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# The Power of Community Voices for Enhancing Community Health Needs Assessments

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*As required by the Affordable Care Act, Community Health Needs Assessments (CHNAs) are formalized processes nonprofit hospitals must perform at least every 3 years. CHNAs are designed to help hospitals better tailor health services to the needs of local residents. However, CHNAs most often use quantitative, population-level data, and rarely incorporate the actual voices of local community members. This is particularly a problem for meeting the needs of residents who are also racial or ethnic minorities. This article discusses one model for integrating residents' voices into the CHNA process. In this model, we videotaped interviews with community members and then coded and analyzed interview data to identify underlying themes. We created a short video aimed at starting conversations about community members' concerns. In addition to demonstrating how other nonprofit hospitals may use qualitative data in the CHNA process, this article illustrates how adding qualitative data may change how we think about health promotion. We find that community members requested that health care providers view culture as a health resource, foster community connections, and be present in the community.*

**Keywords:** social determinants of health; partnerships/coalitions; health disparities; health promotion; cultural competence; community assessment; program planning and evaluation; community organization; needs/assets assessment; qualitative evaluation

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## ► INTRODUCTION AND BACKGROUND

With the passing of the Affordable Care Act, Community Health Needs Assessments (CHNAs) have become part of how nonprofit hospitals understand the needs of persons in their geographic area. Each nonprofit hospital must conduct a CHNA at least every 3 years and adopt an implementation strategy to meet the identified community health needs (Abbott, 2011; Federal Register, 2013). Recently, the National Association for County and City Health Officials (2014) argued that CHNAs should “take into account input from persons who represent the broad interests of the community served, including those with special knowledge of or expertise in public health.”

According to a panel of experts convened by the Centers for Disease Control and Prevention, the ideal state for the CHNA includes using data, engaging stakeholders, and sharing ownership of the needs assessment (Barnett, 2012). The Catholic Health Association was an early leader in community engagement and developed the first uniform standards for community benefit reporting by nonprofit health care organizations. These

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standards were used by the Internal Revenue Service to develop the Form 990, Schedule H for hospitals. Standards are left open to allow hospitals to determine the best way to gather and use data on the communities they serve (Folkemer et al., 2011). So far, however, the potential for CHNAs to truly engage communities is limited by hospitals' reliance on existing quantitative data, such as local health department data, census level data, system-level surveys, or other surveys analyzed quantitatively. While some high quality examples of quantitative CHNA analyses do exist (see, e.g., Sampson, Gearin, & Boe, 2015), qualitative interviews with community members provide additional perspectives on health promotion. The integration of voices from community members would enhance the knowledge gained and the potential for future health promotion activities (Ainsworth, Diaz, & Schmidlein, 2013).

Even when qualitative data are included in CHNAs, participants are typically leaders within an organization that serves the community, and they do not necessarily speak from their own experience as community members. National systematic reviews of CHNA data collection techniques have not yet been published, but smaller scale (state or county level) studies have argued that CHNAs should include both quantitative and qualitative data collection (Kuehnert, Graber, & Stone, 2014; Pennel, McLeroy, Burdine, & Matarrita-Cascante, 2015), though few outline how to best involve community members. In fact, recommendations for mixed methods approaches stop short of naming actual community members as potential sources of qualitative data (King & Roach, 2015; Schafer & Dawson, 2015). A recent study of CHNAs in Texas found that only 28% involved qualitative data collection with community members themselves (Pennel, McLeroy, Burdine, Matarrita-Cascante, & Wang, 2015). We believe qualitative interviews with community members—and not just leaders of community organizations or stakeholders—are beneficial to the CHNA process because they offer a new perspective on issues of health promotion (Woodyard, Przybyla, & Hallam, 2015).

