Linking Community Health Needs Assessments, Community Benefit, and Population Health
Innovation Final Report
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Intent

The intent of this project is to provide guidance to not for profit hospitals on how to optimize their Community Health Needs Assessment (CHNA) and associated provision of community benefits to improve population health for their communities.

Background

Under the Affordable Care Act (ACA), not for profit hospitals are now required by the IRS to do a Community Health Needs Assessment (CHNA) at least once every three years and develop and execute on an implementation strategy and a set of performance metrics for how they will meet the needs identified in the CHNA to benefit their community. Failing to conduct a CNHA every three years will result in an annual penalty of up to $50,000 and a possible revocation of the hospitals' tax exempt status. The CHNA reports must include a description of the community served, identify existing health care resources, and prioritize community health needs. At the same time, the Public Health Accreditation Board requires that health departments complete a Community Health Assessment with community collaboration that results in a Community Health Improvement Plan. The combined efforts of health systems, public health and community-based organizations working together to produce one comprehensive community assessment is an important opportunity to improve the health of their population, particularly vulnerable individuals and subpopulations.

Methods

We conducted a literature scan and nine expert interviews to identify exemplar hospitals using their CHNA to inform and improve their community benefit spending; tools that can be useful for communities; and examples of communities working together on assessments and planning that include all area hospitals working together. The scan and interviews sought to answer four key questions:

1. How can hospitals improve their CHNAs to reflect population health needs in their community?
2. How can hospitals improve the linkage between the needs identified in their CHNAs and their community benefit spending? What are the barriers to doing this?
3. How can IHI help community entities (e.g. health systems, public health departments, and community organizations such as United Way) collaborate on the CHNA and community benefit?
4. How can communities use CHNAs to identify disparities and make meaningful improvements in health equity in communities?

Expert Interviews

Name	Organization

Kevin Barnett	Public Health Institute
Heather Gates	WNC Health Network
Denise Koo	CDC
Janice Lato	WNC Health Network
Jean Nudelman	Kaiser Permanente
Paul Stange	Independent Consultant
Mike Stoto	Georgetown University
Julie Trocchio	Catholic Health Association
Judith Warren	Health Care Access Now (Cincinnati, OH)

Results of 90-Day Scan

Community Benefit

The provision of community benefit by not for profit hospitals has traditionally focused on patient care, e.g. providing uncompensated or charity care and making up shortfalls from Medicaid payments. In 2009, not for profit hospitals spent an average of 7.5% of their operating expenses on community benefit with a majority of spending focused on uncompensated care. Approximately 5% of the total benefits were spent on "community health improvements". According to the same study, "the level of benefits provided varied widely among the hospitals (hospitals in the top decile devoted approximately 20% of operating expenses to community benefits; hospitals in the bottom decile devoted approximately 1%). This variation was not accounted for by indicators of community need."[1] The variation often depends on location, with hospitals located in poor areas providing more charity and Medicaid care.

Community Health Needs Assessments

The first round of CHNAs has been completed, and both published and verbal reports suggest that hospitals have some work to do to improve their CHNA's. While the language of the IRS rule states that hospitals must solicit input from public health and those who represent the broad interests of the community, reviews of CHNAs available online suggest that many hospitals are not meaningfully engaging public health departments and community organizations when completing their CHNAs and implementation strategies. Many health systems hired outside consultants to do their assessment, to comply with the IRS regulations because of inadequate skills and resources within the organizations. This may have limited the opportunity to meaningfully learn about the social and health needs of their communities. CHNAs must be publically reported but the associated implementation strategies are not also required to be made public. For many, there was a disconnection between the assessments and implementation plans, with waning attention and cohesion after the assessment process was completed. Some expert interviewees noted a lack of changes after the assessments, due in part to the fact that hospitals are inundated with new ACA and CMS regulations, changes in federal and state financing, and other priorities that make it difficult to capture attention for the issues identified in the health assessment.

