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## A Commentary on Drivers of Community Health Needs Assessment

**Michael T. Hatcher, DrPH**

Division of Toxicology and Human Health Sciences, Agency for Toxic Substances and Disease Registry, Atlanta, Georgia.

In many communities, perception of an asymmetrical power relationship between public health and hospital leaders exists largely because of the resources hospitals generate and control. The Affordable Care Act's (ACA's) community health needs assessment (CHNA) requirement has likely not changed that dynamic but it may reshape public health and hospital relationships. Three articles presented in this journal's edition explore how the ACA's CHNA requirement may influence interactions and relationships between public health departments and nonprofit hospitals.

The first, of these 3 articles, is written by Laymon and colleagues.<sup>1</sup> The authors examine the potential role that Public Health Accreditation Board (PHAB) standards for community health assessment (CHA) and community health improvement planning may play in increasing public health department collaboration with hospitals having a nonprofit tax exemption, which under the ACA requires the hospital to conduct a CHNA to identify and invest in improving community health under section 501(r)(3) of the Internal Revenue Code. Laymon and colleagues also present information on use of data from the National Profile of Local Health Departments and data from CHA, CHNA, community health improvement planning, and other implementation planning reports to establish a baseline for public health and hospital collaboration.

The second article by Sampson and colleagues<sup>2</sup> presents a case example highlighting increased hospital involvement in the Polk County CHA that also serves as the CHNA for 3 area hospitals. The authors attribute the ACA's CHNA requirement as the stimulus for the increased involvement. The Sampson and colleagues article appears to directly validate the supposition Laymon and colleagues<sup>1</sup> make in their article examining the potential synergy between the ACA's CHNA requirement and PHAB accreditation standards.

In the last of these 3 articles, Bakken and Kindig<sup>3</sup> estimate the per capita level of community benefit across states and examine whether there is an equitable distribution of these resources across and within states. Decision making on use of these resources in meeting identified community health needs may also impact and hopefully improve public health and hospital relationships through the joint community health improvement requirements.

**Correspondence:** Michael T. Hatcher, DrPH, Division of Toxicology and Human Health Sciences, Agency for Toxic Substances and Disease Registry, 4770 Buford Hwy, NE (Mail Stop F-57), Atlanta, GA 30341 (MHatcher@cdc.gov).

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## Engaging Public Health in CHNA

The article by Sampson and colleagues<sup>2</sup> offers their successful CHA case example that demonstrates a history of hospital engagement by Polk County Health Department and expanded collaboration with local hospitals after passage of the ACA. A new level of dialogue, understanding, and resource sharing was also noted as the 3 hospitals and health department learned more about one another's needs for conducting the assessment. It was noted in the case that public health did mature in the relationship with hospitals and indicated that they "learned to stand firm on community engagement and to be direct and persistent when asking medical centers to contribute resources," which suggests some realignment of their relationships with hospitals.<sup>2</sup> The success of this case does inspire general optimism in the expanded peer-to-peer collaboration that resulted.

These authors, like many engaged in public health, optimistically anticipate that increased engagement with nonprofit hospitals can result in population-level health improvements through the investments called for by the ACA CHNA requirement. The ACA's<sup>4</sup> requirement for nonprofit hospitals to conduct CHNAs does offer opportunity to build collaborations and align with public health departments engaged in conducting CHA and community health improvement planning required by the PHAB accreditation standards.<sup>5</sup> However, there is equal or greater opportunity for the CHA and the CHNA to take differing courses. The ACA provides guidance on engaging public health in a CHNA. Specifically, the CHNA statute is as follows:

“(B) COMMUNITY HEALTH NEEDS ASSESSMENT—A community health needs assessment meets the requirements of this paragraph if such community health needs assessment—

- i. takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and
- ii. is made widely available to the public.<sup>4</sup>”

Public comment in regulatory language review resulted on more specific guidance for including public health input. The April 5, 2013, regulatory guidance now states that “A hospital facility must take into account input from the following sources in assessing the health needs of its community—

