

# Community-Based Health Needs Assessment Activities: Opportunities for Collaboration Between Public Health Departments and Rural Hospitals

## Executive Summary

Since the passage of IRS and Public Health Accreditation Board requirements for community-based health assessments in 2011, state and federal agencies have sought ways of encouraging collaboration between local public health departments and rural hospitals. This document explores the framework and regulatory background that have informed how and why rural communities approach community-based health needs assessments. It also looks at opportunities and barriers that local public health departments and rural hospitals face in their attempts to work collaboratively on projects. By scanning models from across the country, the authors are able to explore areas of education and collaboration, funding, and data sharing as opportunities for increased collaboration. Lastly, the scan provides several recommendations for how state offices of rural health and state health officials can work collaboratively to encourage local public health departments and rural hospitals to complete joint community-based health needs assessments.

## Introduction

Developing community-based health needs assessments (CHNAs) has been a cornerstone of local health and human service planning for decades. However, this process was voluntary until IRS released its CHNA requirements for nonprofit hospitals and the Public Health Accreditation Board added CHNAs to its accreditation requirements for health departments. The authors developed this scan at HRSA's request to provide background information and recommendations on CHNAs in rural communities. This document aims to foster dialogue and collaboration on data sharing and CHNAs among rural and public health leaders.

For the purpose of this scan, the term "community-based health needs assessment" is broadly defined according to [CDC's definition](#) of a "process of community engagement; collection, analysis, and interpretation of data on health outcomes and health correlates/determinants; identification of health disparities; and identification of resources that can be used to address priority needs."<sup>1</sup> Although much of the literature discusses "CHNAs" and "community health assessments" (CHAs) interchangeably, for this scan the authors identify CHNAs as the documents that hospitals must develop to meet IRS nonprofit status requirements, while referring to CHAs as the assessments that public health departments must conduct in order to seek accreditation status.

This scan provides background information on two major policies affecting needs assessments: requirements for nonprofit hospitals under federal tax law, and requirements for accredited public health departments as part of their accreditation process. It also covers examples of how states have been planned, conducted, and utilized CHNAs. At the end of the document, we have provided a list of resources and recommendations for policymakers, state offices of rural health directors, state health officers, local public health departments, rural hospitals, and other community planners.

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## Background

In the 1980s, health organizations began developing community engagement documents and initiatives, termed “community appraisals,” in response to the rigidity of traditional epidemiological models and survey questionnaires. Several iterations of the models became popular, including rapid evaluation methods, rapid appraisal methods, rapid community surveys, participatory rural appraisal, and relaxed rural appraisal. One [study](#) found that “when [community appraisals] were perfectly executed, they provided valuable, reliable and timely information on health status, knowledge, attitudes, and behaviors.”<sup>2</sup>

Over the last 15 years, two major changes have directly affected states’ and localities’ needs assessment activities. In 2011, the Public Health Accreditation Board (PHAB) [adopted](#) policies to establish a national system of public health accreditation. Additionally, after the policy changes provided by Public Law 111-148, the IRS modified the Internal Revenue Code in 2010 to require tax-exempt hospitals to provide proof of community engagement. The table below provides an overview of the regulatory timelines and policy changes regarding community-based health assessments.

Timeline of Regulatory and Policy Changes Relevant to Hospitals and Public Health Department Assessments		
Year	Event	Affected Entities
2003	Institute of Medicine publishes <i>The Future of the Public’s Health</i> report discussing public health department accreditation.	Public health departments

2004	CDC <a href="#">publicly supports</a> public health department accreditation.	Public health departments
2005	Robert Wood Johnson Foundation participates in public health department accreditation knowledge gathering.	Public health departments
2007	PHAB launches national standards for public health department accreditation.	Public health departments
2010	IRS proposes new CHNA policies for nonprofit hospitals.	Hospitals
2011	PHAB adopts CHNA accreditation policies.	Hospitals
2014	IRS publishes final rules requiring nonprofit hospitals to prove community engagement.	Hospitals

