

ENGAGING PATIENTS AND COMMUNITIES IN THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS



ACKNOWLEDGMENTS

This guide was developed by the Health Research & Educational Trust, with funding from the Patient-Centered Outcomes Research Institute.

Suggested Citation: Health Research & Educational Trust. (2016, June). *Engaging patients and communities in the community health needs assessment process*. Chicago, IL: Health Research & Educational Trust. Accessed at www.hpoe.org

Accessible at: www.hpoe.org/engagingCHNA

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EXECUTIVE SUMMARY

Nonprofit hospitals across the nation are required to complete community health needs assessments (CHNAs) every three years. CHNAs involve identifying the health needs of the hospital's community and creating strategies to address the prioritized needs. Developers of CHNAs are required to engage the community in this process, for example, by sending out surveys or interviewing key community stakeholders to identify the most important health concerns.

The Health Research & Educational Trust (HRET) of the American Hospital Association (AHA) proposes a new process that involves engaging community members and patients throughout each step of the CHNA process (see Figure 1). By engaging patients and community members throughout the process, CHNA developers obtain valuable insights that otherwise could be missed, get increased community buy-in, and can develop and implement more effective programs to improve community health.

FIGURE 1: COMMUNITY HEALTH ASSESSMENT AND IMPLEMENTATION PATHWAY



Source: HRET, 2016.

PROJECT OVERVIEW

This project is supported through funding by the Patient-Centered Outcomes Research Institute (PCORI). PCORI is an independent, nonprofit organization authorized by Congress in 2010 to fund comparative effectiveness research that will provide patients, their caregivers and clinicians with the evidence needed to make better-informed health and health care decisions.

As part of this project, a diverse range of stakeholders were recruited, including patient and family advocates, applied-communication theorists and those from hospitals and hospital associations. In total, HRET conducted seven focus groups, two panel discussions and 17 interviews, comprising 65 individuals in total. HRET also developed two modules that were pilot tested by representatives from nine hospitals and health systems. Participants provided HRET with robust and insightful ideas regarding patient engagement in CHNAs and community health improvement plans (CHIPs) and how to better integrate research into the CHNA/CHIP process.

Hospitals and health care systems can also make the health improvement strategies of their CHNAs more effective by embedding [patient-centered outcomes research](#) (PCOR), and comparative-effectiveness research more broadly, in their processes. Per the PCORI website, PCOR “considers patients’ needs and preferences and focuses on outcomes most important to them. PCOR findings can help patients and other health care stakeholders, such as caregivers, clinicians, insurers, policymakers and others, make better-informed decisions about their health and health care options.” PCOR can inform the CHNA process by providing evidence-based guidelines for interventions aligned with those identified in CHNAs. Including patient and community stakeholder perspectives in the research process can better position hospitals to address potential barriers to implementation and lead to strategies to achieve desired health outcomes. Additional information on how CHNA developers can embed PCOR into the creation of their CHNAs, including relevant PCORI research findings, can be found in the upcoming HRET guide, *Integrating Research into the CHNA Process*.

BACKGROUND

Community health needs assessments (CHNAs) have the potential to be powerful drivers to enhance the health of communities. Thousands of hospitals across the United States complete a CHNA process every three years. This process includes reviewing quantitative data on community health status, soliciting input from community stakeholders, selecting priority community health needs and devising strategies to address the identified priority needs. The American Hospital Association's review of the Internal Revenue Service's final rules for CHNAs and implementation strategies can be found in Appendix A.

The CHNA process – from assessment through implementation and evaluation – can catalyze hospitals and their focus on illness prevention and the social determinants of health so they can foster community wellness and also provide medical services better tailored to their particular populations. Viewing the CHNA as an ongoing improvement process can make hospitals and health systems more community oriented and help ingrain community health improvement into the hospital's mission and operations. This approach to health and health care is becoming increasingly central as the health care field moves toward a paradigm focused on population health that financially rewards hospitals for preventing illness.

Many resources have been developed over the past decade to support the CHNA process, including approaches to data analytics, county and regional-level health-status data, and evidence-based interventions aligned with CHNA-identified priorities. (Links to relevant resources can be found in Appendix B). With each CHNA cycle, hospitals and health systems are becoming more sophisticated with their approach, and many are going beyond the required elements of the assessment. To elevate the impact of the CHNA both in the hospital and in the community, hospitals increasingly are recognizing the importance of engaging community members and patients in their processes.

COMMUNITY AND PATIENT ENGAGEMENT IN CHNAs

Hospital Benefits from Engaging Patients and Communities

- » Clearer understanding of the community that the hospital is part of, including social determinants of health, specific health issues and root causes of those health issues, and the availability of resources to address them.
- » Strengthened bonds between community and hospital, leading to increased community collaborations around priority issues.
- » Greater community buy-in and a sense of shared ownership of and commitment to community health.
- » Relationships with organizations or individuals who are community assets; these assets can be leveraged during implementation, which will further community involvement throughout the CHNA process.
- » Fostering healthier communities where individuals have access to preventive care and seek care at the appropriate level, potentially leading to lower costs for the hospital.

Community and Patient Benefits from CHNA Involvement

- » A different perspective of their community.
- » Improved communication between community and hospital, contributing to increased collaboration, mutual respect and understanding.
- » Sense of shared ownership and commitment to the CHNA process, providing impetus and motivation to be invested in the health of the community and stay involved in the process and any subsequent community coalitions or collaborative improvement efforts.
- » Ability to apply knowledge and experiences to improve the health of the community.
- » Feelings of respect, involvement and investment in the success of the CHNA process and ready to collaborate in the future.

COMMUNITY AND PATIENT ENGAGEMENT – DEFINING TERMS

It is important to establish a common language to use in this report’s discussion of the CHNA process. Key terms are defined as follows:

Community health needs assessment (CHNA): A systematic process involving the community to identify and analyze community health needs and assets, prioritize the needs, and implement a plan to address significant unmet community health needs.¹

Implementation strategy: The hospital’s plan for addressing community health, including significant health needs identified in the CHNA.²

Community member: Any resident of a community, including an individual at an organization within the community that hospitals can partner with to address community health.

Patient: An individual who has received any sort of health care. Generally, patients are a large subset of the “community member” group. Some individuals use health care services much more than others and have unique and valuable perspectives on health care and community health.

