem E
Health Problem D
Health Problem C

5 = Very High
1 = Very Low

Rating:
IMPORTANCE OF PROBLEM TO COMMUNITY

Rating:
HOSPITAL ABILITY TO ADDRESS PROBLEM
IDENTIFY THE INTERVENTION

The Five Phase Literature Review Process

PHASE I: PubMed Database Search

Key search categories: hospital, program, evaluation, measurement, community benefit

4,917 peer-reviewed citations

PHASE II: Abstracts screened by inclusion criteria

265 full-text articles

PHASE III: Full-text articles reviewed in depth

106 included articles

PHASE IV: Included articles analyzed in summary reports

PHASE V: Key programs selected for final report

21 key programs
Taxonomy of Community Benefit Efforts

Tier I: Venue
- Hospital Facility
- Community Facility

Tier II: Program Type
- a. Enhancement of Patient Care
- b. Clinic-Based Program
- c. Hospital After-Care
- d. Community-Based Program
- e. Benefits and Coverage Counseling

Tier II: Role of Community Partner
- d1. Without Community Partner
- d2. With Community Partner
Distribution of Program Types by Health Topic

- Telemedicine (16)
- Hospice and Palliative Care (15)
- Hospital Readmissions (14)
- Diabetes (13)
- Injury Prevention (12)
- Maternal, Child Health (11)
- Asthma (10)
- Oral Health (9)
- Immunization (8)
- Tobacco, Alcohol, Drugs (7)
- Behavioral Health, Education (5)
- Obesity, Exercise, Nutrition (4)
- Health Education, Behavior (5)
- Screenings (3)
- HIV/AIDS and STDs (2)
- Violence Prevention (1)

(a) In Hospital - Enhancement of Patient Care
(b) In Hospital - Clinic-Based Program
(c) Community-Based - Hospital After-Care
(d1) Community-Based - Program without Community Partner
(d2) Community-Based - Program with Community Partner
(e) Community-Based - Benefits and Coverage Counseling
Fixsen et al.’s (2005) Implementation Model

Incorporating an evidence-based practice into multiple sites or large organizations to ensure sustainability provides challenges to any implementation. As such, the project may require significant guidance from the emerging field of Implementation Science. Implementation Science is the use of methods to promote systematic uptake, establishment, and maintenance of the treatment into routine mental health practice.¹ This concept of implementation in health services research is outlined in the comprehensive synthesis of the literature on successful intervention research involving implementation by the work of Fixsen, et al.² The advantage of the Fixsen model lies in its specificity; it provides specific detail on how to implement evidence-based practices. Fixsen and his colleagues determined the use of seven critical elements of a successful implementation: 1) staff selection to determine appropriate staff to attend the in-service, 2) preservice training on the specific EBPs, 3) expert consultation and coaching of staff and administration to carry out their newly acquired skill, 4) staff evaluation to assess the use and behavior change desired regarding the trained skill, 5) program evaluation to assess and provide feedback on key aspects of the performance of the organization around the new skill, 6) facilitative administrative supports to insure data collected are fed back to administration to focus and inform decision making, and 7) systems intervention to identify financial, organizational, and human resources required to support the work of the practitioners (see Figure 1). Only with the use of all seven core components in planning and implementation can success be ensured.

### Example: Implementation Dashboard

<table>
<thead>
<tr>
<th>Team</th>
<th>Target</th>
<th>Next Steps</th>
<th>Due Date</th>
<th>Lead</th>
<th>DATE last updated</th>
<th>Notes on Challenges/Successes Once Implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1. Select &amp; Dedicate Team; Establish Roles of the Team</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4 Pillars Toolkit Team Members</strong></td>
<td>PCPs RN/MA Front Desk Office Manager</td>
<td><strong>EXAMPLE:</strong> Individuals identified and responsibilities defined</td>
<td>John Doe</td>
<td>4/10/2012</td>
<td>EXAMPLE: Some differences in opinion on changes needed to process flow</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PCPs RN/MA Front Desk Office Manager</td>
<td>Done</td>
<td></td>
<td></td>
<td></td>
<td>EXAMPLE: Implementation Team is meeting on a regular, established basis.</td>
</tr>
<tr>
<td><strong>Implementation Leader</strong></td>
<td>Nurse Manager</td>
<td>Done</td>
<td></td>
<td></td>
<td></td>
<td>EXAMPLE: Nurse Mgr is in contact with research team on an established schedule to meet her needs and PRN</td>
</tr>
</tbody>
</table>

| **Step 2. Train the Team on the Model** |               |            |          |      |                  |                                               |
| **4 Pillars Process Flow created** | PCPs RN/MA Front Desk Office Manager | **EXAMPLE:** Coach Implementation Team in new patient flow |           |      |                  |                                               |
| **EpicCare Smartsets** | PCPs RN/MA Front Desk Office Manager |                |          |      |                  |                                               |
| **Understands protocols** | Front Desk Office Manager |                |          |      |                  |                                               |

