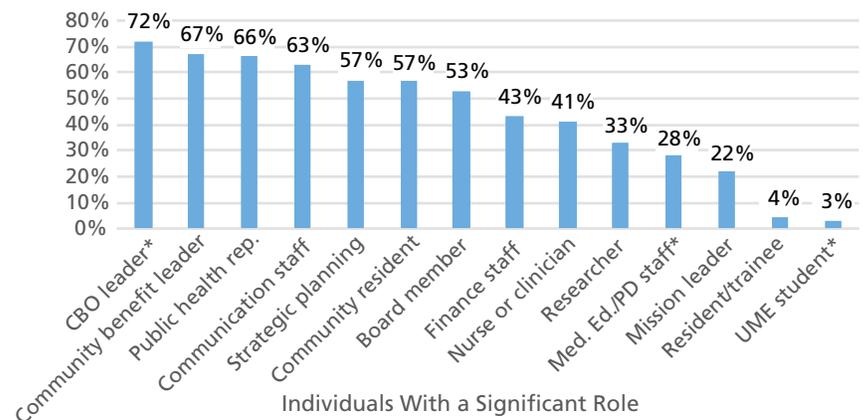


Community Health Needs Assessments: Engaging Community Partners to Improve Health

The Affordable Care Act (ACA) requires that 501(c)(3) hospitals conduct a Community Health Needs Assessment (CHNA) every three years in order to retain federal tax exempt status.¹ This mandate directs hospitals to develop CHNAs in conjunction with the communities they serve and receive input from public health experts when determining and prioritizing the health needs of the community. The Internal Revenue Service (IRS), the agency charged with implementing this section of the law, has proposed—but not yet finalized—regulations that reflect the law's requirements that the CHNA report be made widely available to the public and inform a related implementation strategy (IS) that describes the process and criteria used to prioritize local health needs and how some of those needs will be addressed in the years between assessments. A hospital's failure to meet these requirements can potentially result in a \$50,000 fine.

For hospitals, health systems, and public health agencies to develop, implement, and evaluate tailored community health improvement strategies, an understanding of locally available resources and community residents' specific health and health care needs is essential. Given the impact of the social determinants of health on the well-being of a community and the magnitude and seeming intransigence of health and health care inequities in the United States, engaging with communities to identify and intervene on salient health needs is crucial for academic medical centers and their partners to move the needle toward health and health care equity.²

Figure 1: Percentage of Responses Indicating Various Individuals With a Significant Role in the Development and Implementation of the Hospital's Most Recent CHNA, 2014



Note: *CBO = community-based organization; Med. Ed./PD = medical education/professional development; UME = undergraduate medical education

This *Analysis in Brief (AIB)* explores aspects of AAMC-member hospitals' conduct of their CHNAs in order to understand their current assessment strategies and develop CHNA-related tools and resources that strengthen AAMC members' capacity to improve community health and address salient inequities through the CHNA process.

Methodology

The data presented come from an AAMC-conducted teaching hospital and health system membership survey and a qualitative review of respondents' CHNA reports.

In 2014, a survey was developed collaboratively by the AAMC, the Catholic Health Association of the United States, and VHA, Inc., all of which include hospitals and health systems in their membership. The survey covered various domains related to the CHNA process

including CHNA leadership, how hospitals and public health organizations collaborate to complete the assessment, and how communities are engaged in CHNA planning and implementation. Each association independently administered the survey to its members. Surveys were emailed to individuals with lead responsibility for CHNA activity, when known, or to the hospital or health system CEO with a request to forward to the appropriate contact. Only AAMC-member data are presented in this *AIB*.

Respondents were asked to provide links or copies of their most recently completed CHNA and IS documents for the research team's review. AAMC staff reviewed the CHNA reports to supplement our understanding of how community residents were engaged in the hospital's CHNA process and how they identified and prioritized health needs. Specifically, these reports were analyzed and coded

1. Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148.