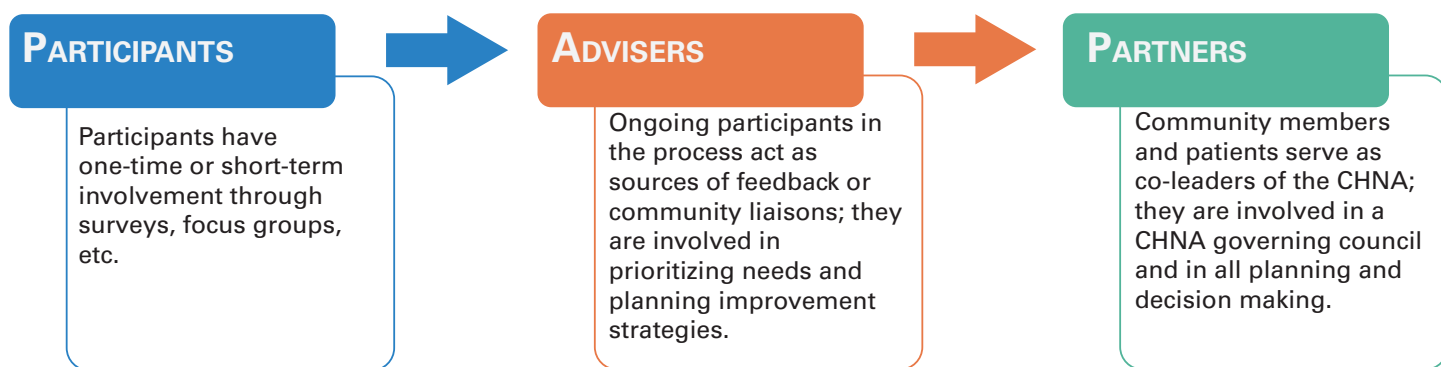
Engagement: The process by which individuals from the community or patient population participate in ongoing relationships with individuals from the health care system to benefit their shared community. When individuals are engaged, they work together to decide which outcomes to pursue and why and how to pursue them. This approach creates a sense of self-efficacy, shared decision making and shared health management for those involved.

Making community and patient engagement a central component of the CHNA process can be mutually beneficial to hospitals and communities alike.

There is not a one-size-fits-all approach to community and patient engagement; the scope of engagement depends on a variety of hospital and community factors and preferences. The spectrum of roles that community members and patients can play in the CHNA process is described in Figure 2.

^{1,2}Catholic Health Association of the United States. (2015). Assessing and addressing community health needs.

FIGURE 2: COMMUNITY AND PATIENT ENGAGEMENT SPECTRUM



Source: HRET, 2016.

While all of these approaches will meet the requirements for the CHNA, emphasizing more robust partnerships with ongoing community and patient engagement as a key component can enhance the quality of the CHNA process. Engaging communities and patients at an advanced level requires a concerted effort to activate and sustain their engagement. Fostering a sense of joint ownership of the assessment – thereby making the community a part of the process rather than the subject of it – will improve the chances that the CHNA will achieve its desired impact, which in turn paves the road toward building a healthier community.

While only nonprofit hospitals are required to complete CHNAs, it is noteworthy that other types of hospitals (e.g., for-profit, those associated with the Department of Veterans Affairs or the Indian Health Service) recognize the strategic benefits of completing the CHNA process and choose to create CHNAs. Similarly, many nonprofit hospitals voluntarily completed CHNAs many years before the Affordable Care Act required them to do so.

COMMUNITY HEALTH ASSESSMENT AND IMPLEMENTATION PATHWAY

The Health Research & Educational Trust (HRET) developed a pathway that supports a robust approach to engaging the community and patients throughout the CHNA process. The pathway's steps are based on the Association for Community Health Improvement's (ACHI) Community Health Assessment Toolkit. Though the toolkit provides a comprehensive approach for all steps on the pathway, this guide will focus on integrating community and patient engagement as a key component of each step.

To inform this guide, HRET conducted a series of interviews, focus groups and pilot tests with CHNA developers, hospital executives, national experts and patient advocates from across the United States. Feedback and input from all of the individuals have been incorporated into our approach. A full description of the research methods can be found in Appendix C.

The Community Health Assessment and Implementation Pathway (Figure 3) represents an eight-step approach to guide the CHNA journey. Community members and patients can be engaged at every step along the pathway. Appendix D contains a handout that can be shared with patients, patients' families and community members to introduce them to CHNAs and encourage their involvement throughout the process.

Community health improvement is an ongoing process. While the formal CHNA occurs at least every three years, implementing strategies around identified needs, evaluating progress, refining the approach and engaging the community should be continuously sustained. Operationalizing the CHNA as an ongoing improvement process will help ingrain community health improvement into the operations of a hospital or health system.

FIGURE 3: COMMUNITY HEALTH ASSESSMENT AND IMPLEMENTATION PATHWAY



Source: HRET, 2016.

The following descriptions of each step will provide guidance and tips for integrating community and patient engagement throughout the CHNA process.

STEP 1: IDENTIFY AND ENGAGE STAKEHOLDERS

Engage with community members, patients and stakeholder organizations early and often. Hospitals can make a stronger impact by working together and coordinating their approaches to support a shared goal – in this case, a healthier community or reduced health care disparities. Establishing these relationships early in the CHNA process fosters an environment that welcomes and engages community stakeholders, creating a stronger sense of joint ownership of the process.

“I wanted to get involved [in the CHNA] because I have an extremely large family and because of personal issues—health issues within my family that I felt the community needed to address—and I was on several other committees with the hospital that I work with. [The hospital] asked me would I participate, and I jumped at the chance because I felt that it gave me an opportunity to express myself on certain things such as obesity, which I felt was one of the main issues, not just within my family but within the community in general.”
 – Patient and Family Advisory Council member

Nonprofit hospitals are not the only organizations that are required to assess the health needs of their communities. Other organizations required to conduct a needs assessment include, but are not limited to, public health departments, social service organizations and United Way. Due to these complementary requirements, collaboration is mutually beneficial.

Writing Collaborative CHNAs with Other Hospitals or Public Health Departments

Hospitals can choose to partner with other hospitals, public health departments or community stakeholders to conduct a joint assessment. (See Appendix A for information regarding final regulations around joint CHNAs.) Conducting a collaborative CHNA has many advantages:

- » Financial – Share the cost of conducting the CHNA.
- » Information sharing – Leverage the expertise from individuals at each organization.
- » Resource sharing – Utilize resources (monetary, in kind, staff, etc.) for assessment and implementation.
- » Data – Align data from electronic health records to provide information on health care usage and health status (see Appendix E). Public health department data repositories are a useful source for population-level data.
- » Relationship building – Strengthen relationships between participating organizations.
- » Aligned implementation strategies – Coordinate implementation strategies to achieve maximum impact on overall population health.

The health of the community is of great interest to many sectors in a society. Individuals from nonhealth sectors also may have insights into the needs and behaviors of certain populations or want to participate in improvement strategies or both. Table 1 suggests potential stakeholders from a variety of sectors. While all of these examples may not be relevant to all communities, it is worth considering how each constituency is tied to health and if they could play a role in the CHNA process. These individuals and organizations can become involved at any point along the CHNA pathway – as collaborators, key informants for interviews or partners in implementing strategies.