**Step 3. 3. Establish policies, protocols, and processes; use SmartSets in EpicCare to foster billing**

*and so forth...*

#### Key
- Incomplete
- In process
- Complete
Identifying and Eliminating Tobacco-Related Disparities

**Inputs**
- UPMC Health Plan
- Community Groups

**Activities**
- Convene a diverse and inclusive group of stakeholders
- Access relevant data sources to identify tobacco-related disparities
- Engage and educate community leaders about tobacco-related initiatives and issues
- Identify prevention marketing concepts to create mass multi-media campaign
- Identify culturally appropriate tobacco interventions

**Outputs**
- Planning group formed
- Capacity, infrastructure and social capital assessed
- Community leaders engaged and educated
- Countermarketing campaign developed
- Training in cultural competency and interventions completed

**Short-term**
- Increased community capacity

**Intermediate**
- Reduced tobacco use in disparate populations
- Increased awareness of tobacco-related health consequences for disparate populations
- Increase in culturally appropriate services

**Long-term**
- Reduced disparities in tobacco-related morbidity and mortality

**Example: Logic Model**

EVALUATE THE IMPACT
The Utilization of the Logic Model as a System Level Planning and Evaluation Device

David A. Julian

Many questions exist about how to evaluate the impacts of local human services delivery systems. This paper presents a potential mechanism for such evaluations and describes the experiences of a large, urban United Way. The mechanism focuses on a tool called the logic model. A description of the local United Way planning and evaluation process and how this process was enhanced through the utilization of the logic model is provided. The United Way experience suggests that the logic model may have application to planning domains where the desire is to achieve long term social objectives through the implementation of multiple, shorter term interventions. The logic model provides a mechanism and conceptual basis for identifying and measuring system impacts.

The Guide to Community Preventive Services

US Department of Health and Human Services and the Community Preventive Services Task Force

*The Guide to Community Preventive Services* provides evidence-based recommendations and finding about what works to improve community health. This online resource can help you choose programs and policies to improve health and prevent disease in your service area. Systematic reviews are used to answer these questions:

- Which program and policy interventions have been proven effective?
- Are there effective interventions that are right for my community?
- What might effective interventions cost; what is the likely return on investment?

[www.thecommunityguide.org/index.html](http://www.thecommunityguide.org/index.html)

Healthy People 2020

US Department of Health and Human Services

For three decades, Healthy People has been committed to improving the quality of our Nation’s health by producing a framework for public health prevention priorities and actions. It is a roadmap and compass for better health, providing our Nation a vision for improving both the quality and quantity of life for all Americans. Health People 2020 continues this tradition by providing new 10-year goals and objectives for health promotion and disease prevention and monitoring progress over time in order to encourage collaborations across communities and sectors, empower individuals toward making informed health decisions, and measure the impact of prevention activities.

[www.healthypeople.gov/2020/about/default.aspx](http://www.healthypeople.gov/2020/about/default.aspx)
Improving Health in the Community: A Role for Performance Monitoring

Institute of Medicine, 1997

This report draws on lessons from a variety of current activities to outline the elements of a community health improvement process, discuss the role that performance monitoring can play in this process, and propose tools to help communities develop performance indicators.

www.nap.edu/openbook.php?isbn=0309055342

Community Benefit Webpage

National Association of County and City Health Officials

This webpage provides resources to help local health departments and non-profit hospitals conduct collaborative community health assessment and improvement planning processes and align their community initiatives.

www.naccho.org/topics/infrastructure/mapp/chahealthreform.cfm

Resource Center for Community Health Assessments and Community Health Improvement Plans

National Association of County and City Health Officials

The resource center provides practical, customizable tools and resources to support completion of the community health improvement process.

www.naccho.org/topics/infrastructure/CHAIP/chachip-online-resource-center.cfm

National Prevention Strategy

National Prevention, Health Promotion, and Public Health Council

This resource presents a vision, goals, recommendations, and actionable items that individuals and public, private, and non-profit organizations can use to reduce preventable disability, disease, and death in the United States.


Partner Tool

Robert Wood Johnson Foundation

This free online social network analysis tool is designed to measure and monitor collaboration.

www.partnertool.net
Following are brief descriptions of the public health content experts involved in this project. Each expert brings an abundance of knowledge from numerous public health disciplines, integral to conducting and evaluating a community health needs assessment.

