

Making the most of community health planning in Ohio

The role of hospitals and local health departments

Introduction

Community health planning is a collaborative process that engages a variety of partners to identify and implement strategies that address a community's most pressing health needs. The overarching aim of community health planning is to improve the health and wellbeing of community residents.

Recent federal and state policy changes require nonprofit hospitals and local health departments (LHDs) to engage in community health planning activities. Hospitals and LHDs are required to collaborate with organizations within their community to prioritize their community's health needs, and develop plans and implement strategies to address those needs. Under this new policy landscape, hospitals and LHDs can play a critical role in aligning and leveraging community health planning activities across the state to improve the overall health of Ohioans.

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Key community health planning terms

Community health needs assessment (CHNA): an assessment conducted by a hospital every three years to identify and prioritize its community's health needs and identify potential measures and resources available to address its community's prioritized health needs.

Implementation strategy (IS): a plan identifying how a hospital will address the significant health needs identified in the CHNA.

Community health assessment (CHA): a collaborative assessment conducted at least every five years by a LHD to describe the health of the population, identify areas for health improvement, contributing factors that impact health outcomes and community assets and resources that can be mobilized to improve population health.

Community Health Improvement Plan (CHIP): a collaborative plan conducted by a LHD that builds upon the CHA to set priorities, direct the use of resources, and develop and implement projects, programs, and policies to improve the health of the population of the jurisdiction that the LHD serves.

Part One

Community health planning requirements for hospitals, LHDs and other entities

Community health planning requirements for hospitals and LHDs share a common goal: to engage in a collaborative process to prioritize their communities' most significant health needs and implement strategies to address those needs. Both hospitals and LHDs are required to focus on the health needs of the "community," which generally includes the surrounding geographic area served by the hospital or LHD. Specific community health planning requirements for hospitals and LHDs are outlined in this section.

Hospitals

501(c)(3) hospital organizations are recognized by the Internal Revenue Service (IRS) as being federally tax-exempt, charitable organizations.

To be recognized as a 501(c)(3) organization and maintain federal tax-exempt status under the Affordable Care Act (ACA), hospitals are required to conduct a community health needs assessment (CHNA) and adopt an implementation strategy (IS) every three years.¹ Most federally tax-exempt organizations are required to file a Form 990, which provides organizational and financial information to the IRS on an annual basis. As part of their Form 990, hospitals are required to provide information on how they are addressing the significant health needs identified in their CHNAs.² Hospitals failing to meet these requirements may be subject to an excise tax and possible revocation of their federal tax-exempt status.³

The ACA requirements went into effect for taxable years beginning after March 23, 2012.⁴ The IRS published a **final rule** in December 2014, providing hospitals with guidance on how to comply with the ACA CHNA and IS requirements.⁵

The new IRS rules clarify that *all* 501(c)(3) hospitals must comply with the CHNA and IS requirements. Certain government hospitals are not required to file a Form 990. However, under IRS guidelines, government hospitals

seeking 501(c)(3) recognition must still develop a CHNA and IS and make their CHNA reports widely available to the public on a website.⁶

Local health departments

Under Ohio Revised Code (ORC) § 3701.13, the director of the Ohio Department of Health (ODH) may require LHDs to apply for accreditation by the Public Health Accreditation Board (PHAB) by July 1, 2018 and be PHAB accredited by July 1, 2020, as a condition for receiving funding from ODH. PHAB's accreditation process, which launched in 2011, is meant to advance the quality and performance of public health departments.⁷ As a prerequisite for PHAB accreditation, LHDs must submit a community health assessment (CHA) and a community health improvement plan (CHIP) that has been updated within the past five years.⁸ All LHDs that submit their PHAB applications after June 3, 2014 are reviewed under the **PHAB Standards and Measures Document Version 1.5**.⁹ This document provides guidance on the CHA and CHIP process as well as the documentation requirements for LHDs.

Figure 11 provides a summary comparison of hospital and LHD community health planning requirements.

Alignment of community health planning requirements for hospitals and LHDs

The requirements for LHDs around implementation plans are more prescriptive than hospital implementation strategy requirements. As part of the CHIPs, PHAB requires LHDs develop measurable objectives and time-framed targets, identify policy changes needed to accomplish set health objectives, and designate responsibility for the objectives to partner organizations and individuals within the community. Compared to hospital requirements, LHDs also are required to place a more explicit emphasis on population health and addressing the underlying causes of poor health (see "What is population health?" box on page 10).

Another notable difference between hospitals and LHDs is the timeline for completion of the CHNA/IS versus the CHA/CHIP. The CHNA/IS must be completed every three years, while

Ohio hospital landscape

As of 2013, 85.2% of hospitals in Ohio were classified as either nonprofit or government-owned, compared to 78.7% of hospitals nationally.¹⁰ To qualify for 501(c)(3) recognition, all of these hospitals are required to comply with the new ACA and IRS regulations. Most of these hospitals have completed their first CHNA and are in the process of conducting a second CHNA and IS for their communities.

Figures 1 through 4 are based on information obtained for 189 nonprofit and government hospital facilities registered in Ohio, as of July 2014.¹¹

Figure 1. Hospitals by facility type¹²

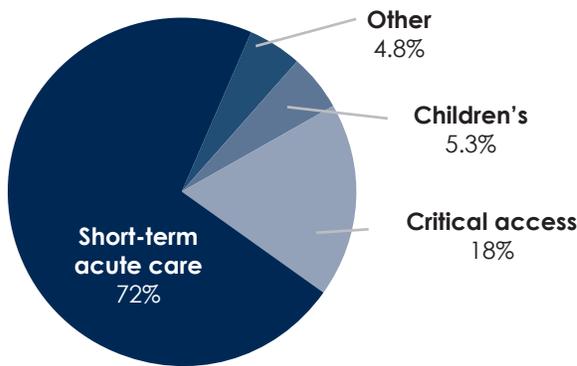


Figure 2. Hospitals by total number of beds¹³

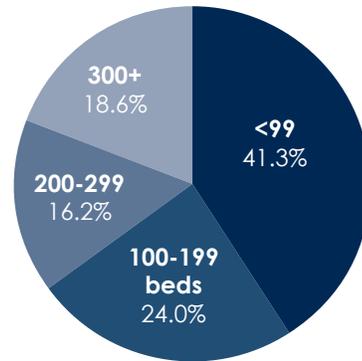


Figure 3. Hospitals by region¹⁴

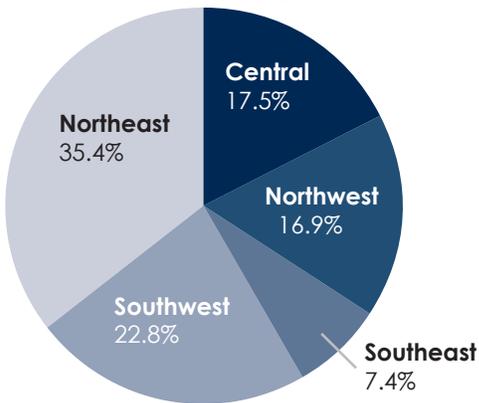


Figure 4. Hospitals by amount of annual expenses¹⁵

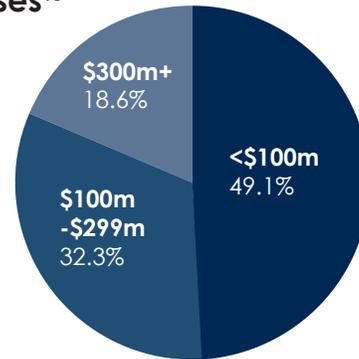
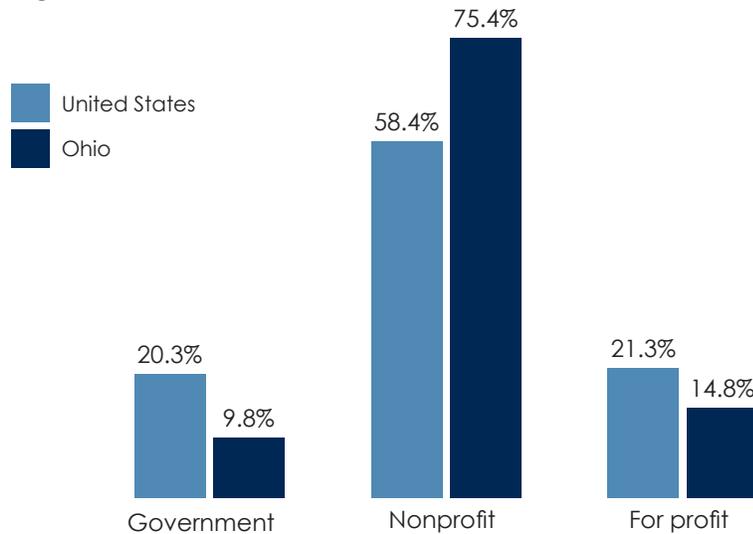


Figure 5. Hospitals by ownership type, 2013¹⁶



Ohio LHD landscape

As of March 4, 2015, five Ohio LHDs had received accreditation from PHAB (Columbus city, and Delaware, Licking, Mahoning and Summit counties).¹⁷ Many LHDs in Ohio are moving towards full PHAB accreditation and have already conducted or are in the process of conducting CHAs and CHIPs for their local health districts.

Figures 6 through 10 are based on information obtained for 124 LHDs in Ohio, as of September 2014. As of May 2015, there are 123 LHDs in Ohio.

Figure 6. LHDs by structure¹⁸

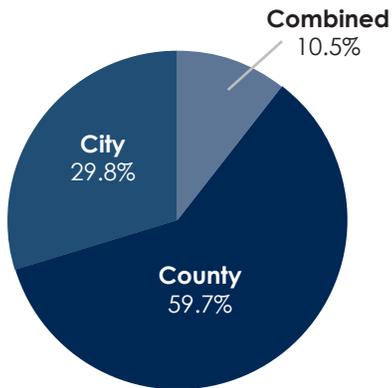


Figure 7. LHDs by jurisdictional population size¹⁹

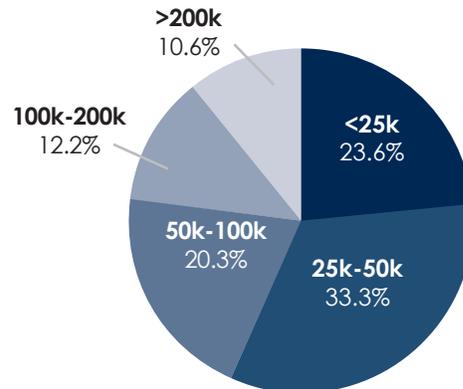


Figure 8. LHDs by per capita budget²⁰

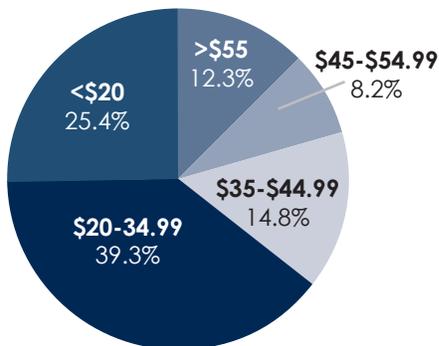


Figure 9. LHDs by number of full-time equivalents (FTEs)²¹

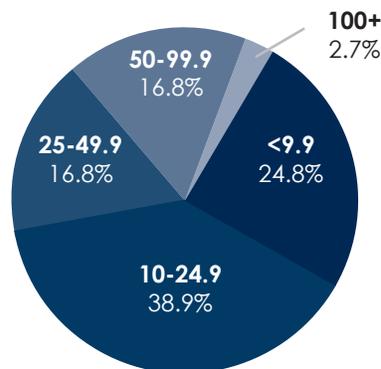
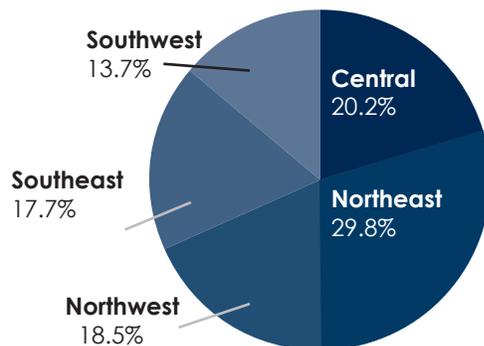


Figure 10. LHDs by region²²



For more about the structure and funding of LHDs in Ohio, see [Ohio Public Health Basics](#).

