Leveraging Nonprofit Hospital Community Benefit Dollars and Community Health Needs Assessment Requirements for Community Health Innovations

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Community health assessment is not a new concept. These assessments have been a widely-used tool in public health for decades to bring community health needs to light and to focus community health programs and advocacy (Kretzmann & McKnight, 1993). The Patient Protection and Affordable Care Act of 2010 made them a hot topic in medicine when the legislation revised the conditions for a hospital to maintain its nonprofit status, including a requirement to conduct a community health needs assessment (CHNA) and community health improvement strategy based on those results every three years. This provides a new opportunity to re-examine hospital community benefits with a population health lens, and a new opportunity to address intractable health disparities occurring among the highest need and highest cost communities they serve. However, limited guidance from both the ACA requirements for CHNA and in the current community benefit standards raises questions about whether the implementation of CHNA is ensuring community health needs are being adequately assessed and met as intended (Rubin, Singh, and Young 2015).

In exchange for nonprofit status and the tax breaks that accompany such designation, hospitals are expected to provide community benefits. The current community benefit standard, ambiguous and in place since 1969, is intended for a healthcare system that looks dramatically different from today (Rubin et al. 2015). This ambiguity leads to considerable variation in the provision of community benefit between hospitals (Young, Chou, Alexander, Lee, & Raver, 2013), with variation down to the level of how hospitals are defining and measuring provision of uncompensated care (C. L. Pennel, McLeroy, Burdine, & Matarrita-Cascante, 2015). Controversy over whether nonprofit hospitals were providing enough community benefit to earn their tax status led to congressional examination and the inclusion of the CHNA requirement in the Affordable Care Act (James, 2016). Thus the new CHNA requirement is intended to guide nonprofit hospitals in their missions to providing community benefits (Roundtable on Population Health Improvement, Board on Population Health and Public Health Practice, & Institute of Medicine, 2014).

Historically, hospitals claimed safety net services as their primary community benefit. But is improved service provision truly a community benefit that extends beyond the already existing mandate of the hospital to serve its community? This tension likely mirrors the two competing definitions of the term population health – one used in medicine that refers to populations of patients and thus focuses on improved outcomes and reduced costs, and one used in social science that refers to the social determinants of health that exist outside of the biomedical model (Diez Roux, 2016). Indeed, it is well-established that individual behaviors, social and economic factors, and the physical environment contribute more to overall health than clinical care. Researchers estimate that these social determinants of health are 80% responsible for health and well-being (Braveman, Egerter, & Williams, 2011; Magnan et al., 2012; Robert Wood Johnson Foundation, 2009). Furthermore, after Affordable Care Act provisions that extend and decrease the cost of coverage to previously uninsured and underinsured patients, the safety net services framework for community benefits no longer fits (Rubin et al., 2015). Unless hospital systems address the other 80% of factors driving patients through their doors, they will be caught in a perpetual cycle of high costs and poor outcomes.

Under CHNA guidelines, hospitals possess broad latitude to define, assess and prioritize community health needs (C. L. Pennel et al., 2015). Vague CHNA guidelines risk failing to ensure that true community needs are being assessed and addressed. These guidelines, for instance, allow health systems to create their own definition of “community” for the purpose of the assessment. Hospitals can choose to define community as their system’s service area, encompassing huge geographic regions with large and diverse populations. For example, the Children’s Hospital of Philadelphia used this service area definition for their 2013 CHNA, which included five counties and nearly 4 million people (The Children’s Hospital of Philadelphia, 2014). Although this definition is permitted under the broad guidelines and is a good place to start, focusing each triennial assessment at such a high population level risks masking differences in health and health risks in communities that span a vast continuum of socioeconomic status, racial segregation, neighborhood environments and unique health needs. Children’s heath needs on the Main Line are very different than health needs in West Philadelphia. Thus the solutions should also be different.

