



Connecticut Association
of Directors of Health

Strengthening local public health.

Guidelines for Conducting a Community Health Needs Assessment

A collaboration of the Connecticut Hospital Association, Connecticut Association of Directors of Health, health departments, hospitals, and Federally Qualified Health Centers in Connecticut

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Introduction

Hospitals, local health departments, and Federally Qualified Health Centers (FQHCs) have been regularly assessing the health of their communities for many years, sometimes working jointly to do so. Today, the need for collaboration is even greater. Under the *Patient Protection and Affordable Care Act* (PPACA), tax-exempt 501 (c)(3) hospitals are now required to conduct a Community Health Needs Assessment (CHNA) every three years with input from public health experts and community members, and develop and adopt an implementation strategy.

Simultaneously, local health departments are preparing for a national accreditation process that requires them to conduct strategic planning, including a CHNA conducted every five years, and a corresponding Community Health Improvement Plan (CHIP).

Representatives from the Connecticut Hospital Association (CHA), the Connecticut Association of Directors of Health (CADH), and Federally Qualified Health Centers (FQHCs) came together over the summer of 2012 to identify and meet aligned goals and to develop a process to foster improvements in health outcomes in Connecticut. Partners in this project include participants from a diverse selection of hospitals, community health centers, and health departments/districts across the state (Addendum 0.1).

The overall goal was to enable a sharing of information through collaboration among community partners to promote healthy communities where people live, work, and play.

The group identified, reviewed, and developed tools and resources to develop a mutual framework and approach to conduct a CHNA and to develop strategies for implementing an implementation strategy. This document is a result of the collaboration – a model template that provides a standardized method for data collection and reporting on benchmark indicators. It is intended to be used by community health centers, local health departments, and hospitals across the state and country.

The guidelines within this document utilize the Association for Community Health Improvement's (ACHI) framework from its ACHI Community Assessment Toolkit, which includes six steps for completing a CHNA. ACHI is a membership group of the American Hospital Association (AHA). The complete Toolkit is accessible [online](http://www.assesstoolkit.org) (www.assesstoolkit.org). This and other references/resources are provided via hyperlink, and at the end of each chapter, and in Addendum 0.2.

It is worth noting that although this process is laid out in a linear fashion, experiences vary. This work frequently involves much iteration and is very time consuming – from the process

of developing relationships and fostering strong group dynamics to building a strong foundation of subject matter understanding.

In the long term, forging sustainable partnerships among hospitals, community health centers, local health departments, and other community partners will result in the leveraging of existing resources to coordinate initiatives and the avoidance of duplicate efforts.

A Note on Terms:

Throughout this document, the term Community Health Needs Assessment (CHNA) is used in the broadest sense to mean both the CHNA required by IRS regulations for hospitals and the Community Health Assessment (CHA) required by Public Health Accreditation Board (PHAB).

Hospital and Public Health Requirements

On July 7, 2011, the IRS issued guidance to tax-exempt 501 (c)(3) hospitals exempt under Section 501(c)(3) of the Internal Revenue Code (Code) for those hospitals to conduct a CHNA as required by new Section 501(r)(3) of the Code, which was enacted by Section 9007 of the Patient Protection and Affordable Care Act (PPACA). The requirements are detailed in [Appendix 1.1](http://www.irs.gov/pub/irs-drop/n-2011-52.pdf), IRS Notice 2011-52 (<http://www.irs.gov/pub/irs-drop/n-2011-52.pdf>).

In brief, the requirements state that hospitals must complete an assessment once every three years, and develop an implementation strategy that meets the community health needs identified through the assessment. In the event a hospital organization includes multiple licensed facilities, each facility must conduct a separate CHNA. The process must include input from persons who represent the broad interests of the community served by the hospital, including those with special knowledge of or expertise in public health. The assessment and improvement plan must be made widely available to the public.

Hospitals must report on their [IRS Form 990 Schedule H](http://www.irs.gov/pub/irs-pdf/f990sh.pdf) (<http://www.irs.gov/pub/irs-pdf/f990sh.pdf>) a description of how the organization or community partner is addressing the needs identified in the CHNA and must include a description of any needs that are not being addressed, together with the reasons why the needs are not being addressed.

Satisfying the CHNA requirement is necessary for hospitals to be recognized as tax-exempt under 501c(3). A \$50,000 penalty will be imposed for a hospital that fails to meet the CHNA requirements for any taxable year.

Additionally, the Public Health Accreditation Board (PHAB), the accrediting body for national public health accreditation for state, local, and tribal health departments, requires that a CHNA and CHIP be conducted every five years. See [Appendix 1.2](#) for [PHAB Standards and](#)

[Measures \(http://www.cthosp.org/documents/community-health/1.2 PHAB-Standards-Overview.pdf\)](http://www.cthosp.org/documents/community-health/1.2_PHAB-Standards-Overview.pdf). PHAB accreditation is voluntary. Requirements differ for IRS and PHAB requirements as noted throughout the document.

A Note on PHAB Requirements

It is important to emphasize that PHAB is generally not prescriptive about many things in the completion of the CHNA/CHIP as long as it meets the related standards and measures set forth by PHAB. The items that PHAB is not prescriptive about include, but are not limited to:

- How the idea or plan for completion of a CHNA and CHIP as one organization or in a collaboration with hospitals, FQHCs, etc. must be presented to local health officials or other top-ranking officials for the participating lead organizations.
- The particular model used to develop the CHNA and CHIP.
- The structure of advisory groups, core teams, committees, etc.
- The structure of the group of partners that are implementing or overseeing implementation of the CHIP.
- Which partners are involved.

Chapter 1 **Getting Started: Identifying the Team and Resources**

Obtain Support From and Educate Senior Executive Leadership in Your Organization and Communities

It is important that senior leaders support the project and collaboration from the beginning. Senior leaders can be defined in different ways, depending on the particular hospital, health department, or community center. For hospitals, key leadership may include the CEO, members of the Board of Trustees, and senior leadership. Depending on a health department's jurisdiction, key leadership could be the highest ranking elected official (e.g., mayor, first selectman, etc.), the governing body (Board of Health), or the Director of Health. Leadership should be presented with an overall summary of the project and how it relates to IRS and PHAB requirements.

In some cases, hospitals may establish or authorize a committee of the Board to oversee this work.

Determine Core Team and its Roles and Responsibilities

The first step in the community health improvement process is to establish a core team. Establishing a solid collaboration between health department officials and key hospital personnel is critical to the success of the project. The core team should include a small group of hospital and health department staff. This small group can be responsible for:

- Completing the day-to-day work.
- High-level planning and oversight.
- Decision making.
- Adhering to a timeline.

Depending on the community, other individuals from key organizations may also be included. Consideration should be made for consultants to fill any gaps. Recommendations for choosing consultants can be viewed [Addendum 1.1](#), "Criteria to Consider When Selecting Consultants for a CHNA."

After establishing the core team, it is necessary to determine the specific roles and responsibilities of each member. Roles may be determined based on individual and organizational strengths.

Core Team Roles:

- Coordinate the overall assessment process.
- Motivate community organizations and community members to participate in outreach with their contacts.
- Collect, organize, and analyze secondary data.
- Consider hiring a consultant for data collection and analysis.
- Determine fiduciary responsibility; who will pay for the CHNA costs.
- Facilitate face-to-face meetings and forums.
- Identify priority issues for health improvement.
- Develop and implement programs and policies to address priority issues.
- Motivate the community to act on priority issues.
- Communicate with partners and the community throughout the process.
- Develop outcome measures.
- Track results.

It is critical to ensure transparency throughout this process and keep all lines of communication open among the core team/advisory group, other stakeholders, and the community-at-large.

Create a Timeline and Work Plan

The core team, and the consultant if one is utilized, should work together to establish a timeline for the process that maps out the necessary steps for the community health improvement process. It will be critical to 1) establish a timeline for each process step and for the various activities that need to be accomplished within each phase, and 2) create a flow sheet that captures milestones, identifies who is responsible for each task, and records dates from start to finish. See [Addendum 1.2](#) for a sample timeline from Norwalk Hospital and Norwalk Health Department. Addendum 1.3, the State Health Assessment and Health Improvement Plan Milestones from the Connecticut Department of Public Health, illustrates the potential timing complexity.

The main elements of the timeline are:

- Identify the team and resources.
- Defining the process and scope.
- Collecting and analyzing the data.
- Selecting priorities.
- Documenting and communicating assessment results.
- Implementing the plan and strategy.
- Monitoring progress and evaluating results.

Develop a Budget and Identify Other Resources as Necessary

The core team develops the budget and plan for securing necessary funds to conduct the Community Health Needs Assessment (CHNA) and implementation strategy. A budget needs to be set before beginning the process regardless of how simple or complex the process appears.

If using a consultant, do not hesitate to ask for options such as a customized list of services that can be tailored to your budget and specific needs.

Costs to be considered when establishing a budget:

- Internal budget for data collection, analysis, and report generation.
- The size of the community.
- How extensive the process will be (mail or e-mail surveys, focus groups, individual interviews, etc.).
- Fees for meeting spaces, supplies, and catering.
- Support staff time.
- Communications plan.

Local government sources and partner funding may be available to support the project. It is important to also explore other resources for financial support (e.g., grants or awards).

Additionally, consulting resources may be available through community partners. Interns from local educational institutions can become involved.

Determine Contributing Partners/Advisory Group

As with the core team, contributing partners should be motivated and willing to take the time necessary to devote to the CHNA and implementation strategy processes. PHAB requires participation of partners outside the local health department that represent community populations and health challenges.

When determining contributing partners, the core team should:

- Brainstorm and develop a list of potential partners.
- E-mail and call potential partners to determine their interest.
- Make sure the partners will help collect/provide secondary data.
- Make sure the partners are willing to participate in primary data collection.
- Seek diverse community representatives.
- Include local academic institutions.
- Include members of medically underserved, low income, and minority populations, as well as populations with chronic diseases.

- Include tribal representatives, if any, with current data or other information relevant to the health needs of the community.

Roles of Contributing Partners/Advisory Group

Contributing partners:

- Provide previous or current quantitative and qualitative data.
- Identify additional appropriate secondary data sources.
- Provide input on primary data collection.
- Motivate and recruit other community members to participate in the assessment process.
- Assist in organizing focus groups.
- Provide technical assistance in their area of expertise.
- Identify priority issues for health improvement.
- Develop and implement programs and policies to address priority issues.

A meeting rhythm should be established early on to meet assessment objectives so partners can be as actively involved as possible. Meetings can be live, or by phone or videoconference.

Each contributing partner should identify the key person(s) involved in each aspect of the project. The appropriate member of the contributing partner's organization should be involved whenever appropriate for the subject matter covered in a meeting. Subgroups and subgroup working meetings may be created to complete specific tasks through the assessment and improvement process, and these may or may not involve all contributing partners.

Share Framework and Process with Partners

Once the contributing partners have agreed to be involved, invite each partner to a "kick-off" meeting to describe the process, ask for help, and provide a call to action. The objectives should be to:

- Inform and engage the CHNA partners on the process.
- Provide an overview of the project.
- Discuss partners' roles.
- Identify resources and other partners for data collection.
- Provide an overview of the CHNA methodology and timeline.

Chapter Notes

Addendum 1.1: [Criteria to Consider When Selecting Consultants for a CHNA](#)

(<http://www.cthosp.org/documents/community-health/Selection-Criteria-for-Consultants.docx>)

Addendum 1.2: Sample Timeline: Norwalk Hospital and Norwalk Health Department

Addendum 1.3: State Health Assessment & Improvement Plan Milestones

Appendix 1.1: [Internal Revenue Service Notice 2011-52](#) (<http://www.irs.gov/pub/irs-drop/n-2011-52.pdf>)

Appendix 1.2: [Public Health Accreditation Board \(PHAB\) Overview of Standards and Measures](#)

(http://www.cthosp.org/documents/community-health/1.2_PHAB-Standards-Overview.pdf)

Chapter 2 **Define the Purpose and Scope**

The overall vision sets the tone and direction for the collaborative process in developing a Community Health Needs Assessment (CHNA) and improvement strategy that meet the needs of hospitals and local health departments. The process of defining scope and purpose will help identify how small or large an effort the CHNA will be. The outline below is based in large measure on the Association for Community Health Improvement (ACHI) framework.

Develop a Shared Vision

Every initiative can benefit from a shared vision that keeps efforts focused. A shared vision is needed for the overall, broader perspective of the collaborative process and to foster buy-in and accountability for the direction the collaborative will take.

The visioning process may precede or run parallel to identifying the team and resources. Once key stakeholders are established, core team members' roles are determined, and the team has committed to working collaboratively, the group should formalize its values, which will serve as the underpinnings for developing a shared vision.

Visioning does not have to be a long and protracted process – the level of effort may depend on how well acquainted the partners are and if they have previously worked together.

There are many techniques or methods that a collaborative can use to develop a vision for community health. One such method is the National Association of City and County Health Officials's (NACCHO's) [Mobilizing for Action through Planning and Partnerships](#) (MAPP) model ([Appendix 2.1](#))

(http://www.naccho.org/topics/infrastructure/mapp/upload/MAPP_Handbook_fnl.pdf).

MAPP provides a step-by-step overview with a reminder that:

- The mission is: WHY DO WE EXIST?
- The vision is: WHERE WE SHOULD BE HEADED.
- The strategic plan is: WHAT IS OUR PLAN TO GET THERE?

MAPP lays out five basic steps:

- Step 1: Identify other visioning efforts and make connections as needed.
- Step 2: Design the visioning process and select a facilitator.
- Step 3: Conduct the visioning process.
- Step 4: Formulate vision and values statements. (Determine how you define "values.")
- Step 5: Keep the vision and values alive throughout the MAPP process.

It is important to note that PHAB does not require a vision be developed as part of its CHNA and CHIP-related standards and measures.

Case Study: The Mission and Vision Statement for the Greater Bridgeport CHNA

The collaborative includes two hospitals, several local health departments/districts, two FQHCs, and other community stakeholders. It is worth noting that several participants in this example have worked together on various other initiatives over the course of more than 10 years.

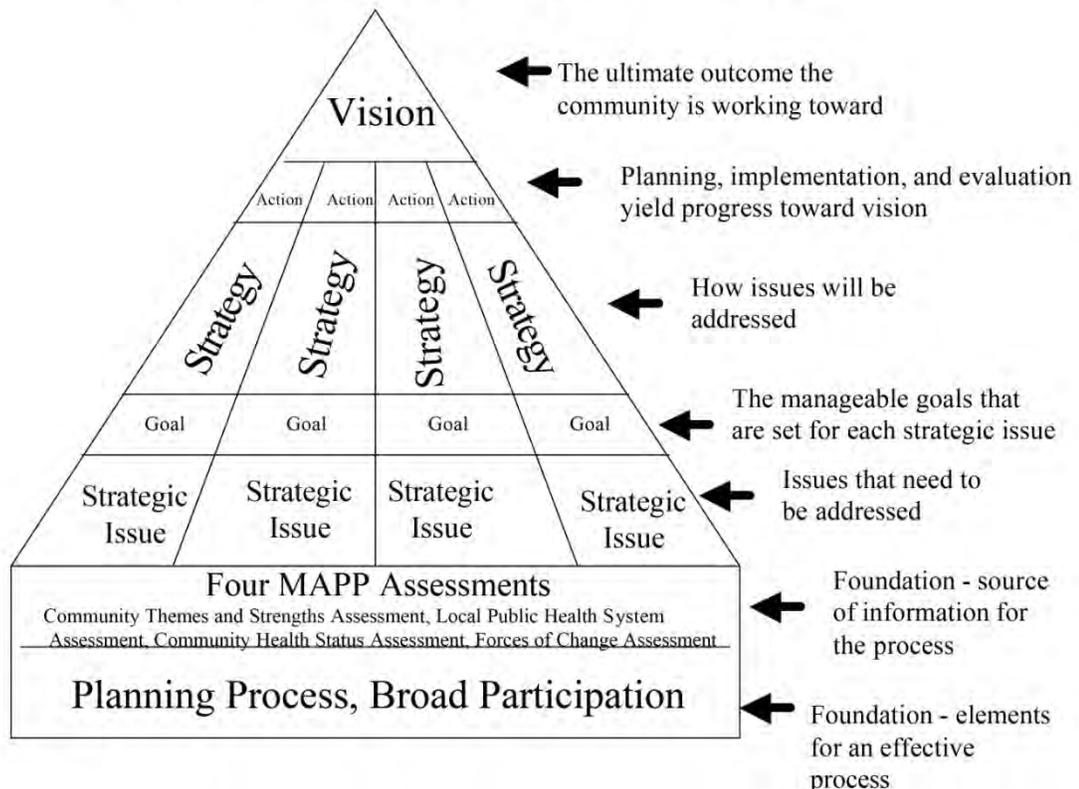
When the CHNA became an agenda item for the larger group, it convened a summit meeting to develop a mission and vision, define the scope and purpose of the CHNA, identify gaps, and choose a consultant. In an afternoon-long session, the following mission and vision was created:

- **Mission:** To improve the health of the community.
- **Vision:** To work together as a coalition to identify, prioritize, and measurably improve the health of our community through healthcare, prevention, education, and services.

Once a vision is determined, it should be communicated at the “kick-off” call-to-action meeting.

Below is a schematic adapted from The MAPP Handbook that illustrates how the different components of the MAPP process relate to the overall planning process. NACCHO encourages people to apply MAPP as intended, rather than piecemeal.

How Do the MAPP Components Relate?



Determine and Document What You Want to Learn About the Community

The core team and advisory group must determine what specific aspects of community health they want to describe within the CHNA. These aspects should be described using both quantitative and qualitative data. The IRS and PHAB requirements provide guidance for what must be included within the health assessment:

Category	IRS Requirements per Form 990 Schedule H, Notice 2011-52	PHAB Requirements
Demographics	Definition and demographics of geography and community served.	Description of population served by: gender, race, age, income, disabilities, mobility (travel time to work or healthcare), educational attainment, home ownership, employment status, etc.
Health Issues and Outcomes	Health needs of the community. Primary and chronic disease needs and other health issues of the uninsured, low income, and minority groups.	Health issues and distribution within the population, based on the factors including disparities among the uninsured/low income, high risk and minority populations, morbidity and mortality, injury, maternal and child health, communicable and chronic disease, etc.
Risk Factors		Includes behavioral and environmental risk factors, built environment, socioeconomic factors, etc.
Assets and Resources	<ul style="list-style-type: none"> • Existing healthcare facilities. • Resources available. 	Assets and resources that can be mobilized and employed to address health issues (e.g., parks, recreation programs, farmer’s markets, clinical services, screenings, mobile clinics, etc.).
Documentation	<ul style="list-style-type: none"> • How data was obtained. • Process for identifying and prioritizing needs, and consulting with those who represent the community’s interests. • Information gaps that limit the ability to assess the community’s health needs. 	<ul style="list-style-type: none"> • Evidence of how the preliminary assessment findings were distributed and how community input was sought (e.g., publications, forums, newsletters, meetings, website postings, etc.). • Regular meetings with partners and stakeholders. • Description of the process to identify health issues and assets. • For a complete guide to PHAB documentation requirements, see the PHAB Documentaton Guidance: (http://www.phaboard.org/wp-content/uploads/National-Public-Health-Department-Accreditation-Documents-Guidance-Version-1.0.pdf)

A collaborative team will want to tell a story with the data, starting with information on **demographics**. This includes data on total population, age distribution, race/ethnicity composition, educational attainment, home ownership, employment status, income, mobility, etc. Another aspect of the story is to look further into **community context**. Data could include information on environmental quality, housing affordability, transportation, crime statistics, civic involvement, food security, and other socioeconomic factors. Part of community context involves looking at the **assets and resources** that can be used to improve health. These include the availability of parks to encourage physical activity, existing healthcare facilities, services available within the community, and any other resources available to meet the needs that are identified through the health assessment. The assessment will also look at **health behaviors** including smoking rates, physical activity, healthy eating, alcohol consumption, immunization rates, etc. Another component will be **healthcare access**, which would include insurance rates, distribution of healthcare providers, availability of healthcare services, etc. Also include data on **health outcomes** and their distribution within the population; health outcomes include cancer incidence, communicable disease rates, chronic disease rates, injury data, hospitalization rates, emergency department visits, morbidity and mortality for various diseases, maternal and child health, etc. The health assessment should also include descriptions of the health issues of the uninsured, low income, and minority populations, and should include trend data when available, including the past 3-5 years of available data.

For more information, see the Connecticut Association of Directors of Health (CADH) Health Equity Initiative [Health Equity Index](http://www.cadh.org/health-equity/health-equity-index.html) (<http://www.cadh.org/health-equity/health-equity-index.html>), a web-based, community-specific tool that profiles and measures the social determinants of health and their correlations with specific health outcomes.

Healthcare Disparities

The CHNA can be a useful tool to address health disparities and inequities. Through examination of evidence-based adverse determinants of health, it is possible to strategize to eliminate persistent and pervasive health inequities, improve health outcomes, and diminish financial costs.

In 2008-2009, the U.S. Department of Health and Human Services' Office of Minority Health convened regional meetings and conversations with thousands of stakeholders around the country, resulting in the [National Stakeholder Strategy for Achieving Health Equity](http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286) (<http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286>). The document is a resource for identifying critical goals and adopting strategies and action steps to achieve them.

Additionally, the [National Partnership for Action to End Health Disparities](http://minorityhealth.hhs.gov/npa/) (NPA) (<http://minorityhealth.hhs.gov/npa/>) was developed to identify and define strategic actions for use throughout the country, providing a roadmap to advance the elimination of gaps and disparities in healthcare and health status.

Determine the Primary Users and Target Audience for the Assessment Results

Hospitals and health departments are primary users of the assessment results, as well as partner organizations. It is wise to determine up front key stakeholders who will use the results of the assessment data. Examples of possible users include:

- Federally Qualified Health Centers (FQHCs)
- Healthcare providers
- Media
- State agencies (DPH, DSS, DMHAS, DEP)
- Elected officials and legislative leaders
- Foundations
- Tribal entities
- Population advocacy groups
- Parks and recreation
- Faith-based organizations
- Public safety and law enforcement
- Civic organizations
- Chamber of Commerce and business leaders
- Libraries
- Transportation
- Housing (including shelters)
- Planning and zoning
- Higher Education

Clarify the Purpose(s)

According to PHAB, the purpose of a CHNA is to describe the status of the population, identify areas for health improvement, determine factors that contribute to health issues, and identify assets and resources that can be mobilized to address population health improvement. The purpose of the Community Health Improvement Plan (CHIP) is to enable the community to work together to improve the health of the population. Similarly, hospitals use these assessments to evaluate the health needs of a hospital's community and to create an implementation plan that addresses those needs.

The core team must define the purpose of conducting the health assessment and improvement plan by answering the question: "What is the collaborative trying to accomplish in the short term as well as the long term?"

Case Study: How Norwalk Hospital and the Norwalk Health Department Defined the Purpose of Their 2012 Community Health Improvement Process:

- Assess health status and broader social, economic, and environmental conditions that impact health.
- Recognize community health assets and strengths.
- Identify priority issues for action to improve community health.
- Develop and implement improvement plan with performance measures for evaluation.
- Guide future community decision making related to community health improvement.

Determine the Geographic Area and Target Populations

A local health department must include all areas of its service jurisdiction. For a municipal health department, this would include the town or city it serves. For a district department of

health, this will include multiple towns and/or cities. According to current IRS guidance, a hospital may take into account all of the relevant facts and circumstances in defining its community, including the interests of medically underserved populations, low-income persons, minority groups, and individuals with chronic diseases and other conditions and needs. Further, a hospital must document within its CHNA a description of its community and how the community was determined. The community will most likely be defined by geographic location, but it may take into account populations served and/or the hospital's principal functions or mission (e.g., focus on a particular specialty area or targeted disease).

Determination of the geographic area must be done very early in the process, given the different needs of the partnering organizations. There are many variations of hospital and health department collaborations. For example, one hospital may work with two or three health departments or one health department may partner with two hospitals. To that end, the geographic area becomes difficult to define. The ideal standard is to determine the largest geographic area necessary to cover the hospitals' and health departments' needs. Each entity can then drill down to the needs of the specific areas they serve.

Target populations might include, for example, populations with documented educational or socioeconomic disparities and vulnerable populations with disparate diseases or conditions. Other considerations include opportunity areas or target neighborhoods with at-risk populations. Patient categories (e.g., general population, children-only, etc.) and areas targeted by community benefit programs could be relevant for hospitals.

Chapter Notes

Appendix 2.1: National Association of City and County Health Officials (NACCHO) [Mobilizing for Action through Planning and Partnerships](#) (MAPP) model
(http://www.naccho.org/topics/infrastructure/mapp/upload/MAPP_Handbook_fnl.pdf)

Sources

- Connecticut Association of Directors of Health (CADH) Health Equity Initiative [Health Equity Index](#) (<http://www.cadh.org/health-equity/health-equity-index.html>)
- [Association for Community Health Improvement \(ACHI\) Community Health Assessment Toolkit](#) (<http://www.assesstoolkit.org/>)
- [National Stakeholder Strategy for Achieving Health Equity](#) (<http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286>).
- [National Partnership for Action to End Health Disparities](#) (NPA) (<http://minorityhealth.hhs.gov/npa/>)
- [PHAB Documentaton Guidance](#) (<http://www.phaboard.org/wp-content/uploads/National-Public-Health-Department-Accreditation-Documentation-Guidance-Version-1.0.pdf>)

Chapter 3 **Data Collection**

Primary data collection is a critical activity of the process. Below is a table that describes the IRS and PHAB requirements for data and documentation for hospitals and health departments. Primary data are data that have not yet been summarized, analyzed, or otherwise examined for reporting. Secondary data are data that originate from another source.

Category	IRS Requirements per Form 990 Schedule H, Notice 2011-52	PHAB Requirement
Documentation	Describe: <ul style="list-style-type: none"> • How data was obtained. • A description of the process and methods used to conduct the assessment. • Process for identifying and prioritizing needs, and consulting with persons representing the community's interests. • Information gaps that limit ability to assess community's health needs. 	<ul style="list-style-type: none"> • Evidence of how the preliminary assessment findings were distributed and community input was sought (publications, forums, newsletters, meetings, website postings). • Information listed under PHAB documentation for communication and input.

