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Community Health Assessment Toolkit

Step 1: Reflect and Strategize

Step 2: Identify and Engage Stakeholders

Step 3: Define the Community

Step 4: Collect and Analyze Data

Step 5: Prioritize Community Health Issues

Step 6: Document and Communicate Results

Step 7: Plan Implementation Strategies

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Step 9: Evaluate Progress

Community Engagement

Background

The Affordable Care Act requires all nonprofit hospitals to complete a community health needs assessment (CHNA) process every three years. While CHNAs are a recent requirement, community health assessments (CHAs) have long been used as a tool by hospitals, public health departments and other social service agencies to identify key community health concerns. A CHA is a systematic process involving the community to identify and analyze community health needs and assets, prioritize those needs and then implement a plan to address significant unmet needs.[1] Upon completing the assessment, hospitals develop implementation strategies to address the significant community health needs identified in the CHA.[2] A community health assessment process can focus your organization's efforts around community health improvement and provide structure for addressing the determinants of health and illness in your community.

It is important for nonprofit hospitals to be knowledgeable about the Internal Revenue Service's regulations for CHNAs. The toolkit provides a foundation for meeting the relevant IRS requirements. The American Hospital Association's review of the IRS's final rules for CHNAs and implementation strategies can be found here (https://www.aha.org/advocacy/compliance/tax-exempt-status).

The Association for Community Health Improvement's **Community Health Assessment Toolkit** offers a nine-step pathway for conducting a CHA and developing implementation strategies. Click on the icon for each step to read about that part of the process.

Citation for Toolkit

Association for Community Health Improvement. (2017). Community Health Assessment Toolkit. Accessed at www.healthycommunities.org/assesstoolkit (/resources/community-health-assessment-toolkit)

1. Catholic Health Association of the United States. (2015). Assessing and addressing community health needs. Retrieved from https://www.chausa.org/communitybenefit/assessing-and-addressing-community-health-needs (https://www.chausa.org/communitybenefit/assessing-and-addressing-community-health-needs)

2. Ibid.

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Community Health Assessment Toolkit

Community Engagement

Purpose

Community engagement is the process by which individuals from the community, stakeholder organizations and hospitals work collaboratively to identify needs most important to residents and pursue meaningful strategies to address those needs.

Making community engagement a central component of the community health assessment process is mutually beneficial to hospitals and communities.

Benefits for Your Hospital

- A clearer understanding of the community served by your hospital, including specific health issues, their root causes and the availability of resources and assets to address them.

- Strengthened bonds between community and hospital, leading to increased collaboration around priority issues.
- Greater community buy-in and a sense of shared ownership of and commitment to community health.
- Stronger relationships with individuals and organizations that are assets for improving community health.
- Healthier communities where individuals have access to preventive care and seek care at the appropriate level, potentially leading to lower costs for the hospital.

Benefits for Your Community

- A different perspective of the community and the hospital's role in health promotion.
- Improved communication between community and hospital, contributing to increased collaboration, mutual respect and understanding.
- A sense of shared ownership and commitment to the community health assessment (CHA) process and any subsequent community coalitions or collaborative improvement efforts.
- The ability to apply knowledge and experiences to improve the health of the community.
- Building involvement and investment in the short- and long-range success of the CHA process.
- The opportunity for leadership development and capacity-building.
- The potential for a healthier community.

Key Components

Identify an engagement approach
There is not a one-size-fits-all approach to community engagement; the scope of engagement depends on hospital and community factors and preferences. The figure below presents a spectrum of levels of community engagement in the CHA process.