2. Alberti PM, Bonham AC, Kirch DG. Making equity a value in value-based health care. *Acad Med.* 88(11):1619-1623

by a two-person team. The development of the initial codes was guided by a list of research questions derived from the survey. The research team reviewed the CHNA reports and assigned codes via open coding. The primary and secondary analyst constructed matrices to identify, compare, and examine relationships among the coding categories.

Results

Seventy-six out of 238 member hospitals/health systems remitted data (a 32 percent response rate³), and because some health systems returned CHNAs for multiple hospitals in its system, a total of 113 CHNA reports were received.

Survey results indicate that at 83 percent of responding institutions, a senior leader such as a CEO, CMO, VP, or comparable position, played a significant role in CHNA development and implementation. Other types of individuals with significant CHNA responsibility include leaders of community-based organizations, community benefit leaders within the hospital or health system, and public health representatives. Researchers, resident trainees, and medical students were unlikely to be significantly involved in the CHNA process (see Figure 1).

As required by the ACA, all responding hospitals and health systems consulted with public health experts and institutions—at the state, county or local level—to obtain demographic and health data about their communities. Half of respondents reported a collaboration with a local school of public health.

AAMC-member hospitals engaged community members in various ways to understand better local needs and assets. Results show that the majority of responding hospitals (77 percent) used more than one method, such as surveys, interviews, and focus groups to engage their local communities in the CHNA process.

As required by the IRS, hospitals used the data collected to prioritize their population’s health needs. Seventy percent or more of the CHNAs reviewed prioritized access to medical care, mental health, and obesity as important community health needs (Table 1).

The ACA requires hospitals to make the CHNA results widely available to the public. Results show that in addition

Table 1: Frequency of Priority Health Need from AAMC-member hospitals; CHNA, 2014

Prioritized Health Need	Percentage/n (total n=113)
Access to Medical Care	93% (105)
Mental Health	81% (91)
Obesity	70% (79)
Social Determinants of Health	67% (76)
Substance Abuse	61% (69)
Physical Activity and Nutrition	58% (66)
Health Insurance Coverage	58% (66)
Cardiovascular Disease and Hypertension	57% (64)
Diabetes	44% (50)
Oral Health	33% (39)

to posting the CHNA report on the hospital’s website, respondent hospitals chose a variety of channels to disseminate their CHNAs both internally and to the communities they serve through internal staff meetings (76 percent), community group presentations (58 percent), printed summaries for their communities (43 percent), and by giving their results to an elected official (36 percent) or distributing the data in a press release (36 percent).

Finally, responses indicate that to improve the health status of their communities, hospitals plan to use the CHNA to work with community partners to address prioritized health needs (83 percent) and develop community-focused health improvement initiatives (80 percent). Other uses of CHNA results endorsed by more than two-thirds of respondents included evaluating their organizations’ community health improvement efforts, informing hospitals’ strategic plans, and seeking funding for community programs.

Discussion

Academic medical centers are committed to improving the health of the communities they serve and the CHNA requirements proffer an opportunity to engage with communities and public health experts to achieve that end. The data reported here provide an early sense of how institutions are developing and conducting their CHNAs and help frame the discussion of how academic medical centers could move beyond compliance and connect the CHNA to their research, clinical, and education missions. Results point to opportunities for the AAMC to develop and disseminate tools and resources that help its members address local health needs and important inequities through the CHNA process.

While many institutions understand that conducting a CHNA is not just a legal requirement, but also an important tool in their efforts to improve the health of their communities, barriers exist. Respondents cited a lack of time and financial and human resources as impediments to completing the CHNA. Additionally, while results demonstrate clear commitment to community health improvement—without a requirement to do so, 77 percent of respondents used multiple methods to engage their communities—such efforts could be more deeply integrated across research, clinical care, and education missions. Fewer than 5 percent of institutions gave significant responsibilities to trainees or students, and only a third of respondents identified researchers as playing a significant role in the CHNA process.

Future research could evaluate the impact of hospital and health system CHNA- and IS-related efforts to address community health needs and inequities so that successful strategies can be disseminated, replicated, and tested in other contexts.

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3. AAMC-member Veterans Affairs and for-profit hospitals are not required to conduct a CHNA and thus were not surveyed.