Figure 11. **Summary of IRS and PHAB community health planning requirements for hospitals and LHDs²³**

Requirement	Hospitals	Local health departments (LHDs)
Assessment	<p>CHNA must:</p> <ul style="list-style-type: none"> • identify significant health needs of the community, • prioritize those health needs, and • identify resources potentially available to address those health needs. 	<p>CHA must:</p> <ul style="list-style-type: none"> • describe the health and demographics of the population, • identify areas for health improvement, • identify contributing factors that impact health outcomes, and • identify community assets and resources that can be mobilized to improve population health.
Definition of “community”	In defining community, hospitals may take into account the geographic area served by the hospital, target population(s) served, and principal functions of the hospital facility (for example, a focus on a particular specialty area or targeted disease).	The community is defined as the jurisdiction served by the LHD.
Timeline	CHNAs/ISs must be completed every three years, effective for taxable years beginning after March 23, 2012. Hospitals must provide information annually to the IRS on how they are addressing the significant health needs identified in their CHNAs.	CHAs/CHIPs must be completed at least every five years.
Collaboration and partnership	<p>CHNAs must include input from persons who represent the broad interests of the community including:</p> <ul style="list-style-type: none"> • those with special knowledge or expertise in public health and • members of underserved, low-income, and minority populations. <p>CHNAs may be conducted in collaboration with other organizations including governmental departments (such as state or local health departments) and nonprofit organizations.</p>	<p>Partnerships with other organizations outside of the health department are required in conducting the CHA and CHIP and documentation of the following must be provided:</p> <ul style="list-style-type: none"> • partners outside of the LHD that represent community populations and a variety of state and local community sectors, • partner representation from two or more populations that are at a higher health risk or have poorer health outcomes than other populations, and • regular meetings or communications with partners.
Solicitation of input and feedback	Hospitals must solicit and take into account written comments received on their most recently conducted CHNA and implementation strategy.	Preliminary findings of the CHA and CHIP must be distributed to the community at large and community input must be sought.
Use of model or template	No specific model or template is required.	While no specific model or template is required, PHAB has identified national and state-based models and resources that can be used to guide the collaborative planning and implementation process for the CHA and CHIP (see Appendix for examples on page 26).
Data collection	Hospitals must describe their method of data collection or cite external sources.	<p>Evidence that comprehensive, broad-based data and information from a variety of sources were used to create the health assessment is required. This includes the use of:</p> <ul style="list-style-type: none"> • qualitative and quantitative data, • primary and secondary data <p>Requires ongoing monitoring, refreshing, and adding of data and data analysis. Data analysis is expected to be neighborhood or community specific in order to understand health inequities and the factors that create them.</p>

Requirement	Hospitals	Local health departments (LHDs)
Public availability and accessibility	CHNA report must be made widely available to the public and must be: <ul style="list-style-type: none"> • posted on a website, and • made available as a paper copy upon request and without charge. 	LHDs must document how they inform partners, stakeholders, other agencies, associations, and organizations of the availability of the CHA and how it communicates the CHA findings to the public.
Prioritization process	Hospitals may use any criteria to prioritize the significant health needs identified in the CHNA, including, but not limited to: <ul style="list-style-type: none"> • the burden, scope, severity, or urgency of the health need, • the estimated feasibility and effectiveness of possible interventions, • the health disparities associated with the need, and • the importance the community places on addressing the need. 	LHDs must have a process to set health priorities. Many of the suggested models/templates in the PHAB guidance contain a process for prioritization.
Multiple determinants of health	Health needs of a community identified in the CHNA may include the need to address financial and other barriers to accessing care, to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community.	CHA must include a discussion of the contributing causes of the health challenges of the community including the social determinants of health.
Implementation	The IS must be a written plan that: <ul style="list-style-type: none"> • describes the actions the hospital facility intends to take to address the identified health need and the anticipated impact of the hospitals actions • identifies the resources the hospital facility plans to commit to address the health need, and • describes planned collaboration between the hospital and other organizations in addressing the health need, and/or • identifies why a hospital does not intend to address an identified health need. 	The CHIP must be developed collaboratively and should describe how the health department and the community it serves will work together to improve the health of the population of the jurisdiction that the health department serves. The CHIP must include: <ul style="list-style-type: none"> • desired measurable outcomes or indicators of health improvement and priorities for action, which includes community health priorities, measurable objectives and improvement strategies and activities with time-framed targets that were determined in the community planning process. Improvement strategies can be evidence-based, practice-based, promising practices or may be innovative to meet the needs of the community health priorities. • policy changes needed to accomplish the identified health objectives, which must include those that are adopted to alleviate the identified causes of health inequity, and • designation of individuals and organizations that have accepted responsibility for implementing strategies outlined in the community health improvement plan.
Alignment with state and national priorities	No mention in the hospital requirements.	LHDs must demonstrate that they considered both national and state health improvement priorities where they have been established such as Healthy People 2020 and the National Prevention Strategy.
Evaluation	The CHNA must include an evaluation of the impact of any actions that were taken since the hospital finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's prior CHNA(s).	LHDs must provide a tracking process of actions taken toward the implementation of the CHIP, as well as documentation of areas of the plan implemented by the LHD and/or its partners. This also includes tracking the status of the effort or results of actions that have been taken. LHDs must provide an annual report on the progress made in implementing strategies in the CHIP and must document that the health improvement plan has been reviewed and revised as necessary based on the report.

Note: This figure provides an overview of IRS and PHAB community health planning requirements for hospitals and LHDs for informational purposes only, as of April 24, 2015. It is not intended to be a comprehensive statement of hospital and LHD community health planning requirements. Independent verification of the information is recommended as requirements may change.

the CHA/CHIP are on a five year time frame. However, because PHAB requires completion of the CHA/CHIP *at least* every five years, LHDs can adjust their community health planning activities to follow the shorter timeline required of hospitals.

Though there are differences in the specificity of the community health planning requirements for hospitals and LHDs, there is also a great deal of alignment on many of the requirements. Specifically, both hospitals and LHDs must:

- have documentation of a needs assessment and a plan or strategy that identifies, prioritizes and addresses the health needs of the hospital's or LHD's "community,"
- identify community resources available to address health needs,
- engage the community and solicit input from a broad range of stakeholders and sectors within the community including vulnerable populations,
- focus on health disparities and the health issues of vulnerable populations,
- review how factors outside of the health care system, such as social, economic, behavioral and environmental factors, impact the health of the community, and
- distribute and communicate their findings to the public.

Requirements for hospitals and LHDs also encourage working with a wide array of partners throughout the community planning process.

Other entities engaged in community planning processes

There are several other entities in Ohio required to conduct community assessments as described in Figure 12, including federally qualified health centers (FQHCs); alcohol, drug and mental health boards; and Family and Children First Councils. While the specific focus of these community assessments differ, they all aim to address the many factors that impact the overall health and wellbeing of the community.

Because the requirements and timetables for hospitals, LHDs and other entities conducting community assessments do not always align, coordination between these different assessment processes can be lacking. This can result in missed opportunities to conduct community health planning in an integrated, meaningful and effective way. Developing alignment and coordination between these different processes can provide a stronger mechanism for effective community health planning at the local level.

Figure 12 Other entities required to conduct community assessments

Organization	Local behavioral health boards (Alcohol, Drug Addiction and Mental Health board [ADAMH], Community Mental Health board [CMH], and Alcohol and Drug Addiction Services board [ADAS]) ²⁴	Family and Children First Councils (FCFCs) ²⁵	Federally Qualified Health Centers (FQHCs) ²⁶	United Ways ²⁷	Community Action Agencies ²⁸	Depository institutions (state member banks, state nonmember banks, national banks, savings associations) ²⁹
Name of the plan/assessment	Community Plans	Shared Plan	Needs Assessment and Planning	Community Assessment, or Community Needs Assessment	Comprehensive Community Needs Assessment	Community Reinvestment Act Performance Context
Requirement (currently required or optional)	Required by and reported to Ohio Department of Mental Health and Addiction Services	Required by state statute (HB 289, 2006). Reported to county's board of county commissioners and the Ohio Family and Children First (OFCF) Cabinet Council	Required by Section 330 of the Public Health Service Act to receive FQHC status and grants from the Bureau of Primary Health Care under the Health Resources and Services Administration (HRSA)	No specific requirement. However, United Way members are required to conduct and submit to United Way Worldwide a community-driven self-assessment of their community impact work, financial management, and organizational governance and decision making, every three years.	Not required, but used to increase competitiveness in applying for grants	Required by the Community Reinvestment Act for depository institutions meet or exceed the asset size thresholds for both of the last two calendar years
Purpose (current objective of plan)	Community Plans serve as a guide for board funding/budget advocacy by defining: local need, what gaps exist in meeting that need, and how additional funds would be used to close those gaps. Plans also help develop learning communities and gather local data to successfully obtain Block Grant Funds from the Substance Abuse and Mental Health Services Administration (SAMHSA) and other funding streams.	County FCFCs Shared Plan Model is intended to align local plans to address priorities, evaluate services, fill service gaps where possible and develops new approaches to achieve better results for families and children.	To receive grants, the FQHC must demonstrate need in a population or area through an assessment defining the target population and the service needs that the health center should be prepared to meet.	Community Needs Assessments are used to help identify emerging needs, gaps in service and programming, and funding priorities. They may address a variety of issues including income, education, health, nutrition, child and family development, housing and more.	Used to identify and address problems facing the community including issues around income, education, health, nutrition, child and family development, and housing.	The Community Reinvestment Act is intended to encourage depository institutions to help meet the credit needs of the communities in which they operate, including low- and moderate-income neighborhoods.
Timeline (current frequency of occurrence)	Every 2 years	Annual	At application for FQHC status and periodically as needed (e.g. when redefining service area)	May vary by local office	Every three years	Annual data reporting

Organization	Local behavioral health boards (Alcohol, Drug Addiction and Mental Health board [ADAMH], Community Mental Health board [CMH], and Alcohol and Drug Addiction Services board [ADAS])	Family and Children First Councils (FCFCs)	Federally Qualified Health Centers (FQHCs)	United Ways	Community Action Agencies	Depository institutions (state member banks, state nonmember banks, national banks, savings associations)
Key components	<p>Community Plans include:</p> <ul style="list-style-type: none"> description of the economic, social, and demographic factors in a community that will influence service delivery challenges and opportunities impacting consumers, providers and the community description of capacity development targets for treatment and recovery support services and prevention services 	<p>Shared Plans should:</p> <ul style="list-style-type: none"> identify local priorities evaluate and prioritize services fill service gaps invent new approaches to produce better results for children and families highlight local interagency efforts align local plans rather than undergoing individual planning 	<p>Plan must include:</p> <ul style="list-style-type: none"> a description of the need for health services in the center catchment area a demonstration that the area or the population group to be served has a shortage of personal health services a demonstration that the center will be located so to provide services to the greatest number of individuals residing in the catchment area or included in the population group 	<p>Guidelines and tools vary by local office. May address issues such as:</p> <ul style="list-style-type: none"> income education health nutrition child and family development housing 	<p>Basic components of the Assessment include:</p> <ul style="list-style-type: none"> demographics education income health care employment housing nutrition 	<p>"Performance context" describes the type of information an examiner must review in order to assess institution performance. This includes institutional and community data relevant to the social determinants of health, such as:</p> <ul style="list-style-type: none"> institutional loan-to-deposit ratio loans to borrowers of different incomes community demographics community credit need community economic trends
Example	ADAMH of Franklin County Community Plan	Knox County FCFC Shared Plan	Clinic and Community Profile template	United Way of Delaware County Community Needs Assessment	Sample report from the Comprehensive Community Needs Assessment Tool	Reports can be accessed by institution and state here. Huntington example, by Ohio county.
Number of entities in Ohio	52 boards ⁵⁰	88 councils ³¹	36 FQHCs ⁵²	70 local United Way chapters ⁵³	50 Community Action Agencies ⁵⁴	—

Part Two

Hospital community benefit: Promoting a population health approach to community health planning

The IRS requires nonprofit hospitals to justify their tax exempt status by allocating a portion of their operating expenses towards the provision of community benefit – defined as initiatives or activities undertaken by hospitals to improve the health of the communities in which they serve. New IRS regulations for community benefit reporting provide an opportunity to integrate population health strategies into a hospital's IS.

The following section outlines the IRS hospital community benefit requirements, discusses how these requirements can promote the implementation of population health strategies as part of a hospital's IS, and provides a closer look at community benefit expenditures for Ohio's hospitals.