Evidence suggests that the focus of a majority of available CHNAs is on service capacity issues such as access to health care services and the provision of clinical care. In a survey of fifty-one hospital CHNAs in fifteen regions, Barnett (2014) found that 73% of priorities identified in hospitals' CHNAs were in the Clinical Care category; 19% were in the Health Behaviors category; 8% were in the Social and Economic Factors category; and none were in the Physical Environment category. Among the posted Implementation Strategies there were a total of 124 priorities, 63% of which were in the Clinical Care category, 31% in Health Behaviors, 4% in Social Economic Factors and none in Physical Environment.[2] Other reports show a similarly strong focus on access to care and service needs: a HRET report surveying over 300 tax exempt hospitals found that the most commonly identified driver of community health needs is a lack of access to care (67%)[3], and a recent survey of members of the Catholic Health Association, Voluntary Hospitals Association, and Association of American Medical Colleges found that 93% of member hospitals prioritized access to medical care in their CHNAs.[4] The same goes for the provision of community benefit spending: in 2009, more than 85% of community benefit expenditures were on access and service provision (such as charity care); only 5% was spent on work improving community health undertaken by the hospital itself (see Appendix 1).[5]

While it makes sense that hospitals would prioritize needs that capitalize on their strengths (e.g. providing clinical care), if hospitals want to make a bigger impact on population health they must move away from just prioritizing service needs to working on other population needs, for example, obesity, behavioral health, and prevention. These population health issues can be addressed through changing the social context to make individuals' default decisions healthy, addressing socioeconomic disparities, and targeting those at highest risk.[6]

There is a clear performance gap in the quality of the first round of CHNAs and in the subsequent implementation plans that focus less on comprehensive population health needs facing communities and more on issues that are well-suited to the hospitals. There is significant opportunity for improvement to both improve the CHNA process as a catalyst to work meaningfully on comprehensive population health improvement and to link the associated findings and implementation strategy with their spending of community benefit dollars. Much of this work will be around supporting vulnerable populations and reducing inequities faced by community members that contribute to poor health outcomes and higher health care costs.

Fortunately for hospitals, they do not need to do this work alone. Hospitals, public health departments, and community organizations such as United Ways and others are partnering and collaborating in communities around the country to work on community health improvement. Based on our scan and expert interviews we identify seven practical suggestions that can facilitate improvements in the CHNA process and in the linkage between the CHNA and community benefit to help hospitals maximize their opportunity to promote population health in the communities they serve.

1. *Building will within the hospital(s) and the community.*

One of the biggest challenges is making the case to leadership for why hospitals should be a key player in population health efforts. The AHA's *Leadership Toolkit for Redefining the H: Engaging Trustees and Communities*[7] provides suggestions for hospitals and health systems who are interested in developing community collaborations to improve community health. This report emphasizes that "the status quo is not enough," and provides practical guidance and examples of hospitals that have invested in the community. Fortunately, more hospitals are talking about social determinants of health.

There are a few ways to build will within hospitals:

A) *Link community health to new business models for health care*. The new business model for many hospitals is population management; as organizations move into ACOs and other risk sharing arrangements, they're going to realize they can't do it alone, and will need more community partnerships. Examining community data will highlight that if they want to have good clinical outcomes on a population level they are going to have to improve their community outcomes due to pervasive disparities. While this work is very important for the communities it is also vitally important to the business of hospitals going forward. While there is still a long way to go, we must reinforce that clinical outcomes are inextricably linked to social determinants of health. Publicizing this linkage can be done through publications that are widely read by hospitals leadership as well as at meetings and conferences they attend. The AHA and CDC have been very active in this space.

B) *Educate hospital leaders and staff about population health*. Population health is not just about risk stratification and identifying who you serve and how to serve them better. Many hospitals may not be fully aware of the paradigm shift and could benefit from some direction around that. For example, learning about the context of a readmission – what does the community look like for someone with congestive heart failure? – is an opportunity to re-focus.

C) *Connect the CHNA and population health work to the hospital's mission and roots in serving the community*. Not for profit hospitals are mission driven, and the staff who work at these hospitals are mission driven as well. Hospitals have become very focused on health care delivery vs. health delivery, and the CHNA process represents an opportunity to re-focus towards the mission. Tapping into people's creativity across the organization and providing an opportunity to connect with people across the whole organization, even those who may work in operations or finances, can help move the whole organization along. For example, Kaiser Permanente has created the opportunity for staff to connect across the whole system, bringing ideas for how to better engage with the community regardless of the staff member's role within the organization.