Determine Who Will Collect and Analyze Data

The core team must determine who will collect and analyze data. Also, the roles and responsibilities of the members should be clearly established prior to launching data collection activities. The individual(s) tasked may include in-house data analysts, consultants, epidemiologists, college interns, or others.

The individual(s) charged with managing data collection should have a thorough understanding of statistics.

Determine Selection Criteria for Measures

Core measures selected as a framework for the Community Health Needs Assessment can (CHNA) align with [Healthy People 2020 Leading Health Indicators](http://www.healthypeople.gov/2020/LHI/default.aspx) (http://www.healthypeople.gov/2020/LHI/default.aspx) – a set of high-priority issues that represent significant themes in public health and health services utilization. Organized under 12 topic areas, there are 26 leading health indicators that address determinants of health that promote quality of life, healthy behaviors, and healthy development across all life stages. The 12 topic areas and accompanying 26 indicators are outlined in Appendix 3.1, Healthy People 2020 Leading Health Indicators. Core measures were identified for standardized

comparability across Connecticut; additional indicators may be selected as needed to explore issues important to a particular community.

The [Agency for Healthcare Research and Quality](http://www.ahrq.gov/research/iomqrdreport/futureqrd4.htm) (AHRQ) provides additional measures, which can be seen in Appendix 3.2 (<http://www.ahrq.gov/research/iomqrdreport/futureqrd4.htm>). Additionally, the Connecticut Association of Directors of Health's [Health Equity Index](http://www.cadh.org/health-equity/health-equity-index.html) (<http://www.cadh.org/health-equity/health-equity-index.html>) is a useful tool for providing standardized local community measures and assessments of health disparities.

Collect Quantitative Secondary Data and Review Previous Assessments

Secondary data refer to statistical materials that originate from another source. Secondary data in Connecticut are available at the state and local level through multiple agencies. Addendum 3.1 provides links to sources of data pertaining to the Healthy People 2020 leading health indicators at the national, state, and local level. As an example, in March of 2012, the Connecticut Department of Public Health (DPH) published the "Connecticut Health Database Compendium," [Appendix 3.3](http://www.ct.gov/dph/lib/dph/hisr/pdf/ct_health_database_compendium_2012.pdf) (http://www.ct.gov/dph/lib/dph/hisr/pdf/ct_health_database_compendium_2012.pdf), which outlines the databases it maintains along with links to resources. Assessment teams may also want to consider collecting data related to morbidity in the form of age-adjusted incidence and prevalence rates and leading causes of mortality.

Working with core team members and local stakeholders, a thorough investigation of previous local assessments should be made and an inventory created. A review of previous assessments conducted by community coalitions including hospitals, health departments, school districts, community organizations, and other entities can lead to a wealth of information and provide useful benchmarks for comparison of current data, as well as information on where to find local data. It is important to keep in mind that the different organizations represented within the core team have different requirements for benchmarking. For example, PHAB requires health departments to compare data (e.g., age-adjusted rates) to other similar socio-geographic areas or to similar data for the same population gathered at an earlier time to establish trends over time.

There are two recommended options when secondary data are not available locally for each of the 26 leading health indicators. The first and preferred option is to collect primary data. The collection and analysis of both primary and secondary data enriches the assessment and coincides with PHAB Standards and Measures Version 1.0, Appendix 1.2. The second option is to substitute proxy measures, which are variables that are used to take the place of another variable that is difficult to measure directly. Examples of proxy measures are referenced in Addendum 3.2.

Collect and Analyze Primary Data

Primary data are data that have not yet been summarized, analyzed, or otherwise examined for reporting. Examples of existing sources of primary data are health department birth and death records, reportable disease records, hospital discharge records, and record-level survey results. Confidentiality restrictions or issues surrounding ownership of the data may limit availability of existing sources of primary data for analysis by the core team. In the case of health department records and hospital discharge records, data sharing agreements may allow both parties to access record-level primary data. Data can be de-identified to protect confidentiality. In cases where primary data are unavailable, data can be collected through methods such as telephone, written or online surveys, face-to-face interviews, focus groups, or similar approaches. After reviewing available primary data, the core team should determine where gaps exist as a result of data unavailability or quality control issues. If the lacking information is critical to the quality of the assessment, the core team should establish a process for moving forward to fill the gaps using primary data collection. Working as a group or with an expert in the subject matter, the core team should decide what data collection method is most feasible based on its resources, and design a primary data collection strategy. The group should give careful consideration to and work with field experts to develop data collection methods and appropriate sampling strategies.

Community Transformation Grants

The CDC-funded Community Transformation Grants is another program to identify and address community health needs. In Connecticut, these grants are currently designed to help residents in less populated areas of the state (population <500,000) reduce chronic disease risk factors. This initiative can provide another source of primary data that can assist in prioritizing health issues and determining strategic pathways to impact policies and practices. The Connecticut Department of Public Health coordinates the grants in partnership with local health departments; multiple collaborators participate in coalition building. These groups include hospitals, healthcare providers, employers, municipal leaders, and other community stakeholders. The focus is on policy improvements that will result in systemic change, best practices for clinical and community preventive care, and chronic disease prevention.

Collect Population, Demographic, and Socioeconomic Data

The core team should determine what population, demographic, and socioeconomic data are important to collect based on the needs of their community. Common variables* include:

- Population
- Population change over time
- Gender
- Age
- Racial composition
- Ethnic origin
- Language other than English spoken at home
- Health insurance status
- Disability status
- Average family size
- Average household size
- Total number of households
- Foreign born population
- Geographic size of town
- Density of town
- Persons living below poverty level
- Educational attainment
- Household income
- Crime

**See Addenda 3.3 and 3.4 for guidance on considerations and limitations associated with reporting population, demographic, and socioeconomic data.*

The variables listed above are searchable using the [U.S. Census Bureau's American FactFinder](http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml) tools (<http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>). While it is possible to find demographic data from other sources, *American FactFinder* is a very comprehensive and reliable source for population, demographic, and socioeconomic data. Users have access to decennial census data (e.g., 2000, 2010) as well data from the *American Community Survey* (ACS). *American FactFinder* provides estimates for national, state, county, town, and sub-town data. The U.S. Census provides links where users can learn more about to how to use *American FactFinder*, including examples of the filters used in querying data as well as frequently asked questions.

Use quantitative data to inform what topics to further probe for qualitative data.

Determine Need and Methods for Qualitative Data Collection

While quantitative data often takes center stage in assessments, it is equally important to provide context through the appropriate use of qualitative data. The term qualitative data refers to data and information describing a particular event or set of circumstances that is not originally organized or presented numerically. There are many ways in which qualitative data can be collected. This section describes some most common methods, and will utilize an example of how the data can be used to enhance a CHNA.

Observations:

Observation data collection involves trained personnel conducting field work where they witness behaviors, programs, or processes. These witnessed observations are first documented in the field and later organized or summarized for inclusion in the needs assessment.

Example:

Quantitative data in the CHNA indicate that the percentage of adults meeting federal physical activity recommendations is lowest in a particular town within the jurisdiction of the health district. From the qualitative standpoint, a group of trained personnel are then deployed around the town to observe the use and physical state of public outdoor recreational facilities.

Key Informant Interviews:

Key informant interviews involve capturing the knowledge, belief, and perspective of a person who has an in-depth understanding of a particular subject, circumstance, geographic area, or population subgroup. Quotations from the key informant and a summary of the interview are commonly included in the health needs assessment.

Example:

Quantitative data in the CHNA indicate higher mortality rates exist in several neighborhoods in the southeast part of the largest town within the primary service area of the hospital. Qualitatively, a local clergyperson who has lived and served the neighborhoods in that area for more than 40 years is interviewed about the history of the area, its development, and the unique challenges the residents face that contribute to the disparities between the southeast and the rest of the town.

Focus Groups:

Focus groups involve a facilitator-directed discussion among 8-12 participants who are thought to have knowledge and understanding about a particular subject, circumstance, or geographic area. Predetermined questions and probing/follow-up questions are asked of the group by a trained facilitator, and the responses and discussion are captured by trained observers. A summary of the attitudes, behaviors, language, and group dynamics is prepared for inclusion in the CHNA.

Together, qualitative and quantitative data help define the scope and breadth of a community's health. Using both forms of data collection can provide rich details and open up new lines of thinking. It is recommended to bring qualitative data forward to stakeholders to solicit their input.

Examine Community Assets

Asset mapping provides an inventory of community resources and helps identify strengths and solutions to possible deficits within the community. Assets provide the foundation for

health improvement, yet many individuals are not familiar with the scope of assets available to them locally. Valuable resources can go unrecognized and underutilized. Asset mapping helps identify resources that can be employed to address particular strategic issues, streamline efforts, and bring community partners together.

A useful framework for asset mapping is exemplified in the [Michigan Healthy Capital Counties](http://www.healthycapitalcounties.org/about-us.html) approach, Appendix 3.4 (<http://www.healthycapitalcounties.org/about-us.html>).

The following resources and tools can also be used to complete an asset inventory:

- Connecticut 2-1-1.
- Yellow pages.
- Interviews with public and private agencies.
- Internet research.

Once the data is collected and analyzed, a meeting of the core group along with the larger advisory group should be organized to share the data with key stakeholders and to begin to prioritize areas that may be selected for improvement plans.

Chapter Notes

Addendum 3.1: Health Indicators at the National, State, and Local Level

Addendum 3.2: Healthy People 2020 Leading Health Indicators – Example Proxy Measures

Addendum 3.3: Considerations for Population, Demographic, and Socioeconomic Data

Addendum 3.4: Limitations and Problems to Note When Reporting Population, Demographic, and Socioeconomic Data

Appendix 3.1: [Healthy People 2020 Leading Health Indicators](http://www.healthypeople.gov/2020/LHI/2020indicators.aspx)

(<http://www.healthypeople.gov/2020/LHI/2020indicators.aspx>)

Appendix 3.2: [Agency for Healthcare Research and Quality \(AHRQ\)](http://www.ahrq.gov/research/iomqrdreport/futureqrd4.htm) measures

<http://www.ahrq.gov/research/iomqrdreport/futureqrd4.htm>)

Appendix 3.3: [Connecticut Health Database Compendium](http://www.ct.gov/dph/lib/dph/hisr/pdf/ct_health_database_compendium_2012.pdf)

(http://www.ct.gov/dph/lib/dph/hisr/pdf/ct_health_database_compendium_2012.pdf)

Appendix 3.4: [PHAB Standards and Measures Version 1.0](http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf) (<http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf>)

(<http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf>)

Appendix 3.5: [Asset Inventory Worksheet \(Healthy Capital Counties, Michigan\)](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CD0QFjAA&url=http%3A%2F%2Fwww.naccho.org%2Ftopics%2Finfrastructure%2FCHAIIP%2Fupload%2FAsset-Mapping.docx&ei=2R9OUKtiEe630QHc5YHIBA&usq=AFQjCNGDBoW9EleLjp5DLFBPRG6lvyyYSg)

(<https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CD0QFjAA&url=http%3A%2F%2Fwww.naccho.org%2Ftopics%2Finfrastructure%2FCHAIIP%2Fupload%2FAsset-Mapping.docx&ei=2R9OUKtiEe630QHc5YHIBA&usq=AFQjCNGDBoW9EleLjp5DLFBPRG6lvyyYSg>)

Sources

- [U.S. Census Bureau's American FactFinder](http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml) (<http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>)
- [ChimeData, Connecticut Hospital Association](http://chime.org) (<http://chime.org>)
- [Michigan Healthy Capital Counties](http://www.healthycapitalcounties.org/about-us.html) (<http://www.healthycapitalcounties.org/about-us.html>)
- [National Association of City and County Health Officials \(NACCHO\)](http://www.naccho.org/) (<http://www.naccho.org/>)
- Connecticut Association of Directors of Health (CADH) Health Equity Initiative [Health Equity Index](http://www.cadh.org/health-equity/health-equity-index.html) (<http://www.cadh.org/health-equity/health-equity-index.html>)

Chapter 4 **Selecting Priorities**

Review the Assessment Data

The data collected during the Community Health Needs Assessment (CHNA) should be thoroughly reviewed and understood by each partner involved in selecting priorities. Data can be disseminated for individual review, however a presentation of the data is recommended to encourage conversation and ensure all parties involved have an equal understanding of the various data elements.

If possible, include maps that indicate the overlap between hospital and local health jurisdictions, as well as service areas of other primary partners. Covering the largest possible scope enables all involved entities to benefit. For an example of mapping and summarizing goal status by town, see Addendum 4.1, the Community Health Needs Assessment of the Primary Care Action Group.

What Are Priorities?

Once the assessment data is gathered, analyzed, and reviewed by the core team and advisory group, priorities should be discussed and set. This step in the CHNA process is an important one; the priorities identified during this portion of the assessment will drive the development of an implementation strategy as well as the resultant outcomes.

The MAPP process considers priorities to be “strategic issues.” Built on the foundation of the assessment, they drive the goals, strategies, and actions linked to the vision and overall goal toward which the community is working.

In [IRS Form 990 Schedule H](http://www.irs.gov/pub/irs-pdf/f990sh.pdf), (Appendix 4.1) (<http://www.irs.gov/pub/irs-pdf/f990sh.pdf>) the IRS requires tax-exempt 501 (c)(3) hospitals to answer questions regarding care for the community and community needs. A prioritization tool from Bridgeport Hospital, the Ease and Impact Grid, can be found in Addendum 4.2.

CHNAs should include the process of identifying and prioritizing community health needs, as well as the services necessary to meet them. Moreover, the IRS requires hospitals to explain *why* they are unable to meet all the needs identified in an assessment (See Chapter 6 for more information). A careful assessment of the data and evaluation of possible priorities will help hospitals answer these questions at the end of each tax year.

Within the [PHAB Standards and Measures Version 1.0](http://www.cthosp.org/documents/community-health/1.2_PHAB-Standards-Overview.pdf) document (http://www.cthosp.org/documents/community-health/1.2_PHAB-Standards-Overview.pdf),

health departments are required to engage stakeholders, community members, and other partners in the priority-setting process. Specifically, health departments are required to provide documentation that a process was created to set community health priorities and to engage the affected community in identifying health issues and themes. A sample prioritization matrix for health departments, and instructions on how to create a matrix, can be found in the [Public Health Quality Improvement Encyclopedia](http://www.phf.org) (www.phf.org), pages 93 and 94. A prioritization matrix is one way to set priorities, but there are many others and PHAB is not specific about what process should be used.

One strategy to share the information and request additional support is to present the data to the community in a “call to action” meeting; this strategy brings the process full circle for community participants. If individuals in the community were consulted for input on the assessment (e.g., via a survey, interview, or focus group) sharing the finished product with them may help to secure commitment and future buy-in to address and prioritize community health strategies.

Determine Who Will Be Setting Priorities

Ideally, priorities will be set in a collaborative manner with as many stakeholders as possible, with the intent that partners will then be committed to addressing the priorities. Agencies represented on the core team carrying out the CHNA should be involved in priority setting, and the priorities selected should be based upon the collected data.

It may be helpful to engage a neutral third party (e.g., a consultant, volunteer corporate facilitator, or other outside party) to help identify priorities, assure an unbiased priority-setting process, and keep the process moving forward.

If multiple stakeholders are at the table during priority setting, the resulting list of priorities may be addressed utilizing different strategies and approaches depending on the partner. This is a more effective approach than what could be accomplished if priority setting were conducted in a silo.

Establish Criteria for Evaluating the Data

If you are setting priorities in a collaborative manner, be sure to agree upon a framework that reflects the group’s vision and values when evaluating the data collected during the assessment.

As a starting point, the Association for Community Health Improvement (ACHI) framework suggests utilizing the following criteria (for more information, see Appendix

4.2):

1. The magnitude of the problem (i.e., the number of people or the percentage of a population impacted).
2. The severity of the problem (i.e., the degree to which health status is worse than the national norm).
3. A high need among vulnerable populations.
4. The community's capacity/willingness to act on the issue.
5. The ability to have a measurable impact on the issue.
6. Community resources already focused on the issue.
7. Whether the issue is a root cause of other problems.

This list of criteria is only a suggestion. Use the expertise of the core team to create a defined list of criteria for evaluation.

Identify the Top Priorities for Action

Employing a consensus process for identifying top priorities will help ensure a commitment to the priority by the participating partners. ACHI suggests three processes to follow if utilizing a consensus approach: gradient of agreement, rating and ranking health problems, and identifying strategic issues. Please see Appendix 4.3 for details on each method.

After a list of top priorities is identified by the priority-setting group, planning should begin. The ultimate list of priorities selected may vary from partner to partner. Priorities taken on by participants will depend on the knowledge, skills, and abilities agencies may have internally to address certain issues. Together, it might be possible to work collaboratively on some priority areas while delegating other priority areas to partners with specific competencies. That is, a community as a whole may work to reduce obesity, but a health department may be more equipped to reduce the amount of lead-based paint in older housing stock, and a hospital may be best suited to increase the free bone density screenings offered in a community to prevent advanced osteoporosis. While all three priority areas (obesity, lead-based paint, and osteoporosis) are being addressed, they are not all addressed by the same group of agencies.

Chapter Notes

Addendum 4.1: Community Health Need Assessment of the Primary Care Action Group

Addendum 4.2: Ease and Impact Grid, Bridgeport Hospital

Appendix 4.1: [IRS Form 990 Schedule H](http://www.irs.gov/pub/irs-pdf/f990sh.pdf) (<http://www.irs.gov/pub/irs-pdf/f990sh.pdf>)

Appendix 4.2: Association for Community Health Improvement (ACHI): Establish Criteria for Evaluating the Data
[Association for Community Health Improvement \(ACHI\) Community Health Assessment Toolkit](http://www.assesstoolkit.org/)
(<http://www.assesstoolkit.org/>)

Appendix 4.3: Association for Community Health Improvement (ACHI): Set Priorities with a Consensus Process
[Association for Community Health Improvement \(ACHI\) Community Health Assessment Toolkit](http://www.assesstoolkit.org/)
(<http://www.assesstoolkit.org/>)

- [PHAB Standards and Measures Version 1.0](http://www.cthosp.org/documents/community-health/1.2_PHAB-Standards-Overview.pdf) (http://www.cthosp.org/documents/community-health/1.2_PHAB-Standards-Overview.pdf)
- [Public Health Quality Improvement Encyclopedia](http://www.phf.org) (www.phf.org), Written by John W. Moran and Grace L. Duffy Public Health Foundation, Washington, DC, 2012. Pages 93,94

Chapter 5 **Documenting and Communicating Assessment Results**

Review Data to Highlight Key Messages

The PHAB and IRS requirements provide guidelines for the overarching messages that must be addressed within the final reports. [Healthy People 2020](http://www.healthypeople.gov/2020/LHI/default.aspx) (<http://www.healthypeople.gov/2020/LHI/default.aspx>) also provides a general framework for topic areas, which include risk factors/lifestyle behaviors, health status and health issues, and assets and resources. It is also recommended that assessment reports include examination of the social determinants of health (e.g., the social, economic, or environmental factors such as poverty, lack of education, inadequate housing, lack of access to adequate healthcare, etc.).

Category	IRS Requirement	PHAB Requirement
Documentation	<p>According to IRS Notice 2011-52 (http://www.irs.gov/pub/irs-drop/n-2011-52.pdf), the report should describe:</p> <ul style="list-style-type: none"> • The community served by the hospital and parameters chosen to define the community. • The process and methods used to conduct the assessment, including information about data, details of collaborations, and any information gaps. • How the hospital took into account input from persons representing the broad interests of the community. • A prioritized description of identified community health needs. • Existing resources. 	<p>According to PHAB Standards and Measures (http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf), data must be reviewed to highlight demographics, health issues, and specific descriptions of population groups with particular health issues, contributing causes of community health issues, and existing community resources to address health issues.</p> <p>PHAB requires the assessment to be distributed to partner organizations and made available to the population of the jurisdiction served by the health department.</p> <p>A communications plan is not required by PHAB.</p> <p>For a complete guide to PHAB documentation requirements, see the PHAB Documentaton Guidance: (http://www.phaboard.org/wp-content/uploads/National-Public-Health-Department-Accreditation-Documentation-Guidance-Version-1.0.pdf)</p>

The [North Carolina Community Health Assessment Guide Book](http://www.healthycarolinians.org/library/pdf/2012GuideBookPhases/12gb-phase5.pdf) provides recommended questions, Appendix 5.1 (<http://www.healthycarolinians.org/library/pdf/2012GuideBookPhases/12gb-phase5.pdf>) that should be addressed when composing key messages. They are summarized below:

- What are the changes from the last Community Health Needs Assessment (CHNA)?

- What health risks seem to be increasing or decreasing?
- What improvements seem to have occurred in the community?
- How does the data compare to the state and peer communities?

Prepare Written Reports

The report may include an executive summary, a summary report that details the main findings and is intended for public consumption, a full report with data profiles, a PowerPoint presentation and/or posters or displays tailored for specific audiences. An example outline for a full report from the North Carolina Community Health Assessment Guide Book can be viewed in Appendix 5.1 and is adapted below.

- **Title Pages, Table of Contents, and Acknowledgments**
 - List the CHNA team members and/or the organizations they represent, and their contributions including committee assignments.
 - A chart or table is a good way to display this information.
- **Executive Summary**
 - Provide a brief overview and description of the community and a summary of the health, social, and environmental issues and resources found during the assessment. The executive summary should be brief enough so it can be easily reproduced for distribution to key individuals and groups in the county, but long enough to present the important information clearly.
 - Emphasize health priorities and emerging issues, and the information that supports them. Also, be sure to recognize community assets. The executive summary is very important as this may be the only part of the CHNA document that many people read.
- **Chapter 1: Background and Introduction**
 - Describe the importance of the CHNA process to the health of residents.
 - Comment on the collaborative relationship between the public health department, hospitals, and other entities.
 - Discuss the process used to establish the team, including information on the recruitment process. If an established community group served as the CHNA team, describe that group and its roles in the process.
 - Describe how the team functioned during the process (e.g., subcommittees established, instruments used to collect community data, data analysis process, data report development, priority-setting process, and plans for action plan development). Discuss key partnerships that were formed or strengthened as the result of this process.

Chapter 2: Brief Community Description

- Geographic – Describe the defined geographic area and the select towns that are included.
- Historical – Describe any historical information that may be relevant for health behaviors.
- Demographic – Describe the population by age, gender, race/ethnicity, urban vs. rural, and year round vs. seasonal. Use maps, charts, and/or graphs to identify clusters or document growth.
- Include context like economic, political, environmental, and social conditions within a community
- Develop a narrative to accompany any visual aids.
- List data sources, including the date(s) data was collected/reported.

• Chapter 3: Data Collection Process

- Describe the process used for collecting primary and secondary data, and briefly review the tools used. Include the tools in the appendix. Outline the process used for analyzing data, and discuss the method used to set priorities.

• Chapter 4: Data Results and Interpretation

- Overview – Describe the overall health status, opinions, and needs of community residents summarized from the data collected. Discuss socioeconomic factors that influence the health of county residents. Use maps, charts, and/or graphs with accompanying narratives.
- If possible, use the [Healthy People 2020 Framework](http://www.healthypeople.gov/2020/LHI/default.aspx) (http://www.healthypeople.gov/2020/LHI/default.aspx) to organize this section.
- Focus on identifying resources and assets available to address relevant issues in your community.
- Provide an overview of the prevention and health promotion needs and resources, and how these impact the health of community residents.
- Describe how community residents view these needs and use the resources.
- Compare this information to the information in the last CHNA. Discuss reasons for the differences, if any.
- Use maps, charts, and/or graphs with accompanying narratives.
- Include information on screenings with educational/promotional programs and community support for healthy behaviors.
- List data sources, including the date(s) data were collected/reported.

• Chapter 5: Implementation Strategy: Community Concerns and Priorities

- This chapter should include the top issues/gaps in community health identified by the needs assessment process.
 - Summarize the results of data that describe the concerns of the community. Recount the process used to choose the community's health priorities. List the priorities that the community plans to work on.
- **Chapter 6: Implementation Strategy Action Plan**
 - This chapter could include a summary of the implementation plan or the entire implementation plan document (if completed before the entire report is disseminated). This is a critical chapter that should be included, even if there will be a separate and more comprehensive implementation plan developed at a later date.

Develop a Communications Plan

The communications plan should reflect the results of the CHNA as well as the entire process of the CHNA and implementation strategy. The development of the communications plan may occur as early as the initial planning of the assessment process. The two key areas of focus for a communications plan are sharing information with key stakeholders about the CHNA and implementation strategy process, and publicizing the assessment findings.

Please note that a communications plan is not required by PHAB.

Preliminary assessment findings should be shared with the community for input before the final report is complete. Methods to seek input include publication of a summary of the findings in the local press with requests for feedback, publication on the health department's, hospital's, or community health center's website with a place to comment, community/town forums, listening sessions, newsletters, presentations, and discussions at other local organizations' meetings.

The communications plan should specify who you are communicating to, what you are communicating, when you will communicate, how you will communicate, and who is responsible for ensuring the communication gets completed. This should be linked back to the key users and stakeholders you identified while defining the purpose and scope (Chapter 2). It will be customized by each community using it.

Here is an example of a communications plan template:

Key Stakeholder	What	When	How	Who
Community Members	Results of assessment	<ul style="list-style-type: none"> • Date 	<ul style="list-style-type: none"> • Community forum-presentation • Report published on website 	<ul style="list-style-type: none"> • Health Dept. and hospital representatives • Project assistant
Health Department Staff				
Hospital Staff				
Board of Health				
Hospital Board				
FQHCs				

Publicize the Findings

Findings should be shared with the community and local partners, community health providers, FQHCs, and local medical associations. Stakeholders may include:

- Health Departments
- Hospitals
- FQHCs
- Healthcare providers
- Media
- State agencies (Department of Social Services, Department of Environmental Protection, Department of Mental Health and Addiction Services, etc.)
- Elected officials
- Grant funders
- Tribal entities
- Community advocacy groups
- Local not-for-profit organizations
- Faith-based organizations
- Public safety and law enforcement
- Civic organizations
- Chamber of Commerce
- Libraries
- Transportation
- Housing (including shelters)
- Planning and zoning
- Parks and recreation
- Higher education
- Advocacy groups

It is recommended that this information be shared in the following ways:

- Websites.
 - Hospital website (For hospitals, required by IRS).
 - Health department website.
 - City, county, or town website.
- Paper copy available to any individual or organization that requests the information.
- Newsletters, e-mails, and other internal and external communications vehicles.
- Hospital grand rounds.
- Town hall forums.
- Public meetings.