Hospital community benefit reporting

Historically, the IRS recognized nonprofit hospitals as charitable organizations qualifying for federal tax exemption because they provided charity care – or free and reduced cost healthcare services to individuals unable to pay.³⁶ However, in 1969, the IRS established community benefit as the legal standard for hospital tax exemption, moving beyond charity care to include charitable activities that are “beneficial to the community as a whole.”³⁷

Notably, charity care and other forms of uncompensated patient care still account for the majority of hospital community benefit activities and expenditures today

What is population health?

The term “population health” acknowledges that our health is a product of factors both inside and outside of the healthcare system, including our social, economic and physical environment. The Health Policy Institute of Ohio, with support from the National Network of Public Health Institutes (NNPHI) through a Robert Wood Johnson Foundation-funded project, convened a group of healthcare and public health stakeholders to develop a consensus definition of population health for Ohio. The workgroup defined population health for Ohio as:

“The distribution of health outcomes across a geographically-defined group which result from the interaction between individual biology and behaviors; the social, familial, cultural, economic and physical environments that support or hinder wellbeing; and the effectiveness of the public health and healthcare systems.”

For more information on population health, refer to HPIO's brief, “[What is 'population health?'](#)”

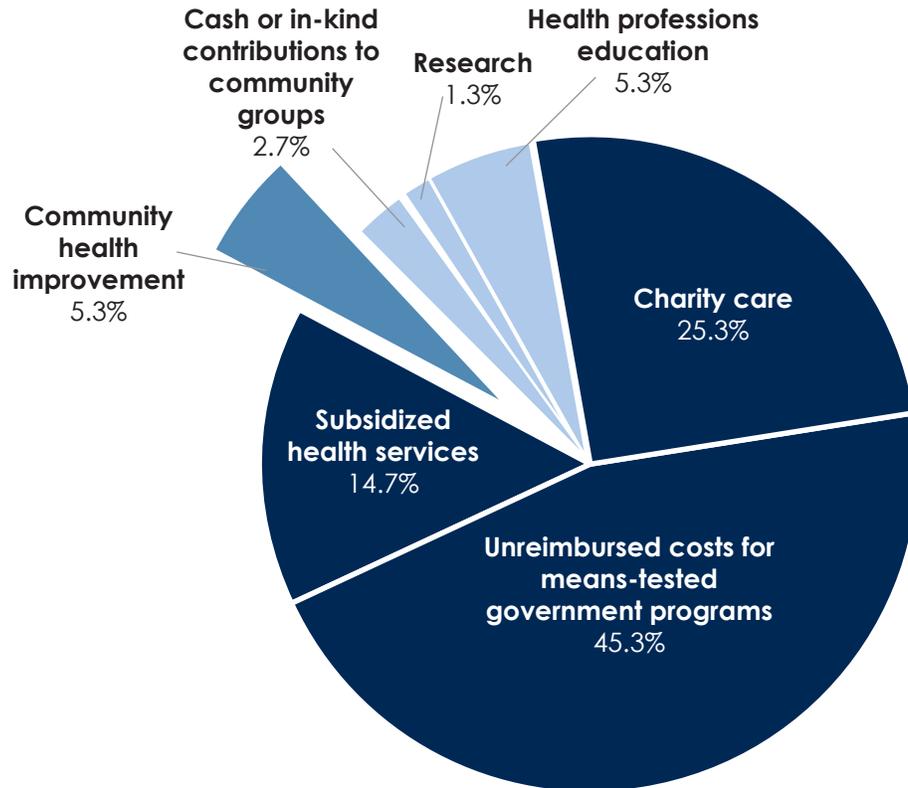
The role of community health planning in population health

Because population health strategies are designed to reach geographically-defined audiences, rather than patient populations, community health planning at the city, county or regional level is an important vehicle for improving population health outcomes.

Community health planning can be the driving force for promoting population health through the implementation of population health strategies that:

- define a target audience as all people living within a geographic area,
- go beyond medical care to address the social determinants of health,
- aim to improve meaningful outcomes, such as morbidity and mortality,
- are designed to reduce disparities and promote health equity, and
- acknowledge shared accountability for improved health, including individuals, public health organizations and healthcare providers.³⁵

Figure 13. National distribution of community benefit expenditures, 2009



Source: Young, Gary J., et. al. "Provision of Community Benefits by Tax-Exempt U.S. Hospitals." *New England Journal of Medicine*, Oct. 2014.

Note: See Figure 14 for a description of these categories.

(see Figure 13).³⁸ This is in part due to a lack of clear standards around the types of activities, beyond direct patient care, that count toward community benefit for the purposes of the IRS. To address this issue, there has been a call for greater transparency and a broadening of the types of activities hospitals can engage in as a part of community benefit.

The filing of a Form 990 on an annual basis is required of most federally tax-exempt organizations.³⁹ As part of a comprehensive redesign of the Form 990 in 2008, and in an effort to standardize community benefit reporting and increase transparency, the IRS added Schedule H to the Form 990.⁴⁰

Schedule H requires hospitals to provide information on their community benefit activities and policies during a tax year. In 2010 and 2011, Schedule H was revised to track compliance with the ACA's new requirements for 501(c)(3) hospitals. As a result, hospitals are now required to provide information on their CHNA and IS in their Schedule H.⁴¹

Under Part I of Schedule H, the IRS outlines eight categories of activities that are considered *legitimate, reportable hospital community benefit*. Part II of Schedule H requires reporting on "community building activities." The specific categories for Part I and II of Schedule H are listed in Figure 14.

Figure 14. Schedule H hospital community benefit reporting categories⁴²

Part 1. Reportable hospital community benefit activities	
Category	Summary definition as described in instructions for Schedule H
Financial assistance at cost or "charity care"	Includes free or discounted health services provided to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services
Medicaid and other means-tested government programs	Hospital unreimbursed costs related to state Medicaid programs and other government health programs for which eligibility depends on the recipient's income or asset level, such as the State Children's Health Insurance Program (SCHIP).
Subsidized health services	Includes clinical services provided despite a financial loss to the organization. The financial loss is measured after removing losses associated with bad debt, financial assistance, Medicaid, and other means-tested government programs. In order to qualify as a subsidized health service, the organization must provide the service because it meets an identified community need. A service meets an identified community need if it is reasonable to conclude that, if the organization no longer offered the service, the service would be: <ul style="list-style-type: none"> • unavailable in the community, • the community's capacity to provide the service would be below the community's need, or • the service would become the responsibility of government or another tax-exempt organization.
Community health improvement services and community benefit operations	Community health improvement services includes activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health. Such services do not generate inpatient or outpatient revenue, although there may be a nominal patient fee or sliding scale fee for these services. Community benefit operations includes activities associated with conducting CHNAs, community benefit program administration, and the organization's activities associated with fundraising or grant-writing for community benefit programs.
Health professions education	Includes educational programs that result in a degree, certificate, or training necessary to be licensed to practice as a health professional, as required by state law, or continuing education necessary to retain state license or certification by a board in the individual's health profession specialty. It does not include education or training programs available exclusively to the organization's employees and medical staff or scholarships provided to those individuals. However, it does include education programs if the primary purpose of such programs is to educate health professionals in the broader community.
Research	Any study or investigation intended to generate increased generalizable knowledge made available to the public.
Cash and in-kind contributions	Contributions made by the organization to healthcare entities and other community groups restricted, in writing, to one or more of the community benefit activities described in Part 1 of Schedule H.
Part 2. Community building activities	
Category	Summary definition as described in instructions for Schedule H
Physical improvements	Includes the provision or rehabilitation of housing for vulnerable populations, such as removing building materials that harm the health of the residents, neighborhood improvement or revitalization projects, provision of housing for vulnerable patients upon discharge from an inpatient facility, housing for low-income seniors, and the development or maintenance of parks and playgrounds to promote physical activity.
Economic development	Includes assisting small business development in neighborhoods with vulnerable populations and creating new employment opportunities in areas with high rates of joblessness.
Community support	Includes child care and mentoring programs for vulnerable populations or neighborhoods, neighborhood support groups, violence prevention programs, and disaster readiness and public health emergency activities, such as community disease surveillance or readiness training beyond what is required by accrediting bodies or government entities.
Environmental improvements	Includes activities to address environmental hazards that affect community health, such as alleviation of water or air pollution, safe removal or treatment of garbage or other waste products, and other activities to protect the community from environmental hazards.

Part 2. Community building activities (cont.)	
Category	Summary definition as described in instructions for Schedule H
Leadership development and training for community members	Includes training in conflict resolution; civic, cultural, or language skills; and medical interpreter skills for community residents.
Coalition building	Includes participation in community coalitions and other collaborative efforts with the community to address health and safety issues.
Community health improvement advocacy	Includes efforts to support policies and programs to safeguard or improve public health, access to health care services, housing, the environment, and transportation.
Workforce development	Includes recruitment of physicians and other health professionals to medical shortage areas or other areas designated as underserved, and collaboration with educational institutions to train and recruit health professionals needed in the community.
Other	Refers to community building activities that protect or improve the community's health or safety that are not described in the categories listed above.

Note: This figure provides an overview of hospital community benefit reporting categories, as of April 24, 2015, for informational purposes only. It is not intended to be a comprehensive statement of community benefit reporting law. Independent verification of the information is recommended as laws and policies may change.

Aligning hospital community benefit, population health and community health planning

“Community building activities” reported in Part II of Schedule H are closely aligned with population health strategies, which move beyond medical care to address the multiple determinants of health. The IRS defines “community building activities” to include economic development, physical improvements and housing, environmental improvements, and other activities outside of the healthcare system that protect or improve the community’s health and safety.

It is important to note that only activities under Part I of Schedule H are designated as legitimate community benefit expenditures for hospital tax exemption purposes.⁴³ However, the IRS indicated in 2012 that some hospital “community building activities” may meet the definition of community benefit. Such activities should be reported in Part I of Schedule H under the “community health improvement” category rather than in Part II. The inclusion of some community building activities as part of community benefit indicates a significant shift in policy away from charity care and toward a population-health-based approach to care. There continues to be dialogue at the federal level to broaden Part I reporting to include *all* hospital community building activities currently reported in Part II of Schedule H.

For expenditures to be reported under the “community health improvement” category in

Part I, there must be an established community need for the activity or program. The IRS Schedule H instructions⁴⁴ state that community need may be demonstrated through:

- a CHNA conducted or accessed by the organization,
- documentation that demonstrated community need or a request from a public health agency or community group was the basis for initiating or continuing the activity or program, and/or
- the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the activity or program carried out for the express purpose of improving community health.

Explicit mention of the CHNA in the guidelines for establishing community need underscores the alignment between hospital community benefit, population health and community health planning.

The Catholic Health Association provides a useful resource for hospitals in identifying the types of activities that count towards hospital community benefit: <http://www.chausa.org/communitybenefit/what-counts-q-a>.

State community benefit standards

Nonprofit hospitals are required to comply with community benefit standards set by the state in which they are located to preserve state tax exemptions. While the IRS defines the categories of expenditures that qualify as hospital community benefit, it does not

Community benefit expenditures for Ohio's hospitals, 2012

HPIO reviewed 107 unique IRS Schedule H forms filed for 159 nonprofit and government hospitals in Ohio in 2012.⁴⁹

Analysis of the Schedule H forms⁵⁰ indicates that Ohio nonprofit and government hospitals spent a total of \$3.86 billion towards net community benefit activities in 2012. This amounts to \$333.97 per capita for the overall population of Ohio.⁵¹ The net community benefit spending represents hospital net or unreimbursed expenses disclosed on Part I of Schedule H (see Figure 14). As reported on the Schedule H forms, net community benefit spending accounted for 6.46% of total hospital expenditures on average.

Only 99 of the 159 hospitals reported net community building expenses on their Schedule H forms. The total amount of net community building spending reported for nonprofit and government hospitals in Ohio amounted to \$18.21 million, or \$1.57 per capita.⁵² Net community building spending represents hospital net or unreimbursed expenses disclosed on Part II of Schedule H (see Figure 14). As described on page 13, some community building activities meet the definition of community benefit and may have been reported in Part I of Schedule H rather than Part II. Consequently, the Schedule H community benefit spending may also capture some hospital spending on community building activities.

Figure 16. **Per capita spending by Ohio nonprofit and government hospitals on community benefit and building activities**



Note: Some community building activities meet the definition of community benefit and may be captured as community benefit in the graphic.

Source: HPIO and the Ohio Research Association for Public Health Improvement (RAPHI) analysis of Ohio nonprofit and government hospital Schedule H forms for 2012.