D) Highlight the gap in performance on the first round of CHNAs. As described above, one issue with some of the CHNAs from the first round is a lack of clarity, direction-setting, and measures. This is an opportunity to highlight the performance gap to make the case that there is more work to be done. CHNAs must have a clear purpose and direction as well as a set of high level measures that will help measure performance from one cycle to the next to encourage forward movement and to allow hospitals measure whether they're making progress and improving from cycle to cycle. Without these in place, there is no performance to measure going forward.

E) *Increase the engagement between the team working on the CHNAs and community benefit and the operational leadership*. Community benefit can sometimes be siloed within a hospital or health system, with hospital leaders and staff lacking awareness or a deeper understanding of their work. Community benefit programs have existing relationships with schools, United Ways, and other community groups that can be leveraged and improved upon. For example, if a hospital examined where patients who are frequently readmitted live and identify that many live in the same low income housing complex, the community benefit program is likely already aware of this location and may be offering programming such as blood pressure screenings there. Additionally, one interviewee noted that when hospital leaders see the data on needs identified by the community such as healthy eating and active living, diabetes, and opportunities for healthier and safe living conditions, they can really see the need and are more likely to buy-in. Hospital leadership are understanding more what resources they have to give and the impact on the health of their patients and community. The ACA's raising up of CHNAs as a tool that is important for hospitals to focus on has raised awareness and thus allowed for the creation of more resources at some hospitals.

F) *Make the work seem feasible through offering practical ideas, suggestions, and examples as well as opportunities for collaboration, emphasizing that the hospitals do not have to do this work alone*. Many hospitals find population health work daunting as, even with the best of intentions, it is not traditionally health care's strength. Thus they often do not know where to start. By offering them concrete ideas to try and the opportunity to learn from exemplars, they can see that they can follow the lead of others and move in the same direction.

G) *Build will in the community*. This work could be a catalyst for communities coming together to carry the work through. An opportunity for future development and work is around how to create will at the community level to partner and collaborative on community health improvement.

2. *Conduct a CHNA that effectively captures the community most pressing health needs as well as community assets.*

A) Hospitals and community partners could conduct the CHNA themselves rather than use consultants, or at least be more active participants in the work. There is a plethora of available tools and resources for hospitals to do a lot more themselves, and the process of doing stakeholder interviews and engaging leadership in reviewing the data and even in doing interviews themselves can be very helpful. Given the number of validated and reliable surveys that are in use by hospitals and public health, one expert interviewee advised against creating a new survey.

B) *An effective CHNA must clearly define "community" and to set the CHNA up in a way that can effectively segment the population.* In Barnett's survey, all hospitals defined their community in terms of their patient service area, 52% did not describe how they defined the geographic area of their community, and only 23% identified geographic concentrations of health disparities in their service area. Thus many CHNAs failed to identify geographic areas of their community who could benefit the most from intervention. Only one hospital in Barnett's survey focused its implementation strategy on those geographic areas with higher concentrations of health disparities. CHNAs must be able to identify both geographic areas and populations with different needs to guide priority setting. Hospitals could start thinking differently about their community, thinking about population service area rather than market service area. This means looking at geographic areas and considering how to take responsibility for the health of community members outside of their patient service area. This was a gap in the first round of CHNAs, with 38% of hospitals not reporting a specific focus on populations or geographic areas with health disparities for any programs. Depending on partnerships with health departments hospitals may want to focus on a broader area than their patient service area – for example, an entire county.

C) *Engage community representatives in all stages of assessment, planning, and execution.* Many CHNAs do not engage community representatives past the assessment stage. This reflects that the IRS rule only requires community member engagement during the assessment process and not for the implementation strategy. While 75% of hospitals in Barnett's survey received direct input from community members in the CHNA process, the engagement of these community stakeholders decreased significantly during priority setting and program planning and implementation. Furthermore, only three sites noted an intention to partner with community stakeholders in the planning and execution of community benefit activities. The identified needs must regularly be brought back to community members to validate the findings.