Adding in the perspectives of residents can enrich the CHNA process in several ways. Qualitative interviews integrate knowledge and interpretations of community members. Taking a social constructivist perspective, which assumes the world is made up of multiple realities, local truths, and subjective experience, these interviews offer otherwise unobservable data that may help bridge the divide between research and practice (Labonte & Robertson, 1996). Additionally, by inviting community members into health promotion discussions, qualitative interviews with community members can reinforce collaborative relationships

between hospitals and the people they serve, integrating principles from community-based research practice (Kreuter, Lezin, & Young, 2000). Qualitative approaches help focus initiatives on what is most important to residents (Leung, Yen, & Minkler, 2004) and provide opportunities to discuss community assets as well as needs (Goldman & Schmalz, 2005). These methods can help improve quality by identifying gaps or current problems in care (Black, 1994).

Importantly, sharing residents' experiences, especially through multimedia outlets like video-voice methods, can also increase the educational potential of the CHNA process (Neuwirth, Bellows, Jackson, & Price, 2012). For instance, in this project, we video-recorded interviews and used that footage to create a short video of the findings presented here (AllinaHealth, 2015). This video has been used to initiate conversations within the larger health system about how health care providers may be responsive to issues of equity, cultural competency, and local community needs.

Integrating community voices may be especially important for confronting health disparities on the basis of race and ethnicity (Grant, Ramos, Davis, & Green, 2015). The Institute of Medicine (2003) defines inequity as a stemming from sociohistorical processes, including racial and ethnic discrimination and economic inequality. As we work to eliminate health disparities, it is critical that we first understand social, cultural, and economic determinants of health (Marmot, Friel, Bell, Houweling, & Taylor, 2008). CHNAs, especially when they include the voices of residents, offer an opportunity to uncover and analyze local processes that produce health disparities (Crossley, 2012). This knowledge can then be used to inform prevention, health promotion, quality improvement, and equity initiatives (Bilton, 2012).

The goals of this article are twofold. First, we will describe one model for integrating the voices of community members. Our qualitative approach sought to enliven discussions about community needs, while also providing a new perspective on how community members think about the role of hospitals in their health. Second, we use the findings from these qualitative interviews to discuss three themes that emerged. These themes demonstrate how including community members in CHNA data collection may change the ways we think about health promotion and meeting community needs.

## ► DATA AND METHOD

This article documents how Allina Health integrated community voices into their CHNA process for Abbott Northwestern Hospital (ANW), located in

Minneapolis, Minnesota. ANW is situated in a racially, ethnically, and socioeconomically diverse community, presenting a unique opportunity to engage a broad range of community residents. In fact, the total population of this region is 41,219, of which persons of color (including African Americans, Latinos, Asian Americans, American Indians, and multiple immigrant groups) make up 62% (U.S. Census Bureau, 2010). This area of Minneapolis is also home to some of the largest health disparities on the basis of race and ethnicity (Snowden, 2015). Given the complex social and economic factors that produce these disparities, ANW selected a mixed methodological approach to their CHNA. In addition to available quantitative measures and community dialogues, we also conducted qualitative interviews with individual community members.

We selected interviewees who lived within one mile of ANW, ensuring that interviewees had first-hand experience living in the communities nearest the site of care. We worked with community partners to identify potential participants who were nexuses of their communities. Because these individuals held collective knowledge of community experiences, we were able to leverage a smaller sample and still yield robust results. Some of these individuals had prior experience with health promotion activities. For these interviewees, we used this knowledge to gain insight on weaknesses of existing strategies. Due to limitations of funding, human resources, and time on the project, we limited ourselves to an initial list of 15 potential participants. Because this project was meant to contribute to the larger CHNA process, we reasoned depth of engagement with interviewees was more critical than a large sample size. Based on participant availability and our selection process to maximize diversity, nine participants were selected for the interviews.

At each interview an interviewer, note taker, and cameraperson was present. Interviews were scheduled to be an hour long with 15 minutes before to give participants the information sheet. Because the institutional review board considered this project to be process-oriented, and therefore not research data, the interviews were considered exempt. However, because project staff wanted to ensure that participants fully understood the risks and benefits of participating, we still provided information sheets on the risks of the project and clarified that participation was elective and respondents could opt out at any time. Information sheets followed basic informed consent structure. Each interviewee was provided with a \$25 dollar gift card to a local department store as a token of appreciation for their time. Interviewees were between the ages of 26 and 68 years.