Community Engagement Spectrum
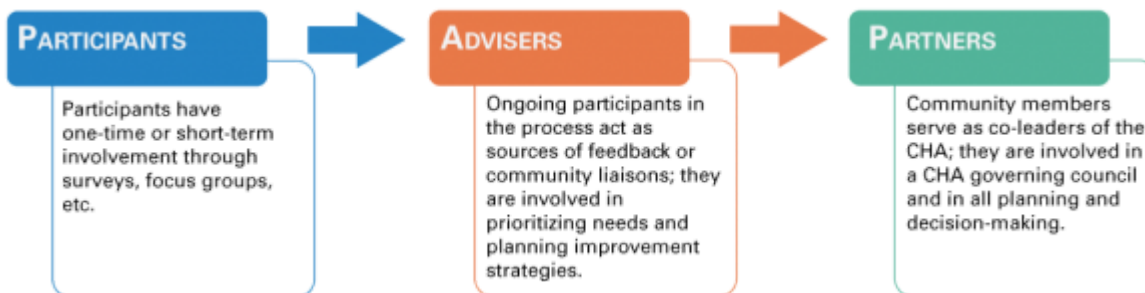
SOURCE: HEALTH RESEARCH & EDUCATIONAL TRUST. (2016, JUNE). ENGAGING PATIENTS AND COMMUNITIES IN THE COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS. CHICAGO, IL: HEALTH RESEARCH & EDUCATIONAL TRUST. ACCESSED AT: WWW.AHA.ORG/AHAHRET-GUIDES/2016-06-09-ENGAGING-PATIENTS-AND-COMMUNITIES-COMMUNITY-HEALTH-NEEDS-ASSESSMENT (HTTP://WWW.HPOE.ORG/ENGAGINGCHNA)

While all of these approaches will meet the requirements for your CHA, emphasizing more robust partnerships can enhance the quality and impact of the CHA process. Engaging communities at an advanced level requires a concerted effort and time to activate and sustain the relationship. Fostering a sense of joint ownership of the assessment — thereby making the community a part of the process, rather than the subject of it — will improve the chances that your CHA will achieve its desired impact, which in turn paves the road toward building a healthier community.

Community engagement should be an ongoing and thoughtful process. Be sure to set reasonable expectations for community members' involvement, and coordinate your efforts with other organizations so that the same individuals are not tapped for multiple assessments. It is important to be culturally sensitive to the needs, norms and values of the community, including recruiting participants in a culturally and linguistically appropriate manner

Engage a range of stakeholders from the community and hospital

You can gain perspectives on the community from soliciting input from a wide range of community members. A **community member** is any resident of a particular geographic area, including anyone who lives or works within that area. The list below describes subgroups of people from your community and hospital that can be engaged in a CHA process.

- **Patients and caregivers:** Patients are individuals who have received any sort of health care. Caregivers are individuals who serve a patient care role, such as relatives — a parent, child, brother, aunt — or a significant other, friend or neighbor. Individuals who have interacted with the health care system may have nuanced insights into how your hospital addresses the health needs of the community.
- **Volunteers:** Volunteers include those who freely offers their time, services, and/or skills within the hospital or health care system. These can include individuals who are part of the community, patients and/or family member groups.
- **Hospital staff:** Hospital staff includes hospital administrators, CHA developers, community benefit staff, clinicians, social workers, community health workers, etc. Increasing engagement in the CHA process within your hospital strengthens relationships across departments and professions.
- **Hospital leadership:** Hospital leadership – C-suite executives and trustees – may be particularly strong partners in a CHA process, as they can advocate for the integration of prioritized community health needs into operations and link population health management strategies with the CHA.
- **Populations experiencing healthy disparities:** It is particularly important to reach out to populations that are known to have significant health challenges, such as economically disadvantaged individuals, homeless persons, legal and illegal immigrants, prisoners, the elderly, physically and developmentally challenged individuals, pregnant women and children living in poverty, and members of medically underserved and minority populations or their representatives. It is particularly important to build relationship with these individuals, as any implementation strategies may address their community's health needs.
- **Stakeholder organizations:** CHA stakeholder organizations may be public or private entities from a wide range of sectors interested in the health of community members. Engaging stakeholders from a wide range of sectors allows diverse perspectives to be represented. Organizations that serve communities with health disparities can provide unique insights and function as implementation strategy partners. The table below suggests potential partners in a CHA process.