Community stakeholders vary widely by community, and this is not an exhaustive list of potential partners. Mapping out community assets early in the process can illuminate unexpected stakeholders or partners to engage in the CHNA process. Appendix F features an asset-mapping template to guide how a hospital could think through the resources available in the community and within the hospital at the individual, group and organizational levels.

TABLE 1. COMMUNITY SECTORS TO CONSIDER FOR PARTNERSHIP IN THE CHNA PROCESS

Sector	Examples of individuals and organizations
Agriculture/Food Suppliers	Farmers (small farms and industrial), food service providers
Employers/Unions	Self-employed individuals, small businesses, corporations, unions
Culture/Arts	Theaters, orchestras, museums, galleries, consumers and supporters of the arts
Education	Public and private K-12 schools, preschools/early childhood education, colleges and universities, boards of education, English as a second language programs, teachers, school administrators, parent/teacher associations, home school organizations, charter schools
Environment	Environmental advocacy organizations, conservation land trusts, environmentalists, hunters/fishers, biologists
Government	Regional, provincial, state and local governments; tribal governing bodies; governmental agencies; elected officials; public health agencies; fire departments
Health Care	Patients, medical and mental health professionals, hospitals and health systems, community clinics/FQHCs, nontraditional health practitioners, health insurance companies, patient and family advisory councils, retail clinics, ambulance/paramedics
Housing and Development	Public and private nonprofit housing agencies, public housing, organizations that provide rent subsidies or affordable housing, developers, fair-housing advocates, transportation companies
Human Services	Nonprofit organizations that provide services such as job training, food, shelter, elder services, services for individuals with disabilities, advocacy for immigrants, etc.
Law Enforcement	Local and state police, court system (judges, probation officers, prosecutors, defense lawyers, etc.), prisons and jails
Media	Newspapers, magazines, radio, TV, social media, blogs, online news magazines, non-English media outlets
Religion	Places of worship or spiritual communities and their members
Service/Fraternal Organizations	Lions, Masons, Rotary, Kiwanis, United Way, fraternities and sororities
Sports and Recreation	Sports clubs, park and recreation departments, athletic associations, YMCAs, gyms, spectators and supporters
Volunteers and Activists	Political activists, neighborhood associations, coalitions
Vulnerable Populations	Economically disadvantaged individuals, homeless persons, veterans, immigrants, refugees, prisoners, elderly, physically and developmentally challenged individuals, pregnant women and children living in poverty
Youth	Individuals under 18 and the organizations that work with them (e.g., Big Brothers Big Sisters, Boys & Girls Clubs)

Source: HRET, 2016.

Engaging Stakeholders Inside Hospital Walls

Increasing engagement in the CHNA process within the hospital can encourage the integration of prioritized community health needs into operations. Staff involvement from outside the CHNA team could improve coordination of consistent messaging in health education materials from clinicians and from a community health program implemented by the CHNA process. Consider engaging clinicians, particularly from the primary care setting, or specialty clinicians whose focus aligns with community health needs (e.g., behavioral health professionals, nutritionists). Hospital administrators, C-suite executives and governing boards are essential partners in the CHNA process and outcomes to ensure that the needs identified in the CHNA become an organizational priority.

Patients and their family members also are key stakeholders in the CHNA process. Though they may be considered community members, their experiences in the health care system give them a different perspective on the community's health needs. Individuals involved in patient and family advisory councils (PFACs) are already engaged with the hospital and may be enthusiastic about contributing to the CHNA process. A handout with information on how to involve patients, families and community members in the CHNA process can be found in Appendix D.

Engaging stakeholders should be a deliberate process. Participants should define their roles and responsibilities and agree upon expectations for involvement. As hospitals begin developing relationships for the CHNA process, they should consider:

- » What role might various stakeholders want to play?
- » Do the stakeholders identified reflect the diversity of the population served?
- » Is this a new or existing partner? How will the hospital's approach differ for new and existing partners?
- » Are there any prior interactions with that stakeholder? What was the nature of the relationship?
- » What do the identified stakeholders know about the CHNA, and why would the CHNA be valuable for them?
- » How can the hospital and other stakeholders build trust between them? Among the stakeholders? How does the hospital foster unity to create a cohesive team?
- » What power imbalances might affect how the stakeholder relates to the hospital? What can be done to alleviate those issues?
- » What stakeholders can be involved in the next CHNA that were not engaged in the past?
- » Is there a shared understanding of vocabulary among the stakeholders? How can all stakeholders foster a shared lexicon?

Community and patient stakeholders interested in getting involved in a CHNA should be encouraged to go through a similar thought process to clarify their preferred role in the CHNA process. Questions for stakeholders to consider include:

- » What role do we want to play? Participant in a focus group or interview? Adviser throughout the process? Leadership role?
- » What is our interest in health? What are our motives for getting involved? What do we want to get out of an assessment?

- » What makes our perspective unique? Are there particular populations that we have advanced insight into? What makes our perspective representative of the community? What are our areas of expertise? What skills and expertise complement those of the other participants?
- » What are challenges to full engagement? Personal? Political? Monetary? Time? What steps can the hospital take to alleviate those barriers?

Ensuring shared understanding of CHNA goals and expectations will facilitate the collaborations.

STEP 2: DEFINE THE COMMUNITY

Defining the community is a key component of the CHNA process as it determines the scope of the assessment and intervention. While most hospitals have a predefined service area, including community members and patients in the conversation will help ensure an inclusive definition of the community.

As part of defining the community, potential questions to discuss with community members and patients include:

- » Describe the community. What population does the hospital serve?
- » Who are the most vulnerable members of the community? Are there community members who are being overlooked?
- » Who would be most affected by community health improvement plans? Are these people the ones who are most in need?
- » Are there any geographic areas in the region that are not covered by a hospital's defined community? How are the health needs of those geographic areas being accounted for and who is doing it?

Collecting and analyzing data on race, ethnicity, language preference, income, disability status, veteran status, sexual orientation, gender or gender identification, etc. will help hospitals better understand their population. It also may be helpful to see how other organizations, such as the local public health department, define the community.

STEP 3: COLLECT AND ANALYZE DATA

The CHNA process involves aggregating primary and secondary qualitative and quantitative data to guide the selection of priority community health needs. While easily accessible quantitative data on community health status can be gleaned from existing population-level reports, this information may elicit follow-up questions and require a deeper dive into the data. This is an opportune time to engage patients and community stakeholders to offer their perspectives to the quantitative findings.

Community- and patient-focused data collection is not merely doing research on people but doing research with them. This approach is known as community-based participatory research (CBPR). The [University of Wisconsin](#) defines CBPR as a “collaborative approach to research that equitably involves all partners in the research process and recognizes the unique strengths that each brings.” The data collection approach should strive to engage and give voice to community members and patients, with a particular focus on vulnerable populations. Community involvement in data collection and interpretation is also an excellent platform to engage community members and patients in an adviser capacity.