- Exhibits or poster displays at community centers, libraries, etc.

The information must be made available until the next CHNA becomes available, so there is never a gap in information to the public.

Media:

Because the goal of this project is to allow the CHNA to be widely shared, we recommend hospitals and health departments share the results of their assessment findings and implementation strategies with the media.

- A template press release for personalization can be found in [Addendum 5.1](#).
- A brochure and poster template can be found in [Addendum 5.2](#).
- Template talking points can be found in [Addendum 5.3](#).

Chapter Notes

Addendum 5.1: Template press release

Addendum 5.2: Brochure and poster template

Addendum 5.3: Talking points template

Appendix 5.1: [North Carolina Community Health Assessment Guide Book](#)

(<http://www.healthycarolinians.org/library/pdf/2012GuideBookPhases/12gb-phase5.pdf>)

Sources

- [Internal Revenue Service Notice 2011-52](#) (<http://www.irs.gov/pub/irs-drop/n-2011-52.pdf>)
- [Healthy People 2020](#) (<http://www.healthypeople.gov/2020/default.aspx>)
- [Public Health Accreditation Board \(PHAB\) Standards and Measures v.1.0](#) (<http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf>)

Chapter 6

Planning, Implementation, and Strategy

IRS Requirements	PHAB Requirements
<p>According to IRS Notice 2011-52 (http://www.irs.gov/pub/irs-drop/n-2011-52.pdf) and IRS Form 990 Schedule H (http://www.irs.gov/pub/irs-pdf/f990sh.pdf), the report should include:</p> <ul style="list-style-type: none"> • Adoption and execution of an implementation strategy. • Participation in development and execution of a community-wide development plan that takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health. • Approved by the hospital's governing body as defined in IRS Notice 2011-52, section 3.09 (http://www.cthosp.org/documents/govrelations/irs_n-2011-52_3-09.pdf). • Must be made widely available to the public: Section 3.07 of Notice 11-52 (http://documents.cthosp.org/documents/community-health/3-07_n-2011-52.pdf) • Reporting requirements: adopted implementation strategies must be included on IRS Form 990 Schedule H (http://www.irs.gov/pub/irs-pdf/f990sh.pdf) 	<ul style="list-style-type: none"> • Emphasis on community involvement during development of improvement plan. • Individuals and organizations that have accepted responsibility for implementing strategies. • Alignment between the community health improvement plan and the state and national priorities. • Additional documentation selection and submission information in the PHAB Guide to Public Health Department Accreditation section V.3 (http://www.phaboard.org/wp-content/uploads/PHAB-Guide-to-National-Public-Health-Department-Accreditation-Version-1.0.pdf).

An important use of the Community Health Needs Assessment (CHNA) findings is to develop effective community health strategies for addressing health issues. Developing successful plans starts with the identification of health priorities, development of measurable objectives to address the priorities, selection of evidence-based interventions, formation of activities that are feasible to implement, and the planning of realistic evaluation methods.

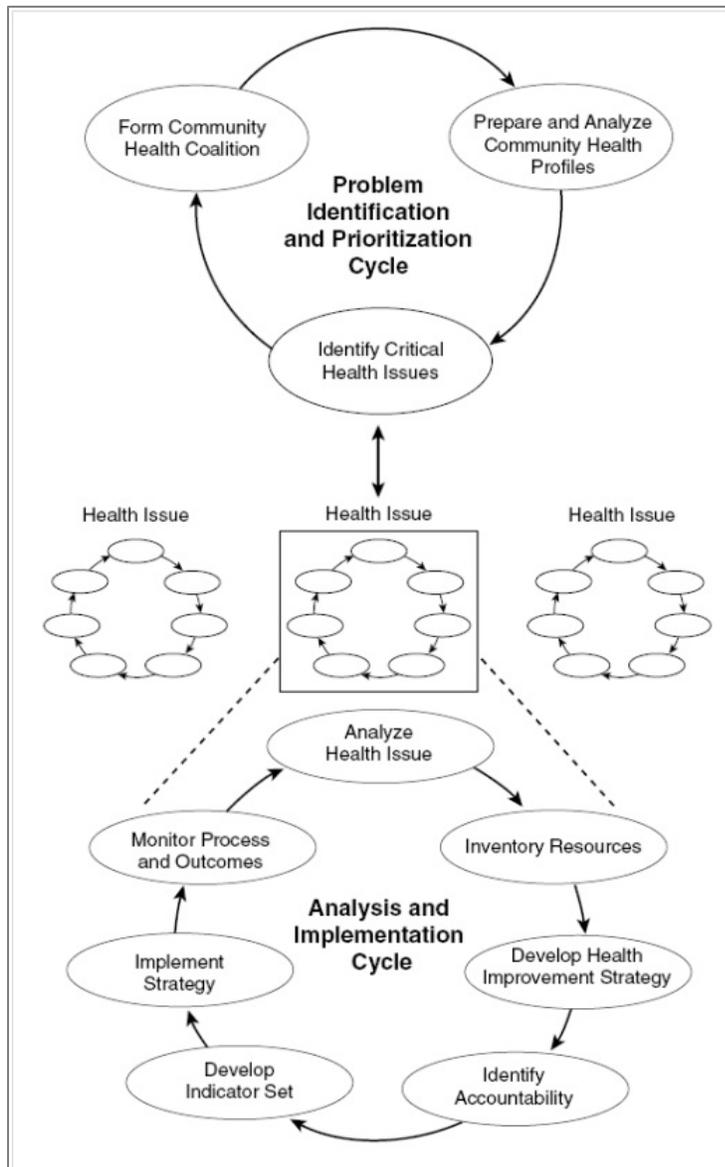
Implementation Team

The planning and implementation process is complex, and emerging needs should be examined in the context of the talents, capabilities, and comprehensiveness of the core implementation team. Additional partners may be required. Participation by other partners may occur on a case-by-case basis when discussing and addressing specific priority areas. Engage stakeholders as early as possible in the planning phase. The involvement of selected partners may vary depending on their capabilities, degree of investment, as well as expected

return on investment. It is crucial for a successful partnership to have clear outlines for every partner's involvement in each step of the project.

Possible partners might include, but are not limited to, advocacy groups, professional organizations, state agencies, healthcare facilities, private stakeholders, elected officials, etc. Including community members of the target population as part of the implementation team ensures that action plans are realistic, culturally sensitive, and well tailored.

Development of an implementation plan follows the diagram below, which highlights a community health improvement model from the Institute of Medicine. By this point in the process, the problem identification and prioritization cycle has been completed and the top priorities for action have been selected. The analysis and implementation cycle is a series of processes intended to devise, implement, and evaluate the impact of the health



improvement strategies that have been chosen to address health priorities. With this framework, there is an emphasis on measurement that links performance and accountability on a community-wide basis. The steps are displayed as sequential, but in practice they interact and are likely to be repeated a varying number of times while a community is engaged in a particular initiative.

Durch, JS et al, Improving Health in the Community: A Role for Performance Monitoring; Division of Health Promotion and Disease Prevention, Institute of Medicine, 1997

Analyze the Health Issue

The implementation team must analyze the data collected during the assessment process to better understand the priority needs and their root causes. It is necessary to identify the factors that contribute to and perpetuate health issues, as well as any potential barriers to improving each issue. In addition to reviewing behavioral and health status, it is important to consider social determinants of health risk factors (e.g., the social, economic, or environmental factors such as poverty, lack of education, inadequate housing, lack of access to adequate healthcare, etc.) that may be contributing to the health problem. In this step, questions will emerge, including:

- Is the problem related to access to needed health services or resources?
- Are services available and can they be accessed by priority populations?
- Is a lack of public policies exacerbating the problem?

Inventory Health Resources

Assessing current community-based programs, services, and resources available for health improvement efforts is an important component of CHNA strategic planning. Knowing what is offered in the community helps identify institutions, organizations, and individuals who can play a role in targeting the identified priority health issues and allows the team to craft strategic implementation solutions that complement those efforts rather than duplicate them. Relevant resources include those that can be utilized for specific tasks (e.g., resources can be used for influence, expertise, or funding), existing factors in the community that can mitigate the impact of adverse conditions, and support available from public- and private-sector sources outside the community (e.g., funding, technical assistance). Through this process, the team will also be able to identify gaps in available resources.

A community health resource inventory may have been developed during the information-gathering phase using asset mapping and information collected from focus groups and key informant interviews; if not, it may be done at this time.

Develop Health Improvement Plan

During the formulation of a health improvement strategy, goal statements related to the identified health issues are formulated, and objectives and strategies for addressing these issues are developed. Goals, objectives, and strategies provide a connection between the current reality (i.e., what the local community looks like now) and the vision (i.e., what the local community will look like in the future).

Step 1: Define Goals, Objectives, and Strategies

The ACHI toolkit outlines how goals, objectives, and strategies can be developed in the implementation phase:

A **goal** is *what you want to happen/what you want to achieve*. It is a broad statement of general purpose that defines the desired result associated with the identified strategic issue. Goals provide fundamental long-term direction.

- Use goals to clarify what is important within a priority area before drafting objectives.
- Begin with action words, such as *reduce, increase, eliminate, ensure, establish*.
- Focus on the end result.
- Consider whether a goal is for the whole community or a specific population.

An **objective** is *how you will know whether you have reached your goal*. It offers specific and measurable outcomes that you want to achieve by a particular date. Objectives define the expected results from a program and intervention. They break the goal down into smaller parts and provide specific, measurable actions by which the goal can be accomplished by outlining the “what, where, and when,” and specifying “how much, how many, or how often.”

- Consider a wide range of criteria that can indicate progress towards a goal (e.g., individual behaviors, service availability, community attitudes, insurance status, policy enactment).
- Be specific about what or who is expected to change, by how much, and by when.
- Use the active voice and action verbs (such as plan, write, conduct, and produce).
- Set short-term objectives (which generally occur soon after the program is implemented, very often within a year).
- Set long-term objectives (which state the ultimate impact of the program or intervention).
- Be realistic about what can be achieved relative to the baseline data.
- Ensure performance is linked to the expected improvement.

The two general types of objectives are **process** and **outcome**:

<p>Process objectives focus on the activities to be completed in a specific time period and explain what you are doing and when you will do it. They enable accountability by setting specific activities to be completed by specific dates.</p>	<p>Outcome objectives express the intended results or accomplishments of a program or intervention activities. They most often focus on changes in policy, a system, the environment, knowledge, attitudes, or behavior.</p>
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The [North Carolina Public Health](http://www.healthycarolinians.org/library/pdf/2012GuideBookPhases/12gb-phase5.pdf), Department of Health and Human Services’ Community Health Assessment Guide Book (http://www.healthycarolinians.org/library/pdf/2012GuideBookPhases/12gb-phase5.pdf) suggests that measurable objectives include:

- The *people* whose behaviors, knowledge, and/or skills are to be changed as a result of the intervention. Whenever appropriate, target populations with health disparities.
- The *desired outcome*, which could include intended behavior, increased knowledge, and/or skills change. Quantify or describe how the intervention will change health status.
- How the progress will be *measured and evaluated*. Available resources and capacity (time, staff, funding, etc.) should be considered when planning the measurement.
- What will be considered a *success* for the health priority? This needs to be realistic.
- What is the *timeframe* for success?

Objectives, according to the Centers for Disease Control and Prevention, should be SMART (specific, measurable, attainable/achievable, relevant, timing). SMART objectives outline the anticipated change in behavior or disease rate, the target population, and the anticipated timeframe to complete the objective.

SMART Objectives:

- ✓ **Specific** – what exactly are we going to do and for whom?
- ✓ **Measurable** – is it quantifiable and can we measure it?
- ✓ **Attainable/Achievable** – can we get it done in the proposed timeframe with the resources and support we have available?
- ✓ **Relevant** – will this objective have an effect on the desired goal or strategy?
- ✓ **Timing** – when will this objective be accomplished?

Objectives should explain **who** is going to do **what, when**, and to **what extent**?

A **strategy** is *how the objective will be reached/what action is needed*. It specifies the type of activities that must be planned, by whom, and for whom. Strategies detail how specific issues or community health problems will be addressed by programs or services.

- Generate a list of strategies that will engage different sectors of the community (e.g. businesses, volunteer organizations, schools, social services, faith communities, government agencies, citizens).
- Research intervention strategies that have been demonstrated to be effective.
- Determine what resources will be used and how they will be managed.

Example:

- **Goal:** To reduce the proportion of children with untreated dental decay.
- **Objective:** Children who are registered at mobile dental clinics will be found to have fewer dental caries in 2013 when compared to 2012, and the overall proportion of children with untreated dental caries will be reduced by 9 percent.
- **Strategy:** To expand the route and hours of the local mobile dental clinic.
- **Indicator:** Proportion of children with dental decay.

Step 2: Develop approaches to address prioritized needs

The possible causes of the health needs have been identified in the previous *Analyze Health Needs* step. Here, the team identifies potential approaches (strategies or interventions) for achieving the proposed goals. Strategies should build on strengths and opportunities and counter the threats reflected in the identified health priorities. Group brainstorming is helpful in conducting this step.

The Catholic Health Association's [Assessing & Addressing Community Health Needs](http://www.chausa.org/Assessing_and_Addressing_Community_Health_Needs.aspx) (http://www.chausa.org/Assessing_and_Addressing_Community_Health_Needs.aspx) guide suggests asking the following questions when designing an intervention:

- 1) Will it prevent the health problem or related risk?
- 2) Does it focus on early detection and treatment with an emphasis on reducing progression?
- 3) Does it concentrate on managing acute manifestations of the problem?

Strategies should be evidence-based and comprehensive, and may include several elements (e.g., educational, policy, environmental, and/or programmatic). Evidence-based interventions that have been implemented within a specific population, critically appraised for their validity and relevance, and found to be effective should be reviewed. When looking at evidence-based practices, it is helpful to evaluate:

- The characteristics of the population where the program was used: Do those characteristics match your community?
- Is the evidence based on credible public health research?
- Magnitude of impact: Has the approach been proven to be very effective? Somewhat effective? Are results still pending?
- Replication of program: Has the program been effectively replicated elsewhere?
- Acceptability to community: Is it a cultural fit in your community?
- Required resources: Do you have, or can you obtain, the resources needed to use the approach?

Step 3: Consider barriers to Implementation

Next, the team should continue brainstorming to identify barriers to implementation. Barriers may take the form of insufficient resources, lack of community support, legal or policy impediments, technological difficulties, etc. Barriers will not necessarily eliminate an intervention alternative, but the team will need to clearly understand the obstacles that may be encountered if that alternative is pursued.

Step 4: Consider Implementation details

In this step, the team reviews details and logistics related to implementing each intervention or program. These discussions should focus on high-level issues that will help specify or refine the approach and guide implementation.

According to the Catholic Health Association's [Assessing & Addressing Community Health Needs](http://www.chausa.org/Assessing_and_Addressing_Community_Health_Needs.aspx) (http://www.chausa.org/Assessing_and_Addressing_Community_Health_Needs.aspx), it is useful to consider the following elements:

- Specific actions that need to be taken.
- Timetables.
- Resource needs.
- Staff, including who will lead and implement the approaches selected.
- Infrastructure, including the need for steering committees, policies and leadership support.
- Budget, including sources of funding.
- Knowledge and expertise needed to carry out the strategy.
- Participation and partnerships that will be needed to implement the strategy.
- Potential need for outside experts and consultants.
- Community support.
- Identification of existing local or external resources that may be available to help address the issues.

Step 5: Select Implementation Strategies

An implementation strategy links the CHNA and improvement plan by addressing the questions asked in the assessment process. By this point, the best implementation strategy to address community health needs will become clearer. Health improvement strategies should seek to apply available resources as effectively as possible, given a community's specific features. Priority should be given to actions for which evidence of effectiveness is available and for which costs are considered appropriate in relation to expected health benefits. A coalition should not ignore issues where evidence of an effective intervention is limited. Rather, it should carefully examine what actions will make the best use of available resources. Coalitions should also evaluate the implications of not acting on a specific health issue.

When choosing between alternatives, it is helpful to ask:

- Which approach will include short-term results? (While some strategies are focused on the longer-term, seeing early successes is important.)
- Does the plan lend itself to partnerships and can it generate community support?
- Are there adequate community resources to carry out the intervention? If not, can additional resources be obtained?
- What other barriers might exist?
- Is the approach sustainable? Would members of the community be willing to assume leadership roles? Are all organizations committed to the initiative?
- Which alternative has the highest impact, lowest cost, and highest probability of success?

Once the best strategy has been selected, coalition members must be clear about what is being done, by whom, and with what measurable results. According to [The Community Toolbox](http://ctb.ku.edu/en/tablecontents/sub_section_main_1089.aspx) (http://ctb.ku.edu/en/tablecontents/sub_section_main_1089.aspx), each action step or change to be sought should include the following information:

- *What* actions or changes will occur?
- *Who* will carry out these changes?
- *By when* they will take place and for how long?
- *What* resources are needed to carry out these changes?
- *Communication* (who should know what?).

Step 6: Develop the written implementation plan

The written implementation plan is a summary that describes what the coalition plans to do to address the identified community health needs. The report provides actionable steps, serves as a reference, confirms consensus, and communicates the top priorities, vision, goals, objectives strategies, and indicators to the team members and the broader community.

Written implementation plans can include:

- The coalition's mission and commitment to community health improvement.
- Summary of the major health needs identified in the CHNA and an overview of the process and criteria used to identify priorities.
- Goals, objectives, strategies, and indicators for each health need being addressed.
- Timelines.
- Target geographic areas and priority populations.
- A description of how the implementation plan was developed, including who advised or participated in the process.
- A description of how the plan will be formally adopted.

- A description of any planned collaboration to meet the identified priority areas, individuals who will be involved, and the roles they will play.
- An overview of the approaches that will be undertaken to address the selected community health needs.
- A review of what the research suggests.

Step 7: Disseminate the Improvement Plan

The plan can be disseminated to key participants, stakeholders, and the community, and may be posted in different forms in different community settings. The form of distribution will depend on target audience, topic, and existing presentation opportunities. Modes of communication similar to those detailed in the preceding chapter may be utilized. Feedback should be encouraged.

Step 8: Ensure compliance with reporting requirements

Hospitals must adopt an implementation strategy that meets community health needs identified through a CHNA in order to meet Section 501(r)(3) of the Code and the IRS Notice 2011-52 requirements. The plan must identify all of the collaborative organizations. To foster greater support among key stakeholders, encourage partners to approve the implementation strategy. In the event a hospital organization includes multiple licensed facilities, each facility must submit a separate implementation strategy. To meet requirements, the implementation strategy must describe how the hospital facility plans to meet the health need or identify the health need as one the hospital facility does not intend to meet, and explain why the hospital facility does not intend to meet the health need.

Choosing NOT to Address a Health Need*

Per IRS requirements, hospitals must document and explain the community health needs identified in the CHNA that are not being addressed. Some reasons hospitals may elect to not undertake certain health needs include:

- The need is being addressed by other organizations in the community.
- There are insufficient resources (financial and personnel) to address the need.
- The issue is not a priority for community members and therefore a program is unlikely to succeed.
- There is a lack of evidence-based approaches for addressing the problem.
- The need is not as pressing as other problems.
- The need is not as likely to be resolved as other problems.
- The hospital does not have the expertise to effectively address the need.

**Information comes from the Catholic Health Association.*

The implementation strategy will be considered to be adopted upon approval of an authorized governing body of the hospital. Governing bodies include:

- Board of Directors, Board of Trustees, or equivalent.

- A committee of the governing body, which may be composed of any individuals permitted under state law to serve on such committee, to the extent the committee is permitted by state law to act on behalf of the governing body.
- To the extent permitted under state law, other parties authorized by the governing body of the hospital organization to act on its behalf by following procedures specified by the governing body in approving an implementation strategy.

A hospital is required to document separately the implementation strategy for each of its facilities. In addition, hospitals are required to attach the most recently adopted implementation strategy to the annual Form 990.

Health Departments: As a prerequisite for accreditation, PHAB requires that health departments present a Community Health Improvement Plan (CHIP) in addition to a Community Health Needs Assessment (CHNA) and department strategic plan. The CHIP must be updated at least every five years.

PHAB's overall goal is to address issues identified by the assessment and community health improvement process and set priorities for remedying them. Required documentation and reporting guidelines are detailed further in [PHAB Standard 5.2](http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf) (<http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf>).

Identify Accountability

Establishing accountability within the coalition is a key component for the performance monitoring of the health improvement initiatives(s) proposed by the team members. Specific entities must be willing to be accountable to the community for undertaking activities that are expected to contribute to achieving desired health outcomes. While there is a collective responsibility among all segments of the community coalition to contribute to health improvements, each entity must accept individual responsibility for performing the tasks that are consistent with its capabilities.

Develop Indicator Set

The implementation strategy should also include performance *indicators* – quantitative measurements used to determine whether the objectives are met. Indicators help stakeholders monitor whether the health improvement strategy is being implemented as intended and whether it is having the desired impact. As health issues are oftentimes multi-dimensional and can be addressed by a variety of sectors in the community, sets of indicators may be needed to assess performance. All partners should be in agreement and have a clear

understanding as to what measures will be used for selected indicators, how frequently data will be collected, and how it will be shared.

Examples of indicators include the number of people served by the program, the average time participants spend in a program, etc.

Implement Strategy

Once the implementation plan has been completed, the coalition is now ready to carry out its strategies. The transition from planning to action can sometimes be difficult for group participants to make, as it requires a different type of involvement. Some community representatives prefer to participate only in planning, while others prefer to be involved in action. Respect these preferences and be sure to involve those most able to help carry out the implementation plan.

Considerations include:

- Implementation may be agency-specific, and will depend on the strategies and timeline set forth to achieve measurable goals.
- Implementation may depend on funding. If this is the case, use the assessment's findings about health priorities and the commitment of partners to make a case for the needed resources.
- A kickoff event or special inaugural meeting with stakeholders may be considered.
- The implementation team should meet periodically as the project transitions into the action phase.
- To sustain the implementation strategy, the plan may need to be updated based on changing community needs and priorities, changing resources, and evaluation results.

Bristol Hospital Community Breast Health Project

An example of an initiative based on community need is the Bristol Hospital Breast Health Project. It has provided more than 3,000 free mammograms to uninsured and underinsured women in Greater Bristol since the project's inception in 1998 – saving countless lives. Bristol Hospital recognizes that early detection saves lives for many women who would normally choose not to have a mammogram because they cannot afford one. For 25 days out of the year, Bristol Hospital makes appointments for these women at the hospital and Women's Health Resource (Bristol Radiology Center). They provide to more than 240 patients a year education, awareness, and financial assistance to cover the cost of a mammogram. The hospital has seen an increase in participation and interest in the program recently, with more women receiving mammograms. The Bristol Hospital Breast Health Project is sponsored by the Charlotte Johnson Hollfelder Foundation, Inc., Women's Health Resource, Beekley Corporation, Team Towanda, Radiologic, and the Bristol Hospital Development Foundation.

Monitor Process and Outcomes

An evaluation plan is a key element for measuring progress toward goals and objectives. Once a health improvement program is underway, performance monitoring becomes essential. See Chapter 7 for more information.

Case Study: The Community Care Team, Middlesex Hospital

Middlesex Hospital's last county-wide health assessment found a disproportionate prevalence of diagnoses related to acute alcohol use, other drug use, and serious mental illness for emergency department (ED) utilization. High ED usage can serve as a proxy for access-to-care issues and the inability to link to support services within a community. In response to this identified priority area, a community-based approach was developed and the Community Care Team (CCT) was formed. The CCT is comprised of nine community agencies that specialize in the delivery of care for patients experiencing substance abuse and/or mental disorders. The team's objective is to provide patient-centered care and improve health outcomes by developing and implementing a safety net of alternative services through multi-agency intervention and care planning. At its core is the belief that collaborations strengthen communities and can significantly impact outcomes if provided in both an evidence-based and innovative manner.

Community Care Team member agencies include: Middlesex Hospital, River Valley Services, Connecticut Valley Hospital, Gilead Community Services, Rushford, Community Health Center, Advanced Behavioral Health, Value Options Connecticut, and St. Vincent DePaul.

Using a HIPAA-compliant release, patients are offered CCT services. Team members meet on a weekly basis to review cases, uncover service gaps, and develop individualized care plans of wrap-around services that best meet the needs of the specific patient. As the patient travels through the continuum of care, he/she is linked to appropriate inpatient and outpatient services. Additional areas of focus include connection to primary care to increase access and linkage to housing for those experiencing homelessness. Since the inception of the program, patients have maintained sobriety, become stabilized, experienced improved access to care, obtained supportive and stable housing, re-entered the workforce, reconnected with family, pursued higher education, rediscovered hobbies, volunteered in the community and achieved the feelings of self-worth and respect that come with improved quality of life. In only 10 months of the formal meeting structure, CCT has case-managed 60+ patients and avoided 200+ ED visits.

The collaboration of the Community Care Team is a direct result of a priority area identified by a health assessment, and demonstrates the impact that a partnership can have on improving both health and quality of life for community members.

Chapter Notes

Sources

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- [National Association of County & City Health Officials \(NACCHO\) MAPP Framework](http://www.naccho.org/chachipresources), www.naccho.org/chachipresources
- Healthy People 2010 Toolkit

Chapter 7

Monitoring Progress and Evaluating Results

Introduction

Program monitoring and evaluation are essential organizational practices that address the accountability concerns of stakeholders; provide a systematic way to measure the progress of goals, objectives, and implementation strategies; give the evidence needed for any necessary mid-course programmatic corrections; improve existing programs; and demonstrate the results of resource investments. Monitoring and evaluation are distinct yet complementary. They are key final steps in ensuring that the health improvement programs built in response to areas of identified need are effective and sustainable.

Monitoring: gives information on *where* a program is at any given point in time relative to respective targets and outcomes. It is a continuous process of collecting, analyzing, and comparing data/indicators in order to provide stakeholders with information on the extent of progress and achievement of objectives and how well a program is being implemented against expected results.

Evaluation: gives information on *whether and why* targets and outcomes are or are not being achieved. It is the systematic and objective assessment of an ongoing or completed program's design, implementation, and results. The purpose is to determine – throughout the life cycle of an initiative – the relevance and fulfillment of objectives, efficiency, effectiveness, impact, sustainability, and lessons learned.