Four participants were women, four were men, and one chose not to identify. Our sample was racially and ethnically diverse: It included three African or African Americans, two American Indians, two European Americans, one East Indian, and one Latino/Latina. Participants were offered an interpreter if necessary; however, all of the interviewees were English speaking.

The interview questions were developed based on county-wide health priorities: maternal and child health nutrition; physical activity and obesity prevention; and, mental health. Initial questions were designed by Allina Health staff, with input from the Cultural Wellness Center, a community nonprofit in Minneapolis. There were a total of ten broad questions with interviewers asking several follow-up questions suggested by responses during the interview. While the county-wide priority questions provided specific data on issues within the community, this article focuses on overarching themes that occurred across the sets of health priorities.

All interviews were transcribed. Two authors coded each transcript independently and met to reconcile a list of main codes. These main codes were derived from direct interpretations of the quotes. We discussed our main codes together, carefully defining each code and combining codes with similar content. After discussing our main codes, we inductively developed overarching themes. Table 1 summarizes the broad themes, the codes within each theme, and provides an illustrative example for each code. These overarching themes were common across participants and specific topic areas: view culture as a health resource, invest in community connections, and be present. After completing coding and reconciliation, we also presented the main findings to participants and stakeholders for member check. From these discussions, we refined our analysis to clarify the main points presented below.

## ► FINDINGS

### *View Culture as a Health Resource*

When asked about general health and well-being, many participants reported concerns over the dissolution of culture. Some linked the dissolution of culture to an unhealthy reliance on pharmaceuticals and consumerism: “When we lose our culture and our language and our teachings, then we’re all going to fall onto the pharmacy, the stores.” Another respondent emphasized knowing one’s self through cultural practice as beneficial to one’s mental health because, “Once you have awareness of who are and where you come from, then you can be comfortable with the other persons,

**TABLE 1**  
**Themes, Codes, and Examples**

View culture as a health resource	
Dissolution of culture	“What I’m noticing from personal experience . . . I’m noticing lack of culture. A lot of that, and that’s the rule to being a complete human being, in my opinion. Once you know who you are, you’ll respect who you are and a lot of these kids, they’re not familiar [with] who they are.”
Honor culture	“Children continually needing to see themselves reflected in the materials that are presented. I mean, it’s not just ‘celebrate your cultural holiday,’ you know. It goes so much more beyond that in terms of what feeds children’s self-esteem and capacity to be able to learn.”
Change attitude toward culture	“We all grew up different, our cultures are all different and I think the hospitals should start . . . if they can take our culture and be respectful and work with them and learn more about our ways and medicines, then I think they’d work together.”
Community connections	
Learn about culture	“[In the] beginning, you do not immediately have deep relationships, but every week you meet. You know, I’m getting to know Puerto Rican culture now, because [community member] is Puerto Rican. Through her I know other know other Puerto Ricans. . . . We are building culture change, we’re knowing each other.”
Healthy activities	“They have fun; they talk about their lives all together. I think that is a very good way to being less stressed and having activities with your children, just like I said just have fun, whatever. Dancing, go for a walk or do what you like and listen to the people you know.”
Be present	
Nonmedical definition of health	“It’s all about making the best care for that person and I’m starting to hear . . . more of traditional healer getting together with a western doctor and trying to make the best possible care for that person. . . . More of a holistic approach, I guess I’m saying, which is a really big deal and just think of the best care for that person.”
Listening	“There would have to be some kind of direct connection between the community and [Abbott Northwestern Hospital] in order to have the conversation or ask the community how they can help.”

because now you understand their worth, cause you know yours.”

