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## **Collaborative Community Health Needs Assessments: Approaches and Benefits for Critical Access Hospitals (FMT Policy Brief #36)**

John A. Gale MS

*University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center*

Andrew F. Coburn PhD

*University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center*

Helen E. Newton BA

*Bowdoin College*Follow this and additional works at: [https://digitalcommons.usm.maine.edu/rural\\_hospitals](https://digitalcommons.usm.maine.edu/rural_hospitals)Part of the [Health and Medical Administration Commons](#), [Health Policy Commons](#), [Health Services Administration Commons](#), and the [Health Services Research Commons](#)

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# Collaborative Community Health Needs Assessments: Approaches and Benefits for Critical Access Hospitals

*John A. Gale, MS, Andrew F. Coburn, PhD, University of Southern Maine  
Helen E. Newton, BA, Bowdoin College*

## Background

Recent policy and regulatory changes are creating an environment in which hospitals, public health departments, and other health care organizations are held accountable for identifying and addressing the health needs of their communities. For hospitals, this accountability is driven by 1) the Internal Revenue Service's 2007 revisions to Form 990, Schedule H that established a mandatory community benefit reporting framework for 501(c)3 (tax exempt) hospitals and 2) the 2010 Affordable Care Act's requirement that tax exempt hospitals conduct triennial community health needs assessments (CHNAs) with input from public health experts and other community stakeholders.<sup>1</sup> For public health organizations, the Public Health Accreditation Board's (PHAB) 2011 national voluntary public health accreditation standards require public health departments seeking accreditation to "participate in or conduct a collaborative process resulting in a comprehensive community health assessment" that is "focused on population health status and public health issues facing the community."<sup>2</sup> In addition, Federally Qualified Health Centers and other community health care organizations are often required by their funders and/or mission statements to conduct local need assessments to support their service delivery plans. Conducting effective CHNAs requires resources and capacity that individual rural hospitals and communities may lack. Collaboration among hospitals and communities has the potential for achieving efficiencies in the collection and analysis of local and regional health data and in supporting a robust community engagement process<sup>3</sup> needed to use these data to identify priorities for community health improvement. In addition to conserving scarce resources, collaboration can help build trust between organizations, identify overlapping interests, and lead to shared strategies to address local health priorities.<sup>4</sup>

## Purpose

The primary purpose of this brief is to inform the efforts of state Flex Programs to support CAHs in conducting collaborative CHNAs. The results of these assessments can be used by hospitals as well as state Flex Programs to inform their ongoing strategic initiatives. The purpose of the CHNA process is to identify unmet acute care needs, population

## Key Findings

- Small hospitals and communities can successfully collaborate on Community Health Needs Assessments (CHNAs).
- Collaborative CHNAs can serve as building blocks for a more comprehensive community health improvement strategy.
- Data requirements for the community assessment obligations of CAHs, rural hospitals, public health departments, and community providers offer a key opportunity for collaboration and economies of scale in collecting and analyzing needed primary and secondary data.
- Collaboration requires the development of trust and rapport among participants; the acknowledgement and management of imbalances of leadership, power, and resources; and recognition of each participant's assessment needs.
- Collaborative CHNAs can provide a foundation to engage diverse hospital, public health and other community stakeholders in the development of strategies to address identified community needs.

*For more information on this study,  
please contact John Gale at  
jgale@usm.maine.edu*

health issues, and local service gaps as well as to identify priority health concerns for use in service planning and development, development of ACA-mandated implementation plans, and preparation of proposals for submission to charitable, foundation, and governmental funding opportunities. The findings from these collaborative assessments can also be used by state Flex Programs to inform their efforts to support population health improvement activities of CAHs and to expand state Flex Program strategic initiatives.

A secondary purpose of this brief is to provide insight into the leadership issues encountered by CAHs and other stakeholders as they conduct their collaborative assessments. Despite the obvious benefits of collaboration, bringing together diverse organizations such as CAHs, public health departments, and other community providers with differing needs, resources, cultures, and missions can be challenging. Leadership is critical factor in the development of a successful collaborative initiative. Although the hospitals and hospital systems often provide significant leadership and funding to support collaborative assessments, they need to be sensitive to power and resource imbalances across community providers and agencies in the exercise of that leadership.