A results-based monitoring and evaluation system helps to answer the questions:

- What are the goals of the initiative?
- Are the goals being achieved?
- How can achievement be proven?

Complementary Roles of Monitoring and Evaluation

Monitoring	Evaluation
<ul style="list-style-type: none"> Performed during implementation to improve program design and functioning. 	<ul style="list-style-type: none"> Studies the outcome of a project with the aim of informing the design of future projects.
<ul style="list-style-type: none"> Ongoing data collection and analysis of indicators; compares actual results with targets. Undertaken more frequently than evaluation. Provides constant feedback. 	<ul style="list-style-type: none"> Examines longer-term results.
<ul style="list-style-type: none"> Links activities and their resources to objectives. 	<ul style="list-style-type: none"> Assesses specific causal contributions of activities to results.
<ul style="list-style-type: none"> Translates objectives into performance indicators and sets targets. 	<ul style="list-style-type: none"> Examines implementation process.
<ul style="list-style-type: none"> Clarifies program objectives. Gives early indications of progress and achievement of goals. Identifies potential problems at an early stage; shows need for mid-course corrections and improvements. Monitors accessibility of the program for the target population. Monitors efficiency of program components and suggests improvement. 	<ul style="list-style-type: none"> Analyzes why intended results were/were not achieved. Identifies how and why activities succeeded, failed, or were changed. Explores unintended results.
<ul style="list-style-type: none"> Reports progress to managers and alerts them to problems. 	<ul style="list-style-type: none"> Provides lessons, highlights significant accomplishment or program potential, and offers recommendations for improvement.

Monitoring:

Once a health improvement program is implemented, performance monitoring becomes an essential guide. Monitoring yields information for critical management decisions in both the short- and long-term and across all levels of program functioning. The information provided by the selected indicators should be reviewed regularly and used to inform further action. In assessing a program's progress, the stakeholders should consider whether accountable entities are taking appropriate actions and whether suitable strategies and interventions have been adopted. Over time, a coalition should reexamine its priorities and determine whether other health issues can be added to the health improvement plan or can replace issues where good progress has been made.

The monitoring process requires access to comparable data from multiple sources. It is important to regularly examine both quantitative indicators and qualitative information to gain a complete picture of the community context. In the monitoring phase, valuable information about the implementation of a health improvement strategy and indicator data interpretation (i.e., what is/is not working; what alternative approaches should be considered) can be obtained from sources including focus groups, key informant interviews, and town hall meetings.

It is important that the coalition determine who will be the point-person(s) to collect data at selected intervals and that the stakeholders meet periodically to monitor implementation and results.

According to the World Bank guide book's *Ten Steps to a Result-Based Monitoring and Evaluation System: A Handbook for Development Practitioners*, key features of results monitoring include:

- Baseline data to describe the problem or situation before the intervention.
- Indicators for outcomes.
- Data collection on outputs, and whether and how they contribute toward achievement of outcomes.
- Focus on perceptions of change among stakeholders.
- Systemic reporting with more qualitative and quantitative information on the progress toward outcomes.
- Performed in conjunction with strategic partners.
- Capturing information on success or failure of partnership strategy in achieving desired outcomes.

Evaluation:

Program evaluation helps maintain momentum by creating a clear picture of accomplishments, providing ongoing feedback, and holding work leaders accountable for ongoing improvement. An evaluation plan guides the process by providing a roadmap for the evaluation of activities. It helps to determine if the measurable objective(s) was met and if so, its effectiveness. The evaluation plan, a fluid document that changes based on numerous factors and changes in circumstance, should be drafted in conjunction with the implementation plan – this encourages the process of program monitoring and assessment at the start of implementation and allows program improvements to be identified as the initiative progresses. All aspects of evaluation development and execution should be overseen by the coalition to ensure ongoing engagement (although a point person or team should be selected to carry out the necessary steps). Coalition members should meet regularly to discuss evaluation results.

A plan may include two levels of evaluation: Process and Impact/Outcome.

Process Evaluation:

The process evaluation measures the process of delivering the intervention in an effort to fully understand how it works and how/why the program produces the results it does. It focuses on the quality and implementation of capacity building activities and intervention. Process evaluation is useful in collecting ongoing data that measure the implementation of the intervention as a means of identifying potential or developing problems (e.g.: Is the intervention being delivered as planned? Are target levels being met? Is the intervention reaching the target population?) and making necessary modifications.

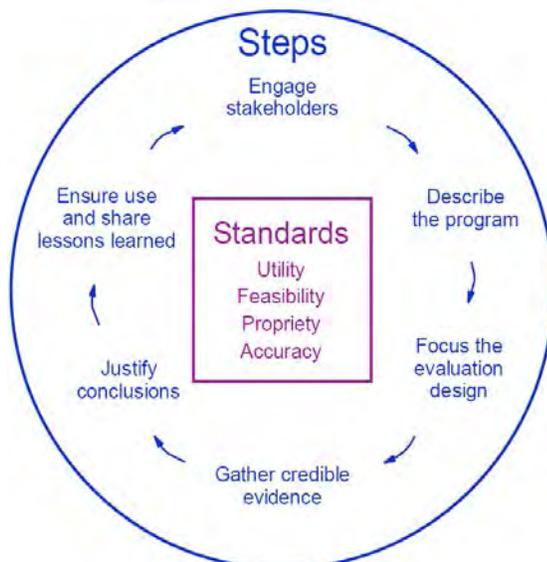
Impact/Outcome Evaluation:

The impact/outcome evaluation measures the intermediate impacts and longer-term outcomes' effects of an intervention or program. It helps to determine whether the intervention is having an impact on the identified target population and if the right program activities were selected. Examples are: changes at the individual level (pre- and post-intervention measures), enhanced learning (e.g., knowledge, perceptions, or attitudes), or conditions of the intervention group compared to the control group.

Evaluation Framework

The CDC offers a six-step framework for program evaluation in public health, [Appendix 7.1](http://www.cdc.gov/eval/steps/index.htm) (<http://www.cdc.gov/eval/steps/index.htm>). The framework is a practical, non-prescriptive tool designed to 1) summarize and organize the essential elements of program evaluation and 2) be a standard for further improvement. Two core elements comprise the framework: steps and standards.

While the individual steps are interdependent, an order of execution exists as completion of one becomes the foundation for the next. Adhering to the six steps creates a basis for understanding a program's context and improves how evaluations are conceived and conducted. The standards assess the quality of program evaluation efforts and answer the question, "Will the evaluation be effective?"



Sources for Steps & Standards: Centers for Disease Control and Prevention. *Framework for Program Evaluation in Public Health*. MMWR 1999; 48(No. RR-11); Joint Committee on Standards for Educational Evaluation. *Program Evaluation Standards: how to Assess Evaluations of Educational Programs*. 2nd ed. Thousand Oaks, CA: Sage Publications, 1994.

The following information draws from the Centers for Disease Control's Framework for Program Evaluation in Public Health.

Steps of an Evaluation

Step 1 – Engaging Stakeholders: It is important to engage all stakeholders to ensure that the evaluation addresses important elements of a program's objectives, operations, and outcomes, and that findings are not ignored or resisted. Appropriate stakeholder engagement improves the utility and credibility of the evaluation, clarifies roles and responsibilities, and helps in executing the framework.

It is critical to identify and engage:

1. Coalition partners, collaborators, administrators, managers, staff, funding officials, sponsors, as well as primary users of the evaluation.
2. Also include those served or affected by the program (e.g., clients, patients, community residents, neighborhood organizations, academic institutions) either directly or indirectly.
3. Make a special effort to promote the inclusion of less powerful groups or individuals.

Step 2 – Describing the Program: Program descriptions convey the mission and objectives of the program being evaluated. Descriptions improve an evaluation's accuracy, ensure a balanced assessment of strengths and weaknesses, and help stakeholders understand how program features fit together and relate to a larger context. Stakeholder agreement on program definition is necessary to ensure effectiveness.

Key components of the program description should include:

- **Need** – A statement of need describes the problem or opportunity that the program addresses, and implies how the program will respond. A program's need includes:
 - 1) The nature of magnitude of the problem or opportunity.
 - 2) Which populations are affected.
 - 3) Whether the need is changing.
 - 4) In what manner the need is changing.
- **Expected Effects** – A description of specific expectations and criteria for success convey what the program must accomplish to be considered successful. As most programs unfold over time, descriptions of expectations should be organized by time, ranging from specific (i.e., immediate) to broad (i.e., long-term) goals.
- **Activities** – Describing program activities (i.e., what the program does to effect change) allows specific steps, strategies, or actions to be arranged in logical

sequence. Program activity descriptions should distinguish the activities that are the direct responsibility of the program from those that are conducted by related programs or partners.

- **Resources** – Include the time, talent, technology, equipment, information, money, and other assets available to conduct program activities. Program resource descriptions should convey the amount and intensity of program services and highlight where a mismatch exists between desired activities and resources available to execute those activities.
- **Stage of Development** – As programs mature and change over time, modification of program practice should be considered during the evaluation process. Development stages include:
 1. *Planning* – Program activities are untested; the goal of evaluation is to refine plans.
 2. *Implementation* – Program activities are being field tested and modified; the goal of evaluation is to characterize the real (vs. ideal) program activities and to improve operations, perhaps revising plans.
 3. *Effects* – The program’s effects emerge after enough time has passed; the goal of evaluation is to identify and account for both intended and unintended effects.
- **Context** – Descriptions of the program’s context should include the setting and environmental influences (e.g., history, geography, social, and economic conditions) within which the program operates. Understanding these environmental influences is required to design a context-sensitive evaluation, help users interpret findings, and assessing the generalizability of the findings.
- **Logic Model** – Describes the sequence of events for bringing about change by synthesizing the main program elements into a picture of how the program is supposed to work.

Step 3 – Focusing the Evaluation Design: Determining the intent or purpose of the evaluation and outlining what steps will be taken increase the chances of success. Focusing the evaluation on assessing the issues of greatest concern to stakeholders allows the strategy to be useful, feasible, and accurate.

Key areas to consider when focusing an evaluation are:

1. **Purpose** – Articulating the intent of the evaluation is necessary to prevent premature decision making on how the evaluation should be conducted.
2. **Users** – Involving users in the evaluation design ensures that the evaluation plan meets their needs. Users help clarify intended uses of the evaluation, prioritize questions and methods, and prevent the evaluation from becoming misguided or irrelevant.
3. **Uses** – Ways in which the information generated from the evaluation will be applied should be defined, planned, and prioritized with input from all stakeholders and with regard for stages of program development and context. See Appendix 7.2, Selected Uses for Evaluation in Public Health Practice by Category or Purpose.
4. **Questions** – Creating evaluation questions encourages stakeholders to express what they believe the evaluation should answer and helps to determine what aspects of the program will be evaluated.
5. **Methods** – Selection of evaluation methods for sampling, data collection, data analysis, interpretation, and judgment should provide the appropriate information to address stakeholder questions; they should be matched to the primary users, uses, and questions. The choice of design has implications for what will count as evidence, how that evidence will be gathered, and what conclusions can be drawn. During the course of an evaluation, methods may need to be revised or modified based on changing conditions and circumstances. For more information, see Appendix 7.3, Selected Sources of Evidence for an Evaluation.
6. **Agreements** – These written protocols summarize the evaluation procedures, outline the roles and responsibilities of all stakeholders, and describe how the evaluation plan will be implemented using available resources. An agreement might be a legal contract, a detailed protocol, or a memorandum of understanding.

Step 4 – Gathering Credible Evidence: The collection of valid, reliable, and systematic information is the foundation of every effective evaluation. To stakeholders, credibility may depend on how the questions were posed, sources of information, conditions of data collection, reliability of measurement, validity of interpretations, and quality control procedures. Data may be experimental or observational, qualitative or quantitative, or can include a mixture of methods. All data collected should have a clear, anticipated use. For more information, see Appendix 7.4, Selected Techniques for Gathering Evidence.

Step 5 – Justifying Conclusions: Conclusions are justified when they are linked to gathered evidence and are consistent with the agreed-upon values or standards set by the

stakeholders. This process involves values clarification, qualitative and quantitative data analysis and synthesis, systematic interpretation, and appropriate comparison against relevant standards.

Key components include:

- **Standards** – They reflect the values held by the stakeholders that provide the basis for forming judgments concerning program performance. Using specific standards allows for priority setting based on reference to explicit values. Standards are used for judging a program’s success. See Appendix 7.5, Selected Sources of Standards for Judging Program Performance.
- **Analysis and Synthesis** – Analysis and synthesis of an evaluation’s findings might result in the detection of patterns in evidence, either by isolating important findings (analysis) or by combining sources of information to reach a larger understanding (synthesis).
- **Interpretation** – Determining what the findings mean is part of the overall effort to understand the evidence gathered in an evaluation. Uncovering facts regarding a program’s performance is not sufficient to draw evaluative conclusions – evaluation and evidence must be interpreted to determine the practical significance of what has been learned. Alternate ways to compare results include comparison with program objectives, a comparison group, national norms, past performance or needs, etc. **Note:** It is helpful to limit conclusions to situations, time periods, persons, contexts, and purposes for which the findings are applicable.
- **Judgments** – Statements concerning the merit, worth, or significance of the program are formed by comparing the findings and interpretations regarding the program against one or more selected standards.
- **Recommendations** – Recommendations require information concerning the context in which programmatic decisions will be made. Recommendations that lack sufficient evidence or those that are not aligned with stakeholders’ values can undermine an evaluation’s credibility.

Step 6 – Ensuring Use and Sharing Lessons Learned: Lessons learned in the course of an evaluation do not automatically translate into informed decision making and appropriate action. Deliberate, strategic effort, along with constant monitoring, is needed to ensure that the evaluation processes and findings are used and disseminated appropriately.

There are five elements that are critical to ensure the use of an evaluation:

1. **Design** – Design (i.e., how the evaluation’s questions, methods, and overall processes are constructed) should be organized at the start of the process in order to achieve the intended uses by the primary users.
2. **Preparation** – Preparing for use of the evaluation findings gives stakeholders time to explore positive and negative implications of potential results and time to identify options for program improvement.
3. **Feedback** – Providing continuous feedback to stakeholders regarding how the evaluation is proceeding, interim findings, provisional interpretations, decisions to be made that might affect likelihood of use, and receiving feedback creates an atmosphere of trust among stakeholders and keeps the evaluation on track.
4. **Follow-Up** – Support that users need during the evaluation and after they receive findings helps to prevent lessons learned from becoming lost or ignored, and ensures that stakeholders aren’t taking results out of context or using them for purposes other than those agreed upon. Scheduling follow-up meetings with intended users to facilitate the transfer of evaluation conclusions into appropriate actions or decisions is helpful.
5. **Dissemination** – Communicating either the procedures or the lessons learned from an evaluation to relevant audiences in a timely, unbiased, and consistent fashion is needed, though a formal evaluation report is not always the best or even necessary product. A reporting strategy should be discussed in advance.

Planning effective communication also requires the consideration of timing, style, tone, message source, vehicle, and format of information products. The goal is to achieve full disclosure and impartial reporting. See Appendix 7.6, Checklist for Ensuring Effective Evaluation Reports. For more on communicating results, see Chapter 5.

Standards for Effective Evaluation

Standards assess whether a set of evaluative activities are well-designed and working to their potential. They provide practical guidelines to follow when having to decide among

evaluation options and help to avoid creating an imbalanced evaluation (i.e., one that is accurate and feasible but not useful, or one that is useful and accurate but infeasible).

- **Standard 1: Utility** – Ensures that the information needs of evaluation users are satisfied. (See Appendix 7.7, Utility Standards.)
- **Standard 2: Feasibility** – Ensures that the evaluation is viable and pragmatic. (See Appendix 7.8, Feasibility Standards.)
- **Standard 3: Propriety** – Ensures that the evaluation is ethical (i.e., conducted with regard for the rights and interests of those involved and affected). (See Appendix 7.9, Propriety Standards.)
- **Standard 4: Accuracy** – Ensures that the evaluation produces findings that are considered correct. (See Appendix 7.10, Accuracy Standards.)

Case Study: The William W. Backus Hospital Rx for Health Program

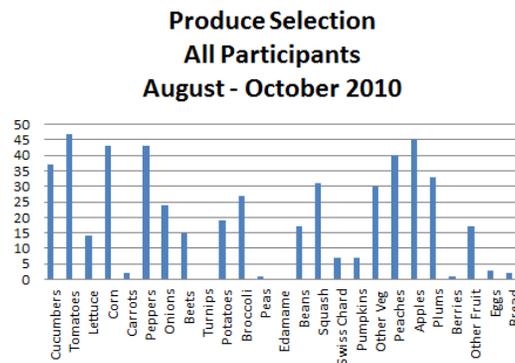
When several local studies, including a Health Needs Assessment by William W. Backus Hospital, showed obesity as a major problem in eastern Connecticut, Backus took action. The hospital collaborated with United Community & Family Services, Generations Family Health Center, the Norwich Community Development Corporation (the agency that coordinates the local farmers' market), and Thames Valley Council for Community Action to improve at-risk families' access to fresh fruits and vegetables and educate them on healthy eating habits.

Physicians identified families who would benefit from healthy food, and wrote "prescriptions." The prescriptions were valid for five trips to the market over the course of a season. The prescriptions were turned over to dietitians, nutritionists, and nurses on the Backus Mobile Health Resource Center, a medical center on wheels that is stationed at the farmers' market, in exchange for nutritional education, healthy recipes, and vouchers for free fruits and vegetables. Vendors at the farmer's market checked off which fruits and vegetables were obtained with the vouchers to ensure that healthy choices were made.

At the end of five trips to the market, families were to have increased awareness of healthy eating and nutrition, as well as motivation to make sustainable change within their everyday lives through continued interaction with their clinician and support staff at the health center. The hospital evaluated the success of the program through a focus group and mail-in survey.

2012 Numbers

- Prescriptions were written for 45 families.
- 893 \$2 vouchers were redeemed, totaling \$1,786.00.



- Overall, participating families indicated that they incorporated more fruits and vegetables into their meals.
- Overall, the group thought their children increased their fruit and vegetable intake during the program.
- Increases were noted as 1-2 fruits/vegetables per day to 3-4 fruits/vegetables.

The positive feedback and constructive criticism received from participants (both via official methods as well as anecdotally through interaction during the program), combined with the low financial cost and collaborative spirit of the initiative, indicated that this program was beneficial. Families reported more awareness of healthy eating. Parents indicated they increased the daily consumption of fruits and vegetables of their families.

Chapter Notes

Appendix 7.1: [CDC Evaluation Steps](http://www.cdc.gov/eval/steps/index.htm) (<http://www.cdc.gov/eval/steps/index.htm>)

Appendix 7.2: Selected Uses for Evaluation in Public Health Practice by Category of Purpose

Appendix 7.3: Selected Sources of Evidence for an Evaluation

Appendix 7.4: Selected Techniques for Gathering Evidence

Appendix 7.5: Selected Sources of Standards for Judging Program Performance

Appendix 7.6: Checklist for Ensuring Effective Evaluation Reports

Appendix 7.7: Utility Standards

Appendix 7.8: Feasibility Standards

Appendix 7.9: Propriety Standards

Appendix 7.10: Accuracy Standards

Sources

- [Centers for Disease Control and Prevention. Framework for Program Evaluation in Public Health.](http://www.cdc.gov/mmwr/pdf/rr/rr4811.pdf) MMWR 1999; 48 (No. RR-11) (<http://www.cdc.gov/mmwr/pdf/rr/rr4811.pdf>)
- Joint Committee on Standards for Educational Evaluation. [Program Evaluation Standards: How to Assess Evaluations of Educational Programs.](#) 2nd Edition. Thousand Oaks, CA: Sage Publications, 1994
- [Centers for Disease Control and Prevention Division for Heart Disease and Stroke Prevention. Evaluation Guide: Developing and Evaluation Plan](http://www.cdc.gov/dhdsdp/programs/nhdsp_program/evaluation_guides/docs/logic_model.pdf) (http://www.cdc.gov/dhdsdp/programs/nhdsp_program/evaluation_guides/docs/logic_model.pdf)
- [Association for Community Health Improvement \(ACHI\) Community Health Assessment Toolkit](http://www.assesstoolkit.org) (www.assesstoolkit.org)
- [National Association of County & City Health Officials \(NACCHO\) CHA/CHIP Resource Center,](http://www.naccho.org/chachipresources) www.naccho.org/chachipresources
- [North Carolina Public Health,](http://www.healthycarolinians.org/) NC Department of Health and Human Services. [Community Health Assessment Guide Book.](#) Revised December 2011 (<http://www.healthycarolinians.org/>)
- [The Community Toolbox. Our Evaluation Model: Evaluating Comprehensive Community Initiatives](http://ctb.ku.edu/en/default.aspx) (<http://ctb.ku.edu/en/default.aspx>)
- Kusek, J; Rist, R; Ten Steps to a Result-Based Monitoring and Evaluation System: A Handbook for Development Practitioners; The World Bank, 2004
- Durch, JS et al, Improving Health in the Community: A Role for Performance Monitoring; Division of Health Promotion and Disease Prevention, Institute of Medicine, 1997

Addenda

Addendum 0.1: List of Collaborators

The William W. Backus Hospital
Bridgeport Hospital
Chatham Health District
Community Health Center, Inc.
Connecticut Association of Directors of Health
Connecticut Hospital Association
Fairfield Health Department
Griffin Hospital
Hartford Health Department
Lawrence & Memorial Hospital
Ledge Light Health District
Middlesex Hospital
Naugatuck Valley Health District
Norwalk Hospital
Norwalk Health Department
Saint Francis Hospital and Medical Center
St. Vincent's Medical Center
Stratford Health Department
Trumbull Monroe Health District

Addendum 0.2: Community Health Needs Assessment/Improvement Plan Resources

Frameworks:

A number of frameworks exist for developing community health needs assessments. The following are samples of other frameworks being used around the country.

- [ACHI Community Health Assessment Toolkit](http://www.assesstoolkit.org/) (http://www.assesstoolkit.org/)
- [NACCHO Online Resource Center](http://www.naccho.org/topics/infrastructure/CHAIP/chachip-online-resource-center.cfm) (http://www.naccho.org/topics/infrastructure/CHAIP/chachip-online-resource-center.cfm)
- [Mobilizing for Action through Planning and Partnerships \(MAPP\) Framework](http://www.naccho.org/topics/infrastructure/mapp/index.cfm) (http://www.naccho.org/topics/infrastructure/mapp/index.cfm)
- [Community Health Assessment Clearinghouse: NYS Department of Health](http://www.health.ny.gov/statistics/chac/) (http://www.health.ny.gov/statistics/chac/)

Guidelines:

- [Community Health Assessment Book: North Carolina Department of Health](http://www.healthycarolinians.org/library/pdf/CHA_Guide_Book1-2011.pdf) (http://www.healthycarolinians.org/library/pdf/CHA_Guide_Book1-2011.pdf)
- [Selecting Indicators for the Community Health Assessment: Presentation from NACCHO Indicators Conference](http://www.naccho.org/topics/infrastructure/CHAIP/upload/NACCHO_PHIS12142011-A-Lomax-ORC.pdf) (http://www.naccho.org/topics/infrastructure/CHAIP/upload/NACCHO_PHIS12142011-A-Lomax-ORC.pdf)
- [Evaluating Community Benefit Programs: Catholic Healthcare Association of the United States](http://www.chausa.org/evalguide/) (http://www.chausa.org/evalguide/)
- [Getting Started: Planning and Preparing for the Community Health Improvement Process: NACCHO](http://www.naccho.org/topics/infrastructure/CHAIP/preparations.cfm) (http://www.naccho.org/topics/infrastructure/CHAIP/preparations.cfm)
- [Kansas Health Matters](http://www.kansashealthmatters.org/) (http://www.kansashealthmatters.org/)
- [The Community Toolbox. Our Evaluation Model: Evaluating Comprehensive Community Initiatives](http://ctb.ku.edu/en/default.aspx) (http://ctb.ku.edu/en/default.aspx)
- Catholic Health Association's [Assessing & Addressing Community Health Needs](http://www.chausa.org/Assessing_and_Addressing_Community_Health_Needs.asp) (http://www.chausa.org/Assessing_and_Addressing_Community_Health_Needs.asp)
- Catholic Health Association's [Model Community Needs Assessment and Implementation Strategy](http://www.chausa.org/communitybenefit/) (http://www.chausa.org/communitybenefit/)

Sample Survey Templates:

- [American Community Survey \(ACS: English and Spanish versions\)](http://www.census.gov/acs/www/Downloads/language_brochures/ACSQandA_ENG10.pdf) (http://www.census.gov/acs/www/Downloads/language_brochures/ACSQandA_ENG10.pdf)
- [Behavioral Risk Factor Surveillance System survey \(BRFSS\)](http://www.cdc.gov/brfss/) (http://www.cdc.gov/brfss/)
- [Consumer Assessment of Healthcare Providers and Systems: Clinician & Group Survey, Patient Centered Medical Home edition \(CG-CAHPS PCMH\)](https://www.cahps.ahrq.gov/Surveys-Guidance/CG.aspx) (https://www.cahps.ahrq.gov/Surveys-Guidance/CG.aspx)
- [Community Tracking Study \(CTS\): Center for Studying Health System Change](http://www.hschange.com/index.cgi?data=01) (http://www.hschange.com/index.cgi?data=01)
- [Current Population Survey \(CPS\): United States Census](http://www.census.gov/cps/) (http://www.census.gov/cps/)
- [Medical Expenditure Panel Survey \(EPS\): Agency for Healthcare Research and Quality](http://meps.ahrq.gov/mepsweb/) (http://meps.ahrq.gov/mepsweb/)
- [California Maternal, Child and Adolescent Health Community Health Assessment Survey](http://fhop.ucsf.edu/fhop/htm/prods/MCAH_cas.htm) (http://fhop.ucsf.edu/fhop/htm/prods/MCAH_cas.htm)

Demographics:

- [U.S. Census Data](http://www.census.gov/main/www/access.html) (http://www.census.gov/main/www/access.html)
- [City Data](http://www.city-data.com/city/) (http://www.city-data.com/city/)

Healthcare Access and Utilization Data:

- [HRSA Data Warehouse](http://datawarehouse.hrsa.gov/advisors.aspx) (http://datawarehouse.hrsa.gov/advisors.aspx)
- [UDS Mapper](http://www.udsmapper.org/about.cfm) (http://www.udsmapper.org/about.cfm) – This mapping and decision-support tool is built from zip-code level Section 330-funded health center reporting data found within the Uniform Data System (UDS), paired with other sources of population data. They allow a user to better understand where federally-funded health centers currently serve, where gaps in the safety net might exist, and which neighborhoods or regions might hold the highest priorities for health center expansion.