Hospitals can gather insights from patients and community members through multiple methods, including surveys, interviews, focus groups and community or town meetings. Suggestions for encouraging community and patient engagement in the CHNA process can be found in Appendix G.

Asking community stakeholders to share the information that they have access to – and care about – is an important part of data collection. In many cases, hospitals and health care systems may not otherwise have access to or knowledge of these data. For example, advocates for the homeless may know the numbers of homeless individuals in their communities and the availability at shelters, or schools may have data on enrollment trends and truancy.

"I felt like we got as involved as possible...We met all the time. [The hospital] really liked our input. They included us in the write-up with our examples. We were part of the focus groups or the town hall meetings, whatever you want to call them. They wanted us to be as involved as we wanted be."

- Community-based CHNA participant

As hospitals and health systems embark on data collection, there are some potential issues to consider:

Measuring social determinants of health. To develop an accurate picture of the community, data on the social determinants of health should be collected and taken into consideration when prioritizing needs. CHNAs may take into account not only health care but also illness prevention and the social, behavioral and environmental factors that affect health. Such social determinants include, but are not limited to, poverty level, educational attainment, access to grocery stores, access to educational and economic opportunities, crime, safe housing and health literacy. For a comprehensive list of social determinants of health and their indicators, visit [Healthy People 2020](#).

Detecting subpopulation disparities. Aggregate data about a population can obscure subpopulation differences. For instance, a community could have a low rate of diabetes across the entire population but an elevated rate within a specific population or geographic area. Stratifying data can potentially identify differences in health status and point to opportunities to engage individuals from those communities during primary data collection. EHRs are a useful resource for tracking and stratifying quality measures (i.e., readmissions) by race, ethnicity and language preference data, as well as other sociodemographic variables (i.e., income, disability status, veteran status, sexual orientation and gender). Additional suggestions for utilizing EHRs can be found in Appendix E. The [Community Commons Vulnerable Populations Footprint tool](#) and the Indicator Report are additional resources to help determine disparities by subpopulations within the community.

Reaching vulnerable populations. Some segments of a population, such as individuals who lack a stable address or who do not speak English, may not be well represented in existing data. These populations may have the greatest health needs; the hospital should make a specific effort to engage individuals from those populations in the CHNA process. Consider where these populations may congregate (e.g., churches, community centers, grocery stores) and perform targeted outreach in these locations. Providing surveys on paper and in multiple languages is a strategy to reach individuals who may not have access to or knowledge of computers.

Qualitative and quantitative data both count. While quantitative data can provide concrete evidence of health needs, qualitative data can add depth and a nuanced understanding of an issue. Both types of data are incredibly valuable as a hospital assesses and prioritizes needs and makes improvement plans. Working with community members and patients to collect qualitative data during interviews and focus groups also may stimulate a desire for augmented involvement in other aspects of the process. Key questions to consider including in any qualitative-data collection process are:

- » What are the top health needs in the community?
- » What resources are available or seem unavailable to address those needs?
- » What challenges to living a healthy life are in the community?

Cultural sensitivity. Being culturally sensitive to the needs, norms and values of the community, including recruiting culturally and linguistically appropriate individuals, is essential for comprehensive community engagement. It is important to remember that one person from a certain cultural group does not represent the views of the entire group.

STEP 4: SELECT PRIORITY COMMUNITY HEALTH ISSUES

The quantitative and qualitative data collected and analyzed in step 3 are the basis for prioritizing community health needs. Hospitals can use various criteria to prioritize community health issues. Hospitals can consider the burden, scope, severity or urgency of a community health need; the health disparities associated with the need; the importance that the community places on the need; and the potential assets that can be leveraged to improve health needs. Quantitative data can illuminate burden, scope and severity; the sense of urgency and the importance placed on particular health issues can be gathered from engaging stakeholders from the community and health system.

Hospitals and health care systems can solicit input on priority community health issues at various steps of the CHNA process. Data can be shared during a prioritization discussion so that community members and patients will have a comprehensive perspective around the scope of the issues. To gain insight about community perceptions of health priorities, hospitals can use surveys, focus groups, stakeholder interviews and community or town meetings (see Appendix G).

It is important to make the prioritization process as inclusive as possible to foster a sense of ownership. Including hospital administrative staff, clinicians, community members and patients in the group making final decisions about which health issues to prioritize will help them feel more invested in the outcome. Using the asset-mapping exercise will help ensure the hospital hears from all of the primary stakeholders (see Appendix F).

As part of selecting priority health issues, potential questions to ask community members and patients include:

- » What are the three to five most important needs for our community?
- » Why are these needs the most important?
- » What factors may contribute to these community needs (e.g., housing, transportation, poverty, disease burden)?
- » What resources already exist to address the identified community needs?
- » What resources are still needed to address the identified community needs?
- » Are any of the identified community needs already being addressed?

Be sure to document the prioritization process so that it is transparent, including what factors were considered most important and how the decisions were made. Consider sharing the final prioritized health issues with all participants before making them publicly available. This is a prime opportunity to reconnect with participants and ask if they would like to be involved in any future stages of the CHNA process.

STEP 5: DOCUMENT AND COMMUNICATE RESULTS

The results of the CHNA must be publicly released to the community at large. (For more information on guidelines around communication, see Appendix A). This could be done on the hospital's or health system's website and through a variety of media outlets. While the primary target audience may be individuals working in health care, the report also should be accessible and proactively disseminated to the community at large.

Preparing the CHNA results for community consumption is a prime opportunity to engage the community and patient stakeholders. Sharing CHNA drafts with stakeholders before the report is finalized will give them a chance to comment and provide additional feedback. Stakeholders also can provide valuable insights about how to present the information (e.g., length of document, language level, acronym use, font size, balance, and use of pictures vs. words), what format to use (e.g., written, audio), if the document needs to be translated into another language and which forms of communication would best reach the community.

Encourage community members and patients who were involved in the CHNA process to serve as community ambassadors to spread the word about the outcomes of the assessment. As part of documenting and communicating results, potential questions to ask community members and patients include:

- » How would populations in the community served by the hospital prefer to have this information presented?
- » How can the hospital make the information accessible to the community? Does the information need to be customized for different populations? Does the information need to be translated to another language? Would an audio version be useful?
- » Is there a preferred length of the document that would encourage community members to read it?
- » How would the community prefer to learn about the information collected (e.g., social media, newsletters, radio, TV, print advertisements)?

STEP 6: PLAN IMPROVEMENT STRATEGIES

The improvement strategy developed to address the identified community health issues will put the CHNA into action. Ample resources are available to direct communities toward evidence-based strategies around their health needs. A few examples:

- » CDC Community Guide - <http://www.thecommunityguide.org/>
- » CDC Community Health Improvement Navigator - <http://www.cdc.gov/chinav/>
- » Community Toolbox - <http://ctb.ku.edu>
- » County Health Rankings and Roadmaps - <http://www.countyhealthrankings.org/>
- » Patient-Centered Outcomes Research Institute - <http://www.pcori.org/research-results/pcori-literature>

- » Practical Playbook - <https://www.practicalplaybook.org/>

Additional resources can be found in Appendix B.