To remedy the dissolution of culture, several respondents made suggestions that would push health care providers to reorient their conception of culture. These suggestions included moving care approaches away from treating culture with sensitivity (Brach & Fraserirector, 2000) and toward viewing culture as a health resource. It is not just accepting cultural diversity and being sensitive to others, but respecting and honoring cultural differences. One respondent said that ANW needs to respect residents’ “cultural needs, their values . . . cause one person’s value is way different from another culture’s value.” Interviewees requested that health care providers become part of the community, learn about culture, respect differences, and have an open mind and heart:

Learn more about each other’s cultures you know and the spirituality. . . . Just respect each other, have open mind, open heart and I think things will work out, you know.

### ***Foster Community Connections***

Interviewees explained that activities that bring together the whole family are useful for engaging the community and recognizing assets that already exist. They described activities that were culturally diverse, and that provided opportunities to learn about other ways of understanding the world. Some involved trying new foods and forms of physical activity. One respondent described how cultural events support health and community:

Teaching my kids to be active is having fun teaching them our culture, our ways of dancing and our dancing is really physical. You know, you can’t be overweight to do our kind of dancing, so to get them feeling good about themselves [sic] and put on some really nice beautiful dance regalia and go out and dance.

The interviewee followed up this story by explaining that some young people took up running to improve their stamina during the dance ceremony.



This community event supported culture as a health resource and helped build healthy habits.

Community-led activities also allowed residents to make connections with other community members. While exercise interventions often focus only on the corporeal benefits, one respondent described that improving her health was secondary to connecting with others:

So for all kinds of reasons I value fitness and I value it for the way it connects me to people. It's social you know, the people that I exercise with are the people that I see more regularly and so I'm involved in community health projects, so then what am I going to do? I'm going to be involved in organizing exercise to bring people together.

This quote highlights that social connection and health practices are interconnected. Additionally, through those connections, this interviewee claimed that she's become more involved in her community, benefiting others as well.

### ***Be Present***

Community members also requested a broad dialog about health issues. They emphasized that conversations needed to start before problems arise, be inclusive, expand beyond conventional medicine, and be driven by the needs of the community. Listening to the community is the first step. The CHNA is an avenue for that. Involving community members in the CHNA process permitted some respondents to feel like the hospital invested in their needs:

You got to know there's a hospital here in our community that's willing to invest in people, for people—Not only through the clinical services, but outside of that as well. . . . I think the relationships have to be promoted.

Interviewees also requested that community members guide these conversations. Putting community members in charge could establish cooperation and benefit future collaborative relationships. Some community members contrasted this to what they characterized as the failings of health care in the past.

[What health care] does a lot is assume they're struggling and maybe set up some type of services without asking the community directly how can we help. So I think that's the, one of the biggest problems in many institutions is they already have these readymade answers and these readymade

programs and they're not doing the work of asking the people directly how can we help and what services could be; how can I make this easier for you?

Full use of the CHNA process would take advantage of community members' willingness to discuss alternatives to ready-made answers. Collecting interview data with community members involves them in setting the health promotion agenda. This involvement can then be used as a catalyst for future community action.

## **► DISCUSSION AND CONCLUSION**

By integrating the voices of community members, this study identified several things health care systems can do to improve the health of their local communities. Specifically, community members requested that hospitals treat culture as a health resource, not just something to treat with sensitivity. They discussed how supporting community connections can encourage activities to improve physical health. Finally, they requested that health care organizations be present through true engagement with community members and taking the time to deeply listen. By integrating interviews with community members, the ANW CHNA process produced data that offer another perspective on how to promote health.

In addition to revealing new insights about how to approach care for local communities, integrating qualitative interviews into the CHNA process has the potential to involve community members in a more participatory fashion, perhaps improving future collaborations between communities and nonprofit hospitals (Ainsworth et al., 2013; Woodyard et al., 2015). Collaboration with community members and other provider organizations is essential for acting on data collected through the CHNA process (Ainsworth et al., 2013; Goodman, Steckler, Hoover, & Schwartz, 1993). These collaborations can help focus initiatives, making them more meaningful and relevant for community members.