Community Sectors and Groups to Consider for Partnership in the CHA Process

SECTOR	EXAMPLES OF INDIVIDUALS AND ORGANIZATIONS
Agriculture/food suppliers	Farmers (including farmers' markets), food banks/pantries, restaurants
Business	Self-employed individuals, small businesses, corporations with local offices
Community information	Libraries, 2-1-1 systems, newspapers, magazines, radio, TV, social media, blogs, online news magazines, non-English media outlets
Culture	Theaters, orchestras, museums, galleries, supporters of the arts

Education	Public and private K–12 schools, preschools/early childhood education, colleges and universities, boards of education, English as a second language programs, teachers, school administrators, homeschool organizations, charter schools
Environment	Environmental advocacy organizations, conservation land trusts, environmentalists, hunters/fishers, biologists, outdoor enthusiasts
Government	Regional, provincial, state and local governments; tribal governing bodies; elected officials; public health agencies; planning departments
Health care	Patients; caregivers; medical, dental and mental health providers; hospitals and health care systems; community clinics/federally qualified health centers; alternative health practitioners; health insurance companies; retail clinics; ambulance companies/paramedics
Housing and development	Public and nonprofit housing agencies, organizations that provide rent subsidies or affordable housing, developers, fair-housing advocates
Public safety	Local and state police, court systems, judges, probation officers, prosecutors, defense lawyers, prisons and jails, fire departments
Public health	State, tribal, local and territorial health departments; public health institutes; nonprofit organizations
Religion	Places of worship and their members and associated organizations
Service/fraternal organizations	Lions, Masons, Rotary, Kiwanis, American Association of University Women, college fraternities and sororities
Social services	United Way; nonprofit organizations that provide services such as job training, food, shelter, elder services, services for individuals with disabilities and advocacy for immigrants
Sports and recreation	Sports clubs, park and recreation departments, athletic associations, YMCAs, gyms, coaches, athletes, sports spectators and supporters
Transportation	Public transit, bicycle advocates, transportation departments, safe routes to school programs
Volunteers and activists	Political activists, block/neighborhood associations, community coalitions
Youth	Individuals under 18 and the organizations that work with them, Big Brothers Big Sisters, Boys & Girls Clubs, Boy Scouts, Girl Scouts

Community stakeholders vary by community, and this is not an exhaustive list of potential partners. Mapping out community assets (/resources/toolkit/files/step2-identify-engage-stakeholders#assetmap) early in the process can illuminate unexpected stakeholders or partners to engage in the CHA process.

It is vital to be accountable and responsible to those community stakeholders who contribute time and energy to the process. Engaging, thanking and reporting back to those stakeholders who have been involved can flow naturally into planning the next CHA together.

See Step 2 (/resources/toolkit/files/step2-identify-engage-stakeholders) for more information on identifying and engaging stakeholders.

Key Resources

> **Community Health Assessment Toolkit**
> **Case Study: Sharp Healthcare**

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Community Health Assessment Toolkit

Step 1: Reflect and strategize

Purpose

Community health improvement is an ongoing process. Before beginning a new assessment cycle, reflect on your previous community health assessment (CHA) to identify what elements worked well, areas for process improvement and whether your implementation strategies had their desired impact.

Key Components

Reflect on the previous assessment

Reassemble your CHA team to think through the previous CHA process. Strategic questions to consider include:

- What elements of your assessment worked well?
- What elements would you like to do differently this cycle?

- Did your implementation strategies achieve their intended impact? Why or why not?
- How successful were your community engagement efforts in the last cycle? Were you able to keep community members engaged throughout the assessment?
- How involved was the community in developing the implementation strategies?
- Are there additional stakeholder organizations with whom you could partner?

Get feedback on the previous assessment

Reporting back to external stakeholders can flow naturally into collaboratively planning the next CHA. Communication should include:

- Sharing CHA findings and progress on health improvement
- Requesting feedback on the CHA process and findings
- Providing information on the next steps to be taken by the hospital
- Providing information on programs currently provided by the hospital to address needs identified in the CHA
- Sharing outcomes from current programs and requesting feedback on those programs

Gather feedback from external and internal stakeholders from across the hospital or health care system to get their impressions of the previous CHA process.