It is important to keep community and patient stakeholders involved throughout the implementation planning process. Stakeholders will likely have valuable feedback about the feasibility and acceptability of proposed interventions and strategies in their communities. Also, individuals who are invested in the process and their community will likely value the opportunity to be part of the solution.

As part of planning and implementing community health improvement plans, potential questions to ask community members and patients include:

- » Who should lead the intervention? Should it be administered through the hospital, through a community organization or through a partnership arrangement?
- » What community members and stakeholders are able and willing to support each initiative?
- » What resources (in kind, financial, technological, etc.) can the hospital and community stakeholders contribute? What roles can each organization play?
- » How should success be measured?

STEP 7: IMPLEMENT IMPROVEMENT PLANS

The entire CHNA process leads to implementing improvement plans, and the importance of implementation cannot be overstated. This is where hospitals and their partners have the opportunity to take strategic action to improve community health.

Implementing a community health improvement plan is an ongoing process that requires the involvement and engagement of patients and community stakeholders from multiple sectors. Engaging community members in implementation creates a sense of ownership and shared commitment and fosters ongoing dialogue between the hospital, community organizations and the populations they serve. Sustaining community engagement over a prolonged period of time requires the attention and commitment of all stakeholders, but ultimately this sustained engagement makes the process and outcome more valuable for all those involved.

Community members and patients can be involved in a process to customize the evidence-based interventions identified (see step 6) to meet the unique needs of their community. It is also important to discuss what roles community members and patients want to play going forward, as there can be ample opportunity for ongoing involvement.

STEP 8: EVALUATE PROGRESS

The key to any community health intervention is evaluation. It is important to plan for evaluation from the start. Questions to consider:

- » What are the desired process and outcomes metrics?
- » What tools are available to gather and synthesize information?
- » Who is involved in the evaluation process?
- » What changes do stakeholders hope to see by the next CHNA?

Community members and patients are invaluable to the success of the improvement plans, including the evaluation of the interventions. Community members and patients can be involved in:

- » Determining what outcomes are meaningful to measure
- » Providing feedback on how the implementation is going so adjustments can be made

As part of evaluating progress, potential questions for community members and patients include:

- » How will we know when an intervention has been successful?
- » What measures can we use to evaluate progress and results?
- » How often should we measure progress?
- » How can we share data between stakeholders, both formally and informally? How often should this occur?
- » How can we continue to engage the community?
- » What is the best communication strategy?

CONCLUSION

As U.S. health care moves toward a population health approach, hospitals and health systems are being challenged to think strategically about community health improvement. Hospitals are becoming much more than brick-and-mortar structures that serve acutely ill patients. Hospital and health system leaders recognize that their organizations will be increasingly rewarded for the value they provide and for keeping their patients healthy. Improved medical care alone will not be sufficient; hospitals need to work outside their walls, with their communities and patients, to address the underlying health needs of the community.

Involving community and patient stakeholders throughout the entire CHNA process is mutually beneficial for the hospital and the community served. Community and patient engagement allows hospitals to gain a clearer understanding of their community's health needs and priorities, increase buy-in and a sense of shared responsibility for community health, and establish relationships with organizations and individuals who are community assets. By participating in the CHNA process, community members and patients can gain a more comprehensive understanding of their community, including health issues, the root causes of those health issues and the availability of resources to address them. The CHNA process also can strengthen bonds between the community and hospital as well as enhance community investment in an effective process and a willingness to collaborate in the future.

When conducted in a systematic and community-engaged manner, the CHNA process can serve as a powerful tool to develop community partnerships and implement evidence-based strategic interventions that address priority community health needs. Furthermore, this process – from assessment through implementation and evaluation – can be an important and insightful first step for hospitals and community and patient stakeholders to work as partners to improve the health of their communities.

APPENDIX A: AMERICAN HOSPITAL ASSOCIATION'S REVIEW OF FINAL IRS GUIDELINES FOR CHNAs

COMMUNITY HEALTH NEEDS ASSESSMENT

Section 501(r)(3) requires that every three years a hospital conduct a CHNA that takes into account input from those representing the broad interests of the community served by the hospital, including those with special knowledge or expertise in public health. An implementation strategy must be adopted to meet the identified needs, and the assessment must be made widely available to the public.

DEFINING THE COMMUNITY SERVED

A hospital has flexibility for how it defines the community it serves. The rule adopts a facts and circumstances approach and recognizes that hospitals will vary in the method used to define their communities (e.g., geographic area, target populations, principal function). It expressly acknowledges that, for some hospitals, the community may be defined by a particular area of specialty or a targeted disease. However, the medically underserved, low-income or minority populations who would otherwise be part of the community based on the method chosen may not be excluded.

ASSESSING THE COMMUNITY'S HEALTH NEEDS

A hospital must identify the significant health needs of the community. It also must prioritize those needs and identify resources potentially available to address them. Hospitals have flexibility for determining what is significant and setting priorities. The health needs include what is important to improve or maintain health status in both the community at large and in particular parts (e.g., those experiencing disparities).

INPUT REPRESENTING THE BROAD INTERESTS OF THE COMMUNITY

There are two categories of persons whose input must be taken into account in conducting the assessment: one (nonfederal) governmental public health department (or equivalent), and members of medically underserved, low-income and minority populations, or organizations serving or representing their interests. The hospital has the option to choose which public health department with information relevant to its community to consult. Input regarding the needs of the underserved, low-income or minority populations would include, but is not limited to, financial or other barriers to access care. When conducting a subsequent CHNA, written input received on a hospital's existing CHNA or implementation strategy must be taken into account.

DOCUMENTING THE CHNA

The CHNA report must include:

- » a definition of the community served and a description of how it was determined;
- » a description of the process and methods used to conduct the CHNA;
- » a description of how the hospital took into account input from those representing the broad interests of the community;

- » a prioritized description of the significant health needs, along with a description of the process and criteria used in determining which needs were significant and which were the priorities;
- » a description of potential resources identified to address the significant needs; and
- » an evaluation of the impact of any actions that were taken to address significant needs identified in the immediately preceding CHNA.

In describing the process and methods used to conduct the CHNA, the report should include:

- » a description of the data and other information used (it is sufficient to cite public data relied on);
- » the methods of collecting and analyzing the information; and
- » any parties with whom the hospital collaborated, or with whom it contracted for assistance, in conducting the CHNA.

In describing how input from the community was taken into account, it is sufficient to summarize, in general terms, the input provided, as well as how it was received and over what period of time. For input from organizations representing specific populations, the name of the organization, the nature and extent of the input received, and population represented should be documented. In describing who participated in community meetings or other opportunities to provide input, identifying individuals or including names is not required.