Part three Selected findings from a study of hospital and LHD community health planning documents

Methods

The Ohio Research Association for Public Health Improvement (RAPHI), housed at Case Western Reserve University, partnered with HPIO on a "QuickStrike" project funded by the Robert Wood Johnson Foundation. As part of the RAPHI-led project, HPIO and RAPHI compiled and reviewed Ohio hospital and LHD community health planning documents. The results of this study are based on document review. The initial findings describe the extent and nature of collaboration between hospitals and LHDs in developing their community health planning documents, as well as the

health priorities hospitals and LHDs identified for their communities.⁵³

Available documents

HPIO identified 189 nonprofit and government-owned hospitals across Ohio. Of these, 170 had completed a CHNA and/or IS and had made at least one of these documents publicly available by posting them on their hospital website as of July 2014.⁵⁴ One hundred and sixty seven (88.4%) had completed a CHNA and 80 (47.1%) had completed an IS within the past three years. The research team housed at Case Western Reserve University identified 124 local health departments in Ohio as of September 2014.⁵⁵ Among the 124 LHDs, 110 (88.7%) had completed a CHA and 65 (52.4%) had completed a CHIP within the past five years.

Figure 17. **Cross-jurisdictional LHD
CHA/CHIP** (n=110)

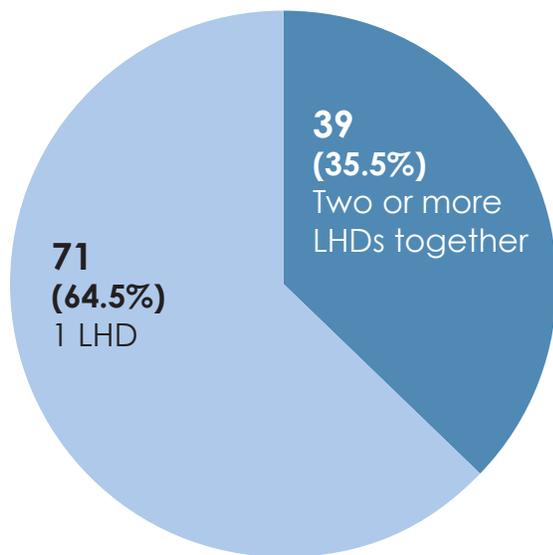
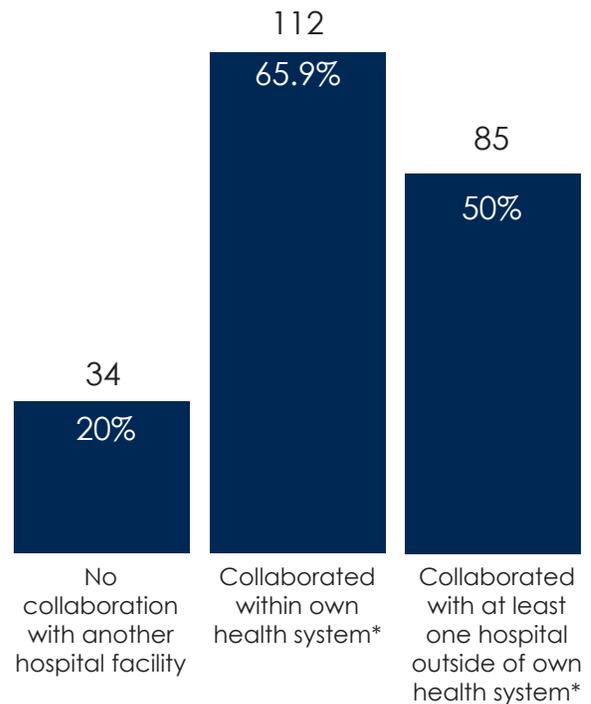


Figure 18. **CHNA collaboration
among hospitals** (n=170)



* Not mutually exclusive

Collaboration between LHDs

Among the 110 LHDs, 39 (35.5%) conducted a cross jurisdictional CHA and/or CHIP – meaning one or more LHDs partnered to develop the CHA and/or CHIP.

Collaboration between hospitals

Of the 170 CHNAs reviewed, 34 (20%) did not involve collaboration with any other hospital facility. One hundred and twelve (65.9%) involved collaboration with hospitals within the same health system, and 85 (50%) involved collaboration with hospitals outside of the health system (not mutually exclusive). Notably, 50 (29.4%) of the CHNAs reviewed were 100% identical to another hospital facility's CHNA document.

Collaboration across hospitals and LHDs

There were various levels of collaboration among hospitals and LHDs in the development of their community health planning

documents. Collaboration ranged from no involvement in the community health planning process to the development of joint CHNA/CHA and IS/CHIP documents. Joint documents indicate that the same document was used by the hospital and LHD for their CHNA/CHA or their IS/CHIP. There was no LHD involvement in the development of the CHNA for 18 (10.6%) of the CHNA documents reviewed. Thirty-two (18.8%) of the CHNAs reviewed were joint CHNA/CHA documents. Similarly, 19 (17.3%) of the CHAs reviewed indicated that hospitals were not involved at any level in developing the CHA; however, only 18 (16.4%) were joint CHA/CHNA documents.

As indicated in figures 19 and 20, it was less likely for collaboration to occur in the implementation phase (the development of the IS or CHIP) than the assessment phase. Only 8 (10%) of the IS documents reviewed were a joint IS/CHIP. Similarly, only 4 (6.2%) of the CHIPs reviewed were a joint CHIP/IS.

Hospital and LHD collaboration

Figure 19. **Percent of hospitals reporting LHD collaboration on the CHNA and IS**

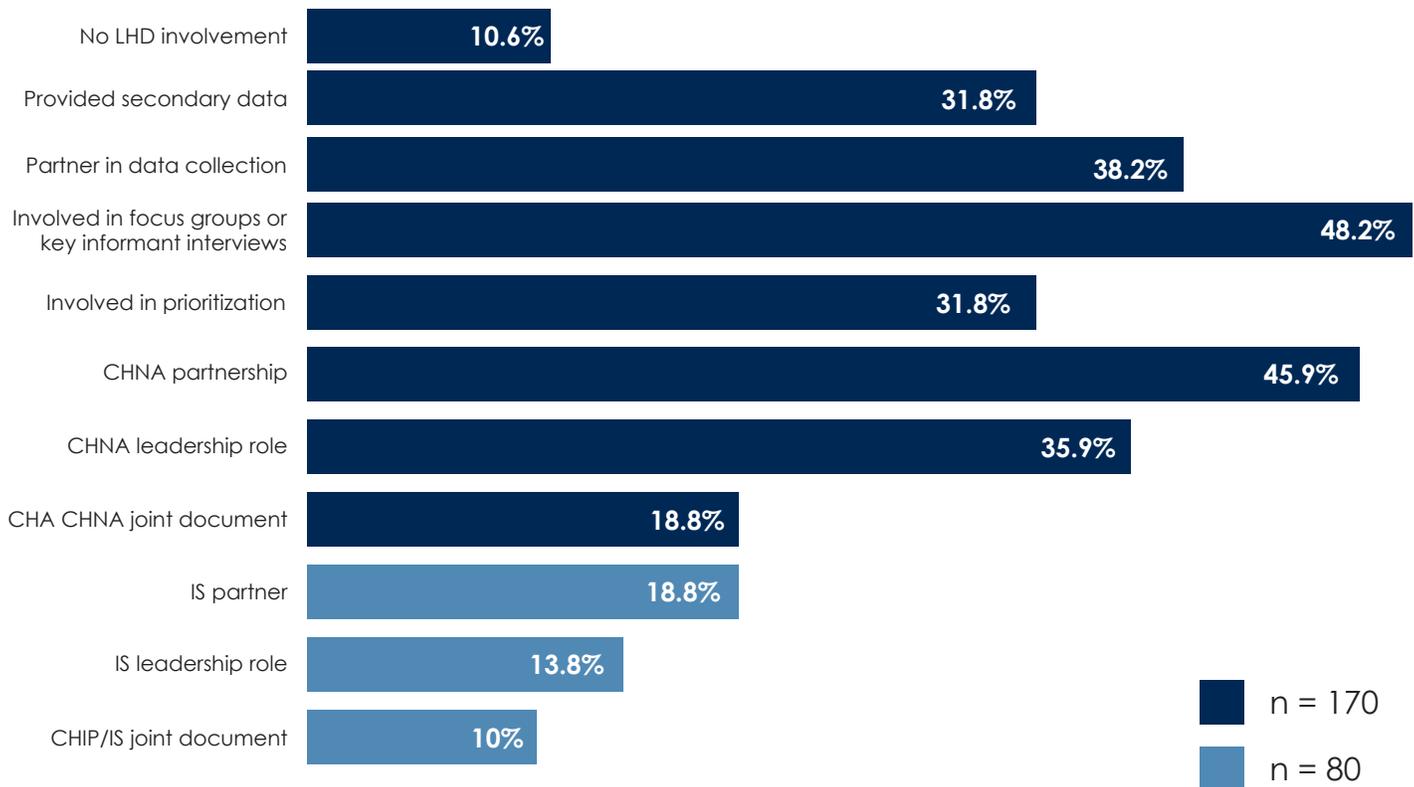
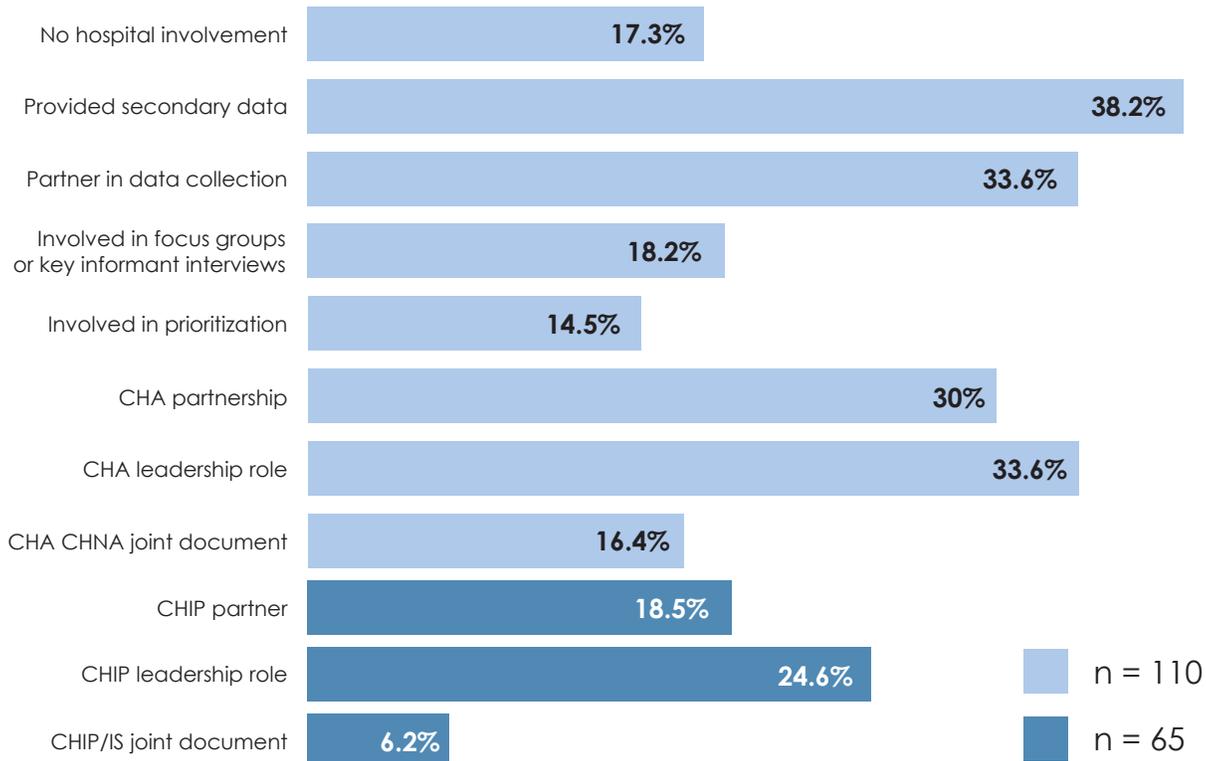


Figure 20. **Percent of LHDs reporting hospital collaboration on the CHA and CHIP**



Identified health priorities

One of the main objectives of a community health assessment is to identify the significant health needs of the community and to prioritize community health issues to be addressed through an implementation plan or strategy. Figure 21 describes the different health needs identified as priorities in the hospital and LHD documents across four categories: health conditions, health behaviors, community conditions, and health system conditions. Note that health priority data includes some CHNA/IS and CHA/CHIP documents where no priorities were identified at all.