D) *Use a mixed methods approach*. Collect quantitative data from multiple sources as well as qualitative data through conversations with community leaders and members outside of health care, such as elected officials, school representatives, and social services who have realistic expectations of what a hospital can and cannot do.

3) *Increase collaboration on community health assessments and implementation plans between multiple hospitals, public health departments, and community organizations.*

There are often duplicative efforts happening on community health improvement activities and community health assessments which could be strengthened through better alignment of efforts that includes sharing of relevant data and information. Barnett recommends that organizations take steps to streamline similar community health improvement efforts underway through 1) attempting to align schedules for assessment and planning processes across community entities; and 2) encouraging all relevant entities (health departments, Community Action Agencies, United Ways, community health centers, and others) to post their assessment findings on their websites in an easily accessible format

and in a timely fashion. WNC Health Network successfully got all of the different community assessments on a three year schedule.

Prybil et al.[8] identify eight core characteristics of successful hospital/community partnerships:

1. Shared vision, mission, and values.
2. Partners demonstrate a culture of collaboration and mutual respect and trust with other collaborators and understand the challenges in working together.
3. Goals and objectives are clearly stated, widely communicated, and fully supported by all parties involved.
4. An organizational structure is in place to carry out the mission and goals. This could be a legal entity, affiliation agreement, memorandum of understanding, or a less formal arrangement such as a community coalition.
5. Leadership by jointly designated individuals.
6. Partnership operations for effectively run programs.
7. Program success and sustainability – partnership has been operational for at least two years, has demonstrated success in both operations and population health outcomes.
8. Performance evaluation and improvement – regular monitoring and measurement of performance based on shared goals, objectives, and metrics.

Implementation of partnership: A partnership needs to focus on both the technical (e.g. compliance with regulations) and strategic aspects of the work, and to appoint an owner for each stream. The collaborative effort should have a formal commitment through a charter, memorandum of understanding, or some type of formal document through which all partners agree as to how they want to proceed on both the assessment and implementation plan.

The collaborative effort should appoint a steering committee of representatives from each partner to set a co-created vision for the work with a common purpose, shared language and regular communications to all members so they are updated and their expectations managed appropriately. The steering committee must also continually work to engage partners, recognizing each partners' areas of expertise and being sure to engage the weaker partners so that they don't withdraw if they perceive that they are not on the same level as the others. The steering committee members should have strong strategic planning skills and be well-regarded by the different partners to maximize engagement. The steering committee should be deliberate about continually clarifying and revisit the purpose of the collaboration, the common agenda, what partnership looks like, and defining their common language. There also needs to be an appointed project manager/point person overseeing the effort. Several expert interviewees noted that this should preferably be an independent entity, such as the WNC Health Network. The steering committee must agree to continue through implementation to see through changes based on the recommendations from the assessment. Coalitions need to also understand and align the connections and assets that are already in place at the community level through its members.

Staffing: They also require staff with sufficient time to devote to the work, and the appropriate resources to allocate to the individuals doing the work on the ground. This intentionally created shared purpose, structure, and staffing, along with a continuing dialogue about purpose within a health improvement frame and a clear understanding about the value of the different pieces of work for different partners

will go a long way towards facilitating success. Working with public health departments and other sectors can be challenging for hospital staff due to different "languages" and the specificity of requirements around accreditation. Hiring staff with public health skills and providing training to staff in some desired skills can be very helpful to facilitate collaborations.

Funding: Each of the multi-stakeholder partnerships with whom we spoke funded the collaborative assessments through inputs from each participating hospital as well as health departments. One option is for hospitals to pay proportionally based on market share (as measured by admissions, beds, or other metrics); a drawback of this approach could be that those who pay more may try to dominate the process. Competition between hospitals can stymie collaboration.

Note that many not for profit hospitals are in rural areas and thus may not have as many partnership opportunities, particularly with other hospitals as they are the only provider. In urban areas we encourage hospitals to work together but recognize that in rural areas this may not be possible or applicable.