ADOPTING THE CHNA

The CHNA must be adopted by the governing body of the hospital, or a committee or other party authorized by the governing body to act on its behalf (to the extent permitted by state law).

COLLABORATION

Hospitals may collaborate with others in conducting a CHNA, and collaborating hospitals may develop a joint CHNA report if certain conditions are met: the collaborating hospitals must define their community to be the same, the report clearly identifies that it applies to the hospital, and the governing body of each hospital facility adopts the joint report.

MAKING THE CHNA WIDELY AVAILABLE

Use of the internet continues to be a vehicle to meet this requirement as long as a paper copy is also available for public inspection without charge at the hospital facility. A CHNA report must be available on the internet and a hard copy at the facility at least until the date when the hospital's two subsequent CHNAs are made widely available. In addition, to be widely available through the internet, a complete version of the CHNA must be "conspicuously" posted, and an individual must not be required to create an account or provide personally identifiable information in order to access the report.

A CHNA is considered "conducted" when it is made widely available.

IMPLEMENTATION STRATEGIES

CONTENT OF STRATEGY

For every significant health need identified in the CHNA, the hospital must describe how it plans to address the need or note that the need will not be addressed and explain why. For needs that will be addressed, in addition to describing the actions the hospital plans to take, it also must include the anticipated impact, the programs and resources the hospital plans to commit, as well as any planned collaboration with others in addressing the needs. The rule recognizes that not every significant need will be addressed and identifies lack of resources or expertise, relatively low priority, and the need being addressed by others as some of the reasons the hospital's strategy may not address a need.

JOINT STRATEGY

Hospitals that collaborated in developing a joint CHNA report also may develop a joint implementation strategy, if certain requirements are met. The strategy must clearly identify that it applies to each hospital; the hospital's particular role and responsibilities must be clearly identified, including the programs and resources it plans to commit; and a summary or other tool must be included to help the reader easily locate those portions of the strategy that relate to the hospital facility.

ADOPTION

Similar to the CHNA report, the implementation strategy must be adopted by the governing body, or an authorized representative (to the extent permitted by state law). As requested by hospitals, the final rule extends the time period within which the implementation strategy must be adopted. Instead of requiring that the implementation strategy be adopted in the same taxable year in which the CHNA is completed, the final rule allows an additional four-and-a-half months (to match the due date, without extensions, of the hospital's Form 990).

REPORTING ON IRS FORM 990

The hospital's most recently adopted implementation strategy must either be attached to the hospital's Form 990 or the Form must include the address (URL) for a website where the strategy has been located and made widely available. The hospital's Form 990 in subsequent tax years must include an update on implementation of the strategy.

Source: American Hospital Association. 2015. Regulatory Advisory: Final "Section 501(r)" Regulations for Charitable Hospitals." Accessed at: <http://www.aha.org/hospital-members/advocacy-issues/tools-resources/advisory/2015/150122-regulatory-adv.pdf>

APPENDIX B: COMMUNITY HEALTH NEEDS ASSESSMENT RESOURCES

Agency for Healthcare Research and Quality: Health Care Innovations Exchange
<https://innovations.ahrq.gov/>

Catholic Health Association of the United States: Assessing and Addressing Community Health Needs
<https://www.chausa.org/communitybenefit/assessing-and-addressing-community-health-needs>

Center for Health Affairs
<http://www.chanet.org/CommunityInitiatives/Community-Health-Needs-Assessment/CHNA.aspx>

Centers for Disease Control and Prevention: Community Health Assessment and Improvement Planning
<http://www.cdc.gov/stltpublichealth/cha/index.html>

Centers for Disease Control and Prevention: Community Health Improvement Navigator
<http://www.cdc.gov/chinav/>

Centers for Disease Control and Prevention: The Guide to Community Preventive Services
<http://www.thecommunityguide.org/>

Community Commons
<http://www.communitycommons.org/chna/>

Community Toolbox
<http://ctb.ku.edu/en>

County Health Rankings and Roadmaps
<http://www.countyhealthrankings.org/>

Healthy Communities Institute
<http://www.healthycommunitiesinstitute.com/>

National Association of County and City Health Officials: Mobilizing for Action through Planning and Partnerships (MAPP)
<http://www.naccho.org/programs/public-health-infrastructure/mapp>

Patient-Centered Outcomes Research Institute
<http://www.pcori.org/research-results/pcori-literature>

Practical Playbook
<https://www.practicalplaybook.org/>

Professional Research Consultants
<http://www.prccustomresearch.com/services/community-health/chna-resources/>

APPENDIX C: RESEARCH METHODS AND APPROACH

For this project, HRET recruited 1) CHNA developers and experts from hospitals and state hospital associations and 2) advocates for patients and patients' families to participate in one-on-one interviews and focus groups. Interviews were conducted in person and by phone with 14 individuals from 12 hospitals. Four focus groups were conducted by phone with a total of 21 participants. Each focus group was moderated by Martin Hatlie, CEO of Project Patient Care, or Julia Resnick, HRET senior program manager. The semistructured interviews and focus groups explored topics including: how hospitals can recruit community and patient representatives; how these persons can be fully engaged in the CHNA development process; how obstacles to effective engagement can be overcome; and how to leverage the representatives in implementing improvement strategies that the CHNA proposes. All interviews and focus groups were recorded and transcribed.

The interviews and focus groups helped to inform the creation of an educational module. This module presents an approach for integrating patient and community engagement into all aspects of the CHNA process. The goal of the module is to support hospital and health system leaders seeking to strengthen their patient and community stakeholder engagement efforts and guide patient and community advocates so they can function more effectively in their roles. For this module, the project team modified an existing HRET model and made patient and community engagement an explicit component of the entire CHNA cycle.

Representatives from two hospitals, St. Mary Medical Center in California and Carolinas HealthCare System in North Carolina, pilot tested components of the patient and community engagement module. Each organization chose which elements of the module to complete, based on where they were in their CHNA cycle. As part of the module, pilot hospitals completed a baseline survey on their patient and community engagement as well as an asset-mapping exercise (Appendix F) to identify resources that could contribute to creating and implementing their CHNA. Pilot sites also completed an end-of-project debrief by phone with HRET program staff. Recommendations and lessons learned from the interviews, focus groups and engagement-module pilot testing informed the creation of this guidance document, in particular on ways to more extensively engage patients and community members in the CHNA process.

APPENDIX D: HANDOUT FOR PATIENTS, FAMILIES AND COMMUNITY MEMBERS

The following can be shared with patients, their families and community members to introduce them to CHNAs and encourage their involvement throughout the process.

What is a community health needs assessment?