*Public Health Accreditation Board Policies*

In 2003, the Institute of Medicine published its report [The Future of the Public’s Health](#), which initially called for a steering committee to examine the potential benefits of accrediting public health departments.<sup>3</sup> In 2004, CDC identified accreditation as a key strategy. With the assistance of the Robert Wood Johnson Foundation, a workgroup of stakeholders convened for the Exploring Accreditation project in 2005, and PHAB launched in May 2007. After developing, testing, and revising the accreditation standards, PHAB launched its national public health accreditation program in September 2011.<sup>4</sup>

*IRS Policies*

Prior to the adoption of Public Law 111-148, nonprofit hospitals had to justify their nonprofit, tax-exempt status by showing that they provided a public benefit. Shortly after the IRS implemented its new community needs assessment requirements in March 2010, health leaders and policymakers recognized that states and localities had already developed a wide range of community-based health needs assessments. In some rural communities, hospitals and local health departments conducted similar surveys of the same people, analyzed data without the benefit of each organization’s access to different types of data, and sometimes planned duplicative or competing program activities for the same populations.<sup>5</sup>

The narrative below highlights aspects of the PHAB and IRS policies, discusses the overlap between the requirements, and identifies barriers to collaboration. The narrative also identifies strategies that SORHs used to foster collaboration between rural hospitals and health departments to complete the required community-based health needs assessments. It further discusses resources and recommendations for SORHs, state health officers, and other rural leaders that may help increase collaboration. The authors hope that this information may help illustrate rural communities’ public health needs and outline ways that hospitals and public health departments can work together to meet those needs.

**Hospital Requirements for Community Health Needs Assessments**

On March 23, 2010, Public Law 111-148 was signed into law, which, in part, established the following federal requirements for tax-exempt hospitals under Internal Revenue Code Section 501(r):

- Conduct a community health needs assessment every three years and adopt an implementation strategy to meet needs identified in the assessment.

- Adopt a written financial assistance policy that includes eligibility criteria, methods used to calculate charges, applications for assistance, and actions associated with billing and collections.
- Limit charges for services to levels equivalent to amounts generally billed for insured patients.
- Make reasonable efforts to determine an individual's eligibility for financial assistance prior to extraordinary measures to secure payment.<sup>6</sup>

After an extensive commenting period, IRS released its final ruling on the implementation of Public Law 111-148, with an effective date of December 29, 2014. The [final IRS ruling](#) defined several processes and requirements regarding CHNAs, including:

- Hospitals may build on previously completed CHNAs, but are required to solicit input from persons representing the broad interests of the community with each CHNA, even if the CHNA builds upon one previously conducted.
- Input from “persons representing the broad interests of the community” must include, at a minimum:
  - At least one state, local, tribal, or regional governmental public health department.
  - Members of the medically underserved, low-income, and minority populations in the community, or individuals or organizations serving or representing the interests of such populations.
  - Written comments received on the hospital facilities' most recently conducted CHNA and most recently adopted implementation strategy.
- While the use of a public health expert in conducting the CHNA is permissible, it does not replace the requirement of soliciting input from the governmental health department.<sup>7</sup>

Since the launch of the IRS requirements, nonprofit hospitals have been required to submit annually two pieces of documentation to the IRS. The first is a simple attestation that the above work has been completed; the second is a list of three focus areas of need that the hospital identified during the CHNA process. The nonprofit hospital must attest on its form 990 that it is undertaking strategies to address these three focus areas of need. In the future, the IRS will require nonprofit hospitals to submit additional information related to their strategies and the financial benefit the hospital is providing to the community.

### **Public Health Accreditation Requirements for Community Health Assessments**

PHAB established its first public health department accreditation processes in 2004, and fully implemented its accreditation standards in September 2011. Public health department accreditation aims to:

- Promote high performance and continuous quality improvement.
- Recognize high performers that meet nationally accepted standards of quality and improvement.
- Illustrate health department accountability to the public and policymakers.

- Increase the visibility and public awareness of governmental public health, leading to greater public trust and increased health department credibility, and ultimately a stronger constituency for public health funding and infrastructure.
- Clarify the public's expectations of health departments.<sup>8</sup>

To become accredited, a public health department must meet certain PHAB requirements, which are divided into domains with subsequent mandatory standards within each domain. Domain 1 indicates that public health departments must “conduct and disseminate assessments focused on population health status and public health issues facing the community.” The subsequent standards require public health departments to:

- Participate in or lead a collaborative process resulting in a CHA.
- Collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population.
- Analyze public health data to identify trends in health problems, environmental public health hazards, and social and economic factors that affect the public's health.
- Provide and use the results of health data analysis to develop recommendations regarding public health policy, processes, programs, or interventions.

