Putting the Community back into Community Health Needs Assessments: Maximizing Partnerships Via Community-Based Participatory Research

Chris Michael Kirk, Sharon Johnson-Hakim, Ashley Anglin, Catherine Connelly

Progress in Community Health Partnerships: Research, Education, and Action, Volume 11, Issue 2, Summer 2017, pp. 167-173 (Article)

Published by Johns Hopkins University Press
DOI: *https://doi.org/10.1353/cpr.2017.0021*

Putting the Community back into Community Health Needs Assessments: Maximizing Partnerships Via Community-Based Participatory Research

Chris Michael Kirk, PhD[1], Sharon Johnson-Hakim, PhD[1], Ashley Anglin, PhD[1], and Catherine Connelly, DMH[2]

(1) Atlantic Center for Population Health Sciences, Atlantic Health System; (2) North Jersey Health Collaborative

Submitted 15 February 2016, revised 13 September 2016, accepted 26 September 2016.

Abstract

The Problem: The community health needs assessment (CHNA) mandate of the Patient Protection and Affordable Care Act (ACA) has the potential to make significant and sustainable change in the health of communities. However, to date many hospital-led assessments have used traditional, top-down data collection approaches that overemphasize individualized community member deficits and underutilize collaboration across sectors.

Purpose: The purpose of this paper is to present the principles of community-based participatory research (CBPR) as a framework for conducting CHNAs in a way that mitigates the potential for harm, waste, and misrepresentation of community assets and needs that characterizes many existing CHNA processes, illustrating the power of applying CBPR partnerships to this process.

Key Points: CBPR is a framework to engage community members directly in research design, the collection and analysis of data, and the creation of action plans that address research findings. Key principles include collaborative involvement, establishment of empowering processes, and long-term commitment. A case example of an innovative community partnership demonstrates the power and challenges of taking a CBPR approach to the CHNA process.

Conclusions: CBPR has incredible potential to be incorporated into ACA-mandated hospital CHNAs, leading to increased impact and shared power with community members.

Keywords

Community health partnerships, needs assessment, community health services, community health research, power sharing

In 2010, President Barack Obama signed the ACA into law. This groundbreaking piece of legislation contained hundreds of provisions intended to improve the quality and control the costs of health care. One such provision (501(r)3) required all charitable (i.e., not-for-profit) hospitals to conduct a CHNA every 3 years and develop an implementation plan to address identified community needs. Monitored by the Internal Revenue Service (IRS), the U.S. government agency responsible for granting and monitoring the status of tax exempt organizations, this practice requires hospitals to gather data on the health needs of the community, take into account input from minority and "medically underserved" populations within a "community-benefit service area" defined by the facility, and identify priority areas for intervention. This new mandate extends rules in place since 1956 (IRS Ruling 56–185), which required that hospitals document "community benefit" activities as a justification of their nonprofit status.

This unfunded mandate has presented a significant challenge and learning curve to many hospitals across the United States. Early results from the first cycle of CHNAs across suggest that the practice of implementing the CHNA requirement may be falling short of the intention of the legislation, generating mostly small-scale changes with often token partnerships that lack sufficient targeting or evidence of

outcomes.[1] Specifically, these problematic assessments tend to be conducted by a single organization in isolation, employing top-down, deficit-based, and individual-focused approaches, which disproportionately bias quantitative information.

Although the IRS regulations dictate that hospitals consult with community representatives, including their local public health departments, the ownership and control of CHNA and implementation plan processes often fall within a single hospital facility or health care system. As an example, Beatty et al.[2] analyzed hospital CHNAs in Missouri. Among 34 hospitals, 18% had no working relationship with the local public health departments and of those who did only 2.9% met the classification for true collaboration.[3] Another study in Texas found that only 13% of CHNAs in the first round had meaningful collaboration with public health entities.[4] In addition, the authors found that most implementation activities included those that were already being conducted by the hospitals, thus limiting the ability of these approaches to create any significant change in the community.[4]

Besides hospitals, other sectors including governmental public health and federally-qualified health centers are also required to conduct similar assessments[1] and need good data to understand how to best direct their services. Without coordination of resources for data collection, analysis, and implementation, community resources are being spent in an inefficient and ineffective manner, unnecessarily using dollars that could be invested in the implementation of activities identified by a shared assessment and planning process. Shared ownership is needed with meaningful collaboration throughout the entire CHNA process, yet it seems that the reported involvement by key organizations is often limited, with control remaining solely in the hands of the hospital. As an example, Barnett's[1] (p. 117) report highlights the experience of one community advocate:

> One of our hospitals asked me and several other community members to participate in the CHNA process. They shared with us preliminary results and I asked them to talk a little bit about what's going to happen in terms of prioritizing, what's going to be your process, will you reach out to us to help with that process and so on? Her response was, 'Oh no we'll just do it internally.'