A community health needs assessment (CHNA) is a document that all U.S. tax-exempt hospitals must complete every three years. To create a CHNA, hospitals look at information on the health needs of their community – the town, city or region they serve – and also talk with patients, patients’ families and community members to learn about their needs. The hospital, along with community members, decide which health needs to focus on and together they make improvement plans.

Why should I get involved?

Being part of a CHNA is a great way to help improve the health of your community. As a patient, a family member of a patient and/or a community member, you know the needs and strengths of your community. For example, in your community, if there are only a few grocery stores, people may have a hard time buying healthy foods. Maybe many people are homeless and need a place to live. Or there may be a lot of air pollution in your community. All of these things can make your health worse. Your opinion and advice are important in deciding the health needs of your community and reaching out to people in your neighborhood.

What will my involvement look like?

You can be part of the process as little or as much as you’d like. Think about if you would like to share your thoughts by taking surveys, being interviewed or being part of focus groups and/or community meetings. Would you like to be an adviser or have a leadership role? Would you like to have a part in the entire process or just one (or more) parts of it?

What can the hospital do to improve community health?

Hospitals have many ways to improve the health of the community. Hospitals can make their programs better when they work together with patients, patients’ families and community members. They also can work together with local organizations to meet community needs. For example, organizations like the public health department, schools, food banks and local businesses have volunteers, leaders, money, equipment and space to help start a program to improve community health.

You may know people or organizations that would be interested in working together with a hospital to decide which health needs are important in your community. Let the hospital’s CHNA team know if this is the case.

How can I get involved?

Contact the hospital(s) in your community and ask to talk with those who work on the CHNA. Let them know you would like to take part improving the health of your community.

APPENDIX E: USING ELECTRONIC HEALTH RECORDS FOR CHNAs

While a majority of hospitals have EHRs, relatively few have used them to identify health issues in their CHNAs. These data can be messy and difficult to access. But EHRs have one major advantage: they specifically describe the hospital's patient population. The EHR shows disease morbidities in the patient populations, patient demographics (including race, ethnicity and language) and any disparate disease burdens or outcomes. These patient-focused data provide a unique window into the health needs of community members who have received care at their hospital or health care system.

Table 2 outlines how EHR fields can align with community health priority issues.

TABLE 2. EHR ALIGNMENT WITH CHNA PRIORITY ISSUES

CHNA Priority Issue	EHR Data
Access to health care	Private vs. public vs. uninsured, points of contact with health care system per year
Diabetes	Rate of diabetes, rate of controlled vs. not controlled, stratified by race, ethnicity and language data
Obesity	Rate of obesity, comorbidities with other chronic diseases
Hypertension	Rate of hypertension, rate of controlled vs. not controlled
Behavioral health	Rate of percentage of patients with behavioral health issues, percentage of patients with poorly controlled issues, comorbidity with other chronic diseases
Substance abuse	Percentage of substance abuse admissions, correlations with other health or demographic issues
Cardiovascular disease	Rate of cardiovascular disease, mortality rate
Maternal and reproductive health	Mortality rate, birth defect rates, prenatal care

Accessing the aggregate EHR data will require working with the IT department to see what data they can pull from the data warehouse. Considerations include:

- » Benchmarking patient data against the health indicators in the hospital's service area
- » Aligning key indicators for the CHNA with the fields being collected in the EHR
- » Linking patient records across the continuum of care
- » Tracking emergency department use

Documenting behavioral health issues in the EHR: Are there any correlations with other chronic diseases or populations?

APPENDIX F: ASSET MAPPING

While CHNAs inherently focus on identifying needs, the engagement components and implementation strategy can focus on leveraging community assets. Resources outside of the community are not always available for improvement plans, but resources within the community can be leveraged for projects. Identifying and utilizing assets that are already in the community allow stakeholders to come together to build on their resources, skills and experiences to address identified needs. Community assets are individuals; organizations, such as libraries and schools; places, such as parks; services, such as public transportation; or other resources.

This asset-mapping exercise will help hospitals think through some key questions about the community and hospital itself, including: Who are the formal and informal leaders in the community? What other organizations are contributing to the health of the community? How can those individuals or organizations align to improve community health? It is helpful to consider which stakeholders to partner and work with on the CHNA; improvement efforts are more effective when more people and organizations are dedicated and engaged in the process.

In completing this asset-mapping project, consider assets within the community as well as individuals or departments that exist within the hospital. It may be useful to convene a small group of people who work on the CHNA process to fill out the asset map.

Assets for Community Health Needs Assessments

Individuals

Groups

Organizations

In the community (e.g., activists, business owners, retirees)	In the hospital (e.g., MDs, RNs, patients, CEO, trustees, PFACs)	Community organizations (e.g., local businesses, advocacy organizations, civic groups, faith-based organizations, community development organizations)	Hospital departments (e.g., primary care, community benefit, advocacy, outreach, population health)	In the community (e.g., other hospitals, industries, colleges/universities, law enforcement, parks and recreation, social services, public health departments)
Examples:	Examples:	Examples:	Examples:	Examples:

APPENDIX G: TOOLS TO ENGAGE COMMUNITY MEMBERS AND PATIENTS

ENGAGEMENT APPROACHES

Below are some suggested practices to engage community members and patients in various components of the CHNA process. While surveys, interviews, focus groups and community or town meetings are typically used during the data collection step, hospitals and health systems can engage with the community through these avenues at any time during the CHNA process.

COMMUNITY SURVEYS

Content and format	<ul style="list-style-type: none"> » Assure respondents of confidentiality. » Collect race, ethnicity and language data in a culturally appropriate manner. <ul style="list-style-type: none"> • Consider using a format that complies with census standards » Ensure that survey questions are culturally appropriate and at a literacy level that respondents can understand. <ul style="list-style-type: none"> • Review the survey draft with community members from the populations being questioned to see what needs to be modified. » Consider using or modifying a validated survey instrument or questions. » Assess amount of health care usage. » Allow space for qualitative answers. » Provide the option for respondents to be contacted for further involvement in the CHNA process. This is an easy way to identify individuals who desire increased engagement. » The survey can be online, on paper, or both. Consider using both methods if there are major segments of the community's population who do not have internet access. » Provide versions of the survey in the languages spoken by community members.
Participants	<ul style="list-style-type: none"> » Consider oversampling vulnerable populations since interventions would likely need to be focused on the needs of those groups, understanding that this can skew results toward those needs. » Find innovative ways to distribute the survey – at churches, local businesses, health fairs, etc. » Advertise the survey using social media, newspaper advertisements, etc. » Engage community leaders to increase participation in the survey. If they encourage participation among their networks, it will likely boost the response rate. » Specifically sample the patient population. Can they fill out the survey in a waiting room? At a support group meeting? » Offer incentives, such as a raffle drawing, for those who complete the survey. » Send reminders to those who have received emailed or mailed versions of the survey but have not filled it out.