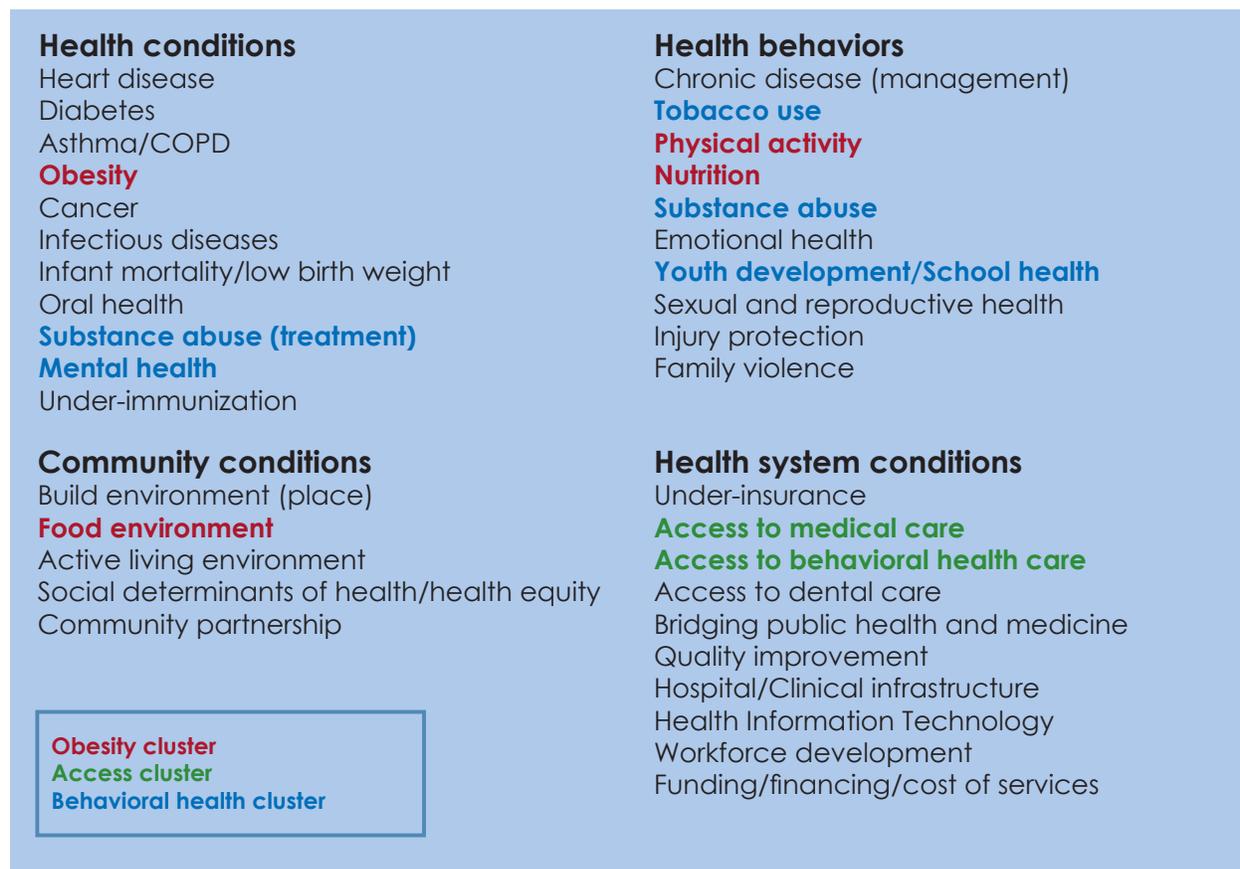
HPIO and RAPHI researchers also identified themes in priorities across categories or priority “clusters” (see Figure 21). Hospitals and LHDs were most likely to identify priorities related to obesity (39.5%), access to care (37.4%) and behavioral health (32.7%).

In addition, both hospitals and LHDs identified obesity and access to medical care as two of their top priorities. Physical activity, nutrition, addiction, and mental health were included in the top ten priorities for both hospitals and LHDs (see figures 22 and 23).

Also, as indicated in Figure 24, LHDs were more likely to address community conditions and health behaviors versus medical conditions. Conversely, hospitals were more likely to address medical conditions.

HPIO and RAPHI plan to release further findings from this study, looking more closely at health priorities by region and the various characteristics that contribute to higher quality CHNA/IS and CHA/CHIP documents.

Figure 21. Hospital and LHD health priority categories and “clusters”



Hospital and LHD priorities

Figure 22. **Top twelve hospital and LHD health priorities*** (n = 280)

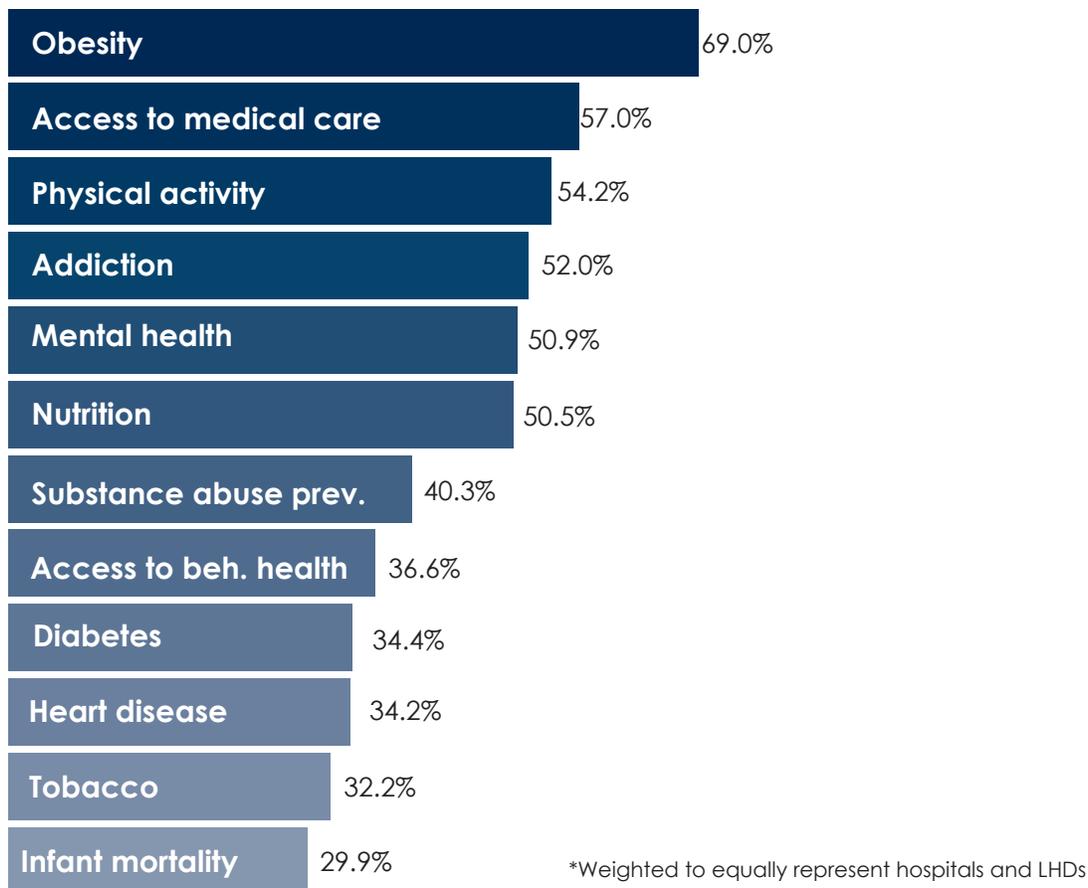


Figure 23. **Top ten hospital and LHD health priorities**

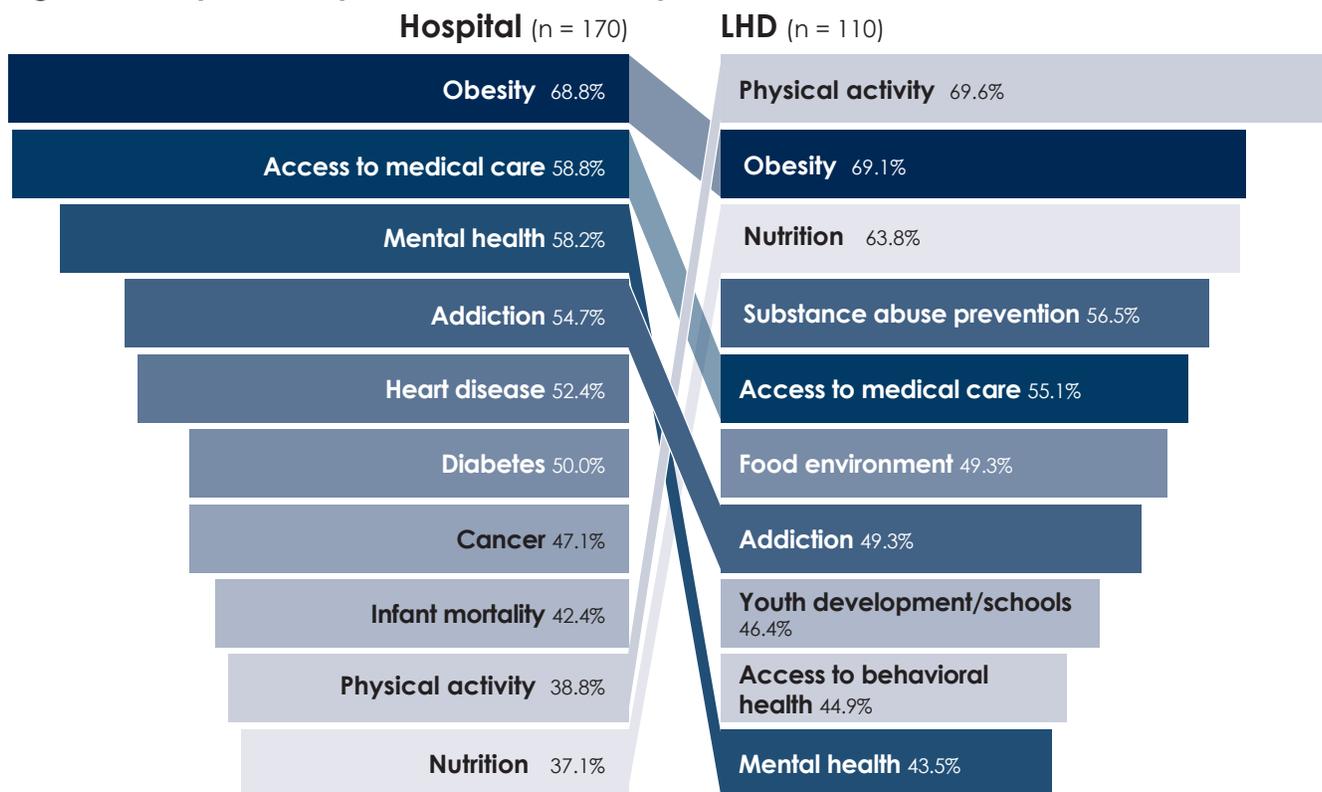
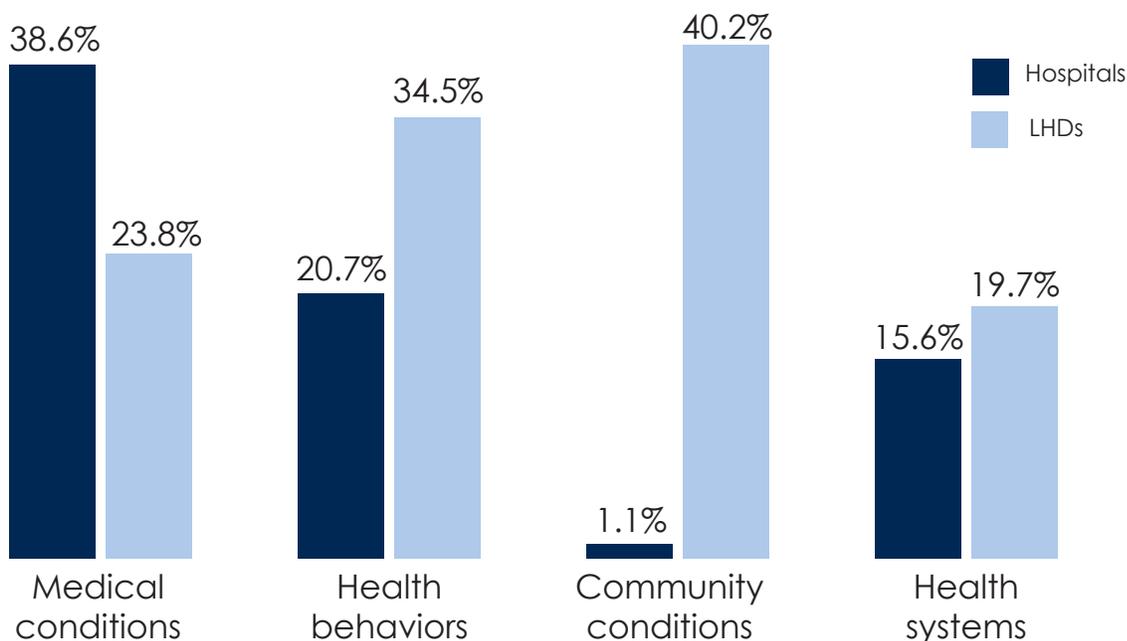


Figure 24. **Comparison of hospital and LHD health priority categories**



Part Four Opportunities for increasing the effectiveness of community health planning

The following section outlines a number of opportunities for hospitals, LHDs, community health leaders, funders and state policymakers to increase the effectiveness of community health planning processes and improvement efforts.