Indicators of Health:

There are a number of factors that make up the health status of an individual, comprising health and socio-economic indicators. A variety of national and statewide resources are available to assist in the identification of health indicators.

National Resources:

- [Healthy People 2020](http://www.healthypeople.gov/2020/LHI/default.aspx) (http://www.healthypeople.gov/2020/LHI/default.aspx) – A comprehensive set of 10-year, national goals and objectives for improving the health of all Americans.
- [Health Indicators Website](http://healthindicators.gov/About/AboutTheHIW) (http://healthindicators.gov/About/AboutTheHIW) – HHS website that provides a user friendly source for national, state, and community health indicators.
- [CDC](http://www.cdc.gov/DataStatistics/) (http://www.cdc.gov/DataStatistics/)
- [National Partnership for Action to End Health Disparities](http://minorityhealth.hhs.gov/npa/) (http://minorityhealth.hhs.gov/npa/) – A website that provides information about health disparities.

Connecticut Resources:

- [Community Health DataScan](http://www.ct.gov/cche/cwp/view.asp?a=3937&q=474154&ccheNav=%7C) (http://www.ct.gov/cche/cwp/view.asp?a=3937&q=474154&ccheNav=%7C) – A compendium of useful information for all people seeking to better understand health and health disparities in Connecticut.
- [County Health Rankings](http://www.countyhealthrankings.org/connecticut) (http://www.countyhealthrankings.org/connecticut) – Provides health outcomes data, which is the primary tool used to rank the overall health of counties.
- [Kaiser Family Foundation - State Health Facts](http://www.statehealthfacts.org/profilecat.jsp?rgn=8&cat=2) (http://www.statehealthfacts.org/profilecat.jsp?rgn=8&cat=2) – A breakdown of all health-related facts of the State of Connecticut.
- [Data Haven](http://www.ctdatahaven.org/) (http://www.ctdatahaven.org/) – A free resource with over 1,000 indicators of community well-being.
- [Connecticut Data Collaborative](http://ctdata.org/) (http://ctdata.org/)
- [Annie E Casey Foundation Kids Count Data Center](http://webstaging/datacenter.kidscount.org/data/bystate/StateLanding.aspx?state=CT) (http://webstaging/datacenter.kidscount.org/data/bystate/StateLanding.aspx?state=CT) – Access to hundreds of measures of child well-being.

- [U.S. City Wellbeing Tracking](http://www.gallup.com/poll/145913/City-Wellbeing-Tracking.aspx) (http://www.gallup.com/poll/145913/City-Wellbeing-Tracking.aspx) – Results by U.S. metropolitan area for overall wellbeing, diabetes, obesity, frequent exercise, frequent produce consumption, city optimism, and the uninsured.
- [CT Rural Health Portal](http://ctdatahaven.org/know/index.php/Rural_Health_Portal) (http://ctdatahaven.org/know/index.php/Rural_Health_Portal)
- [ChimeData, Connecticut Hospital Association](http://chime.org) (http://chime.org)
- [CADH Health Equity Index](http://www.cadh.org/health-equity/health-equity-index.html) (http://www.cadh.org/health-equity/health-equity-index.html) – A web-based, community-specific tool that profiles and measures the social determinants of health and their correlations with specific health outcomes.
- [Health Equity Alliance](http://index.healthequityalliance.us/) (http://index.healthequityalliance.us/) – A community-based electronic tool that profiles and measures the social determinants (including the social, political, economic, and environmental conditions) that affect health in Connecticut and their correlations with specific health outcomes.
- [Connecticut Department of Public Health](http://www.ct.gov/dph/site/default.asp) (http://www.ct.gov/dph/site/default.asp) – Offers a spectrum of indicators, trends, and other important data.
- [Community Commons](http://www.communitycommons.org/) (http://www.communitycommons.org/)

Sample Community Health Needs Assessments:

- [William W. Backus Hospital Community Health Needs Assessment](http://www.backushospital.org/healthsurvey) (http://www.backushospital.org/healthsurvey)
- [New London County \(Connecticut\) Health Study](http://www.ledgelighthd.org/programs/NLCStudy.html) (http://www.ledgelighthd.org/programs/NLCStudy.html)
- [Healthy Hartford: A Community Health Needs Assessment](http://hhs.hartford.gov/Shared%20Documents/Community%20health%20needs%20assessment%202012.pdf) (http://hhs.hartford.gov/Shared%20Documents/Community%20health%20needs%20assessment%202012.pdf)
- [Windham County Healthcare Consortium](http://www.windhamhospital.org/wh.nsf/View/HealthCareNeeds) (http://www.windhamhospital.org/wh.nsf/View/HealthCareNeeds)
- [Examples of Community Health Assessments and Report Cards: NYS Department of Health](http://www.health.ny.gov/statistics/chac/links_examples.htm) (http://www.health.ny.gov/statistics/chac/links_examples.htm)
- [NACCHO CHNA and CHIP examples](http://naccho.org/topics/infrastructure/CHAIP/chachip-online-resource-center.cfm) (http://naccho.org/topics/infrastructure/CHAIP/chachip-online-resource-center.cfm)

Evidence-Based Programs:

Evidence-based public health practices and programs are developed and implemented based on effective strategies proven by valid scientific research. The following offers examples of evidence-based programs.

Examples:

- [The Guide to Community Preventive Services](http://thecommunityguide.org/index.html) (http://thecommunityguide.org/index.html)
- [CDC Healthy Living](http://www.cdc.gov/HealthyLiving/) (http://www.cdc.gov/HealthyLiving/)
- [CDC Healthy Communities](http://www.cdc.gov/healthycommunitiesprogram/) (http://www.cdc.gov/healthycommunitiesprogram/)
- [Knowledge of Nutrition and Activity for Communities in Kansas \(KNACK Online\)](http://www.knackonline.org/information/evidence-based-programs.php) (http://www.knackonline.org/information/evidence-based-programs.php)
- [Promising Practices Resources: NYS Department of Health](http://www.health.ny.gov/statistics/chac/promising.htm) (http://www.health.ny.gov/statistics/chac/promising.htm)
- [Using the "Model for Improvement" to Improve Physical Activity and Nutrition Outcomes in a School Setting: NYS Department of Health](http://www.health.ny.gov/statistics/chac/improvement/index.htm) (http://www.health.ny.gov/statistics/chac/improvement/index.htm)
- [Evidence-based public health resources: NYS Department of Health](http://www.health.ny.gov/statistics/chac/evidence.htm) (http://www.health.ny.gov/statistics/chac/evidence.htm)
- [Hospitals Caring for Communities](http://www.caringforcommunities.org/) (http://www.caringforcommunities.org/)
- [Public Health Reports](http://www.publichealthreports.org/) (http://www.publichealthreports.org/)
- [CDC's Morbidity and Mortality Weekly Report](http://www.cdc.gov/mmwr/) (http://www.cdc.gov/mmwr/)
- [World Bank's Gaps in Results](http://webstaging/cha/community_health/evidencebasedprograms.cfm) (http://webstaging/cha/community_health/evidencebasedprograms.cfm)

Addendum 1.1: [Criteria to Consider When Selecting Consultants for a Community](#)

[Health Needs Assessment](#) (<http://www.cthosp.org/documents/community-health/Selection-Criteria-for-Consultants.docx>)

It is important to invest time in the beginning of the project to interview a range of consulting firms and their references, and to review their CHNA samples; this will save time and money, and is more likely to result in a satisfactory process and product.

A consultant may not be necessary for the entire process. There is the option to begin the project, and then determine if there are aspects that should be carved out for a consultant. Be confident in your ability to negotiate with the consulting firm to get the results you want and extract the maximum value from their work.

Ensure that you have a team leader to liaise directly with the firm to align your interests. Be certain the leader is not adverse to negotiation or conflict, and has the time to the work. Ultimately, the consultant should be a part of your team. They need to have a comprehensive understanding of the goals of the project, who the key players are, and what they are expected to do. Be very clear on what is required (e.g., dates, timelines, examples, etc.).

Strategic points to consider when selecting a consultant

Their level of expertise:

- The breadth and depth of their experience with the entirety or aspects of the Community Health Assessments and Implementation Plans (e.g., coalition building, marketing and communication plans, primary data collection including key informant interviews and focus group discussions, and report writing). Ideally, the firm has previously worked with a variety of clients and their sample reports exhibit range and creativity.
- Types of clients they have previously worked with and the geographic locations of where they have worked. It might be preferable to work with a firm that has knowledge of your community and/or state.
- Level of knowledge of existing requirements, guidelines, and timelines (specifically IRS and PHAB).
- Their existing relationship with firms they have served in the past – this may be an indication of their track record, brand, and perceived value.

The proposed budget:

- Budget and outlined costs, including flexible options if your organization or coalition cannot afford the proposed budget (i.e., you may want to engage them in fewer aspects of the project).
- Do they effectively outline the project's scope so cost and resource allocation for each segment of the project is clear?
- Receptiveness to negotiating.

Quality of their work:

- Quality of the sample reports they provide. We recommend reading the entirety of the sample CHNA reports to ensure they are not cookie-cutter.
- CHNA and CHIP reports.
- Interview and focus group discussion summaries.
- Survey summaries.
- Data analyses.
- Facilitation, communication, and documentation skills.

- Level of analytic rigor, comprehensiveness, relevance, and adherence to IRS and PHAB requirements (if more recent studies). The reports will reveal how well they got to know the communities they assessed.
- Inquire if you will have access to the data, should you wish to perform your own analyses.

Proposed team structure:

- What is the strength of the designated leader on the team? Will he or she be responsive to your needs during the project?
- Technical competence: Does the consultant's team demonstrate the technical prowess you believe is necessary for the project? Inquire about training, especially with qualitative data. (A telephone interview can yield very different results depending on the skills of the interviewer.)
- Number and roles of team members.
- What is their existing workload? Will they be supporting other clients at the same time?

Manageability of the proposed logistics:

- Can they meet your planned deadlines?
- What is their plan for sharing work with you? Does it align with your vision of engagement (e.g., will they have weekly in-person meetings or teleconferences with your team to share updates on their progress)?
- Are they going to work on-site?
- What is the extent of their availability to you?
- What systems do they put in place to effectively transition the work back to the contracting organization (e.g., will they be available after the completion of the engagement if you have questions, at no additional cost)?

Addendum 1.2: Sample Timeline: Norwalk Hospital and Norwalk Health Department

Norwalk Hospital and Norwalk Health Department's Community Health Assessment & Improvement Plan Timeline

The darker shading shows the timeline for each entire process step; the lighter shading underneath shows the timeline for various activities within each phase.

ACHI Phase / Description of Activity	Month																											
	7/11	8/11	9/11	10/11	11/11	12/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12	8/12	9/12	10/12	11/12	12/12										
Identifying the Team and Resources																												
<ul style="list-style-type: none"> ▪ Obtain support from and educate senior leaders 																												
<ul style="list-style-type: none"> ▪ Determine core team & their roles/responsibilities 																												
<ul style="list-style-type: none"> ▪ Create a time line and work plan 																												
<ul style="list-style-type: none"> ▪ Develop a budget and identify other resources needed 																												
<ul style="list-style-type: none"> ▪ Determine contributing partners 																												
<ul style="list-style-type: none"> ▪ Outline roles of contributing partners & when they are engaged 																												
<ul style="list-style-type: none"> ▪ Share framework & process with partners 																												
<ul style="list-style-type: none"> ▪ Develop RFP and send to consultants 																												
<ul style="list-style-type: none"> ▪ RFP due from consultants 																												
<ul style="list-style-type: none"> ▪ Select consultant 																												
Defining the Purpose & Scope																												
<ul style="list-style-type: none"> ▪ Determine and document what you want to learn about the community 																												
<ul style="list-style-type: none"> ▪ Define the primary users and target audience for the assessment results 																												
<ul style="list-style-type: none"> ▪ Clarify the purpose(s) 																												
<ul style="list-style-type: none"> ▪ Determine the geographic area and any target populations 																												

ACHI Phase / Description of Activity	Month																		
	7/11	8/11	9/11	10/11	11/11	12/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12	8/12	9/12	10/12	11/12	12/12	
Collecting & Analyzing Data																			
<ul style="list-style-type: none"> Identify data needed to meet the goals of the assessment 																			
<ul style="list-style-type: none"> Create a data collection plan for secondary data 																			
<ul style="list-style-type: none"> Create a system for managing data 																			
<ul style="list-style-type: none"> Collect secondary data, including comparative data 																			
<ul style="list-style-type: none"> Create a data collection plan for primary data, including assets 																			
<ul style="list-style-type: none"> Collect primary data (survey, focus groups, etc) 																			
<ul style="list-style-type: none"> Analyze primary and secondary data 																			
Documenting & Communicating Assessment Results																			
<ul style="list-style-type: none"> Review data to highlight key messages 																			
<ul style="list-style-type: none"> Prepare a summary assessment report (community health profile) 																			
<ul style="list-style-type: none"> Publish the summary report (community health profile) on paper and electronically 																			
<ul style="list-style-type: none"> Develop and implement a community dialogue and communications plan 																			
<ul style="list-style-type: none"> Prepare a full assessment report 																			
<ul style="list-style-type: none"> Publish the full assessment report electronically 																			
Selecting Priorities																			
<ul style="list-style-type: none"> Determine who will help set priorities for action 																			
<ul style="list-style-type: none"> Consider selecting a facilitator to assist with the priority-setting process 																			

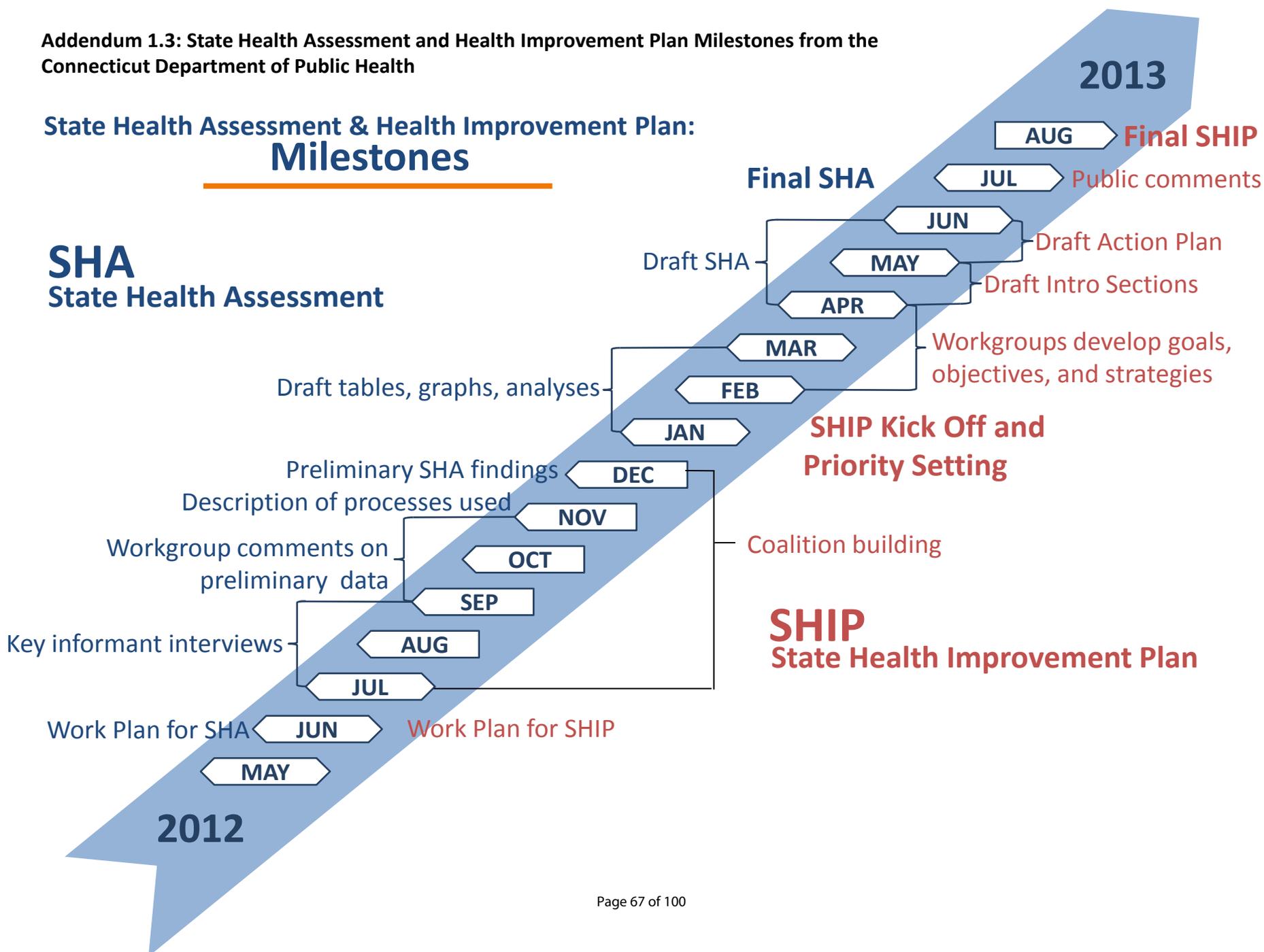
ACHI Phase / Description of Activity	Month																		
	7/11	8/11	9/11	10/11	11/11	12/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12	8/12	9/12	10/12	11/12	12/12	
<ul style="list-style-type: none"> Review and discuss the assessment findings with the priority-setting group 																			
<ul style="list-style-type: none"> Identify the top three to six priorities for action 																			

ACHI Phase / Description of Activity	Month																		
	7/11	8/11	9/11	10/11	11/11	12/11	1/12	2/12	3/12	4/12	5/12	6/12	7/12	8/12	9/12	10/12	11/12	12/12	
Planning for Action & Monitoring Progress																			
<ul style="list-style-type: none"> Incorporate additional partners into the planning and implementation process, if warranted 																			
<ul style="list-style-type: none"> Collect information on existing community efforts and on effective programs for identified priorities 																			
<ul style="list-style-type: none"> Develop the improvement plan, including goals, objectives, strategies, and performance measures for top priorities 																			
<ul style="list-style-type: none"> Disseminate improvement plan 																			
<ul style="list-style-type: none"> Begin implementation of the improvement plan 																			
<ul style="list-style-type: none"> Develop an evaluation plan to monitor implementation and measure results 																			
<ul style="list-style-type: none"> Meet periodically to monitor implementation and results 																			

2013

State Health Assessment & Health Improvement Plan: Milestones

SHA State Health Assessment



Addendum 3.1: Health Indicators at the National, State, and Local Level

Topic Area	Leading Health Indicator(s)	State or Local Data Available	Comments
1. Access to Health Services	<p>1^a Persons with medical insurance</p> <p>1^b Persons with a usual primary care provider</p>	National, CHIME, HEI	<p>1^a http://www.healthindicators.gov/Indicators/Usualprimarycareprovider_372/Profile/Data; http://www.census.gov/hhes/www/hlthins/data/historical/files/hihist6.xls ; http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_1YR_S2701&prodType=table</p> <p>1^b http://www.healthindicators.gov/Indicators/Usualprimarycareprovider_372/Profile/Data</p>
2. Clinical Preventive Services	<p>1^a Adults who receive a colorectal cancer screening based on the most recent guidelines</p> <p>1^b Adults with hypertension whose blood pressure is under control</p> <p>1^c Adult diabetic population with an A1c value greater than 9 percent</p> <p>1^d Children aged 19 to 35 months who receive the recommended doses of diphtheria, tetanus, and pertussis (DTaP); polio; measles, mumps, and rubella (MMR); Haemophilus influenza type b (Hib); hepatitis B; varicella; and pneumococcal conjugate (PCV) vaccine</p>	National	<p>1^a http://www.healthindicators.gov/Indicators/Colorectalcancerscreening_506/Profile/Data; http://healthindicators.gov/Indicators/Colorectal-cancer-screening_506/Profile; http://www.cdc.gov/cancer/colorectal/statistics/screening_rates.htm; http://www.cdc.gov/aging/pdf/promoting_report_tables.pdf</p> <p>1^b http://www.healthindicators.gov/Indicators/Highbloodpressurecontrol_882/Profile/Data; http://healthindicators.gov/Indicators/High-blood-pressure-control_882/Profile</p> <p>1^c</p> <p>1^d http://www.healthindicators.gov/Indicators/Completevaccinationamongchildren_1008/Profile/Data; http://healthindicators.gov/Indicators/Complete-vaccination-among-children-percent_1008/Profile; http://www.cdc.gov/nchs/data/hus/11.pdf#086</p>

Topic Area	Leading Health Indicator(s)	State or Local Data Available	Comments
3. Environmental Quality	3 ^a Air Quality Index (AQI) exceeding 100 3 ^b Children aged 3 to 11 years exposed to secondhand smoke	National	3 ^a Free and downloadable through http://epa.gov/airtrends/aqi_info.html 3 ^b
4. Injury and Violence	4 ^a Fatal injuries 4 ^b Homicides	Town	4 ^a Record-level data available to local health departments for all causes of death 4 ^b Record-level data available to local health departments for all causes of death
5. Maternal, Infant, and Child Health	5 ^a Infant deaths 5 ^b Preterm births	Town	5 ^a 5 ^b
6. Mental Health	6 ^a Suicides 6 ^b Adolescents and adults who experience major depressive episodes (MDEs)	State	6 ^a http://www.nami.org/Content/Microsites158/NAMI_Lexington/Home144/NAMI_Lexington_and_Suicide_Prevention/spnation_alstats.pdf 6 ^b http://www.ct.gov/dph/lib/dph/state_health_planning/healthy_people/hct2010_final_rep_jun2010.pdf

Topic Area	Leading Health Indicator(s)	State or Local Data Available	Comments
7. Nutrition, Physical Activity, and Obesity	<p>7^a Adults who meet current Federal physical activity guidelines for aerobic physical activity and muscle-strengthening activity</p> <p>7^b Adults who are obese</p> <p>7^c Children and adolescents who are considered obese</p> <p>7^d Total vegetable intake for persons aged 2 years and older</p>	<p>National</p> <p>County – BRFSS</p> <p>County - BRFSS</p>	<p>7^a</p> <p>7^b</p> <p>7^c</p> <p>7^d</p>
8. Oral Health	8 Persons aged 2 years and older who used the oral health care system in the past 12 months	State BRFSS 2004	8 http://www.healthindicators.gov/Indicators/Useoforalhealthcaresystem_1266/Profile/Data
9. Reproductive and Sexual Health	<p>9^a Increase the proportion of Sexually active females aged 15–44 years who received reproductive health services in the past 12 months</p> <p>9^b Increase the proportion of Persons living with HIV who know their serostatus</p>		<p>9^a This data comes from the National Survey of Family Growth, and is only a national sample.</p> <p>9^b State estimate is available for PLWHA that are unaware of their status, though method for calculating, tracking, etc. unavailable.</p>

Topic Area	Leading Health Indicator(s)	State or Local Data Available	Comments
10. Social Determinants	10 Students who graduate with a regular diploma 4 years after starting ninth grade	State Dept. of Education data by school district/town/school	10 http://dashboard.ed.gov/statecomparison.aspx?i=e&id=2&wt=0 ; State and Local Data available through: http://www.sde.ct.gov/sde/lib/sde/pdf/pressroom/2011_graduation_rates.pdf ; http://www.csde.state.ct.us/public/cedar/GraduationRates/byDistrict.xls ; http://www.csde.state.ct.us/public/cedar/GraduationRates/BySchool.xls
11. Substance Abuse	11 ^a Adolescents using alcohol or any illicit drugs during the past 30 days 11 ^b Adults engaging in binge drinking during the past 30 days	State BRFSS, Limited Towns – RYASAP, DARE	11 ^a http://www.healthindicators.gov/Indicators/Adolescentsreentuseofalcoholillicitdrugs_1432/Profile/Data ; http://oas.samhsa.gov/2k7State/Connecticut.htm 11 ^b http://apps.nccd.cdc.gov/BRFSS/display.asp?yr=2010&cat=AC&qkey=7307&state=UB ; http://apps.nccd.cdc.gov/BRFSS/display.asp?yr=2010&cat=AC&qkey=7307&state=CT
12. Tobacco	12 ^a Adults who are current cigarette smokers 12 ^b Adolescents who smoked cigarettes in the past 30 days	State Limited Towns- RYASAP	12 ^a http://www.cdc.gov/tobacco/data_statistics/state_data/state_highlights/2010/states/connecticut/index.htm 12 ^b http://www.ct.gov/dph/lib/dph/hems/tobacco/pdf/2011_yts_report_fnl.pdf
13. Quality of Services/Patient Safety	13 ^a Central line-associated bloodstream infections (CLABSIs) 13 ^b Invasive Healthcare-Associated Methicillin-Resistant Staphylococcus Aureus (MRSA) Infections	State level is public; hospital level with restrictions	13 ^a 13 ^b

Addendum 3.2: Healthy People 2020 Leading Health Indicators – Example Proxy Measures

Topic Area	Leading Health Indicator(s)	State or Local Data Available	Comments
1. Access to Health Services	<ul style="list-style-type: none"> • Persons with medical insurance • Persons with a usual primary care provider 	National, CHIME, HEI	Explore UHCF, DSS Medicaid, SBHP, OHCA
2. Clinical Preventive Services	<ul style="list-style-type: none"> • Adults who receive a colorectal cancer screening based on the most recent guidelines • Adults with hypertension whose blood pressure is under control • Adult diabetic population with an A1c value greater than 9 percent • Children aged 19 to 35 months who receive the recommended doses of diphtheria, tetanus, and pertussis (DTaP); polio; measles, mumps, and rubella (MMR); Haemophilus influenza type b (Hib); hepatitis B; varicella; and pneumococcal conjugate (PCV) vaccine 	National	<p>State/town cancer mortality data</p> <p>State/town diabetes mortality data</p>
3. Environmental Quality	<ul style="list-style-type: none"> • Air Quality Index (AQI) exceeding 100 • Children aged 3 to 11 years exposed to secondhand smoke 	National	Town: federal toxic release inventory for air, water, waste - HEI
4. Injury and Violence	<ul style="list-style-type: none"> • Fatal injuries • Homicides 	Town	Record-level data available to LHDs
5. Maternal, Infant, and Child Health	<ul style="list-style-type: none"> • Infant deaths • Preterm births 	Town	Record-level data available to LHDs
6. Mental Health	<ul style="list-style-type: none"> • Suicides • Adolescents who experience major depressive episodes (MDEs) 	State	H.S. data - YRBFS
7. Nutrition, Physical Activity, and Obesity	<ul style="list-style-type: none"> • Adults who meet current Federal physical activity guidelines for aerobic physical activity and muscle-strengthening activity • Adults who are obese • Children and adolescents who are considered obese • Total vegetable intake for persons aged 2 years and older 	<p>National</p> <p>County – BRFSS</p> <p>County - BRFSS</p>	NHIS - state

Topic Area	Leading Health Indicator(s)	State or Local Data Available	Comments
8. Oral Health	<ul style="list-style-type: none"> • Persons aged 2 years and older who used the oral health care system in the past 12 months 	State BRFSS 2004	MEPS AHRQ 2007
9. Reproductive and Sexual Health	<ul style="list-style-type: none"> • Sexually active females aged 15–44 years who received reproductive health services in the past 12 months • Persons living with HIV who know their serostatus 		Proxy: births receiving adequate prenatal care, and chlamydia infection rates
10. Social Determinants	<ul style="list-style-type: none"> • Students who graduate with a regular diploma 4 years after starting ninth grade 	State Dept. of Education data by school district/town/school	
11. Substance Abuse	<ul style="list-style-type: none"> • Adolescents using alcohol or any illicit drugs during the past 30 days • Adults engaging in binge drinking during the past 30 days 	State BRFSS, Limited Towns – RYASAP, DARE	DMHAS?
12. Tobacco	<ul style="list-style-type: none"> • Adults who are current cigarette smokers • Adolescents who smoked cigarettes in the past 30 days 	State Limited Towns- RYASAP	State -Youth Tobacco use
13. Quality of Services/Patient Safety	<ul style="list-style-type: none"> • Central line-associate bloodstream infections (CLABSIs) • Invasive Healthcare-Associated Methicillin-Resistant Staphylococcus Aureus (MRSA) Infections 	State level is public; hospital level with restrictions	NHDR source of data

Addendum 3.3: Considerations for Population, Demographic, and Socioeconomic Data

Population Over Time: Changes in population are often reported as a rate of change from 2000 to 2010, or using a graph to show a change in population over the last few decades. Either of these methods requires looking at U.S. Census data from prior decades.

