

Collaborating through Community Health Assessment to Improve the Public's Health



Introduction

The National Association of County and City Health Officials (NACCHO) represents the nation's 2,800 local health departments (LHDs), which have conducted community health assessments (CHAs) in the United States since the 19th century. In the early part of the 20th century, the public health community developed successive iterations of an appraisal form to be used as a self-assessment tool by local health officers. By 1945, the Emerson Report recommended six basic services, including the collection and interpretation of vital statistics. In 1974, Congress made an effort to organize a comprehensive national health planning system informed by assessment through PL 93-641, the National Health Planning and Resources Development Act. The Act, which created a complex network of local, regional, and state planning agencies with significant responsibility for assessment activities, was allowed to lapse in 1986. In a landmark report near the close of the century, the Institute of Medicine (IOM) recommended that:

Every public health agency regularly and systematically collect, assemble, analyze and make available information on the health of the community, including statistics on health status, community health needs, and epidemiologic and other studies of health problems. Not every agency is large enough to conduct these activities directly; intergovernmental and interagency cooperation is essential. Nevertheless each agency bears the responsibility for seeing that the assessment function is fulfilled. This basic function of public health cannot be delegated.¹

The IOM's three core functions of public health (assessment, policy development, and assurance) were subsequently developed into 10 essential public health services. Two other recent developments have increased the interest in assessment activities. First, the 2010 Patient Protection and Affordable Care Act (ACA) requires nonprofit hospitals to conduct community health needs assessments (CHNAs) every three years and to adopt implementation strategies to meet the needs identified in the assessments. The law stipulates that CHNAs should consider the

broad interests of the community, including those with special knowledge of, or expertise in, public health. Second, in 2011, a voluntary national accreditation program for LHDs was launched; among the accreditation standards is the requirement that LHDs participate in or conduct a collaborative process resulting in a comprehensive CHA and community health improvement plan.

This issue brief describes the current state of CHA activity across the country and encourages continued and expanded collaboration among LHDs, hospitals, and other partners. The report is divided into three sections: assessment, a systems-collaborative approach, and epidemiologic and community considerations. Resources for additional information are also provided.²

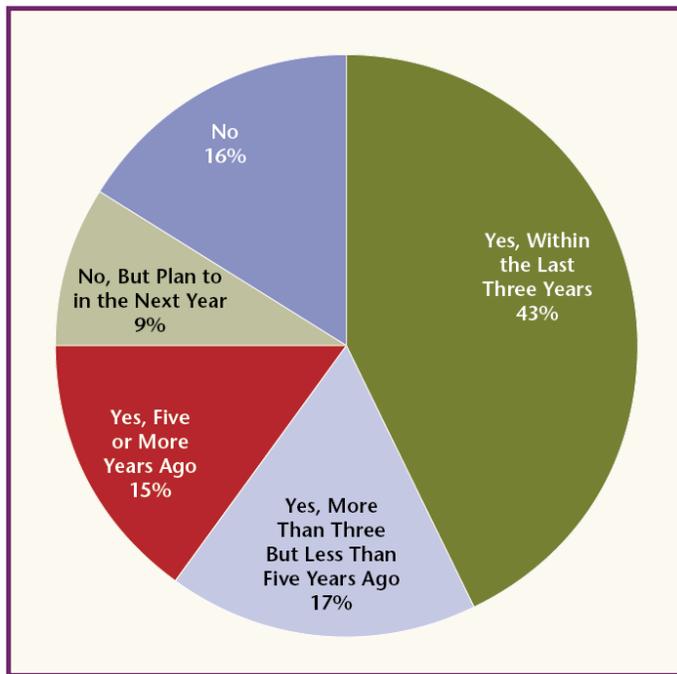
Assessment

LHDs have a broad range of knowledge and competencies required for CHA and community health improvement planning efforts, including community engagement and outreach, epidemiology, health equity, partnership and collaborative techniques, and assessment and planning methodologies.

NACCHO's 2010 National Profile of Local Health Departments study³ (Profile study) showed that 60 percent of LHDs had conducted a CHA in the last five years (Figure 1). An additional nine percent planned to conduct a CHA within the next year. Although down from the 2008 Profile study, which showed 63 percent having conducted a CHA in the last three years, this percentage is expected to increase with the recent launch of voluntary national accreditation of LHDs, which requires the completion of a CHA.

Broader than a CHNA, a CHA is based not only on needs but also on identifying priority community health and quality of life issues. As described in the Mobilizing for Action through Planning and Partnerships (MAPP)⁴ guidance, a robust CHA can include an assessment of community health status, an assessment of community strengths and assets, an assessment of the contextual concerns or forces of change, and an assessment of the local public health system (see sidebar on page 3).