Review the data sources

A thorough review of how data were collected and used in previous CHAs can include the following considerations:

- **Quantitative data:** What sources were used in previous years? Did these sources provide new insights or confirm previous findings? Did the resources address/reflect the needs of specific communities or broader regional areas? Are there new or different data sources available?
- **Qualitative data:** What stakeholders were engaged in data collection? During which steps of the process were they engaged? Did these stakeholders provide new information or confirm previous findings? Were any groups inadvertently excluded? Were participants representative of the community served?
- **Data analysis:** How were trends, comparisons and other methods used to identify significant health needs and their possible causes? What trends or changes can you detect in the data as a result of the previous CHA process?

Establish the assessment infrastructure

Building on existing infrastructures can help ensure that the internal resources and supports are in place to set the stage for a successful CHA process. A strong CHA foundation generally includes these key components:

- Buy-in from key organizational leaders
- Financial support
- An active and committed assessment advisory committee
- A framework that includes preliminary agreement about purpose, scope and time frame

Obtain leadership support

CHA developers should engage hospital leaders at the initiation of the assessment and communicate with them regularly throughout the process. Hospital board members or trustees can be strong supporters and may be able to leverage their organizations' internal resources to support the CHA process.

Organizational leaders and trustees can:

- Lend their names to increase the credibility of the project

- Commit resources, including funding and staff support
- Attract potential assessment partners or external funding sources
- Help overcome any roadblocks that emerge along the way
- Champion the project among policy-makers and elected officials

Build the staff team

An appropriately staffed team keeps the CHA process in motion. This team should include individuals from any relevant administrative departments as well as front-line staff who are experienced in community services and/or who have significant ties to community groups.

The internal staff team should provide:

- Project oversight and operational management (e.g., monitoring timelines and budgets, contracting with consultants, managing staff)
- Data collection and analysis management
- Writing reports and other communications support
- Logistical and administrative support (e.g., sending out meeting notices, securing meeting sites)

Identify and obtain resources

The size of the budget and the nature of financial and in-kind resources will vary with the scope of each assessment. Construct a budget and develop a plan for securing needed resources.

Plan for the following resource needs:

- Staff time (existing staff or hired consultants)
- Assessment design (e.g., scope, objectives)
- Data collection and analysis
- Facilitation of collaboration, planning and priority-setting exercises
- Data visualization technology
- Report writing, production and dissemination
- Operational expenses, including meeting supplies and communications costs

If your assessment takes place by way of a community collaborative, look to your assessment advisory committee to contribute to funding and in-kind support. These stakeholders have an interest in the assessment results—to fulfill organizational or grant requirements or to inform their own organizations' planning — and may be willing to support the process.

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Step 2: Identify and Engage Stakeholders

Purpose

Establishing robust, trusting relationships with community stakeholders fosters a welcoming and inclusive environment, creating a stronger sense of joint ownership of the community health assessment (CHA) process. While this is a discrete step, stakeholders should be engaged throughout the CHA process. Refer to the Community Engagement (/resources/toolkit/files/community-engagement) section for more information.

Key Components

Develop an engagement approach
Engaging stakeholders should be a deliberate process. CHA developers and community stakeholders may have different ideas for what involvement looks like (/resources/toolkit/files/community-engagement). Community

stakeholders and hospital-based CHA developers should work together to define their roles and responsibilities and agree upon expectations for involvement. Ensuring shared understanding of CHA goals and expectations will facilitate collaboration.

Map assets that support community health improvement

The process of mapping community assets emphasizes individuals and resources in the community that can act as change agents to affect hospitals' decisions about services. This process can illuminate unexpected stakeholders or partners to engage in the CHA process.[1]

Types of assets identified include:

- **Human resources:** An organization's staff, board of directors, programs, membership and target population, including individual expertise, talent, training and skills
- **Physical resources**: A geographic location that is accessible to the target population and provides public space and meeting rooms
- **Informational resources**: Formal and informal networks of communication and participation in formal and informal associations
- **Political resources:** Constituencies of elected officials and public and private institutions that advocate for resources and policy changes
- **Existing intervention resources:** Initiatives that are already occurring in the community

The goal is to start with the community's strengths, and then build toward consensus. Community assets may include:

- Individuals, including recipients of current hospital community benefit services
- Government, public, private and philanthropic institutions
- Representatives of the local economy and workforce development
- Holders of physical spaces where the community might be engaged (e.g., community gardens, libraries)
- Associations (neighborhood, tenant, legal, advocacy, faith-based, etc.)