Ethnic Origin: Many communities choose to report the *Hispanic Origin* only.

Language Other Than English Spoken at Home: Instead of or in addition to this variable, a breakdown of languages spoken in a given community is commonly reported.

Age: It is important to provide a median age and a breakdown of population by age. The age groups that are most often reported are *Under 5*, *Under 20 (or 18)*, and *65 and Over*.

Persons Living Below Poverty Level: This rate can be reported in many ways. The two most common ways to report these data is at *100% of the poverty level* and at *200% of the poverty level*. Reporting *100% of the poverty level* includes those that technically qualify as “in poverty” per federal law. Communities often report at *200% of the poverty level* because the federal poverty level has a low threshold.

Health Insurance Status: The data provided in *American FactFinder* are the number and rate of non-institutionalized persons who are uninsured. Breakdowns by age, sex, race, income, education, etc., are also available through the U.S. Census.

Educational Attainment: This is typically reported using two variables, *High School Diploma or higher* and *Bachelor’s Degree or higher*.

Household Income: This is most commonly reported as *Median Household Income* or through a *Distribution of Population by Income*.

Addendum 3.4: Limitations and Problems to Note When Reporting Population, Demographic, and Socioeconomic Data

Availability of the Data: Certain data variables are not available across all geographic scales in *American FactFinder*. This is a common problem with variables such as *health insurance status* or when data, such as *income*, is broken down into subcategories. This is almost exclusively a problem for towns with low populations.

The Issues with Using Projections: Some communities choose to report projections of what certain demographic variables might be in future years. For example, some communities might report what they expect their *population* or the *median age* to be in 2020 and 2030. Such information is not provided in *American FactFinder*.

The Issues with Reporting Unemployment: While unemployment was not identified as a common variable used for reporting population, demographic, and socioeconomic data, some CHNAs have used it as an indicator in the past. There are reasons to avoid using this variable. Unemployment is a variable with significant variation over short periods of time (months). Therefore, unlike with variables such as *race*, the 2010 unemployment figures provided in *American FactFinder* may be obsolete for many geographic areas. Also, unemployment does not provide indication about the “underemployed” population or those who are technically employed but may only be working part-time. A broader measure that would capture all of these issues is the “real unemployment rate.” This measure is not provided in *American FactFinder*.

Community Health Needs Assessment of the Primary Care Action Group

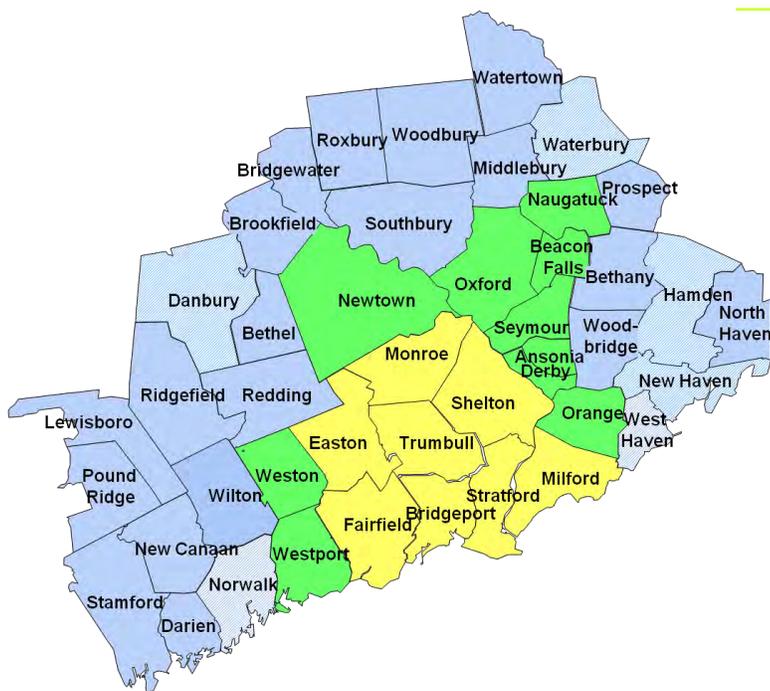
The Primary Care Action Group (PCAG), founded in 2004, is an organization of two hospitals, five departments of public health, federally qualified health centers, and many community and non-profit organizations from the Greater Bridgeport Area, committed to improving the public health and addressing the health needs of people in the community. Because this community health assessment is a collaborative effort with input from each of PCAG's member organizations, this document includes demographic and health data for several towns in the Greater Bridgeport Area.

The towns that this community health assessment covers is Bridgeport, Fairfield, Stratford, Trumbull, Monroe, Easton, and Westport. As shown in the map below, all of these towns are within the primary service area of both Bridgeport Hospital and St. Vincent's Medical Center, except for Westport. Westport is covered because of St. Vincent's Hall-Brooke behavioral health facility. The departments of public health for each of these towns are represented in the Primary Care Action Group.

Note that while Milford and Shelton are part of the primary service area of these hospitals, they are not covered in this community health assessment. Milford Hospital will be conducting a community health assessment for the Milford area. Shelton will be covered with other neighboring towns by a community health assessment in the valley area.

Map of the Greater Bridgeport Area

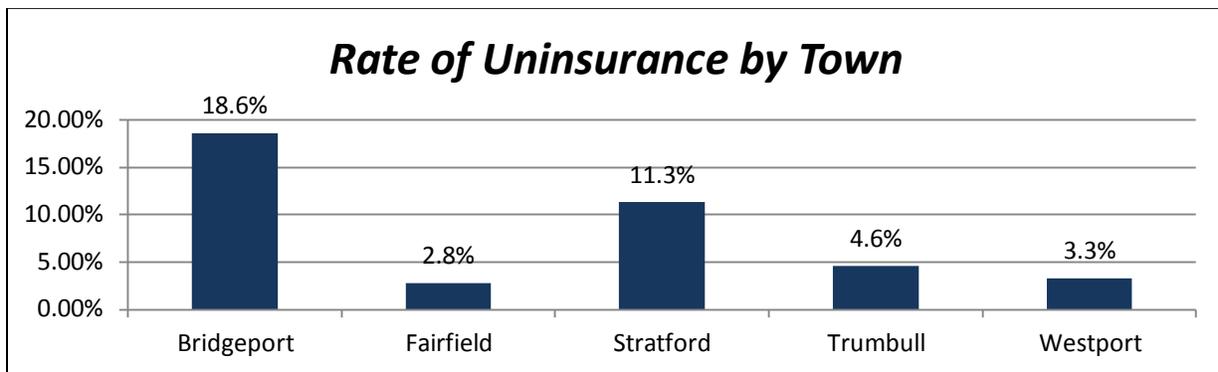
-  = primary service area of the hospitals (85% of discharges)
-  = secondary service area of the hospitals (96% of discharges)
-  = extended service area (large volume, small share of patients)



Health Insurance in the Greater Bridgeport Area

*Health Insurance information is reported for 2010 by the US Census Bureau.
Such information is not available for the Town of Monroe or the Town of Easton.*

Town	Estimated Number of Uninsured Citizens	Estimated Percentage of Uninsured Citizens
Bridgeport	26,586	18.6%
Fairfield	1,612	2.8%
Stratford	5,748	11.3%
Trumbull	1,579	4.6%
Westport	858	3.3%



Town	Uninsured by Age			Uninsured by Sex	
	Under 18	18 to 64 years	65 years and older	Male	Female
Bridgeport	4.4%	27.1%	1.6%	22.4%	15.1%
Fairfield	1.6%	3.8%	0.3%	3.2%	2.3%
Stratford	7.1%	15.5%	0.3%	13.4%	9.4%
Trumbull	1.8%	7.4%	0.0%	5.1%	4.2%
Westport	0.2%	5.8%	0.0%	3.1%	3.5%

Town	Uninsured by Income				
	Under \$5,000	\$25,000-\$49,999	\$50,000-\$74,999	\$75,000-\$99,999	\$100,000 and Over
Bridgeport	18.4%	24.3%	17.9%	15.5%	13.6%
Fairfield	4.8%	7.8%	3.7%	4.4%	1.6%
Stratford	15.3%	18.8%	12.7%	4.0%	9.0%
Trumbull	9.1%	14.3%	8.0%	4.0%	2.6%
Westport	15.6%	5.4%	1.0%	10.0%	1.7%



About the City of Bridgeport

The City of Bridgeport, located in Fairfield County, is the core of the Greater Bridgeport Area, and with a population of 144,229 according to the 2010 Census, it is the largest city in the State of Connecticut and the fifth largest in New England. Famous for its many parks, Bridgeport is also known as “The Park City.”

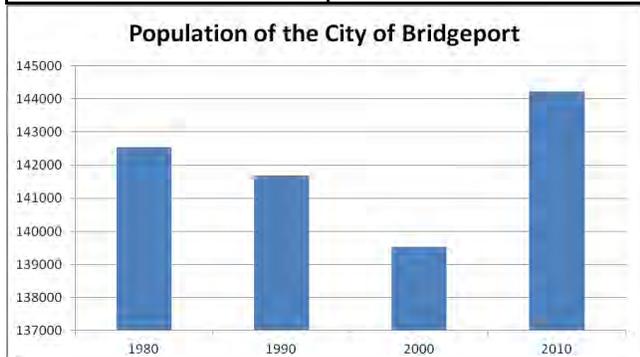
Bridgeport is an urban center which serves a home not only to many families, but also to many businesses. And Bridgeport is currently working on developing Steele Pointe on the East Side, which is expected to draw even more people and business into the city.

Bridgeport has its share of issues including far more poverty than its surrounding suburbs, high crime rates, and a struggling educational system. Also, according to TIME, Bridgeport currently has the fifth worst traffic in the entire nation.

In terms of the public health, Bridgeport is home to two major hospitals, St. Vincent’s Medical Center and Bridgeport Hospital, which service the Greater Bridgeport Area. Bridgeport is also home to many private practices, and to clinics that service the poor and uninsured.

Overall, the leaders in Bridgeport are committed to making this vibrant city a better, safer, and more healthy environment for those who do business in Bridgeport and those who call it home.

Bridgeport 2010 Household Income and Benefits	Percent
Less than \$10,000	8.8
\$10,000 to \$14,999	4.7
\$15,000 to \$24,999	11.5
\$25,000 to \$34,999	11.3
\$35,000 to \$49,999	15.3
\$50,000 to \$74,999	18.6
\$75,000 to \$99,999	13.9
\$100,000 to \$149,999	11.9
\$150,000 to \$199,999	2.7
\$200,000 or more	1.4



2010 Census Data from the American Community Survey – U.S. Census Bureau

Geography	Land Area
City of Bridgeport	15.97 square miles
Density	9,029 people per square mile

Population

Bridgeport	144,229
Connecticut	3,574,097

Selected Race/Ethnic Origin (percent of population)

- White – 42.3
- African-American – 36.8
- Asian – 3.9
- Hispanic Origin – 38.2
- Foreign Born Population – 26.6
- Language Other Than English Spoken at Home – 45.6

Age Distribution (percent of population)

Under 5 years	7.4
Under 20 years	2.5
65 and over	10.0
Median Age	31.3
Female	51.5
Male	48.5

Educational Attainment

Percentage of Persons 25 years and over with:	
High School Diploma or higher	73.5
Bachelor’s Degree or higher	15.8

Percent of Population Uninsured– 18.6 percent

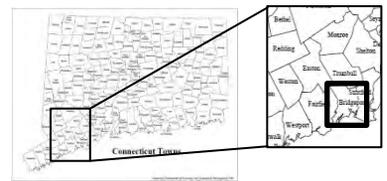
Total Households	– 52,281
Average household size	– 2.72
Average family size	– 3.35

Persons Living:
Below 100% of Poverty Level– 23.1 percent
Below 200% of Poverty Level– 45.7 percent

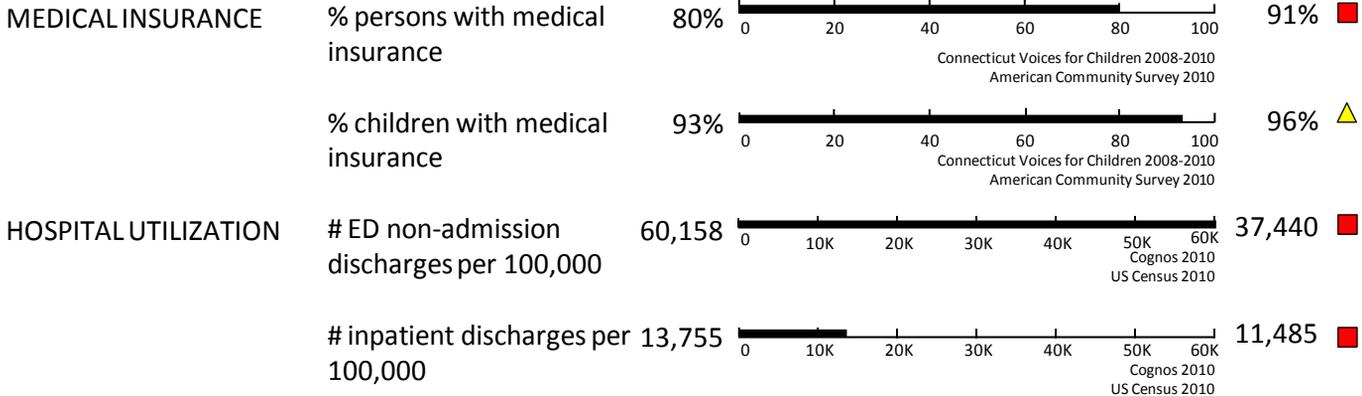
2010 Median Household Income

United States	- \$51,914
Connecticut-	\$67,740
Bridgeport-	\$41,047

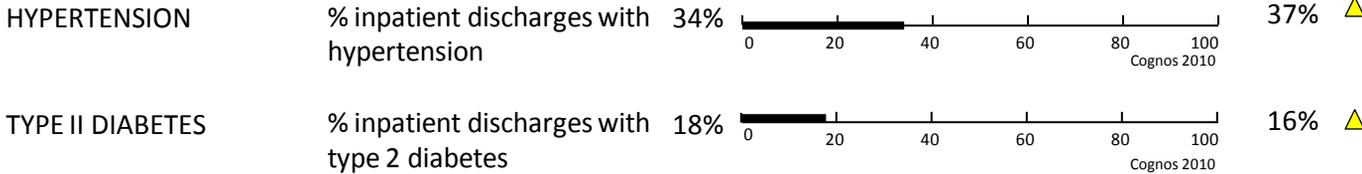
Bridgeport



Access to Health Services



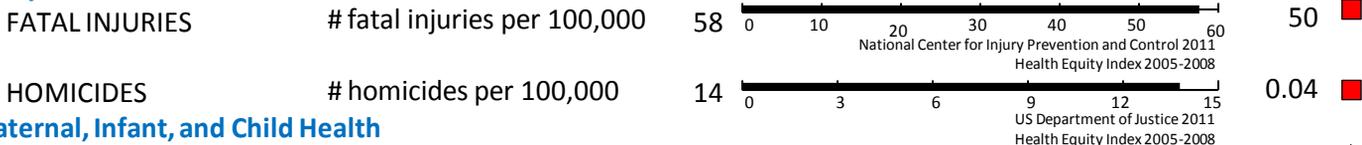
Clinical Preventative Services



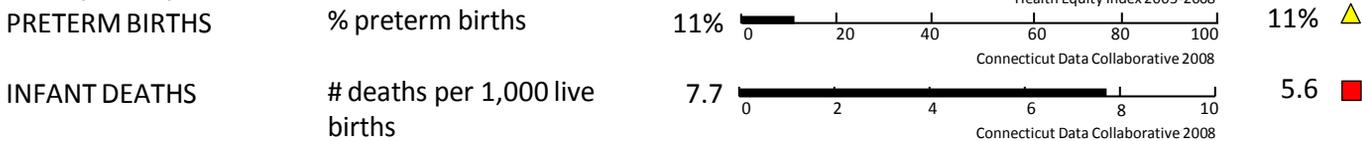
Environmental Quality



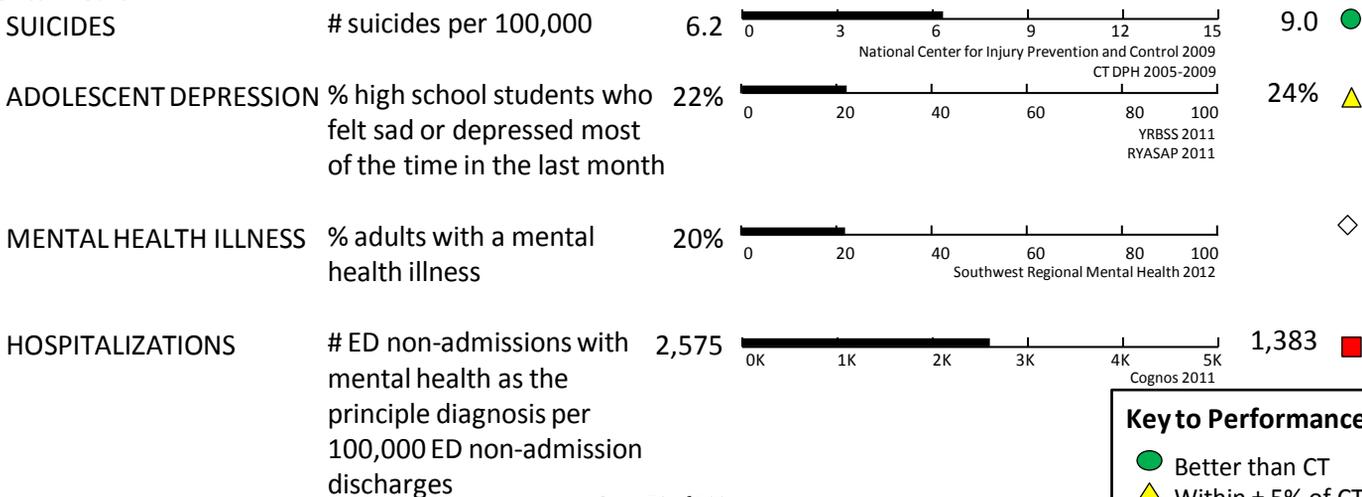
Injury and Violence



Maternal, Infant, and Child Health



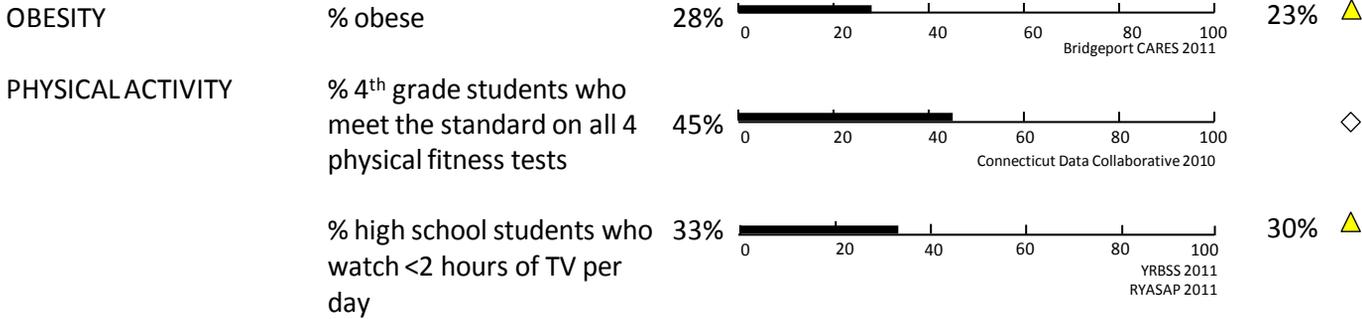
Mental Health



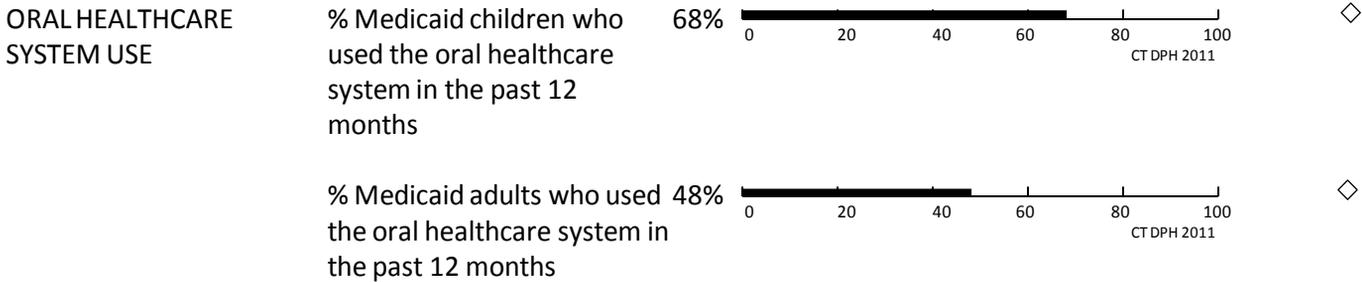
Key to Performance

- Better than CT
- ▲ Within ± 5% of CT
- Worse than CT
- ◇ Unknown

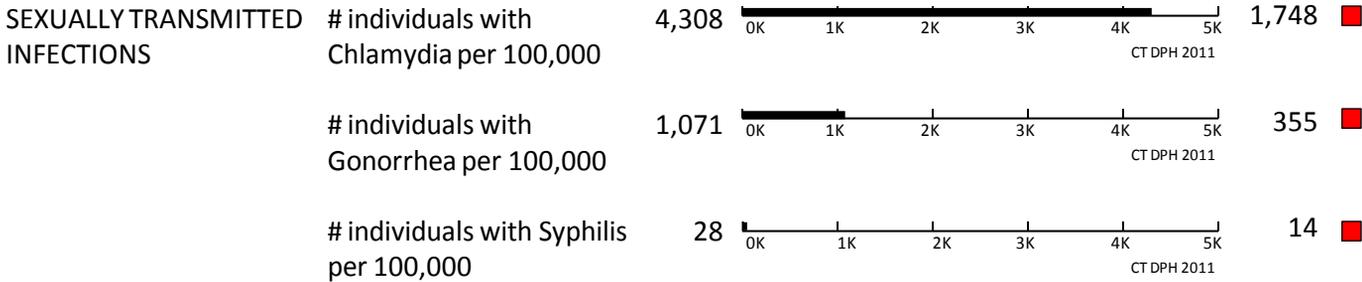
Nutrition, Physical Activity, & Obesity



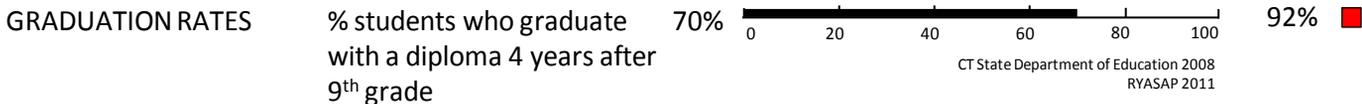
Oral Health



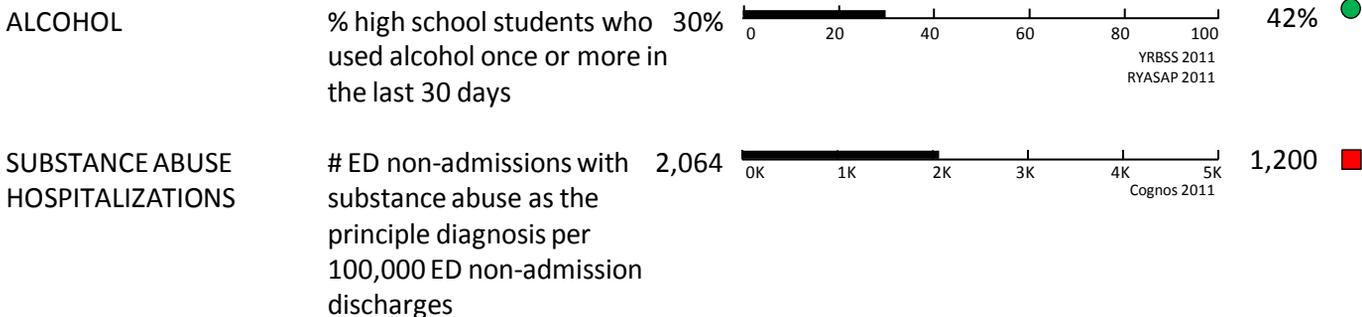
Reproductive & Sexual Health



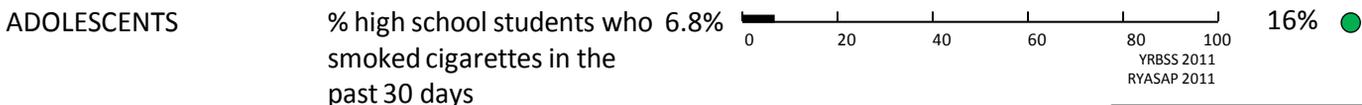
Social Determinants



Substance Abuse



Tobacco



Key to Performance

- Better than CT
- ▲ Within ± 5% of CT
- Worse than CT
- ◇ Unknown

THE TOWN OF FAIRFIELD CONNECTICUT



About the Town of Fairfield

Settled in 1639, the Town of Fairfield is located in Fairfield County, Connecticut on the coast of Long Island Sound between two cities, Bridgeport and Stamford. According to the 2010 US Census, Fairfield has a population of approximately 59,400 people, making it the largest suburban town in the Greater Bridgeport Area.