## **Approach**

We identified four initiatives representing different strategies and models: the **Ohio Regional Community Health Assessments Project**, the **OneMaine Health Collaborative Statewide Community Health Needs Assessment**, the **Western North Carolina Health Impact Initiative**, and the **Wabasha County (MN) Community Health Needs Assessment**. These four initiatives were identified through a combination of sources including our own work with the OneMaine Health Collaborative, work with State Flex Programs, and recommendations from colleagues working in the field. They were selected to represent different organizational approaches to collaboration including a regional initiative developed by a state Flex program (Ohio), a statewide initiative involving health systems (OneMaine), a regional initiative involving a hospital network (Western North Carolina), and a community-level initiative involving a CAH and local public health department (Wabasha County). In each of these initiatives, CAHs are conducting their CHNAs in collaboration with public health agencies, other hospitals and hospital systems, and/or community providers and agencies. Based on interviews with project leaders for each of these initiatives and a review of documents and materials, this brief describes the approach of each of these collaborative CHNA models

and discusses the data collection, community engagement, and other strategies they employed.

## **Limitations**

Given that three of the four collaborative assessment projects involved the development of multi-hospital data tools and assessment reports, we were not in a position to interview specific hospital stakeholders. The fourth assessment project involving the collaboration between a single hospital, local public health department, the state quality improvement organization (QIO), and other community stakeholders had just completed its assessment report at the time of our interview and had yet to develop the related implementation plan. Additional study is needed to understand how the participating hospitals used their assessment reports to identify and implement health services and programs and to satisfy their IRS regulatory requirements through the development of an implementation plan addressing the needs identified through the CHNA.

## **Collaborative Community Health Needs Assessment Projects**

### **Ohio Regional Community Health Needs Assessment Project (Ohio Regional CHNA)**

#### *Context for Collaboration*

In 2011 the Ohio State Flex Program funded this statewide collaborative with the goal of developing four regional CHNAs that would support Ohio's 34 CAHs. By organizing the assessments regionally, Ohio's Flex Program was able to assist 30 CAHs in meeting their regulatory requirements through what was described as a "cost and time efficient" process. In the summer of 2011, the Flex Program, which is located in the Ohio Department of Health, released a request for proposal for vendors to undertake the regional assessment project by organizing the collection and analysis of primary and secondary data at the county level for each of the four regions. A joint proposal developed by the Voinovich School of Leadership and Public Affairs at Ohio University and the University of Toledo Area Health Education Center was selected through a competitive bidding process. After completing the data collection and analysis, the results were presented at regional meetings that included CAH chief executive officers, representatives from local health departments and social service agencies, and other community members. From November 2011 through May 2012, each regional group met four times and created Regional County Health Indicators Data Report, a Regional Health Indicators Profile that prioritized the health needs for the region,

and a Regional Plan detailing strategies to address the priority community needs identified by the data reports. In addition to local and regional dissemination of these materials, all regional reports were published on the Ohio State Flex Program website.<sup>5</sup> The state also funded the preparation of economic impact reports detailing each hospital's economic contribution to its community. Regional participants also collaborated on a "Proudest Moments" report to share their progress and initiated community and regional networking efforts involving hospital leadership to address priority regional health improvement needs.<sup>6</sup>

### ***Participants***

Thirty of Ohio's 34 CAHs participated in the Ohio Regional CHNA program. To guide the process, each region established its own steering committee and community meeting schedule. While public health was not involved at the state level, regional community meetings drew representatives from local health departments as well as social service agencies. Each CAH received county-level primary and secondary data on identified health indicators, a summary of proud moments from CAHs across Ohio, an analysis of its economic impact, and a statewide CAH economic impact report. These tools were designed to support tax-exempt hospitals in preparing their ACA-mandated CHNA reports and implementation plans.