4) *Move beyond identification of needs to prioritize and select population health needs that will be the focus of the implementation strategy.*

The CHNA process helps hospitals think more about the community in which they are situated and to broaden their focus to other populations and determinants of health outside of health care (e.g. environmental, behavioral, and socio/economic). Once the CHNA is completed and it's time to work on the implementation strategy, it can feel like energy has been lost and the collaborative group may not always know what they can do together. One important element of a successful partnership is to clarify the roles of different stakeholders in priority setting in addition to planning, implementation, evaluation and oversight of the related programs. Organizations use different methods to prioritize needs, some of which are described in the Catholic Health Association's book, *Assessing and Addressing Community Health Needs*. They include:

- Quantitative data analysis which weights needs in terms of how important it is to the community and feasibility;
- Holding a community forum in which community members vote on the needs they'd like to see addressed first;
- Checking whether the state has a strategy to assess some of the identified needs, which can help those needs rise to the top; and
- Checking whether there are already system-wide hospital strategies for the identified problem.

Once priority areas have been identified, go back and ask, if there was more community involvement are the selected needs those that the community members would select and prioritize themselves?

5) Better link CHNAs to the allocation of community benefit resources to address population health needs.

Once the community's needs have been identified and prioritized the next step is to identify effective interventions to address those needs. Financial resources for the implementation strategies to meet the selected needs can be a challenge; linkages with United Ways and foundations is important. While community benefit is one way hospitals can put some financial resources towards this work, hospital funding it is not the only source of funding for communities. Although it is beyond the scope of this

paper, others have been thinking about multiple streams of funding for community health improvement.[9] As with other population health work we recommend using a balanced portfolio of interventions, addressing socioeconomic factors, the physical environment, health behaviors, as well as clinical care.

We recognize that because of the way community benefit spending is currently allocated, with the bulk going to Medicaid shortfalls and charity care, that there are limited other available community benefit funds. There were few changes in the allocation of community benefit spending before and after the first round of CHNAs. For a health system to move towards population health they will need to build an internal team to understand population heath, identify where they are and where they need to be, and to start making changes. A hospital's community benefit office can be a champion within the health system as they make the transition to population health. There are some strategies other organizations use to make community benefit most effective. At KP, community benefit is a dedicated position that was created over the past eight years. While this is not the case at some other hospitals, those who are moving towards population health may want to consider creating their own community benefit department with staff with strong public health backgrounds and skills who understand program planning, evaluation, social determinants of health, and grant-making. These staff need to have time to engage meaningfully with external and internal collaborators. The CHNA process has a real opportunity to influence the resources for community benefit and help start movements towards population health from this office throughout the organization.

6) *Measure impact with a mixed methods approach and a shared data system.*

All of the available data can be overwhelming. Mike Stoto notes that a lack of a shared measurement strategy may be the biggest gap in the implementation of CHNAs. A shared set of measures would be useful for hospitals as well as for aggregating measures to priority areas and entire communities, states, regions, and even nationally. Stoto also describes the need for a culture of performance measurement and management focused on population health.[10] Coalitions can also consider partnering with local universities to evaluate the work.

There are numerous data sources and resources that can be utilized as part of a comprehensive CHNA:

- Commonwealth Fund's Health Systems Data Center http://datacenter.commonwealthfund.org/#ind=1/sc=1
- National Center for Health Statistics' Health Indicators Warehouse http://www.healthindicators.gov/
- Dartmouth Atlas http://www.dartmouthatlas.org/
- Dignity Health's Community Need Index http://www.dignityhealth.org/Who_We_Are/Community_Health/STGSS044508
- GIS mapping tools
- CDC Community Health Improvement Navigator (launching April 2015) www.cdc.gov/CHInav
- CDC Community Health Status Indicators: http://wwwn.cdc.gov/CommunityHealth
- County Health Rankings http://www.countyhealthrankings.org/
- Community Commons – http://www.chna.org

- Healthy Communities Institute (http://www.healthycommunitiesinstitute.com/)
- Hospital data – service utilization and epidemiology of common diseases
- Qualitative data – individual interviews, focus groups, and town hall meetings with community members and other community stakeholders

Conclusions and Recommendations

The first round of work indicates that hospitals have significant opportunities for leveraging their CHNA and related implementation strategies work for improved population health. Denise Koo at the CDC suggests that there are, generally, three groups of hospitals in the journey towards hospital engagement and action in population health improvement. The first group are the early adopters, who understand the issues and are already working with the community on interventions with community-wide impact. They will continue to do more in this space. The second group see systems from the first group that are doing well and recognize the importance of this newer approach. Many, however, continue to conflate population health and population management. They are concerned that transitioning from fee-for-service to new approaches is risky, but are open to change and can be brought along using examples of hospitals that have done this well and have seen positive results. This is likely the group that is most primed for intervention. The third group of hospitals are not even considering these changes, perhaps because they do not recognize the connection with the move from volume to value. Given their current position, they are not yet the primary target of intervention efforts.