Align state and local health plans

Requirements for hospitals and LHDs to conduct assessments and develop plans at the local level parallel requirements at the state level (see State-level population health plans box on page 23). Ideally, local and state-level plans would be aligned in their health priorities and coordinated in their implementation plans and strategies. States that have been successful in aligning state and community health planning processes have developed mechanisms for bi-directional communication between state and community health leaders. For example, hospitals and LHDs in New York are required to designate one or more individuals as their community health planning coordinators. These individuals receive updates from the New York State Department of Health (NYS

DOH) and are contacts for the hospital CHNA and LHD CHA processes (see snapshot of New York on page 22).⁵⁶ To ensure alignment between state and local health plans, some states also require hospitals and LHDs address state health priorities in their community health planning processes.⁵⁷ Maryland requires nonprofit hospitals consider the most recent health assessment developed by their state health department, local health department or the jurisdiction where the hospital is located in developing their CHNA.⁵⁸

Encourage collaboration, partnership and meaningful community engagement

Effective community health planning requires collaboration and partnership between the healthcare and public health sectors and other entities including schools, employers, social service agencies, and other community and faith-based organizations. All stakeholders must work together and share accountability and responsibility for moving the needle on improving the health of Ohioans.⁵⁹ To accomplish this, a diverse array of community stakeholders, including those impacted by proposed strategies, should be engaged at every stage of the community health planning process, including: collecting data, identifying priorities, identifying evidence-based interventions, investment in strategies and evaluation.⁶⁰

Although requirements for hospitals and LHDs encourage working with a wide array of partners, there is opportunity for further collaboration. For example, LHDs in North Carolina are synchronizing their timeline for CHAs/CHIPs with the three year timeline required for hospital CHNAs/ISs.⁶¹ North Carolina also has established a formal partnership between healthcare and public health stakeholders. The partnership developed measurable objectives for hospital and LHD community health planning activities around collaboration and improvement of health outcomes for the state's population (see snapshot of North Carolina on page 23).⁶² Other states, such as California and Texas, have instituted state-level guidelines requiring or encouraging hospitals to collaborate with LHDs and other community stakeholders throughout their community health planning process.⁶³

Increase transparency

Increasing transparency around hospital and LHD community health planning activities can encourage collaboration and partnership, community engagement, and alignment between state and local-level health planning. A number of states have implemented their own community health planning and community benefit reporting requirements (see Figure 15). Some of these states, such as Texas, Illinois, New York and Indiana, require hospitals and LHDs to submit their CHNA/IS and CHA/CHIP documents to state agencies and/or make these documents more accessible to the public.⁶⁴ In Ohio, there is no one place to easily access all of Ohio's most recent hospital and LHD community health planning documents or information on hospital and LHD community health improvement activities.

ORC § 3701.07 authorizes hospital registration by the Ohio Department of Health (ODH). As part of the hospital registration process, Ohio hospitals must submit an Annual Hospital Registration and Planning Report (AHR) by March 1 of every calendar year to ODH. Information required to be reported includes data on hospital classification and type, as well as descriptive data on hospital services provided. Hospitals, however, are not required to report on their community planning or

community benefit activities. The Ohio Hospital Association (OHA) has compiled a number of CHNA and IS documents for its member hospitals across the state and made them easily accessible at <http://ohiohospitals.org/Patient-Safety-Quality/Population-Health/Community-Health-Needs-Assessment.aspx>.

LHDs in Ohio are required to report on their activities to ODH through the Health Department Profile and Performance Database.⁶⁵ The Database includes performance, as well as financial and staffing data for LHDs in Ohio and serves as a tool for LHDs to assess their readiness for PHAB accreditation.⁶⁶ LHDs can voluntarily submit their CHA and CHIP documents to the Database. Some CHAs and CHIPs are also available on the ODH Network of Care site (<http://www.networkofcare.org/splash.aspx?state=ohio>).⁶⁷

Invest in the implementation and evaluation of evidence-based population health strategies

Hospitals, LHDs and other entities could be incentivized to invest in the implementation of evidence-based population health strategies as part of their community health planning improvement efforts. Evidence-based strategies refer to specific programs or policy changes that have been evaluated and proven to be effective in improving health. Population health strategies (see "What is population health?" box on page 10) reach a broader number of people, including those who do not need regular medical care and those who lack health insurance or adequate access to care. The implementation of population health strategies can address the health issues of today's patients, tomorrow's potential patients and improve the overall health and wellbeing of community residents.

There are a number of tools that identify evidence-based population health strategies that can be implemented by hospitals and LHDs. For information on evidence-based population health strategies, refer to:

- Guide to evidence-based prevention at <http://www.healthpolicyohio.org/tools/health-policy-tools/guide-to-evidence-based-prevention/>

- What Works for Health at <http://www.countyhealthrankings.org/roadmaps/what-works-for-health>
- The Community Guide at <http://www.thecommunityguide.org/>

Continuous tracking and evaluation of strategies implemented and actions taken to address a community's health needs is fundamental for effective community health planning. To ensure that actions taken are addressing the health needs of the community, it is critical that stakeholders invest in building hospital and LHD capacity to track progress towards defined and measurable objectives and outcomes.

Assess health disparities and promote health equity

To improve opportunities for all to achieve optimal health and to prevent and reduce disparities among different groups, community health planning activities must be built on an understanding of the distribution of health outcomes within a population. "Distribution" refers to differences in health outcomes across subpopulations, such as socioeconomic, racial/ethnic, or age groups.

Health disparities: Differences in health status among distinct segments of the population including differences that occur by gender, race or ethnicity, education or income, disability, or living in various geographic localities.

Health equity: The absence of differences in health that are caused by social and economic factors. Achieving health equity means that all people have the opportunity to achieve their full health potential, with no one at a disadvantage because of social or economic circumstances.

Collection of meaningful data by race, ethnicity, language, income level, zip code, census tract and other characteristics is a critically important aspect of the community health planning process. Using data to identify health disparities and inequities early on ensures that community health improvement

efforts are reflective of the characteristics and distribution of community residents. A focus on health disparities and health equity also promotes investment in targeted strategies that can be more effective for different groups of residents within the community.

State snapshots: what other states are doing to encourage effective community health planning

New York

Nonprofit hospitals in New York are required to complete and submit a community service plan (CSP), which mirrors the CHNA and IS required by the ACA, every three years.⁶⁸ CSPs must address two priorities from the New York State Health Improvement Plan (SHIP), the *Prevention Agenda 2013-17*. Nonprofit hospitals are required to provide annual CSP implementation updates, which include progress made on selected *Prevention Agenda* priority areas, to the Office of Public Health Practice within the state's Department of Health. LHDs are required to follow a similar process in the development of their CHAs. To reduce duplication and to increase the efficiency and effectiveness of community health planning activities, hospitals and LHDs are required to work together on development of their CHAs and CSPs.⁶⁹

Hospitals and LHDs are also required to designate one or more individuals as their CSP or CHA coordinators. These individuals receive updates from the New York State Department of Health (NYS DOH) and are the contacts for the hospital CSP and LHD CHA process. The NYS DOH reviews the submitted CSPs and CHAs and provides feedback on the plans. Technical assistance to support the development of these plans is also provided by the NYS DOH, the Greater New York Hospital Association, the Healthcare Association of New York State and the New York Association of County Health Officials, in addition to local health planning organizations.⁷⁰ The process in New York is intended to encourage collaboration between hospitals and LHDs, increase alignment between hospital and LHD community health planning documents, and track progress towards addressing priorities from the state's *Prevention Agenda*.

State-level population health plans

State Health Assessment (SHA): a requirement for state health department PHAB accreditation, the SHA is a collaborative process to identify and engage system stakeholders, collect and analyze health status data, collect and analyze stakeholder and community input data, and summarize, present and communicate the findings to the public.

State Health Improvement Plan (SHIP): a requirement for state health department PHAB accreditation, the SHIP serves as a system-wide planning guide for states to prioritize and address a state's health needs and identify resources to address those needs. The SHIP is intended to address health improvement, strengthen the public health infrastructure, and engage system partners in contributing to planning, implementation and evaluation of strategies that can improve the health of a state's population.⁷¹ ODH is currently in the process of updating the 2012-2014 SHIP and will begin work on the next SHA and SHIP later in 2015.

State Innovation Model (SIM): an initiative, through the Centers for Medicare and Medicaid Services (CMS), which provides funding for states to design and test new payment and healthcare delivery models. Ohio was one of 16 states to receive a design grant in 2013 for Round One of the SIM to develop a State Health Care Innovation Plan. In 2014, Ohio was one of 11 states in Round Two of the SIM to receive a model test award to implement their State Health Care Innovation Plan.

SIM Plan to Improve Population Health: states receiving a SIM Model test award must develop a state-wide plan to improve population health. Key population level measures proposed by CMS for this plan can be found here: <http://innovation.cms.gov/Files/x/SIMPopHlthMetrics.pdf>.

New Hampshire

New Hampshire defines community benefit broadly to include prevention activities and investments that promote or support a healthier community. The state adopted a data-driven community benefits reporting form that requires hospitals to report on hospital community benefit activities that address identified community needs. The form includes a list of potential community needs that address factors outside of the healthcare system that impact health including: poverty, unemployment, homelessness, economic development, educational attainment, high school completion, housing adequacy, and air and water quality.⁷² By defining community benefit broadly, hospitals in New Hampshire are encouraged to invest in a balanced portfolio of health improvement strategies that move beyond medical care to address the overall health of the population.

North Carolina

In North Carolina, state and local public health leaders, hospitals, and community stakeholders developed the North Carolina Public Health Hospital Collaborative (PHHC). The PHHC has seven primary partners including the North Carolina hospital association, the North Carolina association of local health directors, and the North Carolina Division of Public Health. The goals of the PHHC include promoting collaboration among hospitals and LHDs on their community health planning activities and aligning community health planning activities with hospital community benefit and state-level population health outcome goals. To guide their collaborative work from 2012-2014, the PHHC developed the following objectives:

- By April 15, 2012, 95% of North Carolina hospitals and health departments will understand the new CHA and community benefit requirements and the rationale for joint collaboration.
- By January 1, 2013, 75% of North Carolina hospitals and health departments will be working collaboratively on joint CHA and community benefit activities.
- By April 1, 2014, 20 North Carolina communities will show measurable improvements in Healthy North Carolina 2020 outcomes related to priorities from CHA and community benefit work.⁷³

In addition, the North Carolina Division of Public Health is tracking the number of LHDs in North Carolina that have decided to align with the three year health assessment cycle required of hospitals.⁷⁴

What is Ohio doing?

For the 2016-2017 biennium, Governor Kasich included language in his proposed budget regarding population health planning in Ohio. According to the Governor's Office of Health Transformation (OHT), the proposed budget language aims to improve collaboration among LHDs in Ohio and create new opportunities for regional community health planning to address some of Ohio's most critical health challenges, including infant mortality, tobacco use and chronic disease.⁷⁵ OHT also has indicated a desire to align the regional health plans with the SHIP and SIM population health plan (see State level health plans box for more information on these plans).⁷⁶

The proposed budget required the state to convene a "Population Health Planning and Hospital Community Benefit Advisory Workgroup" to recommend strategies for conducting regional CHAs and developing regional CHIPs. The workgroup would also be required to develop recommendations around the extent to which hospital community benefit should be used to address prioritized population health outcomes aligned with those being addressed in the regional CHIPs.⁷⁷

The proposed population health planning language was removed from the House version of the budget bill in April 2015. It is not clear whether the language will be included in the final version of the budget bill. OHT has indicated that they still plan to pursue discussions around improving the effectiveness of Ohio's community health planning activities.