More information on the PHAB accreditation requirements is available in its comprehensive [Standards and Measures 1.5](#) document.<sup>9</sup>

### **Intersection of Community-Based Health Needs Assessments and Community Health Assessment Requirements**

Although there are some differences between the CHNA process for hospitals and the CHA process for public health departments, both types of assessments aim to establish a clear documentation of needs and response to those needs. Both IRS and PHAB have noted that they prefer entities to collaborate to complete these projects rather than work independently. IRS has also ruled that a hospital facility that collaborates with a governmental public health department to conduct its CHNA may adopt a joint CHNA/CHA report produced by the hospital facility and public health department, as long as the other requirements applicable to joint CHNA reports are met.

PHAB noted in its 2014 [National Public Health Department Accreditation report](#) that accredited health departments can achieve an enhanced improvement initiative by coordinating with a local hospital for the IRS requirements for the CHNA.<sup>10</sup> Domain 1, Standard 1.2 requires health departments to collect and maintain reliable, comparable, and valid data on conditions of public health importance and on the health status of the population.

### **Benefits of and Barriers to a Collaborative Approach**

There are several observable benefits when hospitals and public health departments increase their collaborative efforts to complete joint CHNA/CHAs. Most notably, the limited resources in rural communities are better utilized effectively when entities share staff time and costs. In addition, when

organizations collaborate, their combined expertise and available services can create a stronger focus on the community's health needs and the systems that can address those needs.

Collaboration may also improve patients' access to the system of care, which can otherwise be cumbersome for those with lower health literacy or navigation difficulties. Additionally, successful collaboration between hospitals and public health departments may pave the way for future endeavors, including building a basis for successful grant applications, reducing hospital readmissions, reducing emergency department overutilization, and empowering a community-wide approach to healthcare.

One major barrier to completing a joint CHNA/CHA is the fact that hospitals and health departments have different reporting requirement timelines. PHAB requires health departments to complete CHAs every five years, while the IRS requires hospitals to complete CHNAs every three years. Commentators on the final IRS requirement ruling suggested moving the CHNA requirement to a five-year cycle from the three-year requirement to "avoid duplication of effort and incentivize hospital facilities to collaborate more fully with local public health departments."<sup>11</sup> However, the IRS did not adopt the suggestions, and this barrier remains.

### **State Offices of Rural Health Strategies for Community-Based Health Needs Assessments and Community Health Assessments**

Each state has a dedicated SORH. These offices vary in size, scope, organization, and in available services and resources. Most SORHs are within state health departments (37), but some are based in universities (10) or nonprofit organizations (3).

SORHs aim to help their communities improve rural healthcare delivery systems. Although their funding levels and sources vary, each SORH receives a portion of its funding from the Federal Office of Rural Health Policy (FORHP) through the SORH Grant program, begun in 1991. Through this grant, FORHP expects each SORH to: (1) collect and disseminate information, (2) coordinate rural health care activities in states to avoid duplication, and (3) provide technical assistance to public and nonprofit private entities. These three core activities aim to help support rural communities, make rural public health efforts more efficient, and more effectively utilize rural communities' scarce resources.

Leveraging a variety of funding mechanisms, SORHs have a long history of ensuring appropriate needs assessment for rural communities. Since the SORH program began, many offices have provided data, educated community planning bodies, facilitated community decision-making models, provided technical assistance to identify strategies and options for meeting community health needs, convened and coordinated efforts to engage a wide array of stakeholders, and leveraged resources to support community-based solutions. Although each SORH's capacity to address CHNA activities in its state depends on the rural communities' needs and the SORH's available resources, SORHs often help promote education and collaboration, funding, and data sharing.

#### *Education and Collaboration*

In keeping with their core function to coordinate activities in rural areas and reduce duplication, several SORHs have undertaken initiatives to encourage communities to conduct joint CHNAs/CHAs. **Missouri's Office of Primary Care and Rural Health** has conducted workshops on how to complete a joint



CHNA/CHA, and continues to encourage ongoing collaboration between hospitals and public health departments.