This paper provides some practical guidance on steps hospitals can take to improve this linkage and develop collaborations with like-minded community organizations to make a meaningful impact on reducing health inequities and improving the health of the communities they serve. While starting with work on access and clinical care is reasonable, we want hospitals to move towards tackling broader population health issues in the near future. The CHNA regulation is an opportunity to coordinate currently uncoordinated assessment activity within a community to help communities across the U.S. deal with the cost and health equity issues that are plaguing them. Given IHI's visibility with both hospitals and population health/Triple Aim work, IHI has an opportunity to help catalyze work with hospitals and communities to get the process moving in the right direction and to accelerate those that are already on their way. This is also a practical opportunity to encourage health care organizations to be more involved in working on health equity.

As a first step, we recommend a multi-part web series or seminar with the following core topics:

1. Building will within hospital(s) and the community.
2. Conducting a CHNA that effectively captures the community most pressing health needs as well as community assets.
3. Increasing collaboration on community health assessments and implementation plans between multiple hospitals, public health departments, and community organizations.
4. Moving beyond identification of needs to prioritize and select population health needs that will be the focus of the implementation strategy.

5. Better linking CHNAs to the allocation of community benefit resources to address population health needs.

6. Measuring impact with a mixed methods approach and a shared data system.

We suggest the following individuals as potential faculty for the program:

- Kevin Barnett, Public Health Institute (proposed lead faculty)
- Mike Stoto, Georgetown University
- Heather Gates and/or Janice Lato, WNC Health Network

Because this work has the potential to catalyze community collaboration we may want to explore working with a collaboration of communities to build our knowledge further on this topic.

Appendix 1: Distribution of Community-Benefit Expenditures among Benefit Types (from Young et al. 2013)

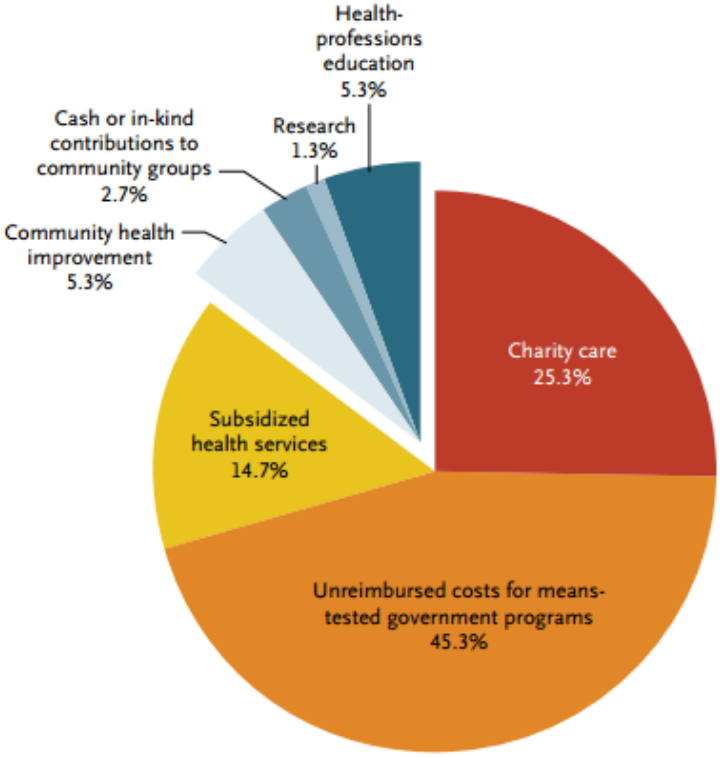

Figure 1. Distribution of Community-Benefit Expenditures among Benefit Types.
Community benefits consisting of direct patient care include charity care, unreimbursed costs for means-tested government programs, and subsidized health services. Community benefits consisting of community services include community health improvement, cash and in-kind contributions to community groups, research, and health-professions education. Values shown are means and represent percentages of the total amount spent on community benefits.