**Steven M. Albert, PhD**

Steven M. Albert, PhD is a Professor and Chair of the Behavioral and Community Health Sciences Department at the Graduate School of Public Health. In addition to the above, Dr. Albert is on the Editorial Board of the Journal of American Medical Directors Associations, Internet Journal of Mental Health. In the past Dr. Albert was the Secretary/Treasury of the Behavioral and Social Sciences section of the Gerontological Society of America, the editor of the Association of Anthropology and Gerontology and Preventive Medicine. He has also been a reviewer for numerous journals.

**Donna Christina Almario-Doebler, DrPH, MS, MPH**

Donna Christina Almario-Doebler, DrPH, MS, MPH is a visiting Assistant Professor in the Department of Behavioral and Community Health Sciences at the University of Pittsburgh Graduate School of Public Health. In addition, she is a quantitative methodologist with a focus on community health. Currently, Dr. Almario-Doebler is working with UPMC to conduct a community health needs assessment for each UPMC hospital.

In the past Dr. Almario-Doebler was a Kellogg Health Postdoctoral Scholar in the Department of Biostatistics, biostatistician at the VA Pittsburgh Health System’s Center for Health Equity Research and Promotion, and analyst at the Institute of Medicine and U.S. Government Accountability Office on various health issues (kidney transplantation, HIV, vaccine safety, allocation of Community Health Center funding).

**Jessica G. Burke, PhD, MHS**

Jessica G. Burke, PhD, MHS is currently an Associate Professor of the Behavioral and Community Health Sciences Department at the Graduate School of Public Health. Her experience includes teaching courses focused on adoption of an ecological approach in the exploration of health determinants that stresses the importance of partnering with communities in needs assessment and intervention development processes. In addition to the above, Dr. Burke is a member of the American Public Health Association, the International Society for Urban Health, the Society for Public Health Education, and the Association of Teachers of Maternal and Child Health. She also serves as a reviewer for numerous journals. She works to design, implement, and evaluate comprehensive interventions to address many important issues. Moreover, she employs a theory-driven, participant-oriented approach to exploring the mechanism and contextual factors influencing the health status of women and children.
George Huber, JD, MSIE, MSSM

George Huber, JD, MSIE, MSSM is a Professor of Public Health Practice at the University of Pittsburgh, Associate Dean for Public Policy, and Of Counsel to Office of the General Counsel. In addition to his duties, he advises on legal, government relations, and policy matters (including research integrity and conflict of interest) to the Senior Vice Chancellor for health related professors, the Executive Vice Chancellor for the University and General Counsel, and the Dean of the Graduate School of Public Health. Current projects include advising as a Board of Directors for: UPMC McKeesport, UPMC Passavant, UPMC Health Plan, and the Community Care Behavioral Health Organization (CCBHO). Moreover, Mr. Huber is a current member of the Board of Directors and is the Chair for the HAP Trustees Leadership Steering Committee.

Although a faculty member at the University of Pittsburgh in various departments since 1975, Mr. Huber was General Counsel for University of Pittsburgh Medical Center for over thirty years, including during UPMC’s formation. Following this role he became Senior Vice President responsible for corporate relations and regional programming, government relations, liability insurance, contracts and grants, and disaster management.

Beth A. D. Nolan, PhD

Beth A. D. Nolan, PhD is an Assistant Professor at the Graduate School of Public Health and the Senior Associate Director of the Institute for Evaluation Science in Community Health. Dr. Nolan has taught Health Program Evaluation and Public Program Evaluation courses; and courses in single subject research design, research methods, adult development and aging. Moreover, she has written and delivered training programs for direct care providers on behavior analytic techniques for people with behavioral health issues. Currently, she is implementing and evaluation several behavioral health and physical health integration projects. Dr. Nolan is a member of the Gerontological Society of America and the American Evaluation Association. Her research interests include the study of implementation processes and program evaluation and program evaluation of programs and systems that provide health care services.

Edmund Ricci, PhD, MLitt

Edmund Ricci, PhD, MLitt is the Director of the Institute for Evaluation Science in Community Health, the Associate Director for the University of Pittsburgh Institute on Aging, and a Professor of Sociology in Public Health at the Graduate School of Public Health. In addition to these duties, Dr. Ricci is currently a member of the Behavioral Sciences Council, Association of Schools of Public Health, on the scientific advisory committee for the International Resuscitation Research Center, and is a member of the editorial board of numerous journals. In the past, Dr. Ricci has served as member of the National Academy of Sciences/National Research Council, committee on emergency medical services, and chair of Health Services Research Training Study section.