Importantly, this approach also examines community assets, instead of focusing on only the needs of communities. An asset-based complement to problem-focused needs assessments is essential for improving trust and community coalitions (Goldman & Schmalz, 2005; Kreuter et al., 2000). Using qualitative methods in conjunction with more traditional quantitative approaches is especially appropriate for studying complex public health issues, like how to orient care to the local needs of community members (Baum, 1995).

This project also highlighted the importance of incorporating visual media into the data analysis process to enliven the results of CHNAs. Thoughts and feedback of

residents are highly impactful when delivered in their own voices. Other CHNAs have integrated this concept into their process and found that it yielded a nuanced understanding of the experiences and environments of participants (Downey & Anyaegbunam, 2010). Sometimes called “photovoice” methods, integrating video into qualitative interviews produces high quality data and visual materials that can be used in health promotion efforts (Neuwirth et al., 2012). These kinds of approaches are especially necessary when thinking about how to mitigate health disparities (Braithwaite, Bianchi, & Taylor, 1994).

Some of the disadvantages of qualitative methods include that interviews can be time and resource intensive and must be incorporated into the overall CHNA plan; it is unwise to use qualitative interviews alone to generalize to populations; and one must consider the safety and confidentiality of respondents. We can reduce the resource burden for qualitative research by developing stronger collaborations with local entities, including health departments, universities, and others invested in community health. We also recommend that others seeking to use this method continue to think about the ethical dimensions of community involvement. Although our institutional review board did not require formal consent because they did not consider these to be research data, we recommend that interviewees be fully informed of their rights and ability to withdraw from the interviews, especially as video recordings make confidentiality difficult to protect.

Limitations of our article do exist. First, our sample of community members was biased toward those who were already engaged with health improvement activities. Their perception of how ANW may improve could differ from those who have not elected into these kinds of activities. However, their experiences as nexuses in their community also make them especially knowledgeable about what others in the community may think. They are in an ideal position to bring findings back to the community and help engage others in health promotion efforts. Second, our sample is relatively small and from a single location. We cannot generalize to the population from our sample. Our goal was to capture a diversity of perspectives that would complement existing quantitative analyses, so generalizability was not a key factor in this data collection. Despite these limitations, the response to the video and member check process has been quite good. Our findings have stimulated new conversations within the organization, which is a primary goal of the CHNA process.

Our findings suggest a reorientation to how community members interface with health care systems. So how can hospitals translate our findings into action? There are a number of opportunities to authentically

engage patients, families, and communities in care delivery redesign to assure that care is relevant and meaningful to community members. The CHNA process is one mechanism for this engagement—and a good precursor to deeper engagement and collaboration. While it may not be feasible for all hospitals to conduct formal qualitative research due to time and resource constraints, it may be possible to involve local hospital leaders in conducting community-based interviews with their local residents. This can create a deeper sense of engagement and accountability by local hospitals in the CHNA process and resulting action plan. Direct engagement between hospital leaders and community members can also begin to build cross-cultural relationships, trust, and mutual exchange, which are prerequisites for future collaborations. Building on this foundation, hospital staff and community members can work together to explore the root causes of health disparities and to co-create clinical and community-based solutions.

The next step for this project is to use the video in organizational strategic planning to encourage conversations about how best to support local residents. The video, along with a presentation describing the process, has already been shown to multiple Allina staff members ranging from the department responsible for the CHNAs to the ANW stakeholder group that advised on the ANW CHNA, to an equity stakeholder group, and to an employee forum open to all ANW employees. Many staff members commented that they found the video to be informative and engaging and spoke about potential action steps. For example, members of the human resources department thought it could be useful for cultural competency workshops at ANW. Others thought it was important to hear community members use a definition of health that is broader than traditional health care and discussed how to acknowledge that in their respective work. The organizational support for this effort has been encouraging as we discuss how viewing community members as essential partners in the CHNA process can make health promotion efforts more relevant and responsive to disparities on the basis of race and ethnicity.

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