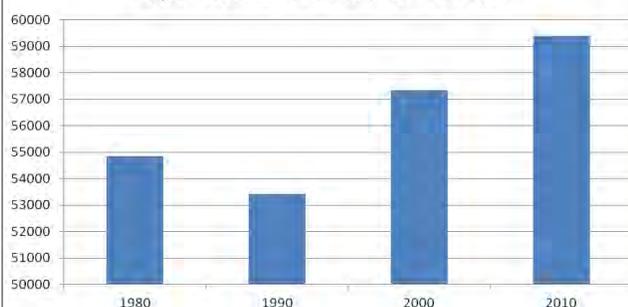
Despite its proximity to poor urban neighbors in Bridgeport, the citizens of Fairfield are generally more wealthy and enjoy a higher standard of living, including having better access to health services and good schools.

Additionally, Fairfield has great access to public parks, beaches, and recreational areas. And in July of 2006, Fairfield earned the distinction from *Money Magazine* of being the ninth "best place to live" in the United States, in addition to being the best place to live in the Northeast.

Fairfield has plans to expand through new development in the Black Rock area and the creation of a new metro station. Fairfield's leaders are committed to improving and developing the town, as well as addressing the health and other needs of its residents.

Fairfield 2010 Household Income and Benefits	Percent
Less than \$10,000	2.4
\$10,000 to \$14,999	2.5
\$15,000 to \$24,999	4.4
\$25,000 to \$34,999	4.5
\$35,000 to \$49,999	6.7
\$50,000 to \$74,999	11.8
\$75,000 to \$99,999	11
\$100,000 to \$149,999	19.1
\$150,000 to \$199,999	11.1
\$200,000 or more	26.4

Population of the Town of Fairfield



2010 Census Data from the American Community Survey – U.S. Census Bureau

Geography	Land Area
Town of Fairfield	30.6 square miles
Density	1,960.5 people per square mile

Population

Fairfield	59,404
Connecticut	3,574,097

Selected Race/Ethnic Origin (percent of population)

White	93
African-American	2.2
Asian	4.5
Hispanic Origin	5
Foreign Born Population	8.6
Language Other Than English Spoken at Home	12.1

Age Distribution (percent of population)

Under 5 years	5.9
Under 18 years	25.4
65 and over	15.0
Median Age	40.0

Female	52.5
Male	47.5

Educational Attainment

Percentage of Persons 25 years and over with:	
High School Diploma or higher	94.5
Bachelor's Degree or higher	59.3

Percent of Population Uninsured– 2.8 percent

Total Households	19,220
Average household size	2.69
Average family size	3.19

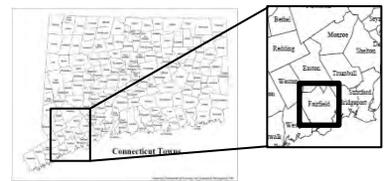
Persons Living:

Below 100% of Poverty Level – 3.3 percent
Below 200% of poverty Level– 9.2 percent

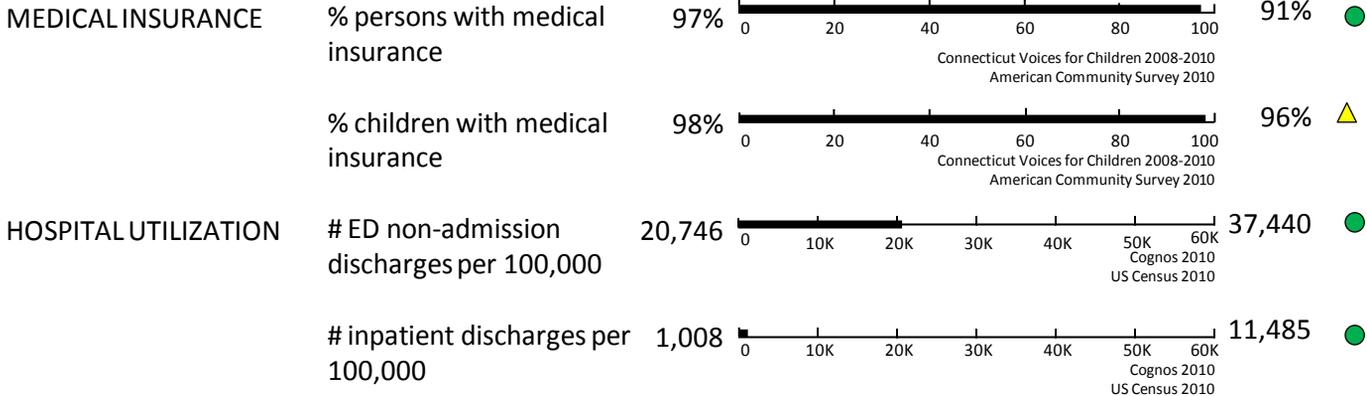
2010 Median Household Income

United States	\$51,914
Connecticut	\$67,740
Fairfield	\$113,248

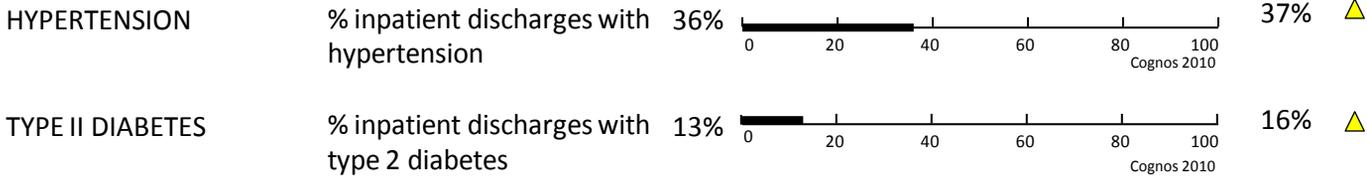
Fairfield



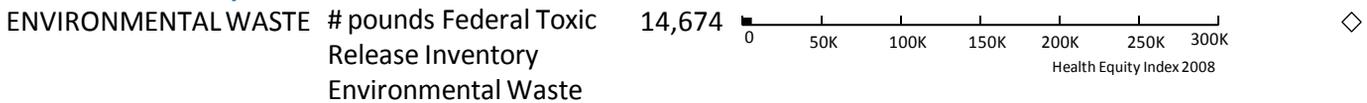
Access to Health Services



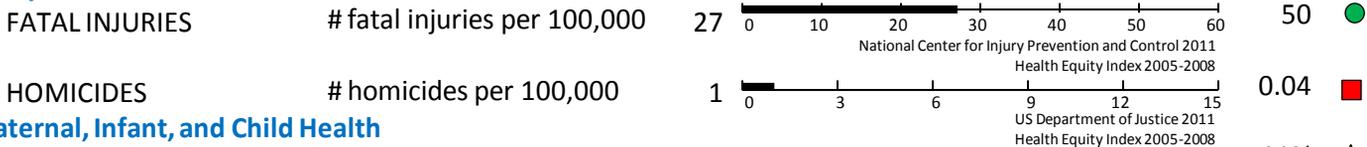
Clinical Preventative Services



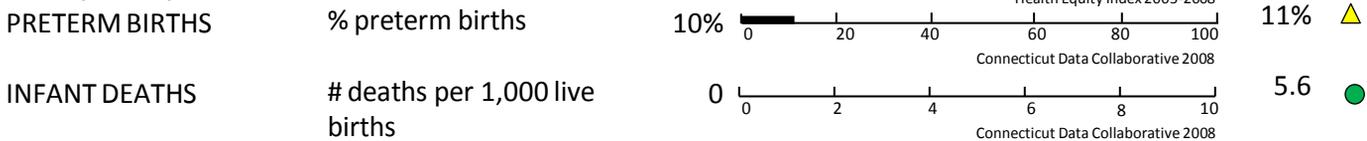
Environmental Quality



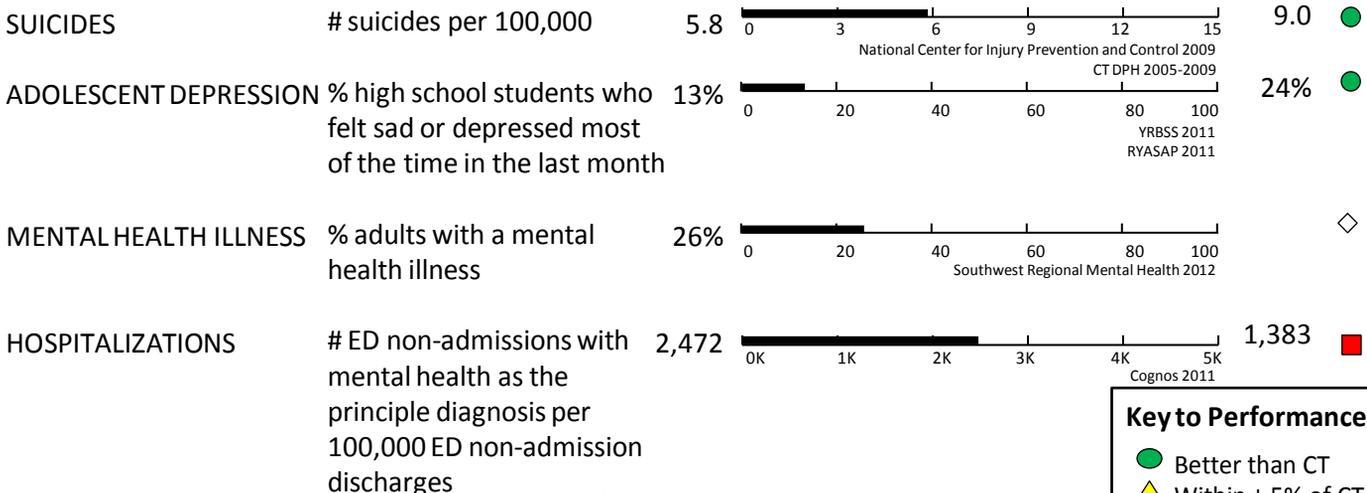
Injury and Violence



Maternal, Infant, and Child Health



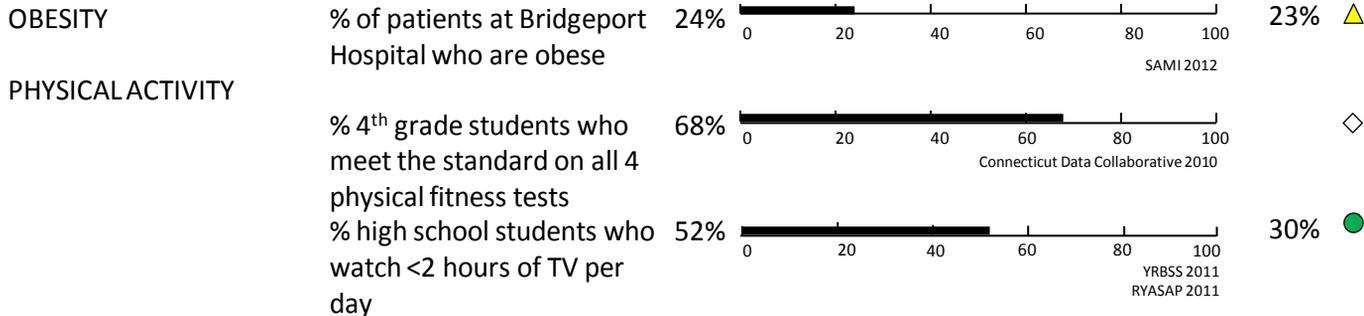
Mental Health



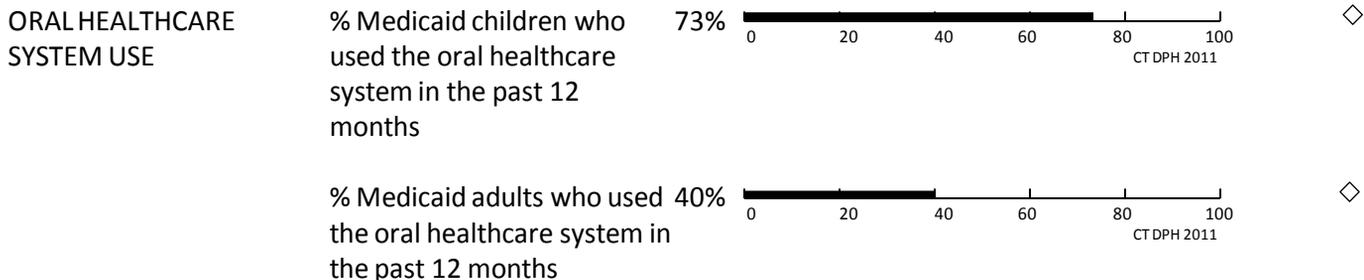
Key to Performance

- Better than CT
- ▲ Within ± 5% of CT
- Worse than CT
- ◇ Unknown

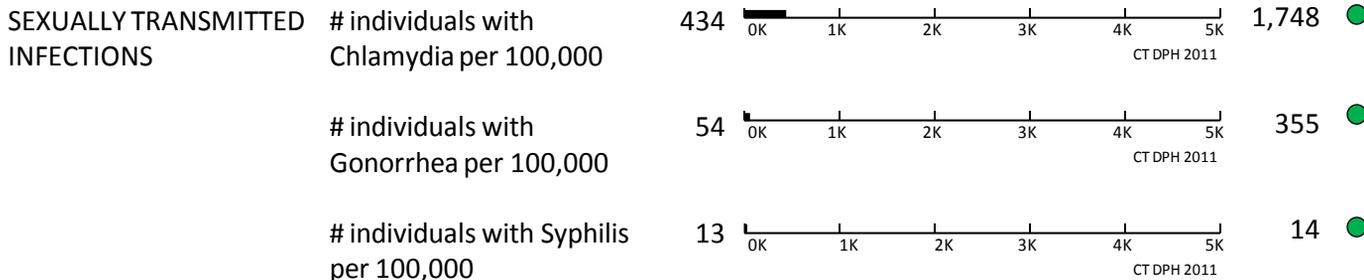
Nutrition, Physical Activity, & Obesity



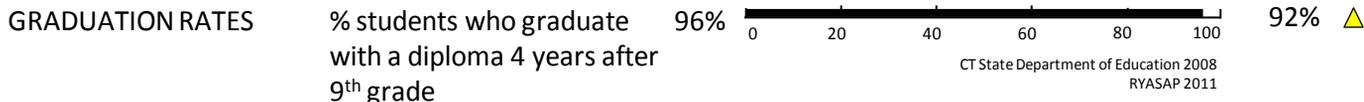
Oral Health



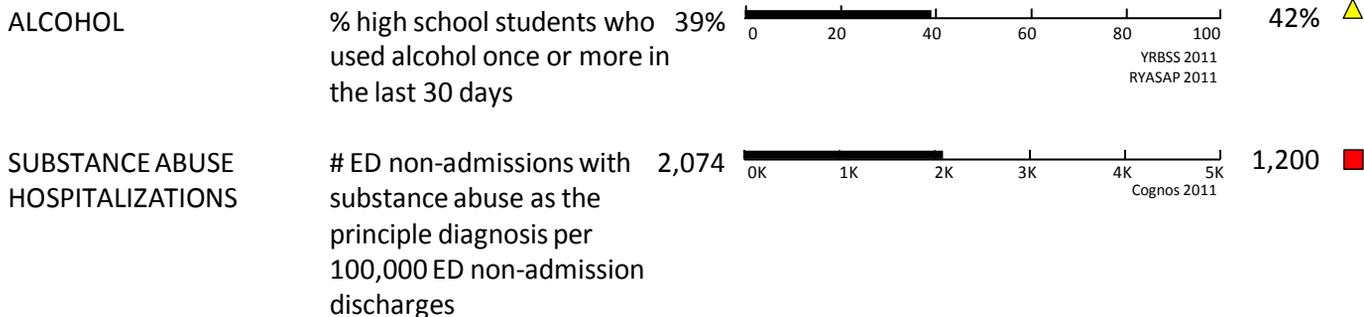
Reproductive & Sexual Health



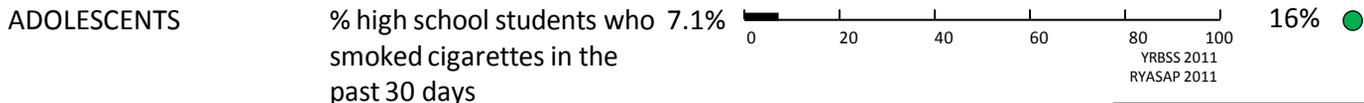
Social Determinants



Substance Abuse



Tobacco



Key to Performance

-  Better than CT
-  Within ± 5% of CT
-  Worse than CT
-  Unknown



About the Town of Stratford

Situated on Long Island Sound and bounded to the east by the Housatonic River, Stratford is a densely developed urban/suburban town with a population of approximately 51,000. Stratford is a town that has diverse natural resources and is host to a variety of cultural attractions, including the Shakespeare Theatre and Boothe Memorial Park. Stratford has a long association with the aviation industry and is home to the world's leading helicopter manufacturer, Sikorsky Aircraft, which designs and produces helicopters for military and commercial applications.

Stratford neighborhoods bordering Bridgeport share many of the same socioeconomic characteristics as the city, including high percentages of low-income families, racial/ethnic minorities, and crime. As with similar communities, health disparities associated with urban challenges are evident.

Stratford has its share of environmental concerns including brownfields and a federal Superfund Site as a result of the inappropriate waste disposal practices by Raymark Industries, Inc., a brake pad manufacturer during the early part of the 20th Century.

Stratford leaders are committed to working together with residents, business owners, and other partners to improve the quality of life in town by promoting health, preventing disease, and ensuring a clean and safe environment.

2010 Census Data from the American Community Survey – U.S. Census Bureau

Geography	Land Area
Town of Stratford	17.48 square miles
Density	2,939.4 people per square mile

Population

Stratford	51,384
Connecticut	3,574,097

Selected Race/Ethnic Origin (percent of population)

- White –76.4
- African-American – 14.3
- Asian – 2.4
- Hispanic Origin – 13.8
- Foreign Born Population – 12.5
- Language Other Than English Spoken at Home – 22.2

Age Distribution (percent of population)

- Under 5 years 5.4
- Under 20 years 22.0
- 65 and over 17.5
- Median Age 42.2
- Female 52.9
- Male 47.1

Educational Attainment

- Percentage of Persons 25 years and over with:
- High School Diploma or higher 88.2
- Bachelor's Degree or higher 28.5

Percent of Population Uninsured– 11.3 percent

- Total Households – 19,638
- Average household size – 2.57
- Average family size – 3.11

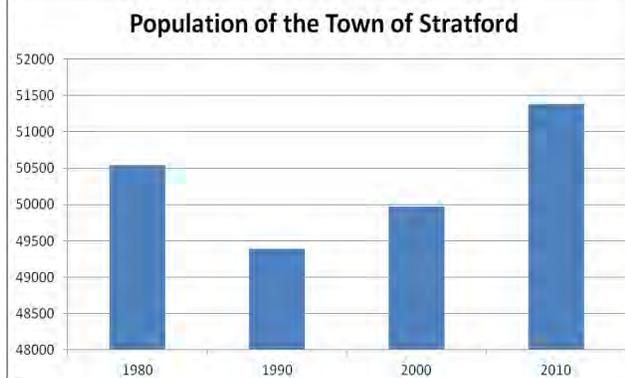
Persons Living:

- Below 100% of Poverty Level – 5.4 percent**
- Below 200% of Poverty Level- 17.4 percent**

2010 Median Household Income

- United States - \$51,914
- Connecticut- \$67,740
- Stratford- \$67,530

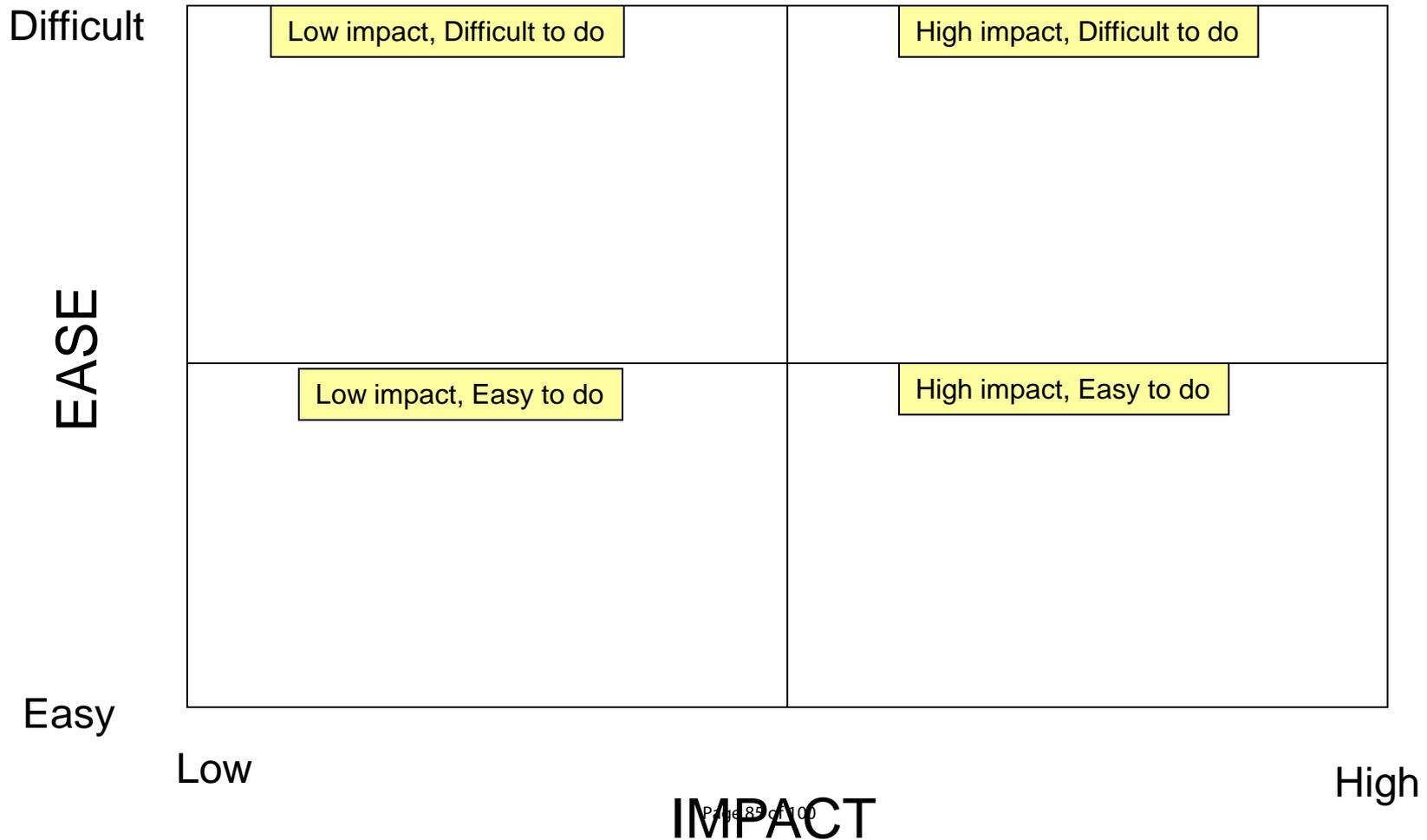
Stratford 2010 Household Income and Benefits	Percent
Less than \$10,000	3.5
\$10,000 to \$14,999	2.9
\$15,000 to \$24,999	8
\$25,000 to \$34,999	8.8
\$35,000 to \$49,999	12.6
\$50,000 to \$74,999	19.9
\$75,000 to \$99,999	14
\$100,000 to \$149,999	18.7
\$150,000 to \$199,999	7.1
\$200,000 or more	4.5



Addendum 4.2: Ease and Impact Grid, Bridgeport Hospital

Ease/Impact Grid

Directions: Write the letter (A to O) of each potential objective in the appropriate square to reflect the “impact of” and “ease to do” the idea



Addendum 5.1: Template Press Release

A template press release for personalization can be found [here](http://www.cthosp.org/documents/community-health/PressReleaseTemplate.docx) (http://www.cthosp.org/documents/community-health/PressReleaseTemplate.docx) and below:

(Insert Your Logo Here)

FOR IMMEDIATE RELEASE

Contact:
Phone:
E-mail:

[Name(s)] Shares Initial Findings from Community Health Needs Assessment *Community Invited to Attend*

Location – [Name(s)] have completed a major milestone in their Community Health Needs Assessment. Members of the community are invited to attend a presentation on [Time, Date, Location], when findings will be shared with the public.

The preliminary findings represent several months of research collecting and analyzing data, including interviews and community focus groups. The assessment includes [specify community area(s)].

The last community health assessment was conducted in [year]. With this new data, health officials will develop and implement a health improvement plan, with the goal of improving community health and guiding future decision making based on the strengths and needs of the community.

Community Health Assessment Findings (Open to Public)

[Date]

[Time]

[Location]

To attend, please RSVP to [Name and contact].