Appendix 2: AHA's Leadership Toolkit – Common Themes and Recommendations when Engaging Communities

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LEADERSHIP TOOLKIT

Common Themes and Recommendations When Engaging Communities:

- Collaborate through building trust and engagement among all stakeholders
- Start locally when considering transformation
- Envision a future when care looks different than today
- Engage in broad-based dialogue
- Drive policy changes that support collaboration
- Provide frequent and ongoing communication
- Use community health needs assessments as a critical planning tool
- Consider a holistic approach to health care

Current High-Performance Governance Practices:

- Define a clear mission and vision for a transformed enterprise
- Create an environment of trust
- Establish a foundation of effective communication
- Build a board-CEO co-leadership partnership

New Bold Steps to Equip Boards for Transformation Work:

- Develop trustees for the future
- Ensure the right governance dialogue
- Commit to continuous trustee education and knowledge building
- Have courage to make the difficult decisions

Appendix 3: Minimum Compliance vs. Commitment to Transformation Approach (from PHI, 2014)

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Table 1: Compliance and Transformation[17]

Actions by Tax-Exempt Hospitals in Community Health Improvement that Reflect a "Minimum Compliance" Approach Versus a "Commitment to Transformation"

Minimum Compliance	*Commitment to Transformation*
Shared Ownership	
Co-finance consultant to conduct CHNA Hold meetings to discuss design Return to hospital to set internal priorities	Ongoing stakeholder engagement to build common vision & shared commitments Set shared priorities & take coordinated action
Diverse Community Engagement	
Solicit input through surveys, focus groups, town halls on health care needs Meet with local or state PH officials	Engage diverse community stakeholders as ongoing partners with shared accountability ID shared priorities for community health
Broad Definition of Community	
Define community as hospital service area Identify underserved pops in service area Design programs at service area level	ID concentrations of health inequities in region that includes hospital service area Select geo focus where needs are greatest
Maximum Transparency	
Post CHNA report on hospital website Attach Implementation Strategy (IS) to Schedule H submittal or post on website	Post CHNA & IS in multiple settings ID defined roles for diverse community stakeholders in specific projects
Innovative & Evidence-Informed Investments	
Describe how hospital will address priority unmet needs	Survey practices to ID strategies with evidence of effectiveness or that offer promise Establish shared metrics to document outcomes
Incorporate Continuous Improvement	
No action required	ID and monitor indicators that validate progress towards outcomes Adjust strategies based upon emerging findings
Pooling and Sharing of Data	
No action required	Share utilization data across hospitals, local health departments, and community health centers to assess total cost of care Proactive identification and monitoring of institutional return on investment & community level social return on investment[18]

[17] Seven categories adapted from Rosenbaum, S., and Byrnes, M. "The Affordable Care Act's Community Health Needs Assessment Reforms: Guiding Principles for Successful Community Health Improvement, George Washington University, online resource, August 11, 2012.