**Ohio's Rural Health Section** leveraged available funding to conduct four [Regional Community Health Needs Assessments](#) through multiple partnerships.<sup>12</sup> This assessment provided quantitative and qualitative data down to the county level to help hospitals and health departments complete joint CHNAs/CHAs. The program also offered webinars through national partnerships with the National Rural Health Resource Center.

Recent work by **Nebraska's Office of Rural Health** culminated in a study, through a collaborative effort with the Nebraska Center for Rural Health Research, identifying several trends in assessment work from 31 rural Nebraska hospitals that participated in the study. Most notably, the research indicated that "hospitals that had a strong partnership with their local health departments were more likely to have more complete [implementation] plans (e.g., a description of data collection methods, a more detailed analysis of the data, and clearer implementation strategies)."<sup>13</sup> In addition, the research noted that local health departments played a lead role in coordinating the CHNA process for 65 percent of the hospitals, with the health departments typically utilizing the Mobilizing for Action through Planning and Partnerships process to complete the assessments.

**Arizona** has very large geographic counties that are diversely populated. The state is home to 22 tribes, and faces concerns related to border health, such as language barriers. As a result, health professionals must be cognizant of such differences as they pursue completion of community-based health needs assessments. The Arizona Department of Health Services has provided additional funds to local health departments to help them work toward accreditation as part of their statewide accreditation process. Because of the state's vast land mass, shortage of healthcare providers, reduced availability of state funding, and diverse cultural beliefs, its rural communities recognize the need for high levels of collaboration. **Arizona's Center for Rural Health** has found that its unique placement at the University of Arizona's Mel & Enid Zuckerman College of Public Health allows it to leverage its relationships with both hospitals and health departments to engage and further this natural collaboration.

**Oklahoma's Office of Rural Health**, the **Colorado Rural Health Center**, and the **Montana Office of Rural Health** continue to facilitate CHNAs and encourage collaboration between hospitals and local health departments. When timelines align between the health departments seeking accreditation and local hospitals, the SORH facilitators encourage these entities to complete joint CHNAs/CHAs and reports. If the timelines do not align, the SORHs will still encourage local health departments to stay engaged as stakeholders, instead of just key informants, throughout the process.

**Oklahoma's Office of Rural Health** has developed one strategy to address the issue of timeline misalignment. When facilitating a hospital CHNA on a different schedule from the public health department CHA, they look to see if the public health department has recently completed a CHA. If so, the SORH coordinates with the public health department to use metrics and methodology from the CHA as the foundation for the hospital's CHNA. Through additional focus groups and input from the local health department, the hospital can leverage the work of the public health department in completing their CHNA even with misalignment of timelines.

The **North Dakota Center for Rural Health**, the state's SORH, developed a rural-specific CHNA model that it details in the report [Conducting Community Health Needs Assessments in Rural Communities: Lessons Learned](#).<sup>14</sup> The SORH found that the most effective model of conducting a CHNA/CHA in rural communities was the rural community group model, loosely based on the [National Center for Rural Health Works' CHNA toolkit](#). In this model, the local community is required to establish a steering committee composed of local leaders from hospitals, public health departments, and other community organizations. In addition, the Center for Rural Health recently modified the survey tool to meet the needs of the hospital CHNA and the public health CHA. Under this model, the hospital and health department collaborate to align their efforts through a bottom-up approach to community engagement. The process has evolved from simply conducting the CHNA for the community to a collaborative effort between the Center for Rural Health and community members, with the intent of building capacity, increasing community member' understanding of the process and value of the information gathered, and determining how to best utilize findings to create community solutions.

#### *Funding*

To encourage CHNA/CHA joint development, some state departments of health have started providing mini-grants and assistive funding to hospitals and public health departments for this process.

**Kansas' Bureau of Community Health Systems** provided a framework, in collaboration with Kansas Department of Health and Environment's Local Public Health Program, to provide mini-grants for rural communities that were completing a joint CHNA and CHA. The program, which ASTHO highlighted in a [case study](#), aimed to facilitate collaboration between the local public health departments and hospitals.<sup>15</sup>

Although **Arizona's Center for Rural Health** does not provide funding to rural communities to complete a joint CHNA/CHA, Arizona Department of Health Services does provide funding to encourage local health departments to initiate the process of accreditation. This funding is one of the mechanisms by which the Arizona's SORH can support collaboration in communities that are not already doing so.