FIGURE 1. PERCENTAGE DISTRIBUTION OF LHDS, BY PARTICIPATION IN CHA



n=2,091
Source: 2010 National Profile of Local Health Departments

LHDs and hospitals use CHAs in many ways, including using the data from CHAs to inform strategic plans and community improvement plans.⁵ They also use CHAs to strengthen grant applications and secure resources, justify health initiatives, prioritize health issues and the efforts to address them, support the work of partners, advocate for policy changes, and monitor health trends in the community.

A Systems-Collaborative Approach

NACCHO's 2008 Profile study showed two important facts related to collaboration. First, the LHD was frequently part of a broader coalition in the development of the local CHA, with about six in 10 LHDs (among those that had conducted a CHA) having participated with a local coalition in its development. Second, LHDs are collaborating with many organizations in the community. Almost all LHDs (97%) already partner with their local hospitals in some capacity, with 90 percent reporting information exchange, 53 percent reporting regular meetings, 40 percent reporting shared personnel or resources, and 39 percent reporting an existing written agreement.

In a CHA process, each partner brings unique experiences, resources, and expertise. LHDs are uniquely positioned to conceptualize the challenges and the assets a community brings to achieving improved population health. LHDs have expertise particularly with collecting and analyzing public health data, leading strategic planning processes to improve community

health, and understanding the process of using data to develop priorities and action plans for community health improvement. They also work directly with members of the community and offer skills such as organizing coalitions and facilitating focus group discussions, which are important to successful assessment processes. LHDs also have an ability to engage non-traditional partners, such as community-based and grassroots organizations, which may not be typical partners for hospitals.

Hospitals provide financial resources and manpower to the CHA process, particularly during a time when LHDs across the country are facing severe budget cuts and staffing issues. Hospitals not only offer financial resources for the assessment itself but also commit resources to the initiatives that arise from the process. Hospitals often have access to unique datasets that can inform assessments, particularly specialty hospitals (e.g., military hospitals or Indian Health Service hospitals). Hospitals are able to engage other members of the medical community that LHDs may not typically have access to, such as specialty providers. Hospitals are very powerful within a local community. As prestigious and credible stakeholders, they can gain attention from the media and bring population health more readily to the public eye.

Factors leading to successful LHD and hospital CHA collaboration often include the following:

- Previous collaboration on other types of initiatives, such as preparedness planning;
- Friendly, professional relationships between hospital and LHD leaders;
- Recognizing common goals between the agencies and establishing a common vision;
- Having an established forum for leadership to discuss population health issues;
- Maintaining a credible intermediary, such as a health planning council, advisory group, or formal network board with key stakeholders and experts from the health community;
- Recognizing the strengths of each other's agency—for example, that the hospital considers the LHD the expert in population health issues;
- A mutual understanding of political and financial environments, which can be driven by the health officer and CEO;
- A formal memorandum of understanding, which can set the foundation and be a precedent for collaboration across a range of activities, regardless of changes in leadership; and
- Being clear about roles, responsibilities, and expectations of collaborators and partners.

Epidemiologic and Community Considerations

CHAs are based in the science of public health: epidemiology. Although shrinking economic resources have meant more sharing of epidemiologists among LHDs, LHDs still have access to a broad range of epidemiologic information pertinent to a CHA. The 2008 Profile study noted that data sources related to vital statistics and disease outbreak investigation were available to over 80 percent of LHDs.

Centralized state databases with county-level data collection, comprehensive hospital inpatient databases searchable by zip code and by patient, qualitative data from the field, community health surveys and focus groups, data from non-traditional partners, such as law enforcement databases, Healthy People benchmarks, County Health Rankings, and vital statistics are examples of data sources that are valuable both to LHDs and hospitals.

One particular epidemiologic concern is defining the geographic boundaries of the community. Many different approaches to defining community for purposes of conducting CHAs exist; the most important consideration seems to be not the specific method of defining the geographical boundaries but rather the assurance that all partners agree on the definition.

In addition to the requirement in the ACA that nonprofit hospitals assess community health needs, the law also requires non-profit hospitals to provide a description of how the organization is addressing the needs identified in each community health needs assessment conducted under Section 501(r)(3) and a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed.⁶

LHDs have significant expertise implementing solutions to issues identified through an assessment process, including experience in addressing the root causes of health inequities and the social determinants of health.

The 2008 Profile study collected information on the percent of LHDs conducting activities to reduce health disparities and the type of activities that were conducted. Among LHDs serving larger (and usually more urban) populations, over 80 percent reported supporting community efforts and using data to describe disparate health outcomes by marginalized population groups.