### ***Scope and Impact***

Although organized by four defined regions, county level analyses of the health indicators were presented to each of the participating CAHs along with the hospital-specific economic assessments. The regional organization of this project provided for economies of scale in collecting and analyzing county level health data recognizing that CAHs and communities in a given region share common health problems and overlapping health improvement needs. Moreover, the strategy allowed for the development of regional health improvement approaches and provided a network for further collaboration in addressing those needs. The value of regional networking was reflected in the "proud moments" materials that were developed that described the group's accomplishments during the past year. Participants also believe that the county-level and regional CHNA reports will provide a building block for the state rural health association to engage individual communities in developing local strategy plans.

### ***Resources Shared***

Ohio Flex funding supported primary data collection, the analysis of primary and secondary data, a webinar

for the CAHs on needs assessments and the IRS requirements conducted by the representatives from the Technical Assistance and Services Center (TASC), education events sponsored offered by the Ohio Hospital Association, preparation of county and regional-level data summaries and reports, a resource list on the project website, and collaborative planning activities.

## **OneMaine Health Collaborative (OMHC) Statewide Community Health Needs Assessment**

### ***Context for Collaboration***

The OMHC Statewide CHNA was funded in 2010 by the OneMaine Health Collaborative, a partnership of three major health systems: MaineHealth, Eastern Maine Health Systems, and MaineGeneral Health. The goal was to prepare "Health Status Assessments" summarizing the results of a statewide survey as well as secondary data for each of Maine's 16 counties. The Health Status Assessments summarized a wide range of risk factor, prevalence, mortality, and utilization data across an array of acute care and public health domains.<sup>7</sup> Through a competitive bidding process, OMHC contracted with the University of New England and the Muskie School of Public Service at the University of Southern Maine to conduct the Statewide CHNA.<sup>8</sup> Project activities included development and implementation of the statewide health survey, analysis of the primary data and secondary data, analysis of key domain areas by county, recruitment and management of the advisory committee, and preparation of the overall and county level reports.

The results of the analysis and all reports were disseminated widely to hospitals and community organizations across the state through postings on the three health systems' websites. In addition individual hospitals used the results of the assessment to conduct community forums to share the results of the assessments and solicit input into local health system planning efforts. The health systems used the data reports to complete their ACA-mandated CHNAs and implementation plans for each of their affiliated hospitals with deadlines dictated by their fiscal years. They also use the reports to support hospital and health system service planning efforts and the solicitation of grant and foundation funding requests.

### ***Participants***

The OMHC Statewide CHNA represented the combined effort of three major health systems: MaineHealth, MaineGeneral Health, and Eastern Maine Healthcare Systems, and state leaders in public health: the Maine Center for Disease Control and Prevention,

regional Public Health District Coordinating Councils (state-funded public health planning and coordinating bodies), municipal public health departments, and local Healthy Maine Partnerships (public health coalitions). MaineHealth's members include one CAH in New Hampshire and three CAHs in Maine. Eastern Maine's members include three CAHs.

To ensure that the assessment reports would be useful to a wide range of community organizations, an advisory committee was assembled to guide the project and review final products. Members of the advisory committee included representatives from behavioral health, state government, Maine's tribal and minority communities, and the public health organizations described above. The project was conducted by a collaborative team of researchers from the University of New England and the Muskie School of Public Service at the University of Southern Maine. Following production of the final data report and county-level analyses, participating hospitals organized and conducted community forums to present the data and obtain input into the process of developing health improvement priorities. Participants in these forums included local providers and agencies, community leaders, and public health stakeholders with the mix of representatives varying from community to community.

### ***Scope and Impact***

This statewide initiative was designed to provide county-level data resources for use by hospitals within each health system and by other hospitals, Healthy Maine Partnerships, providers, and communities to conduct their own local CHNAs, ideally in collaboration with other health care stakeholders in their communities. According to OMHC leaders, the three health systems used the data and reports to engage local stakeholders in discussions about local needs and priorities for health improvement. Together with qualitative data obtained through community forums and community engagement activities, the OMHC data have been used to prepare required assessment and implementation strategy reports specific to the service area for each hospital in their systems. For example, Stephens Memorial Hospital (a CAH in Norway, Maine and a member of the MaineHealth system) used the OMHC data and input from the resulting community forum to create the Oxford Hills Wellness Collaborative, a community-wide initiative targeting the priority health needs identified through their local assessment.