Try going through an asset map of your community using this template (/system/files/media/file/2019/09/asset-mapping-for-chna.pdf) as a guide.

Identify stakeholders to participate in the CHA

Stakeholders can come in many forms; they can be individuals or organizations, from the hospital or from the community – all of those voices are valuable. See the Community Engagement (/resources/toolkit/files/community-engagement) section for ideas of stakeholders from a variety of sectors. Stakeholders should be representative of the community to ensure that all voices are heard. It is particularly important to engage populations most at risk for having health disparities; having those individuals be part of the process will help you identify the root causes of the disparities and develop culturally appropriate approaches to address them.

Form an external assessment committee

Assemble an external assessment committee that includes community members to provide guidance throughout the CHA. Consider which organizations and individuals from the community should be on the committee. The committee can be most effective if it consists of a range of community stakeholders who:

- Represent different community interests and sectors
- Bring different strengths and/or resources to support the process
- Are energetic, committed and willing to collaborate

Define elements that promote team functioning, including:

- The charge of the committee (e.g., advisory versus steering)
- Staff and committee members' specific roles and responsibilities
- Committee structure and leadership or chairperson responsibilities
- Committee participation guidelines, including any expectations related to time commitments, meeting frequency and opportunities for lesser or greater involvement
- Shared language, expectations and goals for the CHA
- Decision-making processes and responsibilities

1. ABCD Toolkit. (2015). H. Daniels Consulting. Asset-Based Community Development Institute. http://www.abcdinstitute.org/ (http://www.abcdinstitute.org/)

Key Resources

**Community Health Assessment Toolkit
Case Study: Vanderbilt University**

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Step 3: Define the Community

Purpose

Specifying the geographic focus and population characteristics determines the scope of your assessment and any implementation strategies. This includes having access to data by ZIP code, census tract or neighborhood as well as connecting with community members to truly understand their concept of community.

Key Components

Describe the geographic community
The geographic focus can include counties, cities or towns, neighborhoods, school or other governmental districts, or a collection of ZIP codes. Consider the hospital's service area as a starting point to describe the community. In some

cases, it can be beneficial to go beyond primary and secondary service areas, to areas with greater unmet health needs. Organizations that have completed a CHA can look back to see how the community was defined in earlier assessments and determine if the definition needs to change.

Identify population groups

Though the geographic focus can be broad and inclusive (e.g., all people in a defined region), hospitals can dig deeper into specific population groups relevant to the assessment's purpose. Examples of population characteristics that can be targeted include:

- Age (e.g., children and youth, adults, seniors)
- Race and ethnicity
- Income level
- Education level
- Insurance status
- Language preference
- Disability status
- Veteran status
- Sexual orientation
- Gender

It maybe be helpful to focus on populations of interest (e.g., a particular minority group assumed to be affected by health disparities) to ensure that they are represented in the overall assessment. Examples of target populations include:

- Uninsured or impoverished adults
- Students within a school district
- Specific racial or ethnic groups in a defined region
- Recipients of a particular social service (e.g., WIC, SNAP)
- Individuals with financial stress
- Homeless individuals
- Neighborhoods with environmental risks (e.g., factory pollution, high lead exposure)

Identify other organizations conducting health assessments

Nonprofit hospitals are among the many organizations that are required to assess the health needs of their communities, including, but not limited to, public health departments and social service organizations. Due to these complementary requirements and processes, collaboration with those groups is mutually beneficial. It can be mutually beneficial to partner with other local health systems or hospitals even if they have a different geographic scope than your hospital. Building on these mutual interests will ensure that priority populations such as uninsured and underinsured persons, the medically underserved, low-income populations and minority populations are included in the assessment, and will also create more meaningful opportunities to address their needs.