Both LHDs and hospitals are cognizant of the unequal burden of health problems on marginalized populations. Both have experience in serving these groups, and each have data on the health problems that exist in communities where the marginalized reside. These data provide the basis for CHAs, which is a springboard for developing actions that address health inequities.

In a local public health system assessment, members of the local public health system convene to assess how well they work together to deliver the 10 essential public health services. The local public health system assessment is completed using the local National Public Health Performance Standards Program⁷ (NPHPSP) instrument, which provides performance standards and measures that help determine how well the local public health system operates. The NPHPSP instrument acknowledges that no one entity is responsible for delivering essential services. Thus, in order to understand fully what contributes to community health conditions, it is important to assess how well different entities work together in assuring the public's health.

Findings from a recent report, based on data submitted through the Version 2 NPHPSP Respondent Information Form,⁸ show that as of July 2011, among the 190 local systems that had conducted the Version 2 NPHPSP assessment of the local public health system, 97 percent had included the LHD and 79 percent had included a local hospital as a participant in conducting the assessment. The majority of local participants felt that the assessment process had positive or somewhat positive effect among public health system partners on knowledge of the public health system (85%), communication (86%), knowledge of systems improvement needs (83%), collaboration (80%), and intent to implement system improvements (80%).

[ISSUE BRIEF]

December 2011



Conclusion

By collaborating in a CHA process, LHDs, nonprofit hospitals, and other community stakeholders can describe the current health of the community they serve and provide an organizing framework for improving the public's health. Moreover, a collaborative effort can work to align efforts, avoid duplication, and increase efficiencies. When collaboration occurs, CHAs are more likely to be developed according to a process that meets the ACA's explicit requirement to take into consideration the broad needs of the community. Although a collaborative approach to CHA may appear more time-consuming, communities that engage in such a model will be the most likely to reach their public health goals.

References

1. Institute of Medicine Committee for the Study of the Future of Public Health. (1988). National Academy Press, Washington, DC.
2. The Community Health Assessment/Community Health Improvement (CHA/CHIP) Planning Resource Center provides an online and publicly accessible venue to LHDs and related partners for information on practical, customizable tools, key source material, examples from the field, and upcoming webinar trainings on CHA/CHIP topics at www.naccho.org/chachipgeneral.
3. The Profile study includes data on LHD jurisdictions, governance, budget, staffing, activity levels, and other topics. First conducted in 1989, the most recent Profile study was the sixth in the series. It was fielded in the summer of 2010 and yielded a response rate of 82 percent. The 2008 Profile study had a similarly high response rate and included detailed information on community health assessment and planning.
4. MAPP is a framework for developing, implementing, and evaluating collaborative community health improvement plans, which are informed by robust CHA data.
5. In summer 2011, NACCHO conducted two focus groups with 16 LHD top executives or their representatives on CHA as related to the community benefit provisions in the ACA.

"Relationships are really the foundation for moving forward with community health assessment in our area."—LHD representative

6. Patient Protection and Affordable Care Act (Public Law 111–148), Section 4959. Retrieved Nov. 28, 2011, from <http://docs.house.gov/energycommerce/ppacacon.pdf>.
7. The Centers for Disease Control and Prevention (CDC) National Public Health Performance Standards Program (NPHPSP) supports a national partnership initiative that has developed National Public Health Performance Standards for state and local public health systems and for public health governing bodies. The mission of the NPHPSP is to improve the quality of public health practice and performance of public health systems.
8. More information on the National Public Health Performance Standards Respondent Information Form report is available through the Public Health Foundation.

Acknowledgments

Funding for this project was provided by the Centers for Disease Control and Prevention (cooperative agreement #CDC-RFA-HM08-80503CONT11) and the Robert Wood Johnson Foundation. The contents of this document are solely the responsibility of NACCHO and do not necessarily represent the official views of the sponsors.

FOR MORE INFORMATION, PLEASE CONTACT:

Julia Joh Elligers

Director, Assessment, Planning, & Workforce Development
202-507-4234
jjoh@naccho.org

NACCHO

National Association of County & City Health Officials

The National Connection for Local Public Health

www.naccho.org



The mission of the National Association of County and City Health Officials (NACCHO) is to be a leader, partner, catalyst, and voice for local health departments in order to ensure the conditions that promote health and equity, combat disease, and improve the quality and length of all lives.

1100 17th St, NW, 7th Floor Washington, DC 20036

P (202) 783 5550 F (202) 783 1583

© 2011. National Association of County and City Health Officials.