#### *Data Sharing*

Data sharing can be very beneficial to rural communities. **Indiana** undertook such a project, which ASTHO highlighted in a [case study](#).<sup>16</sup> Multiple divisions of the Indiana State Department of Health (including **Indiana's State Office of Rural Health and Primary Care**) collaborated with the Indiana Hospital Association, the Indiana University Public Policy Institute, and the Indiana Business Research Center to develop an online platform to provide data sharing. The Indiana INdicators [website](#) provides an online dashboard for users to explore local data sets, providing a comprehensive list of county-level data used in conducting and completing community-based health needs assessments.<sup>17</sup>

#### *Tying Strategies Together: New York Prevention Agenda*

**New York's** state health improvement plan, the [New York Prevention Agenda](#), discusses many strategies related to education and collaboration, funding, and data sharing.<sup>18</sup> This plan specifically highlights the core areas of chronic disease prevention; healthy and safe environments; healthy women, infants, and children; mental health and substance abuse; preventing HIV, sexually transmitted diseases, vaccine-preventable disease, and healthcare-associated infections. Each core area contains evidence-based interventions associated with achieving the core area's goals. When a hospital or health department in



the state completes a community-based health needs assessment, it is required to identify at least two of the core areas and evidence-based interventions from the prevention agenda for implementation. The collected information is reported back to the state, which then houses the data in the online, publicly available [Prevention Agenda Dashboard](#).<sup>19</sup> The New York State Department of Health, which includes the **New York Office of Rural Health**, continuously provides education and technical assistance to local hospitals and health departments as they strive toward their goal of making New York the healthiest state.

### **Recommendations for Collaboration on Community-Based Health Needs Assessments and Community Health Assessments**

To ensure the best use of staff expertise, community engagement, and documentation of need, SORH directors and state health officials should consider a collaborative approach to planning for the needs of rural populations. The following recommendations are meant to provide a starting point for such discussions, which may ultimately result in better strategies for assessment and health planning:

- Ensure that the target populations and areas served are aligned, and identify timelines of assessment report completion.
- Conduct preliminary meeting(s) to identify available data from public health departments and hospitals, and note what data will need to be identified.
- Agree to a model for conducting a community-based health needs assessment that encourages collaboration, either using an experienced facilitator or using the [Rural Community Group Model](#).<sup>20</sup>
- Ensure joint messaging around the purposes of the assessment to encourage hospitals and health departments to work together.
- Develop partnerships with key stakeholders, including other rural providers, such as federally qualified health centers, rural health clinics, and other non-health entities that serve rural populations.
- State health officials can ensure funding to local public health departments for completing their community health assessments and work with SORHs to encourage collaboration between public health departments and hospitals during the process.
- Develop a joint implementation strategy to share scarce resources and reduce burden to a single organization.

The above recommendations can help policymakers and executives foster collaboration between public health departments and hospitals in rural areas. This collaboration may ultimately lead to better health outcomes for rural areas, a decrease in possible duplicated services, and better synergy between the work of SORHs and state health officials.

### **Conclusion**

There are multiple requirements and standards encouraging rural health stakeholders to complete community-based health needs assessments, most notably IRS standards for rural hospitals and PHAB standards for health departments. These are both products of trends over the last two decades. To address the unique needs of rural communities, SORHs have the potential to be useful and insightful

stakeholders in the CHNA process for these communities. SORHs, health departments, and rural hospitals can collaborate on CHNAs in several concrete ways. The approaches listed above are just some of many ways in which improved communication, relationships, and data usage can be integrated with existing required activities to improve access to care and care outcomes in rural areas.

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**Appendix A:**  
**Resources for Conducting a Joint CHNA and CHA**

There are many resources available to communities seeking to complete a joint CHNA/CHA, including:

*Rural Health Information Hub*  
[Resources for Community Health Projects](#)

*ASTHO*  
[Health Systems Transformation: Community Health Needs Assessments](#)  
[Public Health Accreditation and Performance](#)

*Center for Rural Health Works*  
[Community Health Needs Assessment Toolkit](#)

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