###

[Insert Boilerplate(s)]

Addendum 5.2: Template Brochure

An alterable brochure and poster template can be found [here](http://www.cthosp.org/documents/community-health/BrochureTemplate.docx) (http://www.cthosp.org/documents/community-health/BrochureTemplate.docx) and below:

A Community Health Needs Assessment for [Community]

Residents in [communities] are [positive element, e.g., more physically active], but need to improve [negative aspect]. Those are some of the findings of a community health needs assessment conducted by [name(s)] to address the health status and broader social, economic, and environmental conditions that impact the health of residents in [communities].

The key healthcare themes of the study were:

- [list item 1]
- [list item 2]
- [list item 3]
- [list item 4]
- [list item 5]

Key findings include:

- [list item 1]
- [list item 2]
- [list item 3]
- [list item 4]
- [list item 5]

With this new data, health officials will develop and implement a health improvement plan, with the goal of improving community health and guiding future decision making based on the strengths and needs of the community.

Background

The Patient Protection and Affordable Care Act requires tax-exempt 501 (c)(3) hospitals to complete a community health needs assessment every three years and develop an implementation strategy that meets the community health needs identified through the assessment. This is an IRS requirement for all tax-exempt 501(c)(3) hospitals.

Additionally, the Public Health Accreditation Board (PHAB), the accrediting body for national public health accreditation for state, tribal, local, and territorial public health departments, requires a health needs assessment for accreditation.

Accreditation is a voluntary process. It is not mandated by law or funding requirements.



Addendum 5.3: Template Talking Points

Template talking points can be found [here](http://www.cthosp.org/documents/community-health/TalkingPointsTemplate.docx) (http://www.cthosp.org/documents/community-health/TalkingPointsTemplate.docx) and below:

Why Conduct A Community Health Needs Assessment?

- The Patient Protection and Affordable Care Act requires tax-exempt 501 (c)(3) hospitals to complete a community health needs assessment every three years and develop an implementation strategy that meets the community health needs identified through the assessment. This is an IRS requirement for all tax-exempt 501 (c)(3) hospitals.
- Additionally, the Public Health Accreditation Board (PHAB), the accrediting body for national public health accreditation for state, tribal, local, and territorial public health departments, requires a health needs assessment for accreditation.
- The community health needs assessment includes input from those who represent the broad interests of the community. It helps hospitals, health departments, and FQHCs understand and address their community's health status and needs.

What Are The Findings?

- The assessment includes: population characteristics, health status of the population, positive and negative factors affecting health, available services, how the community feels about its needs, guidance from healthcare stakeholders, and state and national priorities.
- [Summarize key findings]
- [Summarize key themes]

Why Is This Important?

- Strong communities require strong leadership and guidance by hospitals, health departments, FQHCs, etc. The community health needs assessment gives us the opportunity to identify chronic diseases prevalent in our community, and address them.
- It allows us to address the health issues faced by vulnerable populations.
- It provides a guide to identify needed policy and system changes to help the population prevent, detect, and manage disease.

What's Next?

- With this new data, health officials will develop and implement a health improvement plan, with the goal of improving community health and guiding future decision making based on the strengths and needs of the community.

Appendix

Appendix 1.1: [Internal Revenue Service Notice 2011-52](http://www.irs.gov/pub/irs-drop/n-2011-52)

(<http://www.irs.gov/pub/irs-drop/n-2011-52.pdf>)

Appendix 1.2: [Public Health Accreditation Board \(PHAB\) Overview of Standards and Measures](http://www.phaboard.org/wp-content/uploads/PHAB-Standards-Overview-Version-1.0.pdf)

Appendix 2.1: [National Association of City and County Health Officials \(NACCHO\) Mobilizing for Action through Planning and Partnerships \(MAPP\) model](http://www.naccho.org/topics/infrastructure/mapp/upload/MAPP_Handbook_fnl.pdf)

(http://www.naccho.org/topics/infrastructure/mapp/upload/MAPP_Handbook_fnl.pdf).

Appendix 3.1: [Healthy People 2020 Leading Health Indicators](http://www.healthypeople.gov/2020/LHI/2020indicators.aspx)

(<http://www.healthypeople.gov/2020/LHI/2020indicators.aspx>)

TOPIC AREAS	LEADING HEALTH INDICATORS
1. Access to Health Services	<ol style="list-style-type: none"> 1. Persons with medical insurance. 2. Persons with a usual primary care provider.
2. Clinical Preventive Services	<ol style="list-style-type: none"> 3. Adults who receive a colorectal cancer screening based on the most recent guidelines. 4. Adults with hypertension whose blood pressure is under control. 5. Adult diabetic population with an A1c value greater than 9 percent. 6. Children aged 19 to 35 months who receive the recommended doses of diphtheria, tetanus, and pertussis (DTaP); polio; measles, mumps, and rubella (MMR); Haemophilus influenza type b (Hib); hepatitis B; varicella; and pneumococcal conjugate (PCV) vaccines.
3. Environmental Quality	<ol style="list-style-type: none"> 7. Air Quality Index (AQI) exceeding 100. 8. Children aged 3 to 11 years exposed to secondhand smoke.
4. Injury and Violence	<ol style="list-style-type: none"> 9. Fatal injuries. 10. Homicides.
5. Maternal, Infant, and Child Health	<ol style="list-style-type: none"> 11. Infant deaths. 12. Preterm births.
6. Mental Health	<ol style="list-style-type: none"> 13. Suicides. 14. Adolescents who experience major depressive episodes (MDEs).
7. Nutrition, Physical Activity, and Obesity	<ol style="list-style-type: none"> 15. Adults who meet current federal physical activity guidelines for aerobic physical activity and muscle-strengthening activity. 16. Adults who are obese. 17. Children and adolescents who are considered obese. 18. Total vegetable intake for persons aged 2 years and older.

TOPIC AREAS	LEADING HEALTH INDICATORS
8. Oral Health	19. Persons aged 2 years and older who used the oral healthcare system in the past 12 months.
9. Reproductive and Sexual Health	20. Sexually active females aged 15–44 years who received reproductive health services in the past 12 months 21. Persons living with HIV who know their serostatus.
10. Social Determinants	22. Students who graduate with a regular diploma 4 years after starting ninth grade.
11. Substance Abuse	23. Adolescents using alcohol or any illicit drugs during the past 30 days. 24. Adults engaging in binge drinking during the past 30 days.
12. Tobacco	25. Adults who are current cigarette smokers. 26. Adolescents who smoked cigarettes in the past 30 days.

Appendix 3.2: [Agency for Healthcare Research and Quality \(AHRQ\) measures](http://www.ahrq.gov/research/iomqrdreport/futureqrd4.htm)

(<http://www.ahrq.gov/research/iomqrdreport/futureqrd4.htm>)

BOX 4-2
AHRQ's Current Criteria and Principles for Prioritizing Measures

Primary Criteria

1. **Importance**
 - impact on health (e.g., clinical significance, prevalence);
 - meaningfulness; and
 - susceptibility to being influenced by the health system (e.g., high utility for directing public policy, and sensitive to change).
2. **Scientific Soundness** (assumed because AHRQ only uses consensus-based endorsed measures).
3. **Feasibility**
 - capacity of data and measure for subgroup analysis (e.g., the ability to track multiple groups and at multiple levels so a number of comparisons are possible);
 - cost or burden of measurement;
 - availability of required data for national and subgroup analysis; and
 - measure prototype in use.
4. **Usability**: easy to interpret and understand (methodological simplicity).
5. **Type of Measure**: evidence-based health care process measures favored over health outcome measures because most outcome measures were too distal to an identified intervention.

Secondary Criteria

- applicable to general population rather than unique to select population;
- data available regularly/data available recently;
- linkable to established indicator sets (i.e., *Healthy People 2010* targets); and
- data source supports multivariate modeling (e.g., socioeconomic status, race, and ethnicity).

Balancing Principles

- balance across health conditions;
- balance across sites of care;
- at least some state data; and
- at least some multivariate models.

SOURCE: AHRQ, 2005.

Appendix 3.3: [Connecticut Health Database Compendium](#)

(http://www.ct.gov/dph/lib/dph/hisr/pdf/ct_health_database_compendium_2012.pdf)

Appendix 3.4: [Asset Inventory Worksheet \(Healthy Capital Counties, Michigan\)](#)

(<https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CD0QFjAA&url=http%3A%2F%2Fwww.naccho.org%2Ftopics%2Finfrastructure%2FCHAIIP%2Fupload%2FAsset-Mapping.docx&ei=2R9OUKTIe630QHc5YHIBA&usg=AFQjCNGDBoW9EleLjp5DLFBPRG6lvyyYSg>)

Healthcare Services	Hospitals Urgent care centers Private physicians Community health centers and free clinics Public health departments Community mental health and mental health providers Substance abuse treatment and recovery providers Nursing homes, rehabilitation, home health and hospice
Cultural Assets	Museums Performing arts organizations Historical organizations Public spaces Community events and festivals Media organizations
Recreational Assets	School-based athletics and community education programs Community centers Parks and public recreation programs Walking/biking trails and sidewalks YMCA and not-for-profit recreation and fitness organizations Private membership fitness clubs
Food System Assets	Full-service grocery stores Community gardens Farmer’s markets Restaurants with healthy food choices Food-related organizations
Public Safety Assets	Police and fire departments Environmental protection organizations
Employment Assets	Major employers Small employers Self-employed and startups Unemployment and job-placement services Chambers of Commerce and business associations
Transportation Assets	Public transportation providers Health visit transportation providers Regional transportation and land use planning

Housing Assets	Homeless prevention and housing organizations Weatherization, home improvement, and home safety programs Rental housing landlords and developments
Educational Assets	Childcare and preschool providers (0-5) K-12 school districts Colleges and universities Public libraries
Organizational Assets	Informal groups and meetings Multi-sector coalitions Human services collaborative Local charities, grant makers, foundations

Appendix 4.1: [IRS Form 990 Schedule H \(http://www.irs.gov/pub/irs-pdf/f990sh.pdf\)](http://www.irs.gov/pub/irs-pdf/f990sh.pdf)

Appendix 4.2: Association for Community Health Improvement (ACHI): Establish Criteria for Evaluating the Data

Establishing criteria for evaluating the data creates a common, agreed-upon framework that reflects the priority-setting group’s vision and values.

Criteria can be used to help identify the most significant community health problems, as well as evaluate which problems make the most sense for the group to prioritize. These problems can be different; the most significant issues are not always ones that a community is prepared to address. Conversely, some problems that you are equipped to act upon may not be as important as reflected in the data.

Criteria that can be used to identify the most significant health issues include:

- The magnitude of the problem (e.g., the number of people or the percentage of population impacted)
- The severity of the problem (e.g., the degree to which health status is worse than the national norm)
- A high need among vulnerable populations

Criteria that can be used to evaluate which health issues you should prioritize include:

- The community’s capacity to act on the issue, including any economic, social, cultural, or political considerations
- The likelihood or feasibility of having a measurable impact on the issue
- Community resources (e.g., programs, funding) already focused on an issue (to reduce duplication of effort and to maximize effectiveness of limited resources)
- Whether the issue is a root cause of other problems (thereby possibly affecting multiple issues)

Appendix 4.3: Association for Community Health Improvement (ACHI): Set Priorities with a Consensus Process

Obtain agreement on a clear priority-setting and decision making process prior to selecting priority issues. Identification of criteria, above, is the first part of this activity. Next is the process of discussing the assessment in light of those criteria, to choose priorities for action.

Generally speaking, processes that do not build consensus among participants (such as a single decision-maker or a majority-rules voting process) are more expedient on the front end, but may result in problems later if substantial numbers of community stakeholders do not feel ownership of the results and therefore do not participate in developing and implementing action plans.

A consensus-building process, alternatively, is most likely to produce outcomes that are mutually agreeable to all participants. These processes are more time- and labor- intensive initially, but participants are more likely to feel that they have a stake in the results and may be more willing to participate in addressing the issues.

There are many ways to facilitate a consensus on priorities. Three processes are summarized here:

1. **Gradients of Agreement** Group members vote along a continuum of support, indicating to what degree they agree or do not agree with a priority. Discussion can be held around issues where there are only moderate degrees of support to create more consensus in those areas. (Kaner, S. et al. (2007). *Facilitator's Guide to Participatory Decision-Making*, 2nd edition. San Francisco: Jossey-Bass)

2. **Rating and Ranking Health Problems** Group members score each health issue from 1 to 10 on each of the identified criteria, then rank them according to their scores. Scores are added together to obtain the Problem Importance Index. The group selects the three to six priorities as appropriate to your community's resources, then discusses to determine whether there are any barriers to addressing these priorities. (Healthy Carolinians Community Assessment Guide Book.)

3. **Identify strategic issues** Strategic issues are those fundamental policy choices or critical challenges that must be addressed in order for a community to achieve its vision. The process of identifying them includes: (1) brainstorming potential strategic issues, (2) developing an understanding of why an issue is strategic, (3) determining the consequences of not addressing an issue, (4) consolidating overlapping or related issues, and (5) ordering the list of issues. (Mobilizing for Action through Planning and Partnerships)

Appendix 5.1: [North Carolina Community Health Assessment Guide Book](http://www.healthycarolinians.org/library/pdf/2012GuideBookPhases/12gb-phase5.pdf)

(<http://www.healthycarolinians.org/library/pdf/2012GuideBookPhases/12gb-phase5.pdf>)

Appendix 7.1: Steps in Evaluation Practice and Standards for Effective Evaluation

Steps in Evaluation Practice:

- **Engage stakeholders** - Those persons involved in or affected by the program and primary users of the evaluation.
- **Describe the program** - Need, expected effects, activities, resources, stage, context, logic model.
- **Focus the evaluation design** - Purpose, users, uses, questions, methods, agreements.
- **Gather credible evidence** - Indicators, sources, quality, quantity, logistics.
- **Justify conclusions** - Standards, analysis/synthesis, interpretation, judgment, recommendations.
- **Ensure use and share lessons learned** - Design, preparation, feedback, follow-up, dissemination.

Standards for Effective Evaluation:

- **Utility** - Serve the information needs of intended users.
- **Feasibility** - Be realistic, prudent, diplomatic, and frugal.
- **Propriety** - Behave legally, ethically, and with regard for the welfare of those involved and those affected.
- **Accuracy** - Reveal and convey technically accurate information.

Center for Disease Control and Prevention. [Framework for Program Evaluation in Public Health](#). MMWR 1999; 48(No. RR-11).

Appendix 7.2: Selected Uses for Evaluation in Public Health Practice by Category of Purpose

Gain insight:

- Assess needs, desires, and assets of community members.
- Identify barriers and facilitators to service use.
- Learn how to describe and measure program activities and effects.

Change practice:

- Refine plans for introducing a new service.
- Characterize the extent to which intervention plans were implemented.
- Improve the content of educational materials.
- Enhance the program's cultural competence.
- Verify that participants' rights are protected.
- Set priorities for staff training.
- Make midcourse adjustments to improve patient/client flow.
- Improve the clarity of health communication messages.
- Determine if customer satisfaction rates can be improved.
- Mobilize community support for the program.

Assess effects:

- Assess skills development by program participants.
- Compare changes in provider behavior over time.
- Compare costs with benefits.
- Find out which participants do well in the program.
- Decide where to allocate new resources.
- Document the level of success in accomplishing objectives.
- Demonstrate that accountability requirements are fulfilled.
- Aggregate information from several evaluations to estimate outcome effects for similar kinds of programs.
- Gather success stories.

Affect participants:

- Reinforce intervention messages.
- Stimulate dialogue and raise awareness regarding health issues.
- Broaden consensus among coalition members regarding program goals.
- Teach evaluation skills to staff and other stakeholders.
- Support organizational change and development.

Center for Disease Control and Prevention. Framework for Program Evaluation in Public Health. MMWR 1999; 48(No. RR-11).

Appendix 7.3: Selected Sources of Evidence for an Evaluation**Persons:**

- Clients, program participants, nonparticipants.
- Staff, program managers, administrators.
- General public.
- Key informants.
- Funding officials.
- Critics/skeptics.
- Staff of other agencies.
- Representatives of advocacy groups.
- Elected officials, legislators, policymakers.
- Local and state health officials.

Documents:

- Grant proposals, newsletters, press releases.
- Meeting minutes, administrative records, registration/enrollment forms.
- Publicity materials, quarterly reports.
- Publications, journal articles, posters.
- Previous evaluation reports.
- Asset and needs assessments.
- Surveillance summaries.
- Database records.
- Records held by funding officials or collaborators.
- Internet pages.
- Graphs, maps, charts, photographs, videotapes.

Observations:

- Meetings, special events/activities, job performance.
- Service encounters.

Adapted from Taylor-Powell E, Rossing B, Geran J. Evaluating Collaboratives: Reaching the Potential. Madison, WI: University of Wisconsin Cooperative Extension, 1998.

Appendix 7.4: Selected Techniques for Gathering Evidence

- Written survey (e.g. handout, telephone, fax, mail, e-mail, or Internet).
- Personal interview (e.g. individual or group; structured, semistructured, or conversational).
- Observation.
- Document analysis.
- Case study.
- Group assessment (e.g. brainstorming or nominal group [i.e., a structured group process conducted to elicit and rank priorities, set goals, or identify problems]).
- Role play, dramatization.
- Expert or peer review.
- Portfolio review.
- Testimonials.
- Semantic differentials, paired comparisons, similarity or dissimilarity tests.
- Hypothetical scenarios.
- Storytelling.
- Geographical mapping.
- Concept mapping.
- Pile sorting (i.e., a technique that allows respondents to freely categorize items, revealing how they perceive the structure of a domain).
- Free-listing (i.e., a technique to elicit a complete list of all items in a cultural domain).
- Social network diagramming.
- Simulation, modeling.
- Debriefing sessions.
- Cost accounting.
- Photography, drawing, art, videography.
- Diaries or journals.
- Logs, activity forms, registries.

Adapted from a) Taylor-Powell E, Rossing B, Geran J. Evaluating Collaboratives: Reaching the Potential. Madison, WI: University of Wisconsin Cooperative Extension, 1998; b) Phillips JJ. Handbook of Training Evaluation and Measurement Methods. 3rd ed. Houston, TX: Gulf Publishing Company, 1997; c) Weller SC. Systematic Data Collection. Thousand Oaks, CA: Sage Publications, Inc. 1988; and d) Trochim WMK. Introduction to Concept Mapping for Planning and Evaluation. Available at <<http://trochim.human.cornell.edu/research/epp1/epp1.htm>>. Accessed July 1999.

Appendix 7.5: Selected Sources of Standards for Judging Program Performance

- Needs of participants.
- Community values, expectations, norms.
- Degree of participation.
- Program objectives.
- Program protocols and procedures.
- Expected performance, forecasts, estimates.
- Feasibility.
- Sustainability.
- Absence of harms.
- Targets or fixed criteria of performance.
- Change in performance over time.
- Performance by previous or similar programs.
- Performance by a control or comparison group.
- Resource efficiency.
- Professional standards.
- Mandates, policies, statutes, regulations, laws.
- Judgments by reference groups (e.g., participants, staff, experts, and funding officials).
- Institutional goals.
- Political ideology.
- Social equity.
- Political will.
- Human rights.

Adapted from a) Patton MQ. Utilization-Focused Evaluation: the New Century Text. 3rd ed. Thousand Oaks, CA: Sage Publications, 1997; b) Scriven M. Minimalist Theory of Evaluation: the Least Theory that Practice Requires. American Journal of Evaluation 1998;19(1):57–70; c) McKenzie JF. Planning, Implementing, and Evaluating Health Promotion Programs: a Primer. New York, NY: Macmillan Publishing Company, 1993; d) Joint Committee on Standards for Educational Evaluation. Program Evaluation Standards: How to Assess Evaluations of Educational Programs. 2nd ed. Thousand Oaks, CA: Sage Publications, 1994; and e) Gostin L, Mann JM. Towards the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies. Health and Human Rights 1994;1:59–80.

Appendix 7.6: Checklist for Ensuring Effective Evaluation Reports

- Provide interim and final reports to intended users in time for use.
- Tailor the report content, format, and style for the audience(s) by involving audience members.
- Include a summary.
- Summarize the description of the stakeholders and how they were engaged.
- Describe essential features of the program (e.g., including logic models).
- Explain the focus of the evaluation and its limitations.
- Include an adequate summary of the evaluation plan and procedures.
- Provide all necessary technical information (e.g., in appendices).
- Specify the standards and criteria for evaluative judgments.
- Explain the evaluative judgments and how they are supported by the evidence.
- List both strengths and weaknesses of the evaluation.
- Discuss recommendations for action with their advantages, disadvantages, and resource implications.
- Ensure protections for program clients and other stakeholders.
- Anticipate how people or organizations might be affected by the findings.
- Present minority opinions or rejoinders where necessary.
- Verify that the report is accurate and unbiased.
- Organize the report logically and include appropriate details.
- Remove technical jargon.
- Use examples, illustrations, graphics, and stories.

Adapted from Worthen BR, Sanders JR, Fitzpatrick JL. Program Evaluation: Alternative Approaches and Practical Guidelines. 2nd ed. New York, NY: Logman, Inc. 1996.

Appendix 7.7: Utility Standards

The following utility standards ensure that an evaluation will serve the information needs of intended users:

- **Stakeholder identification.** Persons involved in or affected by the evaluation should be identified so that their needs can be addressed.
- **Evaluator credibility.** The persons conducting the evaluation should be trustworthy and competent in performing the evaluation for findings to achieve maximum credibility and acceptance.
- **Information scope and selection.** Information collected should address pertinent questions regarding the program and be responsive to the needs and interests of clients and other specified stakeholders.
- **Values identification.** The perspectives, procedures, and rationale used to interpret the findings should be carefully described so that the bases for value judgments are clear.
- **Report clarity.** Evaluation reports should clearly describe the program being evaluated, including its context and the purposes, procedures, and findings of the evaluation so that essential information is provided and easily understood.
- **Report timeliness and dissemination.** Substantial interim findings and evaluation reports should be disseminated to intended users so that they can be used in a timely fashion.
- **Evaluation impact.** Evaluations should be planned, conducted, and reported in ways that encourage follow-through by stakeholders to increase the likelihood of the evaluation being used.

Joint Committee on Standards for Educational Evaluation. Program Evaluation Standards: How to Assess Evaluations of Educational Programs. 2nd ed. Thousand Oaks, CA: Sage Publications, 1994.

Appendix 7.8: Feasibility Standards

The following feasibility standards ensure that an evaluation will be realistic, prudent, diplomatic, and frugal:

- **Practical procedures.** Evaluation procedures should be practical while needed information is being obtained to keep disruption to a minimum.
- **Political viability.** During planning and conduct of the evaluation, consideration should be given to the varied positions of interest groups so that their cooperation can be obtained and possible attempts by any group to curtail evaluation operations or to bias or misapply the results can be averted or counteracted.
- **Cost-effectiveness.** The evaluation should be efficient and produce valuable information to justify expended resources.

Joint Committee on Standards for Educational Evaluation. Program Evaluation Standards: How to Assess Evaluations of Educational Programs. 2nd ed. Thousand Oaks, CA: Sage Publications, 1994.

Appendix 7.9: Propriety Standards

The following propriety standards ensure that an evaluation will be conducted legally, ethically, and with regard for the welfare of those involved in the evaluation as well as those affected by its results:

- **Service orientation.** The evaluation should be designed to assist organizations in addressing and serving effectively the needs of the targeted participants.
- **Formal agreements.** All principal parties involved in an evaluation should agree in writing to their obligations (i.e., what is to be done, how, by whom, and when) so that each must adhere to the conditions of the agreement or renegotiate it.
- **Rights of human subjects.** The evaluation should be designed and conducted in a manner that respects and protects the rights and welfare of human subjects.
- **Human interactions.** Evaluators should interact respectfully with other persons associated with an evaluation, so that participants are not threatened or harmed.
- **Complete and fair assessment.** The evaluation should be complete and fair in its examination and recording of strengths and weaknesses of the program so that strengths can be enhanced and problem areas addressed.
- **Disclosure of findings.** The principal parties to an evaluation should ensure that the full evaluation findings with pertinent limitations are made accessible to the persons affected by the evaluation and any others with expressed legal rights to receive the results.
- **Conflict of interest.** Conflict of interest should be handled openly and honestly so that the evaluation processes and results are not compromised.
- **Fiscal responsibility.** The evaluator's allocation and expenditure of resources should reflect sound accountability procedures by being prudent and ethically responsible, so that expenditures are accountable and appropriate.

Joint Committee on Standards for Educational Evaluation. Program Evaluation Standards: How to Assess Evaluations of Educational Programs. 2nd ed. Thousand Oaks, CA: Sage Publications, 1994.

Appendix 7.10: Accuracy Standards

The following accuracy standards ensure that an evaluation will convey technically adequate information regarding the determining features of merit of the program:

- **Program documentation.** The program being evaluated should be documented clearly and accurately.
- **Context analysis.** The context in which the program exists should be examined in enough detail to identify probable influences on the program.
- **Described purposes and procedures.** The purposes and procedures of the evaluation should be monitored and described in enough detail to identify and assess them.
- **Defensible information sources.** Sources of information used in a program evaluation should be described in enough detail to assess the adequacy of the information.
- **Valid information.** Information-gathering procedures should be developed and implemented to ensure a valid interpretation for the intended use.
- **Reliable information.** Information-gathering procedures should be developed and implemented to ensure sufficiently reliable information for the intended use.
- **Systematic information.** Information collected, processed, and reported in an evaluation should be systematically reviewed and any errors corrected.
- **Analysis of quantitative information.** Quantitative information should be analyzed appropriately and systematically so that evaluation questions are answered effectively.
- **Analysis of qualitative information.** Qualitative information should be analyzed appropriately and systematically to answer evaluation questions effectively.
- **Justified conclusions.** Conclusions reached should be explicitly justified for stakeholders' assessment.
- **Impartial reporting.** Reporting procedures should guard against the distortion caused by personal feelings and biases of any party involved in the evaluation to reflect the findings fairly.
- **Metaevaluation.** The evaluation should be formatively and summatively evaluated against these and other pertinent standards to guide its conduct appropriately and, on completion, to enable close examination of its strengths and weaknesses by stakeholders.

Joint Committee on Standards for Educational Evaluation. Program Evaluation Standards: How to Assess Evaluations of Educational Programs. 2nd ed. Thousand Oaks, CA: Sage Publications, 1994.