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Step 4: Collect and Analyze Data

Purpose

Community health assessments (CHAs) include a combination of quantitative demographic and health data as well as qualitative data that reflects the experiences and opinions of community stakeholders. Summarize and synthesize these data to develop a picture of overall community health and to highlight the particular health needs of various populations in your community.

Key Components

Considerations for data collection
Defining demographic indicators - Indicators are the measures describing a community's health that are related to desired health outcomes; they should allow for identification of health inequities by geography, age, race/ethnicity and

socioeconomic status when feasible. Before gathering data, identify meaningful indicators of health and health determinants.

Detecting disparities - Aggregate data about a population can obscure subpopulation differences. Electronic health record (EHR) data may be useful for tracking and stratifying health status by race, ethnicity and language, as well as other sociodemographic characteristics (e.g., income, disability or veteran status, sexual orientation and gender).

Reaching populations facing inequities - Some segments of a population—such as individuals who lack a stable address or who do not speak English—may not be represented in existing data. Make a specific effort to engage individuals from those populations. Consider where these individuals congregate and conduct targeted outreach in these locations.

Apply research principles to the CHA process

Your CHA will include a combination of primary data that you collect yourself and secondary data that comes from other sources, such as the local health department. With both primary and secondary sources, there are two main types of data:

- **Quantitative***:* numerical population data that can establish a benchmark for health indicators and conditions.
- **Qualitative***:* descriptive data based on opinions and perceptions that can illustrate how people think or feel; typically gathered from interviews, focus groups, photovoice, participatory action research or town hall meetings.

Community-based participatory research (CBPR) methodology is particularly applicable to the CHA process. It is a collaborative approach to research that equitably involves all partners in the research process, recognizing the unique strengths that each partner brings and facilitating collaborative partnership through the research. CBPR principles align well with the CHA process.

CBPR PRINCIPLES[1]	RELATION TO CHA PROCESS
Recognizes community as a unit of identity	The unit of analysis for CHAs is the geographic community.
Facilitates collaborative partnerships in all phases of the research	CHA developers can foster long-term, collaborative partnerships with community members and stakeholders throughout the process.
Integrates knowledge and action for the mutual benefit of all partners	The hospital gains a more nuanced perspective of community health issues.
Promotes a co-learning and empowering process that attends to social inequalities	Engaging the community throughout the CHA process promotes a sense of joint ownership and equity between the hospital and community.
Involves a cyclical and iterative process	The CHA process is an ongoing cycle that should include periodic reflection and course correction.
Addresses health from positive and ecological perspectives	CHA developers are encouraged to target the social determinants of health in the community in order to address the upstream factors affecting health.
Disseminates findings and knowledge gained to all partners	CHA results are publicly available and widely distributed to participants, stakeholders and the community at large.

Develop a data strategy

When planning the data collection process, the CHA advisory committee can discuss the following considerations:

- Is this the hospital's first CHA or an update from previously published CHAs?
- Will the collected data be new, updated from existing data or both?
- What requirements need to be fulfilled?
- Is the hospital operating alone or with other partners?
- Is the CHA representing one community, one hospital or multiple jurisdictions?
- Will you be conducting the CHA in partnership with local health departments or other hospitals?
- Is there a system in place to store and manage CHA data?
- Does the hospital require additional support to compile, assess and publish the data?
- What level of geographic granularity is needed to identify disparities and unmet needs?

The hospital can call on both internal and community resources to advise on data collection and provide data. This can include:

- Hospital staff
- Public health departments
- Local colleges/universities
- Research organizations
- Community volunteers
- Consulting firms
- Public health institutes

Decide what data to include

Comprehensive CHAs include a thorough review of the statistics regarding a range of population health indicators. Data collected and analyzed should reflect the clinical and non-clinical factors that impact health. Guidelines for key metrics can be found in the County Health Rankings & Roadmaps Model:

County Health Rankings model © 2014 UWPHI
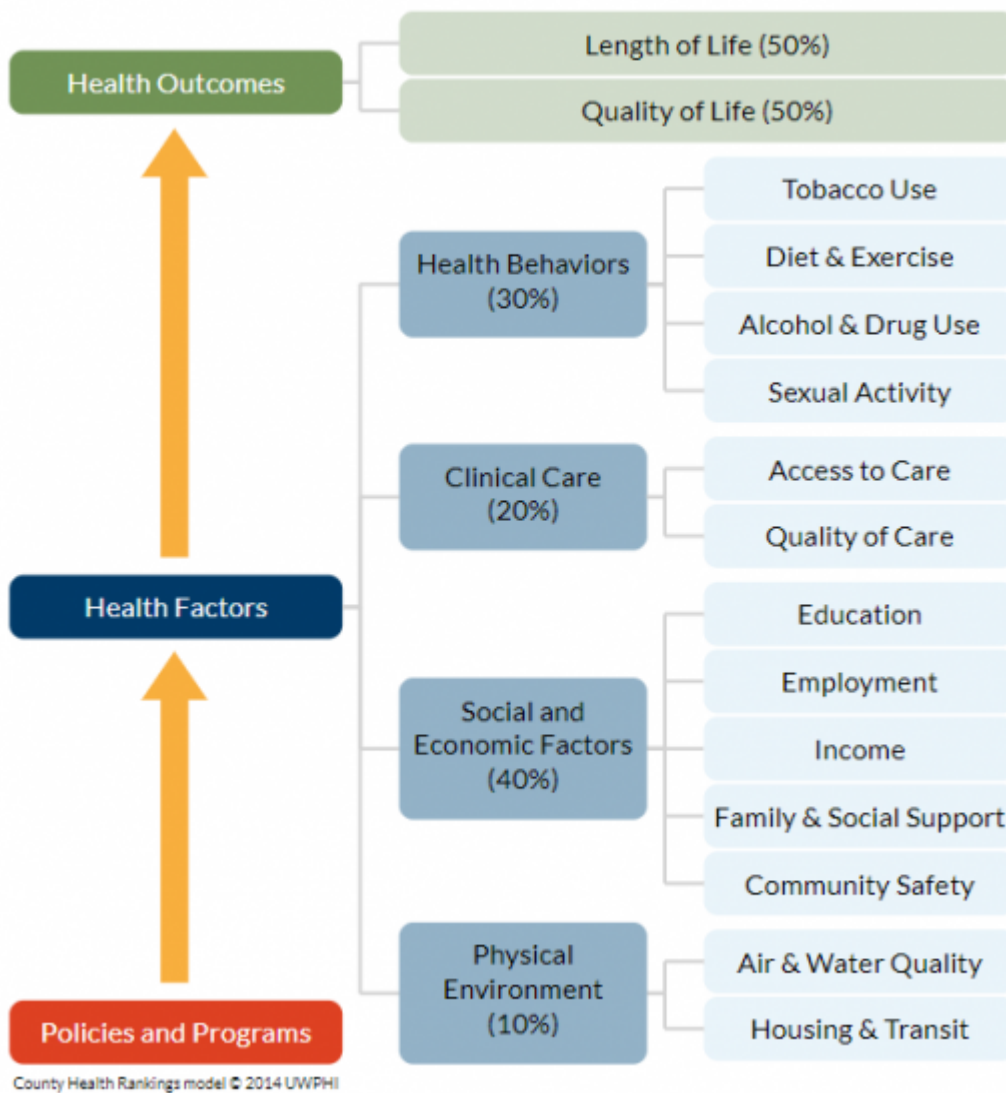
Source: University of Wisconsin Population Health Institute. (2016). County Health Rankings & Roadmaps: Our approach. Accessed at https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model (https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model)

Collect secondary quantitative data

Demographic and health data are compiled by local and state health departments as well as by national sources such as County Health Rankings & Roadmaps (http://www.countyhealthrankings.org/), Community Commons (http://www.communitycommons.org/) and the Centers for Disease Control and Prevention (CDC) (https://www.cdc.gov/). Selection of data sources will depend in part on the definition of your hospital's geographic service area. Local health department epidemiologists can assist with ensuring data quality and validity. Input from local community and neighborhood groups on access to health care, social determinants of health and other health conditions can also enhance the quality of data collected, as it is coming directly from the community.