Implications for action: How can hospitals, LHDs, community health leaders, funders and state policymakers increase the effectiveness of community health planning processes and improvement efforts?

1. Align state and local health plans.
2. Encourage collaboration, partnership and meaningful community engagement throughout all stages of the community health planning and improvement processes.
3. Increase transparency and access to community health planning documents and information on the impact of community health planning activities.
4. Invest in the implementation and evaluation of evidence-based population health strategies.
5. Assess health disparities and promote health equity.

Notes

1. Affordable Care Act (ACA) § 9007.
2. Internal Revenue Service Rules and Regulations. "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return." Federal Register 79, no. 250 (December 31, 2014): 78954. <http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf>
3. ACA §9007(b). "Excise Tax for Failures to Meet Hospital Exemption Requirements," established I.R.C. §4959, which imposes a \$50,000 excise tax for each year a tax-exempt hospital organization fails to meet the community health needs assessment requirement.
4. ACA §9007 (f)(2).
5. Internal Revenue Service Rules and Regulations. "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return." Federal Register 79, no. 250 (December 31, 2014): 78954. <http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf>
6. Ibid.
7. National Association of County & City Health Officials. "Local Health Department Accreditation: Findings from the 2014 Forces of Change Study." May 2014. <http://www.naccho.org/topics/research/forcesofchange/upload/Accreditation.pdf>
8. Public Health Accreditation Board. "Standards & Measures." December 2013. <http://www.phaboard.org/wp-content/uploads/SM-Version-1.5-Board-adopted-FINAL-01-24-2014.docx.pdf>
9. Ibid.
10. 2013 data. "Hospitals by Ownership Type." The Henry J. Kaiser Family Foundation. Accessed April 24, 2015. <http://kff.org/other/state-indicator/hospitals-by-ownership/>
11. The hospital list was retrieved from the Ohio Department of Health (ODH) Interactive Data Warehouse, Health Care Provider Report & Information Extract, Directory of Hospitals in April 2014. The list was then reconciled with hospital data from the Centers for Medicare and Medicaid Services (CMS) and the Health Resources Services Administration (HRSA). Hospital information is current as of July 25, 2014.
12. Medicare classification. "Health Care Provider Report & Information Extract." ODH Interactive Data Warehouse. Accessed January 2015. http://publicapps.odh.ohio.gov/eid/reports/EID_Report_Criteria.aspx
13. Data from Fiscal Year (FY) 2013. "Hospital Profile Quick Reports." American Hospital Association DataViewer. Accessed January 2015. <http://www.ahadataviewer.com/quickreport/>
14. Regions defined by AOHC. <https://odhgateway.odh.ohio.gov/LHDInformationSystem/Directory/GetLHDReport>
15. Data from Fiscal Year (FY) 2013. "Hospital Profile Quick Reports." American Hospital Association DataViewer. Accessed January 2015. <http://www.ahadataviewer.com/quickreport/>
16. 2013 data. "Hospitals by Ownership Type." The Henry J. Kaiser Family Foundation. Accessed April 24, 2015. <http://kff.org/other/state-indicator/hospitals-by-ownership/>
17. Public Health Accreditation Board, "Accredited Health Departments" Accessed April 24, 2015. <http://www.phaboard.org/news-room/accredited-health-departments/>
18. Based on data collected in "Quickstrike Project". See pg 15.
19. "Ohio Annual Financial Report." 2012. Ohio's Health Department Profile and Performance Database. Accessed September 2014.
20. Ibid.
21. Ibid.
22. Regions defined by AOHC. <https://odhgateway.odh.ohio.gov/LHDInformationSystem/Directory/GetLHDReport>
23. Internal Revenue Service. Rules and Regulations. "Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return." Federal Register 79, no. 250 (December 31, 2014): 78954. <http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf>. See also Public Health Accreditation Board. "Standards & Measures." December 2013. <http://www.phaboard.org/wp-content/uploads/SM-Version-1.5-Board-adopted-FINAL-01-24-2014.docx.pdf>
24. "Community Plan." ADAMH. Accessed April 22, 2015. <http://www.adamhfranklin.org/who-we-serve/community-plan/>; See also "Community Plan Guidelines." Ohio Department of Mental Health & Addiction Services. Accessed April 22, 2015. <http://mha.ohio.gov/Default.aspx?tabid=153>
25. Ohio Family and Children First. "HB 289 Shared Plan Guidance." November 2010. <http://fcf.ohio.gov/>

Notes (cont.)

- Portals/0/Home/Building%20Community%20Capacity/Shared%20Plan%20Guidance%2011.22.10.pdf; See also "FCFC Shared Plan Model (HB 289)." Ohio Family and Children First. Accessed April 22, 2015. <http://fctf.ohio.gov/BuildingCapacity/FCFCSharedPlanHB289.aspx>
26. "Health Center Program." Ohio Association of Community Health Centers. Accessed April 22, 2015. <http://www.ohiochc.org/?page=241&hhSearchTerms=%22need+and+assessment%22>; See also "What is the Section 330 Public Health Service Act Health Center Program?" Rural Assistance Center. September 17, 2013. <http://www.raconline.org/topics/federally-qualified-health-centers/faqs#whatisphs330>; See also National Association of Community Health Centers. "So You Want to Start a Health Center...? A Practical Guide for Starting a Federally Qualified Health Center." July 2011. <http://www.nachc.com/client/documents/Starting%20a%20FQHC%20Manual-September%202011.pdf>; See also "Program Requirements." Health Resources Services Administration. Accessed April 22, 2015. <http://bphc.hrsa.gov/about/requirements/>
27. United Way Worldwide. "Amended and Restated Bylaws of United Way Worldwide." May 13, 2009. https://secure.unitedway.org/page/-/UWWbylaws_Approved-2009.pdf; See also United Way of Delaware County. "2010 Community Needs Assessment." 2010. <https://www.liveuniteddelawarecounty.org/why-united-way/community-needs-assessment>
28. Community Action Partnership. "Community Needs Assessment Online Tool." August 17, 2012. <http://www.communityactioncna.org/ReportCardExample.pdf>; See also "About CAAs (Community Action Agencies)." Community Action Partnership. Accessed April 22, 2015. http://www.communityactionpartnership.com/index.php?option=com_content&task=view&id=21&Itemid=50; See also "Benefits of the Community Action Partnership Comprehensive Community Needs Assessment Online Tool." Community Action Partnership. Accessed April 22, 2015. <http://www.communityactioncna.org/benefits.aspx>
29. Federal Financial Institutions Examination Council. "Correspondence Date: March 25, 1996." March 25, 1996. http://www.ffiec.gov/cra/letters/letter_19960325.htm; See also "Community Reinvestment Act." Federal Financial Institutions Examination Council. January 21, 2015. Accessed April 22, 2015. <http://www.ffiec.gov/cra/default.htm>; See also Federal Reserve Bank of Chicago. "CRA Strategy Development: Developing a Bank CRA Strategy." December 20, 2010. <https://www.chicagofed.org/-/media/others/events/2011/cra-interagency-workshop-chicago/module-6-cra-strategy-12-20-10.pdf.pdf>
30. Ohio Association of County Behavioral Health Authorities (OACBHA). "County Board Directory." Accessed April 17, 2015. <http://www.oacbha.org/docs/MemberDirectory.pdf>
31. "About Ohio Family and Children First." Ohio Family and Children First. Accessed April 22, 2015. <http://www.fctf.ohio.gov/>
32. Federally-funded FQHCs (FQHC look-alikes are excluded). 2013 data. "Number of Federally-Funded Federally Qualified Health Centers." The Henry J. Kaiser Family Foundation. Accessed April 17, 2015. <http://kff.org/other/state-indicator/total-fqhc/>
33. "Find a Local United Way Organization." United Way. Accessed April 17, 2015. <http://apps.unitedway.org/myuw/ui/index.cfm?id=browsecities&zip=00000&ab-r=OH&app=>
34. From the Community Action Partnership directory. "Find a CAA." Community Action Partnership. Accessed April 17, 2015. http://www.communityactionpartnership.com/index.php?option=com_spreadsheets&view=search&spreadsheet=cap&Itemid=188
35. Health Policy Institute of Ohio. "What is Population Health?" November 2014. http://www.healthpolicyohio.org/wp-content/uploads/2014/11/WhatsPopHealth_PolicyBrief.pdf
36. The Hilltop Institute. "What are hospital community benefits?" February 2013. <http://www.hilltopinstitute.org/publications/WhatAreHCBSTwoPager-February2013.pdf>
37. Nelson, Gayle D. et. al. The Hilltop Institute. "Hospital Community Benefits after the ACA: State Law Changes and Promotion of Community Health." February 2015. <http://www.hilltopinstitute.org/publications/Hospital-CommunityBenefitsAfterTheACA-StateLawChanges-sueBrief10-Feb2015.pdf>; See also Rev. Rul. 69-545, 1969-2 CB 117, 119.
38. Bakken, Earl, and Dave Kindig. "Is Hospital Community Benefit Charity Care?" Wisconsin Medical Journal 111, no. 5 (2012): 215-19. See also Young, Gary J., et. al. "Provision of Community Benefits by Tax-Exempt U.S. Hospitals." New England Journal of Medicine, Oct. 2014.
39. I.R.C. § 6033.
40. Internal Revenue Service. "Chronological History; Redesign of the 2008 Form 990 and Corresponding Instructions." Accessed April 27, 2014. <http://www.irs.gov/Charities-&Non-Profits/Charitable-Organizations/Chronological-History-Redesign-of-the-2008-Form-990-and-Corresponding-Instructions>
41. Internal Revenue Service Rules and Regulations. "Additional Requirements for Charitable Hospitals: Community Health Needs Assessments for Charitable Hospitals; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return." Federal Register 79, no. 250 (December 31, 2014): 78954. <http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/2014-30525.pdf>
42. Internal Revenue Service. "Instructions for Schedule H (Form 990)." Accessed April 22, 2015. <http://www.irs.gov/pub/irs-pdf/990sh.pdf>
43. Ibid.
44. Ibid.
45. Rev. Rul. 69-545, 1969-2 C.B. 117, 119. The IRS uses a "facts and circumstances" test to determine if a hospital's community benefit expenditures are sufficient to support 501(c)(3) charitable status. See also statement by Lois Lerner, Director of the IRS Exempt Organizations Division, on the IRS Report on Nonprofit Hospitals, at a Press Briefing, Feb. 12, 2009. Retrieved from http://www.irs.gov/pub/irsteget/emerstatement_hospitalproject_021209.pdf; U.S. Congressional Research Service, Tax-Exempt Section 501(c)(3) Hospitals: Community Benefit Standard and Schedule H (2008). Retrieved from http://assets.opencrs.com/rpts/RL34605_20080731.pdf
46. Somerville, Martha H., Gayle D. Nelson, and Carl H. Muelner. The Hilltop Institute. "Hospital Community Benefits after the ACA: The State Law Landscape." March 2013. <http://www.hilltopinstitute.org/publications/Hospital-CommunityBenefitsAfterTheACA-StateLawLandscape-sueBrief6-March2013.pdf>; See also The Hilltop Institute, "Community Benefit Briefing" June 2011. Retrieved from <http://www.hilltopinstitute.org/publications/HCBP%20Newsletters/HCBPNewsletter-June2011.pdf>
47. California defines community benefit activities to include sponsoring food and shelter, as well as education and transportation. See Cal. Health & Safety Code §127345(c). Maryland's definition of community benefit includes community building activities such as physical improvements and housing and economic development that address an assessed need within the community. See Maryland Health Services Cost Review Commission. "Community benefits: 2015 Guidelines and definitions." 2015. http://www.hsrcr.state.md.us/documents/HSCRC_Initiatives/CommunityBenefits/DataCollectionTools/2015/Final-FY15-Community-Benefits-Guidelines-and-Definitions.pdf
48. Nelson, Gayle D. et. al. The Hilltop Institute. "Hospital Community Benefits after the ACA: State Law Changes and Promotion of Community Health." February 2015. <http://www.hilltopinstitute.org/publications/Hospital-CommunityBenefitsAfterTheACA-StateLawChanges-sueBrief10-Feb2015.pdf>
49. HPIO in partnership with RAPHI, collected and reviewed 107 unique Schedule H forms for Ohio nonprofit and government hospitals from 2012, based on a list of nonprofit and government hospitals retrieved from the Ohio Department of Health (ODH) Hospital Directory (see note 11 regarding hospital list). HPIO was able to collect Schedule H information for 159 of the hospitals identified in the ODH list. Forty-nine hospitals were included on a group Schedule H (more than two hospitals included on the Schedule H), 28 hospitals were included on a pair Schedule H (two hospitals included on the Schedule H), and 82 hospitals filed a Schedule H individually. Hospital community benefit and community building expenses were reported in aggregate on the group and pair Schedule H forms. Other hospital facilities not identified on the ODH list may have also been included in the Schedule H forms.
50. For the purposes of the community benefit analysis, Shriners Hospitals for Children was excluded because its group Schedule H included more than two hospitals outside of Ohio. Grace Hospital and Specialty Hospital of Lorain were also excluded from the analysis as outliers, due to their reporting of negative net community benefit spending.
51. Based on Ohio 2013 population estimate of 11,572,005. United States Census Bureau. "Ohio QuickFacts." March 31, 2015. Accessed May 1, 2015. <http://quickfacts.census.gov/qfd/states/39000.html>
52. Ibid.
53. HPIO and RAPHI worked together to modify an existing CHA/CHIP review tool developed by the University of Wisconsin Population Health Institute. The modified CHA/CHIP review tool includes a version tailored to review hospital CHNA/IS documents. Additionally, the modified tool focuses on analyzing health priorities identified in hospital and LHD community health planning documents, which was a feature not included in the Wisconsin tool. The hospital CHNA/IS version of the tool shares many of the same or similar items with the LHD CHA/CHIP version of the tool. The HPIO and RAPHI research teams used these modified and standardized tools to review and extract data and information from the hospital and LHD CHNA, IS, CHA and CHIP documents.
54. Communities covered by at least one CHNA included all but four counties in Ohio. Counties not covered were: Clinton, Fayette, Pickaway and Vinton.
55. As of April 2014, there are 123 LHDs in Ohio.
56. New York State Department of Health. "Local Health Department Community Health Assessment and Improvement Plan and Hospital Community Service Plan Guidance, 2013." December 10, 2012. https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/planning_guidance.pdf
57. Ibid.
58. The Hilltop Institute. Community Benefit State Law Profiles. "A 50-State Survey of State Community Benefit Laws through the Lens of the ACA". Maryland. Accessed April 27, 2014. http://www.hilltopinstitute.org/hcbp_cbl.cfm
59. Rosenbaum, Sara. The George Washington University School of Public Health and Health Services, Department of Health Policy. "Principles to Consider for the Implementation of a Community Health Needs Assessment Process." June 2013. http://nnpri.org/CMSSuploads/PrinciplesToConsiderForTheImplementationOfACHNAProcess_GWU_20130604.pdf
60. Ibid.
61. "Community Health Assessment: Assessment Cycle." NC Division of Public Health. Accessed April 24, 2015. <http://publichealth.nc.gov/lhd/cha/cycle.htm>
62. "NC Public Health/Hospital Collaborative." UNC Gillings School of Global Public Health. Accessed April 24, 2015. <http://sph.unc.edu/nciph/nciph-home/nciph-ph-hosp-collab/>
63. The Hilltop Institute. Community Benefit State Law Profiles. "A 50-State Survey of State Community Benefit Laws through the Lens of the ACA". Accessed April 27, 2014. http://www.hilltopinstitute.org/hcbp_cbl.cfm
64. Ibid.
65. Ohio Department of Health. "State Fiscal Year 2012 Annual Report." 2012. <https://www.odh.ohio.gov/-/media/ODH/ASSETS/Files/health%20resources/reports/Annual%20Report%20FINAL%20VERSION%202012.ashx>
66. "Profile and Performance." Ohio Department of Health. December 31, 2014. Accessed April 24, 2015. <https://www.odh.ohio.gov/localhealthdistricts/profileandperformance.aspx>
67. "Network of Care: Ohio." Network of Care. Accessed April 2015. <http://www.networkofcare.org/splash.aspx?state=ohio>
68. N.Y. Pub. Health Law § 2803-I.
69. New York State Department of Health. "Local Health Department Community Health Assessment and Improvement Plan and Hospital Community Service Plan Guidance, 2013." December 10, 2012. https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/docs/planning_guidance.pdf
70. Ibid.
71. Association of State and Territorial Health Officials. "State Health Improvement Plan (SHIP) Guidance and Resources." 2011. <http://www.astho.org/accr/accr/ship/>
72. Nelson, Gayle D. et. al. The Hilltop Institute. "Hospital Community Benefits after the ACA: State Law Changes and Promotion of Community Health." February 2015. <http://www.hilltopinstitute.org/publications/Hospital-CommunityBenefitsAfterTheACA-StateLawChanges-sueBrief10-Feb2015.pdf>
73. "NC Public Health/Hospital Collaborative." UNC Gillings School of Global Public Health. Accessed April 24, 2015. <http://sph.unc.edu/nciph/nciph-home/nciph-ph-hosp-collab/>
74. "Community Health Assessment: Assessment Cycle." NC Division of Public Health. Accessed April 24, 2015. <http://publichealth.nc.gov/lhd/cha/cycle.htm>
75. Office of Health Transformation. "Improve Population Health Planning." February 2, 2015. Accessed April 24, 2015. <http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=VKS1JKWUH48%3d&tabid=252>
76. Ibid.
77. Ibid.