KEY STAKEHOLDER INTERVIEWS

Participants	<ul style="list-style-type: none"> » Consider whom to interview: <ul style="list-style-type: none"> • Key stakeholders can be from a variety of sectors in the community (see Table 1). • Engage clinicians for interviews as they likely have insights into the health needs of patients in the hospital. Include physicians, nurses, community health workers, etc. • If the hospital’s data show health disparities for certain subgroups, consider engaging individuals from that population. • Secondary data may be sparse in certain topics, such as mental or behavioral health. Consider finding community members who are knowledgeable in these topics to interview. » Find innovative ways to recruit for stakeholder interviews: <ul style="list-style-type: none"> • Ask community leaders if they know and could provide connections to potential participants with the characteristics being targeted. • Engage clinicians in hospitals or any associated medical groups and practices to identify patients for interviews. • Talk to hospitals’ patient and family advisory councils (PFACs). » Encourage interview attendance through reminder notices (by mail, email and/or phone) before the interview. » If possible, offer child care and incentives, such as gas cards, compensation for participants’ time or a raffle drawing.
Location	<ul style="list-style-type: none"> » Make sure the location is easily accessible for stakeholders; consider factors such as proximity to public transportation, availability of parking, time of day, child care, etc. » Hold the interviews in a neutral space (i.e., not the hospital). » Consider holding online or phone interviews to reduce barriers to participation.
Facilitator	<ul style="list-style-type: none"> » Ensure that the interview facilitator is culturally competent and speaks the language(s) spoken by the interviewees. » Use a facilitator who is well trained in moderating interviews, including keeping participants on topic and maintaining a neutral position. » Consider using a facilitator from a neutral third party, so participants feel more comfortable.
Developing interview questions	<ul style="list-style-type: none"> » Develop a list of questions, so the same questions are asked across multiple interviews. <ul style="list-style-type: none"> • Avoid asking yes or no questions. • Ask short and open-ended questions to encourage dialogue on various topics. • Be aware that the interviewer facilitator cannot ask people to identify their health conditions. • Review the list of questions ahead of time with community members who are culturally and linguistically similar to the interview attendees to see if modifications are needed. • If possible, provide the questions to attendees ahead of time.

Conducting the interviews

- » If possible, provide food. Consider allergies and other food restrictions.
- » Establish realistic expectations for what the hospital and partners can do to address community needs.
- » Explain to participants how their input will be used.
- » Establish confidentiality of the participants' responses. Especially in small communities, participants can be worried about their names being attached to their comments.
- » Give participants an estimated timeline of when final results will be shared.
- » Assess whether the individual would like to be involved in future stages of the CHNA and set the process for continued engagement.

*FOCUS GROUPS***Participants**

- » Consider who to sample: a cross-section of the whole community and/or more targeted groups?
- » Contemplate recruiting from existing groups (e.g., PFACs, church groups).
- » Find innovative ways to recruit for focus groups (advertisements on social media, in newspapers, on the radio, at churches, local businesses, etc.).
 - Engage clinicians to identify patients for focus groups.
- » Consider members of the community who may not be easily reached and brainstorm how they can be recruited.
- » Encourage attendance through reminder notices (by mail, email and/or phone).
- » If possible, offer child care and incentives, such as gas cards, compensation for participants' time, or a raffle drawing.
- » Limit focus groups to 10 or fewer participants to ensure that everyone's opinions can be heard.
- » Consider one-on-one interviews instead of focus groups for those in small communities or for patients mindful of confidentiality issues.

Location

- » Make sure the location is easily accessible for community members. Consider factors such as proximity to public transportation, availability of parking, time of day, child care, etc.
- » Hold the focus groups in a neutral space (i.e., not the hospital).
- » Consider holding virtual or phone focus groups to reduce barriers to participation.
- » Focus groups should typically last no longer than 90 minutes.

Facilitator

- » Ensure that the interview facilitator is culturally competent and speaks the language(s) spoken by attendees.
- » Use a facilitator who is well-trained in moderating focus groups, including keeping participants on topic and on a time schedule, making sure that everyone participates and is listened to and maintaining a neutral position at all times.
- » Consider using a facilitator from a neutral third party, so participants feel more comfortable.

Developing focus group questions	<ul style="list-style-type: none"> » Develop a list of questions, so the same questions are asked across multiple focus groups. <ul style="list-style-type: none"> • Avoid asking yes or no questions. • Ask short and open-ended questions to encourage dialogue on various topics. • Be aware that the interview facilitator cannot ask people to identify their health conditions. • Review the draft questions with community members who are culturally and linguistically similar to focus group attendees to see if modifications are needed. • If possible, provide the questions to attendees ahead of time.
Conducting the focus groups	<ul style="list-style-type: none"> » If possible, provide food during focus groups. Consider allergies and other food restrictions. » Establish realistic expectations for what the hospitals and partners can do to address community needs. » Explain to participants how their input will be used. » Establish confidentiality of the participants' responses. Especially in small communities, participants can be concerned about their names being attached to their comments. » Give participants an estimated timeline of when final results will be shared. » Assess whether the individual would like to be involved in future stages of the CHNA and set the process for continued engagement.

COMMUNITY OR TOWN MEETINGS

Participants	<ul style="list-style-type: none"> » Advertise the meetings using social media, newspapers, radio, announcements and flyers, organizations, support groups, PFACs, etc. » If possible, offer child care.
Location	<ul style="list-style-type: none"> » Make sure the location is easily accessible for community members; consider factors such as proximity to public transportation, availability of parking, time of day, child care, etc. » Hold the meetings in a neutral space (i.e., not the hospital). » Consider coordinating the meeting with existing community or town meetings.
Finding a facilitator	<ul style="list-style-type: none"> » Ensure that the facilitator is culturally competent, speaks the languages spoken by community members and is sensitive to attendees' needs. » The facilitator should be well trained in moderating community meetings, including keeping participants on topic and on a time schedule, ensuring that louder voices do not drown out others, and maintaining a neutral position.

Developing an agenda and questions	<ul style="list-style-type: none"> » Develop a draft agenda and questions and, if possible, distribute them to attendees ahead of time » Ask participants open-ended questions to encourage dialogue about various topics. » Review the list of questions ahead of time with community members who are culturally and linguistically similar to attendees to see if modifications are needed.
Meeting Logistics	<ul style="list-style-type: none"> » If possible, provide food. Consider allergies and other food restrictions. » Establish realistic expectations for what the hospital and its partners can do to address community needs. » Explain to participants how their input will be used. » Consider using voting devices (clickers, cell phones apps, etc.) to gain input from more community members, especially those who may not feel comfortable speaking up in a public setting. » Use audiovisual equipment as appropriate. » Tell all participants how their feedback will be used and when results will be shared. » Provide the option for participants to be contacted for further involvement in the CHNA process; this is an easy way to identify individuals who desire increased engagement.