- i. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of that community.”<sup>6</sup>

The fact that the ACA has explicit expectation that a CHNA is to include input from “at least one state, local, tribal, or regional governmental public health department”<sup>6</sup> in its regulatory language is reason for optimism. This more specific language will ensure that public health departments are consulted in CHNAs, specifically information and/or expertise relevant to the health needs of that community.<sup>6</sup> However, it does not ensure ongoing involvement with the hospital's CHNA process. Some hospitals may have public health skills within their organizational structure. For example, Mount Sinai Hospital's 2013 CHNA noted that staff

in its Urban Health Institute had public health degrees, including 1 author who was a “founding member of the Epidemiology Program of the Chicago Department of Public Health.”<sup>7</sup> The report stated that “the public health credentials of the authors of this report are substantial and notable.”<sup>7</sup> In addition to the Urban Health Institute, Mount Sinai Hospital also supports its Sinai Community Institute that serves as the implementing arm for community programs.<sup>8</sup> Mount Sinai Hospital is not the only hospital system with public health capacity to perform assessment, intervention design, and evaluation. The roles of public health departments working with hospitals like Mount Sinai Hospital will likely require public health leaders to rethink how to coordinate and create synergy with hospitals that are well equipped to assess community health and deliver community health programs.

## Per Capita Community Health Investment

Of great interest and benefit is the analysis Bakken and Kindig<sup>3</sup> offered on per capita community benefit distribution within states served by nonprofit hospitals. This information gives cause to be optimistic. It provides insight on opportunities to leverage local resources to improve population health through CHNA, consensus building, and application of proven intervention programs that provide returns on community benefit investments. The modeling estimates provided by Bakken and Kindig<sup>3</sup> demonstrate a wide variation in potential community benefit resource ranging from \$56 to \$703 per capita across states.

Even the lowest per capita benefit of \$56,<sup>3</sup> cited by Bakken and Kindig, can support effective community interventions. The Trust for America’s Health found that investing \$10 per capita per year to implement proven community-based programs will improve health.<sup>9</sup> These proven programs focus on increasing physical activity, improving nutrition, and preventing smoking and other tobacco use. It is estimated that these types of programs can offer the nation a savings of more than \$16 billion annually within 5 years of implementation.<sup>9</sup> The \$10 per capita support is reported to provide a return of \$5.60 for every \$1 invested.<sup>9</sup>

## Challenges to Improve Community Health

Public health and nonprofit hospital leaders share more challenges today than in recent years. As the ACA is implemented, more integration between public health and health care is likely to occur and specialized functions will be differentiated. Roles and relationships are in flux as multiple initiatives reshape public health and health care. The ACA’s CHNA requirement is one key element of this integrated focus to improve the health of community populations. Accreditation of public health departments through PHAB standards is helping to strengthen and shape public health capacity to better engage nonprofit hospitals in CHNA and community health improvements efforts.

It is important that public health and hospital leaders continue this dialogue on roles and relationships needed to undertake collaborative community actions. Laymon and colleagues<sup>1</sup> report a few key needs agreed upon nationally that will impact local actions. These include developing infrastructures and strategies to manage and sustain community engagement; improve health assessment and planning; integrate, apply, and visually present local data for

decision making and planning; and support delivery of effective interventions that address inequities and social determinants of health within communities.<sup>1</sup>

This CHNA requirement also creates an opportunity for public health agencies and hospitals to partner with other organizations in the community to accelerate community health improvement. To facilitate these opportunities, the Centers for Disease Control and Prevention provides resources (<http://www.cdc.gov/policy/chna/>) to support critical partnerships, which includes *Principles to Consider for the Implementation of a Community Health Needs Assessment Process*.<sup>10</sup> Centers for Disease Control and Prevention will further enhance this site in early 2015 with a community health improvement technical package that will support implementation of these principles. The technical package will include a searchable database to facilitate selection of high-value interventions to achieve community health improvement as partners work together.

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