Recognizing the economies of scale inherent in conducting collaborative CHNAs, the OMHC has reached out to the state's public health agency, the Centers for Disease Control and Prevention, and to other hospitals and health organizations in the state to develop a formal structure and for a coordinated, collaborative CHNA strategy. The intent

of this effort is to establish agreements on a set of standard indicators, measures, community engagement processes, and a coordinated timeline for the data collection process that can support the multiple CHNAs requirements for the voluntary public health accreditation processes and the triennial IRS requirements for the hospitals. A multi-sector planning committee representing the OMHC and other hospitals, state and local public health organizations, FQHCs, and other organizations has worked for over a year to develop a common set of health indicators and measures, a defined community engagement process, a timeline for the collection of data to support these measures using the Behavioral Risk Factor Surveillance Survey, and an agreement for sharing resources to support this initiative. Implementation of this system will begin with CHNAs to be conducted in 2015.

### ***Resources Shared***

OMHC funded primary and secondary data collection and analysis, engagement of the advisory committee, and preparation of the overall assessment report and county level analyses. The products included the full report, an executive summary, and summary reports with results analyzed by county, health status issue, and Maine's eight public health districts.<sup>7,9</sup> The full set of reports is available on the three hospital system websites.<sup>7</sup>

### **Western North Carolina Healthy Impact Initiative**

#### ***Context for Collaboration***

The Western North Carolina Healthy Impact Initiative (WNC Healthy Impact) is a partnership of CAHs, prospective payment hospitals, and health departments in 16 western North Carolina counties. The project is coordinated by the WNC Health Network (a tax-exempt alliance of hospitals and healthcare providers in North and South Carolina, Virginia, Tennessee, Pennsylvania, and Kentucky) and the Western North Carolina Partnership for Public Health (a North Carolina Public Health Incubator Collaborative representing teams of local health departments working together voluntarily to address public health issues in the region).

North Carolina's Department of Health and Human Services' efforts to support CHNAs date back to 2004 with the advent of Healthy Carolinians, a statewide effort that encourages counties to identify priority health issues and create coalitions and collaborative efforts to address them.<sup>10</sup> North Carolina has a robust system for county public health data collection and community needs assessments. Therefore, WNC Healthy Impact's goal is to regionalize county-level data collection to improve time and cost efficiency. Similar to the effort in Maine, the timeline of the state's public health accreditation was aligned with the triennial hospital assessment requirements to create

a single timeline to encourage and support coordinated CHNA activities. Led by a steering committee and five task-specific workgroups, this regional process addressed issues related to the availability and use of secondary data, the collection of primary data, CHNA communications and marketing, understanding hospital IRS requirements, and planning the implementation of a coordinated regional CHNA strategy.

WNC Healthy Impact contracted with Professional Research Consultants (PRC) to collect primary county-level data via a telephone survey and analyze both primary and secondary data. The project was based locally as each hospital was required to self-identify their service areas and work with county health departments to create a CHNA report and community health improvement plans (CHIPs) using a template created by WNC Healthy Impact. These county-level CHNA and CHIP reports are available on WNC Healthy Impact's website.<sup>11</sup>

### ***Participants***

The WNC Healthy Impact Initiative was conducted by the WNC Health Network and the Western North Carolina Partnership for Public Health. Participants included 16 hospitals in western NC, five of which are CAHs, and the 16 county health departments. In addition to PRC, the project was supported by the WNC Healthy Impact Steering Committee, five different task-related workgroups, staff from the health departments, hospitals, and regional partners, a data collection vendor, and a regional coordinator.

### ***Scope and Impact***

WNC Healthy Impact provides another example of a centralized, cost-effective approach to data collection (including a county-level health survey) and analysis for the 16 counties.