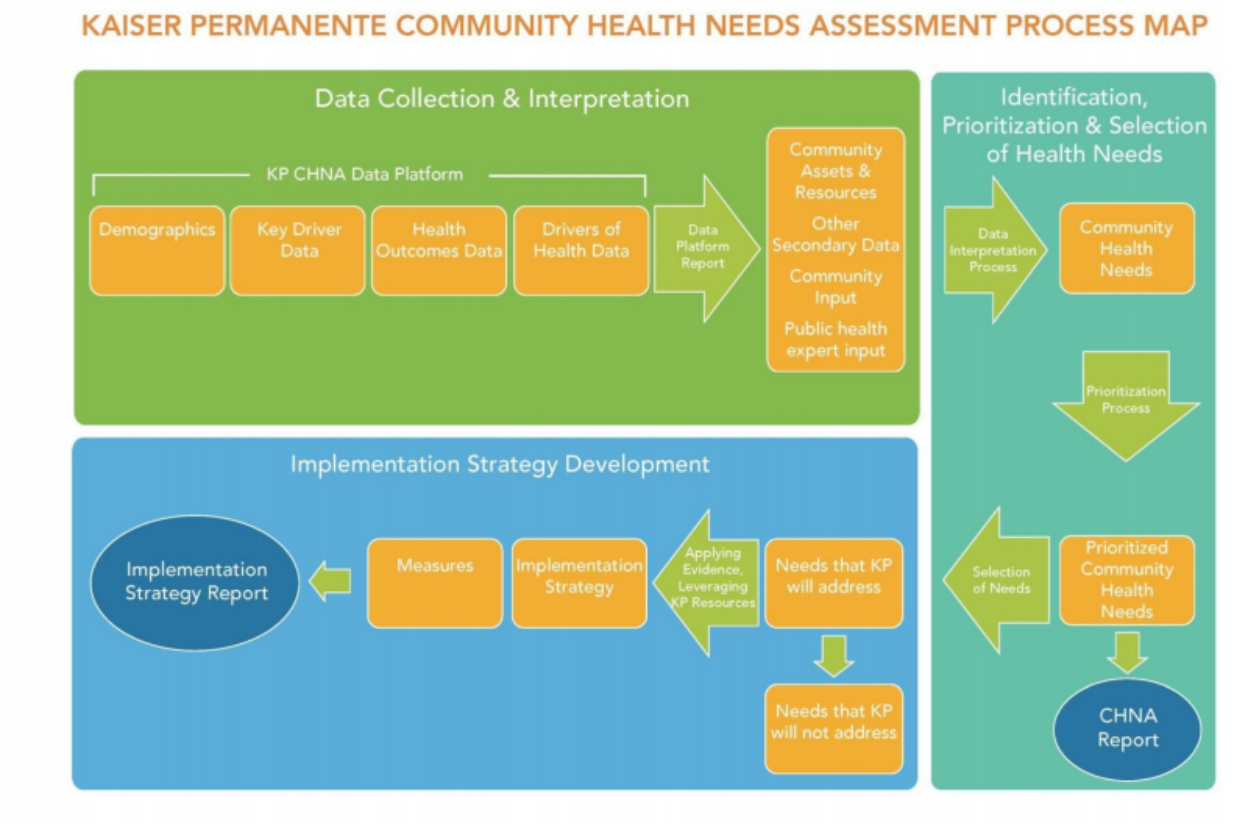
Appendix 4: Strategic Considerations for Hospitals and Health Systems to Support a Culture of Health (HRET, 2014)

Table 3: Strategic Considerations – Hospital and Health Care System Characteristics

Mission Alignment
To what degree are your organization's mission, vision and values aligned with community and population health?
Does your strategic plan incorporate goals to improve community health?
Does the culture of your organization support a culture of health in your community?
Leadership Engagement
To what degree is your board of trustees committed to population health as an institutional priority?
To what extent are your CEO and senior management team passionate about population health? Do they make commitments of time, resources and/or money?
Do you have an organizational champion(s) who is assigned to lead population health initiatives (e.g., chief population health officer, leader who has significant time dedicated to population health initiatives)?
Resource Commitment
What resources can your organization commit to support culture of health initiatives (e.g., financial, time, facility space, staff, information technology, in-kind or other resources)?
Core Competencies
Does your organization have staff expertise and internal capacity to support population health initiatives?
Does your organization provide continuing staff education and skill building on population health?
What expertise and competencies can your organization contribute toward building a culture of health in your community?
Financial and Care Delivery Model Alignment
To what degree do your financial and care delivery models align with population health? For example, does your organization participate in financial reimbursement or care delivery models that support population health (e.g., accountable care organizations, patient-centered medical homes, value-based payments such as bundled payments or capitation)?
How can you make a business case for engaging in culture of health initiatives?
Are other funding sources available to support culture of health initiatives (e.g., community benefit, revenue tithing, grant funding)?
Are your clinicians committed to care delivery practices that promote population health across the continuum of care (including prevention and wellness)?
Community Influence
What is your organization's level of influence in the community (e.g., size, market share, brand strength, reputation)?

Source: HRET, 2014.

Appendix 5: KP Community Health Needs Assessment Process Map



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