The lack of meaningful partnerships may result in isolated and duplicative approaches to the CHNA that are impotent to create any real change in population health. For example, top-down approaches systematically collect data on the community and then implement planning independent of community voices.[5] These approaches tend to take data from people and make plans about people, resulting in disempowerment and solutions that are disconnected from the reality of those affected by the need. These "expert-driven" approaches[6] hoard the power and control of the process within only a few stakeholders, leading to diminished results.

In addition to challenges with single-sector ownership, CHNAs often deploy deficit-based approaches. Indeed, the term "needs assessment" itself emphasizes the search for what is "wrong" with the community. This is most often accomplished by contrasting a mean score within a particular geography or subpopulation with a national or state mean, showing that the particular area is "worse off" than another. An emphasis on community deficits is problematic because it ignores the strengths and resilience of the community and fails to present the opportunity for self-definition influenced by the community's history, culture, and values.

Current CHNA practices have the tendency to overemphasize aggregate individual behaviors and outcomes and underemphasize structural patterns, environmental characteristics (both built and natural), and the impact of policy. Although data on the prevalence and incidence of particular diseases is important, an over-reliance on these data ignores the growing evidence that systems and structures have a broad impact on health.[7] The emphasis on individuals presents a narrow set of conclusions for priority planning and may lead to individual-focused solutions, like health education, that ignore context and system determinants. In contrast, community-level interventions emphasize collaboration, multi-level activity, and culturally situated approaches that drive toward sustainable impact[8].

Finally, although many CHNAs have included qualitative methodology (namely, focus groups and key informant interviews), often these are deployed as secondary elements to guide intervention on a pre-determined set of problems, not as equally valid information collected alongside quantitative, aggregated measures. The bias toward quantitative methods (e.g., the prevalence of a particular disease or behavior) limits the ability of hospitals to create sustainable change. Prevalence and incidence rates are very important, especially for moni-

toring and evaluation, but they fail to provide deep descriptions of phenomena or to explore the multiple, interacting causes underlying these numbers that present the way toward impactful intervention. Experts have cited that qualitative data are increasingly important to obtain a good understanding of the CHNA process.[1] As Trickett et al.[8] shared, "we find it implausible to understand the multiple effects of this intervention in the absence of elements of the story told on this issue, beginning with the cultural surround in which it occurred."

PURPOSE

The purpose of this paper is to present the principles of CBPR as an enhanced framework for hospitals and their partners to approach CHNA requirements. Using a brief case study of a multisectoral health collaborative, this article illustrates the potential for hospitals and their partners to conduct better assessments and develop better implementation plans via a community-based participatory approach.

KEY POINTS

CBPR is a framework that engages community members directly in research design, the collection and analysis of data, and the creation of action plans that address research findings. In a seminal article on CBPR, Israel, Schulz, Parker & Becker[9] identified nine characteristics of this framework. As shown in Table 1, these characteristics present an opportunity for improvement of CHNA practices of U.S. not-for-profit hospitals that addresses the prevalent deficits described above.

BRIEF CASE STUDY: A CBPR CHNA

In 2013, a group of not-for-profit hospitals conducted a CHNA in their region, using a broad-based, quantitative approach that included limited involvement from community partners. As this process was completed, two things became very clear. First, although many partner organizations were "at the table," the assessment was clearly perceived as the "hospital's assessment," severely limiting the ability to plan broad-scale, cross-sectoral interventions. Second, it was discovered that duplicative processes were being deployed by other agencies (e.g., local and county departments of public health) in the community to assess and address community assets and needs. These processes were resulting in a waste of resources, limited depth of data, and independent plans that were not strategically aligned toward shared goals.