So how can the opportunity and spirit of the Affordable Care Act requirement be used to drive effective community health improvement plans and make a dent in widening health disparities? Public health has struggled to slow pervasive health disparities driven by widening societal inequalities. Evaluating and sharing what has worked before becomes the evidence base for best practices to improve health at the population or community level. But until we do a better job of including communities in the identification of best practices - through identifying health priorities, assessing existing assets as well as needs, and tailoring programs to their unique context - we will continue the same cycle of dropping prepackaged programs into the community without ownership, or even buy-in, and then continue to wonder why they didn’t work.

A solution lies with true community engagement in the process of conducting CHNAs and developing and implementing the community health improvement plans. Community-engaged research is an approach to research that includes individual and organizational representatives of the communities being researched in the research process (Meredith Minkler, 2012). Community-engaged research includes a variety of settings and intensity of community engagement, including community-based or practice-based research; levels of community engagement in at least one phase of the research process (e.g., planning, data collection, data analysis or interpretation, results dissemination); or the gold standard, community-based participatory research, where community stakeholders are involved in all phases of research (Anderson et al., 2012; Israel, Schulz, Parker, & Becker, 1998; Lasker & Weiss, 2003; M. Minkler & Wallerstein, 2003).

A June 2013 Institute of Medicine report identified community engagement as a key priority for its national Clinical and Translational Science Awards, arguing that community stakeholders are essential for identifying health needs and priorities, providing data and input, and promoting successful participation in important research (National Academy of Sciences, 2013). Indeed, growing literature demonstrates clear benefits to research from community engagement, including community member recruitment, improved data collection design, and better use of results to inform interventions (Heaney et al., 2011; Jagosh et al., 2012; Santilli, Carroll-Scott, Wong, & Ickovics, 2011; Wallerstein & Duran, 2010). It also serves to address the pervasive mistrust associated with academic and medical research among minority populations experiencing the worst health disparities (Corbie-Smith, Thomas, Williams, & Moody-Ayers, 1999; Freimuth et al., 2001; Fryer et al., 2015).

Recent reviews of the first rounds of CHNAs are finding that although community stakeholders are engaged in some aspects of the CHNAs, few engage diverse community members and community-based organizations in “meaningful participation” throughout the CHNA and community health improvement plan development process (C. L. D. Pennel, McLeroy, Burdine, Matarrita-Cascante, & Wang, 2015). Yet there exists high demand from community-based organizations to conduct their own CHNAs or to be knowledgeable and equitable partners in the process (Carroll-Scott, Toy, Wyn, Zane, & Wallace, 2012). As has been found in a community-engaged CHNA model in New Haven for Yale-New Haven

Hospital, engaging communities in their own assessments reveals needs and assets not apparent in a catchment-level assessment, and can begin to drive more effectively tailored solutions to health improvement efforts (Santilli, Carroll-Scott, & Ickovics, 2016).

Another answer lies in the collection and dissemination of such data collected at the neighborhood or community level, as has been addressed by Axler and colleagues.A new and innovative movement in open data, invigorated by technology that enables web-based data visualization more intuitive to lay audiences than traditional scientific publications (Kingsley, Coulton, & Pettit, 2014; Pettit, 2014). By sharing CHNA results and aggregated data routinely collected by hospitals at the neighborhood level, communities can define their own neighborhood or community boundaries themselves and use the data they need for identifying community health priorities and planning for community-driven interventions.

The solution is not that hospitals themselves collect new data in each neighborhood or use the data to address each community's health needs, but partner and invest in existing population-based health data collection processes and use the CHNA as an opportunity to creatively and strategically share these data and other routinely-collected information with those who are the natural leaders in the community. This will enable the needed paradigm shift from service delivery planning to population-based community health planning (Rice, 1993).

Rather than looking at the CHNA as a requirement to be minimally met, hospitals should see them as an opportunity to think more broadly about how to address pervasive health disparities among the communities they serve, in turn avoiding the intractable “hot spots” of high costs and poor health outcomes. This presents the perfect opportunity for hospitals to develop mutually-beneficial partnerships with community members and the public health workforce so that all involved can use their professional and shared experience to understand community health needs, and then empower community-driven solutions. This approach can amplify a hospital’s community benefit well beyond their patient population, and into the communities where they live, work, worship and play.

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