

Advancing Community Health Together: Aligning Health Needs Assessment and Planning Efforts

March 2026

Many health sector organizations are required by their oversight or accrediting bodies to conduct regular community health needs assessments and create community or population-based health improvement plans. Aligning health assessment and planning efforts across sectors creates a shared strategy that informs community benefit investments, population health management strategies, and cross-sector health improvement initiatives focused on social drivers of health. This document provides general guidance for aligning assessment and planning efforts across health sector partners (partners) to increase efficiency, cost effectiveness, and community impact.

Common Partners and Requirements

Appendix A includes a high-level overview of common health-sector partners' assessment and planning requirements set forth by their oversight or accrediting body, including:

- Certified Behavioral Health Clinics (SAMHSA)
- Federally Qualified Health Centers (HRSA)
- Health Departments (PHAB)
- Managed Care Plans (NCQA)
- Non-Profit Hospitals (IRS)

Benefits of Alignment:

- Reduces administrative burden, costs, and duplication.
- Maximizes data quality and community input.
- Increases cost effectiveness.
- Fosters shared ownership of community priorities.
- Fosters collective impact.
- Creates opportunities for coordination across population, clinical, behavioral, and social drivers of health.
- Supports value-based care goals
- Can be designed to meet each partner's unique needs and requirements.

Aligning Cycles:

- Map current cycles. Plot each participating partner's assessment and planning deadlines on a shared timeline.
- Find overlap. Adjust future schedule to a 3-year cycle.
- Align. Agree on updated cadence and adjust individual partner's cycles to align.
- Establish a joint review schedule.

Joint Assessment Tips:

- Start with shared governance. Create a joint steering committee or other governing body to guide the work.
- Agree on definition of "community" and clarify geographic boundaries across partners.
- Conduct cross walk of regulatory and data related requirements by partner to ensure data collection sources and methods match needs.

- Coordinate data collection. Pool resources for primary and secondary data collection, analysis, and reporting, reducing reliance on separate, parallel engagements and costs.
- Ensure all voices are heard. Including partners, patients, clients, and diverse community member perspectives.
- Consider using the body of the plan to address shared population health data needs and requirements across all partners (e.g., population health indicators) and include partner specific data needs in an appendix (e.g. aggregate patient data, data by service/catchment area) in appendices.
- Document for all partners' standards/requirements. Keep notes showing compliance.
- Identify shared priorities. Use actionable data to establish a set of shared priorities that drives collective improvement planning.
- Co-brand and co-promote. Consider joint media launch of assessment findings and next steps.

Joint Planning Tips

- Consider an outside facilitator. An outside facilitator can bring neutrality and objectivity to the process.
- Use Collective Impact. Align and integrate work across the identified priorities to maximize community impact.
- Include measurable objectives. Ensure the structure meets partner requirements.
- Assign shared responsibility. Clearly indicate who "owns" objectives and action items.
- Co brand and co-promote. This shows joint ownership and shared responsibility.
- Track progress together. Create a shared performance dashboard and review on an agreed upon cycle.
- Agree on review process between cycles.

Examples from the Field:

Below are a few examples of joint health assessment and planning efforts at the local level. It is worth noting that some states require joint hospital/health department planning in statute (e.g., California, New Hampshire, New York, Maryland, Rhode Island, Texas).

- [King County Community Health Improvement Plan](#) (WA). Co-created community plan, led by the health department, with a focus on social drivers of health (e.g. income/employment and housing). Steering committee includes representatives from healthcare systems, public health, community health centers, and Tribal leadership working together to align population health strategy.
- [Center for Community Health](#) (MN). Collaborative between health plans, hospitals, and public health agencies in seven-county metropolitan area. Partners share data and processes to identify health needs and implement innovative approaches to advance community health, well-being, and equity.
- [Franklin County Health Map](#) (OH). Joint health assessment and prioritization process co-led by hospital systems and local health departments in the county. Other partners include, but are not limited to: ADAMH, FQHCs, and human services chamber. Priorities include health issues (e.g., mental health) and social drivers of health (e.g. housing).
- [Santa Clara County Partners for Health](#) (CA). Joint assessment and planning process led by health department using Mobilizing for Action through Planning and Partnerships (MAPP) and Collective Impact models. Steering committee includes health department, hospitals, clinics, payers, businesses, and other community organizations.

PHAB's Consultation and Facilitation Services:

PHAB staff are available to support health sector partners with alignment and facilitation of assessment and planning processes. Visit our [website](#) and/or email the PHAB team at phabta@phaboard.org to learn more.

APPENDIX A: General Health Assessment and Planning Requirements by Partner

This table provides a high-level summary of general health assessment and planning requirements across an expanded list of health sector partners. This table should not be used as the source of truth, rather users should consult each partner’s oversight/accrediting body for specific details. Links are provided below.

Community Partner	National Oversight or Accrediting Body	Frequency	Required Assessment Components	Required Planning Components
Certified Behavioral Health Clinics (CCBHCs)	SAMHSA	Every 3 years	<ul style="list-style-type: none"> Defined service area/population served Data for the defined service area including, prevalence of mental health/substance use, economic and social determinants of health, service gaps and barriers to access, current outcome data, cultures and languages of population served Input from community partners including those with lived experience List of partners and 	<ul style="list-style-type: none"> Goals and plans for program development to address identified gaps Description of how staffing plan addresses findings
FQHC	HRSA	Every 3 years	<ul style="list-style-type: none"> Defined service area (reviewed/updated annually) Data including population health status, disparities, provider ratios, factors affecting access to health services, demographic factors impacting need/demand for health services 	<ul style="list-style-type: none"> Findings from assessment integrated into program planning
Health Department	PHAB	Every 6 years	<ul style="list-style-type: none"> Primary and secondary data sources including input from community partners and residents Demographics of population served and disparities by select sub-populations Description of key findings or themes emerging from the data Documentation of partners and the process 	<ul style="list-style-type: none"> Priorities based on health assessment data with measurable objectives and activities including responsible individuals/organizations List of assets and resources to support implementation Process for monitoring and tracking progress Documentation of partners and the process
Managed Care Plans	NCQA	Annually	<ul style="list-style-type: none"> Assessment of member needs and characteristics 	<ul style="list-style-type: none"> Population Health Management (PHM) strategy that describes how the health plan will meet needs of its members.
Hospital (Non-profit)	IRS §501	Every 3 years	<ul style="list-style-type: none"> Defined service area Data on general health status/needs of the population residing in the defined service area Input from community partners Identified priorities based on assessment data Documented process Assessment report available to the public 	<ul style="list-style-type: none"> Implementation strategy addressing priority needs based on assessment results If priority not addressed in plan, description of why