To combat this, a group of these hospitals worked with organizations in public health, social services, and business to

Table 1. Community-Based Participatory Research Principles as Applied to Community Health Needs Assessments (CHNA)

CBPR Principle	CHNA Application
Community as unit of identity	"Community" of focus is defined in conversation with community members, not by hospital service area or stereotypical demographic categorization
Emphasis on strengths and resources	Deficit-based, top-down approach is replaced with an emphasis on community assets and what is already working
Collaborative involvement	Diverse community members are involved in every phase of the CHNA process from design to evaluation
Mutual benefit	Process is designed to benefit all stakeholders, not just help hospitals meet their regulatory requirements
Empowering processes	Process focusses on shared power and equity in the process, relinquishing control from the hospital to as many stakeholders as possible
Cyclical, iterative process	Static, linear process is replaced with an on-going cycle of data collection, analysis, planning, and evaluation
Positive and ecological perspectives	Overemphasis on deficits and individualized health outcomes is replaced with a contextual focus that assume potential for progress
Shared knowledge	Findings are disseminated in a way that all people can understand and utilize
Long-term commitment	While CHNAs are more than a three-year process, hospitals choose a long-term investment beyond the reporting period or the tax year

From Israel, Schulz, Parker & Becker, 1998.[9]

form an independent, not-for-profit collaborative (henceforth described as "the Collaborative") with the responsibility of conducting shared community health assessments and improvement plans through a coordination of resources, expertise, and data. The Collaborative was designed to maximize ownership and investment in the process. Governed by a Board of Trustees with representation from each of the more than 20 funding partner organizations, the Collaborative is a collection of well over 100 diverse organizations who serve on various regional (i.e., Board of Trustees, Executive Committee, Data Committee) and local committees and workgroups to guide priorities and partnerships tailored to each area. Decision-making power is intentionally shared throughout the organization. During the CHNA, all partners shared an equal vote to prioritize assessment methods and areas of need. A regional data committee developed the assessment methodology and worked together to the point of co-editing needs assessment summary text to obtained shared voice.

Diversity of partners is a core value of the Collaborative, which mirrors CBPR principles. Partners were recruited in iterative local processes nested within a regional conversation. The Board alone represents this diversity, with members ranging from a multinational corporation to small, local, not-for-profit organizations. An intentional effort was made to engage a diverse set of organizations, including "non-health" partners, such as parks and recreation departments and immigration centers. This allowed for a group of organizations of various sizes and perspectives, including those that incorporated issues that are parallel to, but not explicitly focused on health (e.g., affordable housing). Together, these organizations provided a rich perspective on the assets and needs that existed in the community that would not be possible with a more limited involvement and connected the collaborative process to their constituents, clients and community members.

As shown in Figure 1, the Collaborative explicitly tracks level of engagement by sector and targets outreach to those sectors that are less involved, adjusting outreach to relevant stakeholders as needs were identified and prioritized. For example, using a scorecard tool,[10] the Collaborative identified a gap in engagement by governmental social services. By intentionally reaching out to this group, the collaborative was able to establish a unified health and social service assessment in one county and engage a critical new partner to lead efforts to target obesity in low-income children in another. Although this diversity of voices was a tremendous asset to the process, the inclusion also created some discomfort among organizational leaders because discordant ideas were presented by nontraditional partners. Additional training was provided to