The following goals were established for WNC Healthy Impact:

- Partnership—Enhance partnerships between hospitals and health departments in the community health improvement process.
- Local Leadership & Engagement—Continue and support local-level health assessment, planning, and related community engagement.
- Efficiency & Standardization—Standardize collection and reporting of health related data for all 16 counties in the region.
- Regional Value & Synergy—Work together regionally to develop a collaborative process to efficiently and effectively assess and address health needs across the region.
- Accountability to the Community—Meet hospital and health department requirements for conducting

community health (needs) assessments, action plans, and implementation strategies.

- Strategic Investment—Better align community investments with the health priorities identified through the community health assessment process.

Although the steering committee and workgroups represented the region, local county hospitals and health departments are responsible for creating the individual reports and implementation plans. Hospitals, community, and public health partners received a WNC Healthy Impact Regional Data Report which presented the results of the secondary data analysis and the regional telephone survey at both a regional and county level. These regional reports are available on WNC Healthy Impact's website along with a discussion of the survey methodology, a sample of the survey, press releases, and other resource materials.<sup>11</sup> Using these data resources as well as the county-level CHNA and CHIP reports, participating hospitals had the necessary data and tools to meet their IRS assessment and implementation plan requirements.

Based on the county-level community health assessment priorities, WNC Healthy Impact stakeholders identified two regional health priorities.<sup>9</sup> The first priority area is chronic disease prevention and management focused on access to care, healthy living, obesity, and tobacco. The second priority area is mental health and substance abuse. As part of their work, WNC Healthy Impact stakeholders identified regional strategies to address these priorities.<sup>12</sup>

According to participants, WNC Healthy Impact recognizes that community health improvement (including health assessment and planning) is a local process. WNC Healthy Impact was designed to support local efforts by standardizing data collection, streamlining reporting, supporting communication, encouraging collaboration, and sharing evidence-based practices.<sup>11</sup> Region-wide data collection for this project was completed in July 2012, local-level health assessments were completed in December 2012, and community health improvement plans were completed in June 2013. Implementation and evaluation activities are currently underway and will continue through 2015 (which coincides with the three-year CHNA requirements for tax exempt hospitals).

### ***Resources Shared***

WNC Healthy Impact funding supported primary and secondary data collection and analysis, preparation of a regional data report, development of templates for the CHNA report and implementation plans, training on how to use assessment and implementation report data to complete the IRS Form 990, Schedule H, technical assistance and training for hospitals and health departments, and a website to disseminate information

on the project, data reports, regional priority reports, and county-level CHNA and CHIP reports.

## **Wabasha County Community Health Needs Assessment (WCCHNA)**

### ***Context for Collaboration***

Saint Elizabeth's Medical Center, a CAH in Wabasha, Saint Elizabeth's Medical Center (a CAH in Wabasha, MN) established a partnership with the Wabasha County Public Health Department, Stratis Health (the Minnesota Quality Improvement Organization), and the Minnesota Department of Health to conduct a collaborative CHNA. WCCHNA was led by a management team consisting of the Director of Community Relations for Saint Elizabeth's, the Director of the Wabasha County Public Health Department, the Program Manager for Stratis Health, and the Regional Consultant for the Minnesota Department of Health. Members of the CHNA project collaborative first met in the summer of 2012 and adopted the Minnesota Department of Health Community Health Assessment Model as a framework for analyzing county health needs.<sup>13</sup> Participants described this initiative as opening the door between public health and the hospital, allowing an unprecedented exchange of resources.