Appendix

Community health planning resources

Resource	Description	Website
ACHI Community Health Assessment Toolkit	The ACHI Community Health Assessment Toolkit is a guide for planning, leading and using community health needs assessments to better understand -- and ultimately improve -- the health of communities. This toolkit includes examples and guidelines to an assessment framework.	http://www.assesstoolkit.org/
Assessment Protocol for Excellence in Public Health	The Assessment Protocol for Excellence in Public Health (APEXPH) is a flexible planning tool developed for local health officials to: <ul style="list-style-type: none"> • assess the organization and management of the health department; • provide a framework for working with community members and other organizations to assess the health status of the community; and • establish the leadership role of the health department in the community 	http://www.naccho.org/topics/infrastructure/APEXPH/
Asset-Based Community Development Institute	The Asset-Based Community Development Institute (ABCD) is at the center of a large and growing movement that considers local assets as the primary building blocks of sustainable community development. Building on the skills of local residents, the power of local associations, and the supportive functions of local institutions, asset-based community development draws upon existing community strengths to build stronger, more sustainable communities for the future. This Institute offers tools and trainings to mobilize asset-based community mapping and development.	http://www.abcdinstitute.org/about/
Catholic Health Association, Assessing and Addressing Community Health Needs	Assessing and Addressing Community Health Needs was developed to help not-for-profit health care organizations strengthen their assessment and community benefit planning processes. Using CHA's previous work, the experience of community benefit professionals and public health expertise, this book offers practical advice on how hospitals can work with community and public health partners to assess community health needs and develop effective strategies for improving health in our communities.	https://www.chausa.org/communitybenefit/printed-resources/assessing-and-addressing-community-health-needs
Centers for Disease Control and Prevention's Community Health Improvement Navigator	A one-stop-shop that offers hospitals and other community stakeholders expert vetted tools and resources for: <ul style="list-style-type: none"> • identifying geographic areas of greatest need within communities, • establishing effective collaborations, • finding interventions that work for the greatest impact on health and wellbeing for all 	www.cdc.gov/CHInav
Community Commons	County-level data on health outcomes, health behaviors, clinical care, social and economic factors and the physical environment. Maps of sub-county-level data available for some indicators. Vulnerable Populations Footprint tool provides sub-county maps of low educational attainment and high poverty. Breakouts by age, race/ethnicity, and other characteristics available for some indicators. Trend data available for some indicators. Includes data visualization, mapping, and CHNA report tools.	http://www.communitycommons.org/
Community Guide (Guide to Community Preventative Services)	The "gold standard" source for evidence-based public health interventions in community settings. Covers a wide range of health topics. Provides recommendations and identifies interventions for which there is insufficient evidence.	http://www.thecommunityguide.org/
Community Health Advisor	Database of evidence-based policies and programs to reduce tobacco use and increase physical activity. Includes interactive tool that generates state and county-level estimates of the health and cost impact of implementing specific interventions.	http://www.communityhealthadvisor.org/
Community Indicators Consortium	CIC offers a variety of resources to help indicators' practitioners as well as those just interested in learning about indicators projects, including: webinar, a database of community indicators projects, and resources relevant to the field of community indicators.	http://www.communityindicators.net/resources

Resource	Description	Website
County Health Rankings Action Cycle	Each step on the Action Cycle is a critical piece of making communities healthier. There is a guide for each step that describes key activities within each step and provides suggested tools, resources, and additional reading.	http://www.countyhealthrankings.org/roadmaps/action-center/assessneeds-resources
County Health Rankings & Roadmaps	County-level data on health outcomes, health behaviors, clinical care, social and economic factors, and the physical environment.	http://www.countyhealthrankings.org/
HPIO Guide to Evidence-Based Prevention	Description of key concepts in evidence-based decision-making and guidance on how to identify credible sources of what works to improve health. Includes links to recommended sources of evidence to address Ohio's highest priority health problems.	http://www.healthpolicyohio.org/tools/health-policy-tools/guide-to-evidence-based-prevention/
Healthy People 2020 MAP-IT Guide	The MAP-IT framework can be used to help: <ul style="list-style-type: none"> • mobilize partners. • assess the needs of a community. • create and implement a plan to reach Healthy People 2020 objectives. • track a community's progress. 	https://www.healthypeople.gov/2020/tools-and-resources/Program-Planning
HPIO Health Value Dashboard	Identifies Ohio's greatest health challenges and strengths. Includes state-level data for population health, healthcare cost, prevention and public health, access, healthcare system, social and economic environment, and physical environment. Provides links to local-level data when available.	http://www.healthpolicyohio.org/2014-health-value-dashboard/
Mobilizing for Action through Planning and Partnerships	Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning tool for improving community health. This tool includes detailed steps and guidelines for conducting a community assessment.	http://www.naccho.org/topics/infrastructure/mapp/framework/index.cfm
NACCHO Resource Center for Community Health Assessments and Community Health Improvement Plans	The Resource Center for Community Health Assessments and Community Health Improvement Plans (CHA/CHIP Resource Center) provides practical, customizable tools and resources to all local health departments (LHDs) in a central and publicly accessible location. The resource center is intended to support LHDs and their partners in completing community health improvement processes, including the conduct of a community health assessment (CHA) and the development of a community health improvement plan (CHIP), for the purpose of improving the health of local communities.	http://www.naccho.org/topics/infrastructure/CHAIP/chachip-online-resource-center.cfm
National Public Health Performance Standards	The National Public Health Performance Standards (NPHPS or the Standards) provide a framework to assess capacity and performance of public health systems and public health governing bodies. This framework can help identify areas for system improvement, strengthen state and local partnerships, and ensure that a strong system is in place for addressing public health issues.	http://www.cdc.gov/nphps/
Ohio Department of Health Network of Care	County- and city-level data on a wide variety of health outcomes and behaviors as well as the social and physical environment. Breakouts by age, race, ethnicity, and other characteristics available for some indicators. Trend data and peer county comparisons available for some data.	http://www.odh.ohio.gov/features/odhfeatures/Network%20of%20Care.aspx
Principles to Consider for the Implementation of a Community Health Needs Assessment Process	This document identifies guiding principles to inform the implementation of the Affordable Care Act's community health needs assessment provisions applicable to not-for-profit hospitals that seek federal tax-exempt status. These principles offer a pathway for hospitals, public health entities and other interested parties to work collaboratively to address the health needs of their communities.	http://nnphi.org/CMSuploads/PrinciplesToConsiderForTheImplementationOfACHNAProcess_GWU_20130604.pdf
University of Kansas Community Health Toolbox	This toolkit provides guidance for conducting assessments of community needs and resources. This includes examples and outlines for conducting community assessments.	http://ctb.ku.edu/en/assessing-community-needs-and-resources
What Works for Health (County Health Rankings)	Searchable database of evidence-based programs and policies to address health behaviors, clinical care, social and economic factors, and the physical environment. Includes a rating of the strength of evidence for each strategy.	http://www.countyhealthrankings.org/roadmaps/what-works-for-health

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