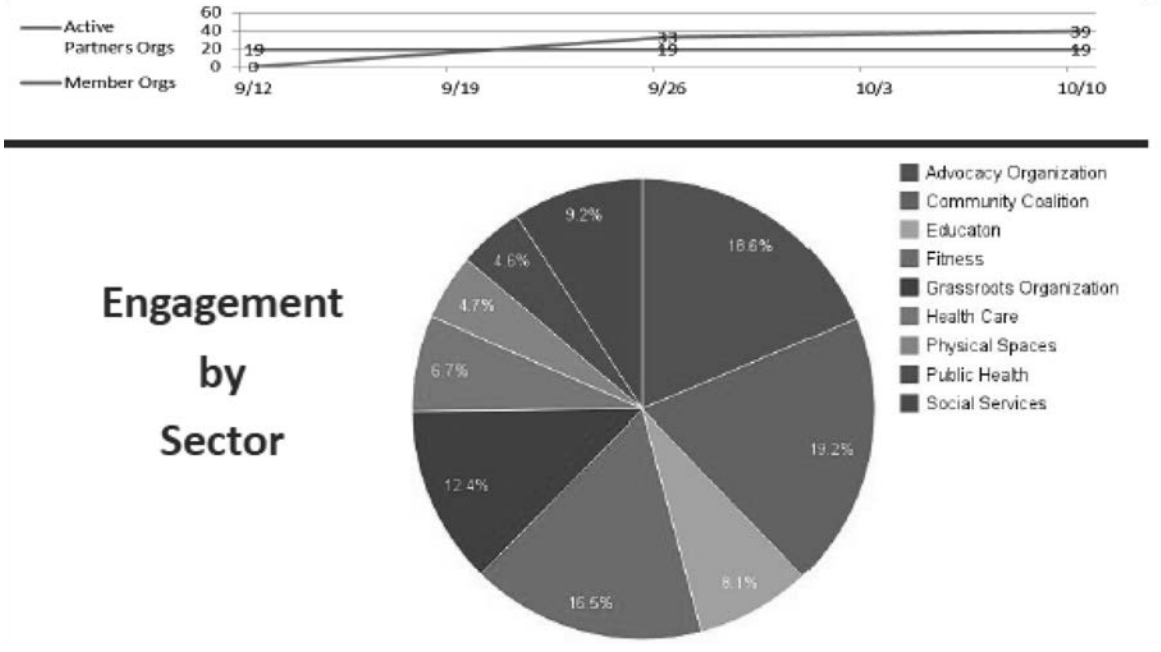

Figure 1. Engagement scorecard.

Collaborative leadership successfully facilitate these interactions, and a transparent process was designed to show how all ideas were vetted and prioritized.

By applying the principles of CBPR, the Collaborative-led CHNA was conducted using a dramatically different process in 2015. To combat the tendencies toward deficit-based approaches and to increase engagement, the Collaborative reframed the "assessment" to talk about "painting a picture of community health." Although this semantic difference was more welcoming to nontraditional partners like faith communities, grassroots organizations, and social services, the differences extended beyond the title to the data itself. By incorporating key informant surveys, a community-wide art contest, and a series of open community meetings, the data for the assessment consisted not only of quantitative indicators, but also included stories, pictures, and even crayon drawings from children. The "Show Us Health" art contest asked members of the community to send stories, images, and artwork that demonstrated their perspective of what health looks like, awarding prizes for top selections in each category and linking submissions alongside the quantitative data on the website and in Collaborative meetings. By creating opportunities for community residents to participate in a modality in which they were most comfortable, the Collaborative broadened engagement and developed a much deeper understanding of what was working and what was not working to produce healthier communities.

This unprecedented diversity of engagement and data fueled an ongoing cyclical process. Each meeting brought new information and perspectives, refining subsequent data collection, analysis, and guiding future meetings. Although there was a defined endpoint to the process during which needs were prioritized and plans were developed, this process did not impose a predefined set of categories in which communities could decide and was committed to uncovering and addressing root causes or drivers of needs, not just the surface symptoms (e.g., poverty as a driver of obesity). This strategy created a transparent, decentralized source of data that was publicly available via a website, managed by a cross-sector data committee, and facilitated a shared conversation around the data for collective impact.

By adopting a CBPR approach, the Collaborative was able to generate a diversity of engagement, to arrive at a set of priority needs that were co-owned, and to set the stage for a planning process in which hundreds of organizations are aligning their efforts for collective impact. Although the specific outcomes of the action plans will take time to emerge, the Collaborative has leveraged tens of thousands of hours of expertise and resources, transforming a process that was previously done in isolated organizations with limited feedback to one which incorporates shared decision making from hundreds of individuals. A recent evaluation of the Collaborative demonstrates the success of the process and the power of the potential. Partners talked about the benefits of shared planning, networking, and how bringing "everyone under one roof and allows for more effective communication." One partner shared:

> The strengths of (the Collaborative) are that of the partners who are attending and the partnerships that are being built . . . In the past . . . there was no follow through. I think that it is exciting to see the hard work, and I am anticipating positive outcomes, hoping there can be an impact in the areas determined to be high priority.

As shown, the CBPR approach to CHNAs has tremendous value for the hospital, the community partner organizations, and community residents, but the work is not without its challenges. Most notably hospital (and other professional organizations) using a CBPR approach must cede control for the outcome of the process and be flexible to additional time that may be required by including diverse voices and implementing an iterative process. A CBPR approach is not the quickest route to completing an assessment and practitioners must be prepared to elongate their timeframe to some degree.

Although the Collaborative has been incredibly successful at obtaining engagement from a diverse set of secondary stakeholders, an effort has been made to engage more primary stakeholders (i.e., those affected directly by an issue) in the process. To be clear, the inclusion of these new voices in the health planning conversation is a disruption to the standard way of doing business for most professional organizations. Although this resulted in more culturally tailored data analysis for the Collaborative, it required significant adjustment on the part of many partners. The attempt to include more primary stakeholders was positively received in theory, but in practice the professional organizations had to realize that the price of inclusion meant a degree of discomfort and inconvenience (e.g., moving the meeting time to evening).