The leadership team organized their analysis of secondary health data sets around a set of themes: opportunity for health, healthy living, chronic disease and conditions, infectious disease, and injury and violence. The project team identified key findings that were presented to major community stakeholders and residents during two workshops in November 2012. According to participants, they used a variety of collaboration and quality improvement tools in these community forums, including the Minnesota *Technology of Participation*© facilitation process (a collaborative decision making process),<sup>14-17</sup> affinity diagrams (an idea and data organization tool),<sup>18</sup> nominal group technique (a group problem solving process),<sup>19</sup> and the decision matrix (a tool to systematically identify, analyze, and rate the performance of relationships between sets of values and information).<sup>20,21</sup>

Participants in the community stakeholder meetings offered input into the selection of a set of priorities that created a consensus vision for a health community. Stakeholders also participated in the identification of the top 11 health needs based on data presented, creation of a preliminary list of community resources and assets, prioritization the top four health needs in Wabasha County, and development of preliminary strategies to improve community health. Four work teams were created to address the priority health needs, led by stakeholders recruited and trained to undertake the job. To ensure accountability, progress reports of the workshops and

workgroups were submitted to the hospital leadership and project advisory board as well as the leadership in the Public Health Department, such as the County Commissioner. The leaders of these subcommittees retained responsibility for developing and implementing a Wabasha County CHNA Implementation and Improvement Plan using the Minnesota Department of Health Community Health Improvement Planning Process.<sup>22</sup>

### ***Participants***

The WCCHNA represented the collaborative efforts of key staff from Saint Elizabeth's Medical Center, Wabasha County Public Health Department, Stratis Health, and the Minnesota Department of Health. More than 400 community residents from the following organizations were invited to participate in a two-part workshop series to review the data and set priorities: Wabasha County Public Health Department; Wabasha County Public Health Advisory Committee; South Country Health Alliance; City of Wabasha; Wabasha County; Minnesota Department of Health; Wabasha County Social Services; Three Rivers Community Action; United Way; Saint Elizabeth's Medical Center; Lake City Medical Center; Health Partners; dental clinics; hospice; Stratus Health; Elder Network; Senior Advocacy; Common Closet; Wellness Center; and local churches.

### ***Scope and Impact***

The WCCHNA focused primarily on the issues of Wabasha County although project partners engaged in discussions with providers and public health officials in adjoining Minnesota and Wisconsin counties to identify overlapping needs. The project team used the small and tight-knit community to its advantage in engaging major stakeholders in the assessment and implementation process. Given limited resources and the availability of robust county-level data that aligned well with the hospital's and public health department's service areas, the project team decided that a survey to collect primary data on local needs was not necessary. They solicited community input and participation through invitations to the assessment workshops. The workshops were led by members of the project team who also served as co-leaders for the development of implementation plans to address identified priority health needs.

The results of the WCCHNA process were disseminated and published on St. Elizabeth's website in 2013.<sup>23</sup> The report summarized the results of the assessment process and outlined the following priority health needs: senior health, prevention and wellness, mental health, and oral health. It also laid out a process for implementation planning to address these priority health needs and

committed WCCHNA to develop a reporting process for community progress among community partners.

### ***Resources Shared***

Each of the respective partners supported the costs related to their involvement in the CHNA including staff time for the project leaders. Saint Elizabeth's Medical Center and the Wabasha County Public Health Department funded the costs of developing and disseminating the assessment report. The Minnesota Department of Public Health provided access to prior assessments reports and secondary data as well as the substantial online CHNA tool kit.

### **Observations on the Benefits and Challenges of Collaborative Community Health Needs Assessments**

These four examples of successful collaborative community health needs assessments suggest opportunities for CAHs, rural hospital systems, public health departments, and community organizations including school systems, charitable organizations, social service agencies, faith-based groups, governmental organizations, employers, and others to work together to identify and address unmet community health needs. Economies of scale in collecting and analyzing necessary primary and secondary data are some of the primary benefits of a collaborative approach. In addition, by pooling resources across hospitals, public health departments, and community providers, collaborative CHNAs allow for a more robust use of community, county, and regional health data sets. At the same time, collaboration on CHNAs may help build trust and rapport among the participants that can provide a foundation for the development of collaborative strategies to address identified community needs. Although each of these collaborative CHNA initiatives developed and were carried out in a unique state and local context, they suggest several important, cross-cutting lessons regarding critical determinants of success as well as the challenges. In this final section we offer a set of observations gleaned from our interviews and review of these initiatives designed to inform efforts by state Flex Programs and CAHs to replicate the approaches illustrated by these collaborative CHNA models.