The Collaborative learned a great deal about the "unit of identity" in how individuals define their communities. Larger organizations tended to focus on broader regions, while many smaller organizations and individuals were only interested in one town or neighborhood or the shared experience of a particular community-defined group. The Collaborative is learning how to navigate these interconnected and nested contexts, providing the right opportunities in the right places for the right people. For example, the structure of the Collaborative allows grassroots organizations focused on issues of a particular neighborhood to draw on the experience and resources of entities across the region. Likewise, county-level planning initiatives are being increasingly informed by the information obtained by locally nuanced descriptions of assets, needs, and strategies that add to a more robust and complex implementation strategy. The Collaborative is continuing to develop these pathways of communication and shared learnings from which all participants may benefit.

Finally, collaborative leadership is a challenge. In many cases, the hospital may not employ individuals with a CBPR background and other community leaders may not have the significant training or expertise to work across sectors or embrace a democratic process with community residents. For example, some Collaborative partners cited a lack of opportunity for involvement in some workgroups and the need for "better leadership, communication, and understanding around the focus" of those groups, presenting an opportunity for growth. In these case local universities or public health offices may be a potential resource and capacity-building trainings and learning groups can be intentionally built among partner organizations to enhance skills in this new area. Even in situations where a "CBPR expert" is not available and where this approach to the community is new to everyone, hospitals can adopt the basic principles of the CBPR framework described here, grounding their approach to the community with the desire to listen, to respect the community voice, and to take collaborative action together.

CONCLUSION

CHNAs present a tremendous opportunity to create significant and sustainable change in the health of communities. However, many existing practices limit the ability of this mechanism to generate change and may cause more harm and alienation to the community over time. Top-down, deficit-based, and isolated approaches that oversimplify and overemphasize individual behaviors cannot generate the type of broad-based effort that is needed to truly transform communities.

In contrast, the principles of CBPR present an opportunity for those leading CHNAs to put the community back into the CHNA process. For hospitals to drive the type of change envisioned by the writers of the ACA, this approach offers a way to move beyond just "checking the box" to making a significant investment that will benefit both the community and the health care institution over time. By embracing the complexity and inclusivity of this framework, practitioners can achieve better data, broader community engagement, and the type of cross-sectoral coalition that can align resources for collective impact. As demonstrated by the case example, hospitals can move from traditional to CBPR approaches. Although the process of developing and implementing a community-informed CHNA is filled with challenges, the potential for impact is great.

REFERENCES

1. Barnett K. Best practices for community health needs assessment and implementation strategy development: A Review of scientific methods, current practices, and future potential. Oakland (CA): Public Health Institute; 2012.
2. Beatty KE, Wilson KD, Ciecior A, et al. Collaboration among Missouri nonprofit hospitals and local health departments: Content analysis of community health needs assessments. Am J Public Health 2015;105 Suppl 2:S337-S44.
3. National Association of County and City Health Officials [cited 2015 Jun 23]. Section two: Building collaboration. Retrieved from: www.naccho.org/topics/environmental/pullingtogether/sectiontwo.cfm.
4. Pennel CL, McLeroy KR, Burdine JN, et al. Nonprofit hospitals' approach to community health needs assessment. Am J Public Health 2015;105(3);e103-e113.
5. Potvin L, Cargo M, McComber AM, et al. Implementing participatory intervention and research in communities: Lessons from the Kahnawake Schools Diabetes Prevention Project in Canada. Soc Sci Med 2003;56:1295–305.
6. Minkler M, Wallerstein N. Community based participatory research for health. San Francisco: Jossey-Bass; 2003.
7. Marmot M, Friel S, Bell R, et al. Closing the gap in a generation: Health equity through action on the social determinants of health. Lancet 2008;37(9650):1661–9.
8. Trickett EJ, Beehler S, Deutsch C, et al. Advancing the science of community-level interventions. Am J Public Health 2011;101:1410–9.
9. Israel BA, Schulz AJ, Parker EA, et al. Review of community-based research: assessing partnership approaches to improve public health. Annu Rev Public Health 1998;19:173–202.
10. Anglin AA, Kirk CM, Johnson-Hakim S. Making collaboration count: A tool for tracking and building participation in community collaboratives and coalitions. Global Journal of Community Psychology Practice 2015;6(2).