### ***Data collection and analysis strategies***

Whether prescribed by the IRS's mandatory community benefit reporting framework for 501(c)3 (tax exempt) hospitals or the Public Health Accreditation Board's requirements for public health accreditation, effective CHNAs require considerable effort and expense associated with the collection, analysis, and reporting of health indicators and measures and associated community engagement activities. The experience of these four collaborative CHNAs demonstrates that data collection

and analysis activities provide a very clear opportunity for cost-effective and efficient collaboration. In most states, secondary health data are readily available and accessible, but considerable work is involved in selecting and using the data to populate appropriate CHNA indicators and measures. Many small hospitals do not have staff with the data skills or time to conduct these analyses. Given the common data elements likely to be used by different hospitals, collaborating on the production of county level quantitative data reports simplifies the assessment process for hospitals and allows participants to focus on obtaining qualitative community-level input and data.

Given the availability of robust secondary county level data in most states, new surveys may not always be necessary. Triangulating community input and qualitative data with available secondary data can be an effective strategy for small hospitals and collaborative partnerships. Although primary data collection can add significant validity to the CHNA effort, it can be expensive to collect and requires careful adherence to proper survey methodology. A poorly implemented survey may yield inaccurate data that compromises hospital and community strategic planning. Collaborative regional or statewide survey strategies are more cost efficient, allows for more robust survey methodologies and avoid the problem of obtaining results which vary dramatically from other officially-reported community health data.

### ***Collaborative relationships***

In each of the collaborative CHNAs described here, we observed an inevitable tension between the needs of the individual participants (i.e. CAHs, public health agencies) and the collective interests represented in the collaborative project. In each case, for example, hospitals have had to customize the results of the collaborative regional assessments and strategy plans to develop their own assessment report and implementation plan focused on the needs of their service areas. Nevertheless, participants felt the projects helped foster communication across participating organizations and develop opportunities for further collaboration.

Inevitably, hospitals, public health, and other community providers have different organizational missions and identify different needs and expectations for their assessments. The cultural divide between public health, hospitals, and the healthcare community is often referenced as a major hurdle for effective collaboration. These collaborative CHNAs demonstrated that where such problems exist, they can be overcome.

For example, the hospital and public health partners in the OMHC initiative worked through issues regarding community-level dissemination and presentation



of the data reports. These issues stemmed from the different assessment obligations of the different partners. Hospitals have one set of Internal Revenue requirements mandated by the ACA, Healthy Maine Partnerships engage in the Mobilizing for Action through Planning and Partnerships (MAPP) process, and the Public Health District Coordinating Councils are expected to undertake regional community health assessment and improvement planning. It is important to the success of collaborative initiatives that potential differences be discussed and resolved in advance. Doing so will help to ensure that each stakeholder's needs are met.

The CHNA is only the first stage of a process leading to the implementation of community and regional health improvement strategies. Collaboration, open communication, and sharing of scarce resources are especially critical at this stage in the CHNA process given that most population health problems are not easily resolved by any single organization. Participants in these initiatives noted, for example, that it is important for all participants to share the "credit" for the results and to be aware of leadership, power, and resource imbalances.

## Conclusion

The experience of the four initiatives featured in this brief demonstrate that small hospitals and communities can successfully undertake collaborative CHNAs which can serve as the building blocks for a more comprehensive community health improvement strategy. It is challenging to find available time and staff resources to undertake a CHNA in these small organizations where staff members wear many different hats and have difficulties devoting significant amounts of time to special projects. Sharing the leadership and staff resources across multiple organizations is yet another benefit of a collaborative approach identified by these collaborative CHNAs.

State Flex Programs, hospital associations, and other organizations play a critical role in helping to coordinate and support collaborative CHNAs. They can serve as conveners to help build the collaborative partnership necessary for undertaking a collaborative CHNA. They are also a potential educational and technical assistance resource bringing information about CHNA requirements and approaches to the collaborative process. And finally, these statewide entities can provide or secure third-party funding to support the collaborative CHNA process.

## Endnotes

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