National data sets can help you identify disparities at the local level. Notable among these are:

- CDC's Behavioral Risk Factor Surveillance System (http://www.cdc.gov/brfss/index.html)
- CDC's Community Health Status Indicators (https://www.cdc.gov/nccdphp/dch/)
- Dignity Health's Community Need Index (http://cni.chw-interactive.org/)

- Community Common's Vulnerable Population Footprint (http://www.communitycommons.org/2014/11/what-does-the-vulnerable-population-footprint-mean/)
- U.S. Department of Health & Human Services' Health Data (https://www.healthdata.gov/)

Access electronic health record data

EHR data can provide a unique window into the health needs of community members who have received care. Accessing the aggregate EHR data will require working with the IT department to see what data they can pull from the data warehouse. Considerations include:

- Benchmarking patient data against the health indicators in the hospital's service area
- Aligning key indicators for the CHA with the fields being collected in the EHR
- Linking patient records across the continuum of care
- Tracking emergency department use
- Documenting behavioral health issues and comorbidities with other chronic diseases in the EHR

Collect community-engaged primary data

Information not available in existing databases should be collected directly from your community. This is an ideal opportunity to engage your community. There are four main approaches to obtaining primary data:

- **Community surveys:** written surveys distributed widely to the community on paper and/or online
- **Key stakeholder interviews:** one-on-one conversations between trained facilitators and community stakeholders
- **Focus groups:** group-based conversations of 5 to 10 participants led by a trained facilitator
- **Town hall meetings:** community-wide meetings led by a trained facilitator

Guiding principles to consider when soliciting the opinions of community members about their community health needs include:

- Involve community members in developing surveys or interview guides to ensure that questions are culturally appropriate, are understandable and will elicit desired responses. Do not use health care jargon, as most people outside of the field will not understand it.
- When developing questions, make sure the questions accurately and directly address what is being measured.
- Keep the wording of questions simple, with clearly defined terms. Avoid leading questions, two-part questions or questions that make assumptions about the respondent.
- Test the questions on a small sample of potential respondents so they can give feedback and identify any confusing terms or suggest modifications.
- Keep surveys short to reduce the time burden on the respondents and increase the response rate. Include only relevant, necessary questions.
- Collect responses from a large and diverse group of individuals who are representative of the community served. If there is a significant non-English-speaking population, consider approaches that would allow those individuals to participate in their native language.
- Train individuals who will be conducting interviews and focus groups to perform this work consistently and neutrally so as not to influence responses.
- Develop standard processes for analyzing data. This is particularly important when coding qualitative data, as it is a fairly subjective process.

Below are some suggested practices for engaging community members in the data collection process:

COMMUNITY SURVEYS

Content and format	Assure respondents of confidentiality.
	Collect race, ethnicity and language data in a culturally appropriate manner.
	Ensure that survey questions are culturally appropriate and at a literacy level and language that respondents can understand.
	Review the survey draft with community members to see what needs to be modified.
	Provide versions of the survey in the languages spoken by community members.
	Consider using or modifying a validated survey instrument or questions.
	Assess regularity of health care usage as frequent users may have a unique perspective.
	Allow space for qualitative answers.
	Provide the option for respondents to be contacted for further involvement in the CHA process.
	Distribute the survey online, on paper or both. Consider using both methods if there are major segments of the community's population who do not have internet access.
Participants	Consider oversampling vulnerable populations since interventions would likely need to be focused on the needs of those groups.
	Distribute the survey where people live, work, learn and play—at churches, local businesses, health fairs, etc.
	Widely advertise the survey using social media, newspaper advertisements, etc.
	Engage community leaders to encourage participation in the survey among their constituents.
	Consider specifically surveying the patient population.

KEY STAKEHOLDER INTERVIEWS

Participants	Consider whom to interview:

- Interview stakeholders from a variety of sectors in the community.

- Engage clinicians—including physicians, nurses, community health workers, etc.—for interviews as they likely have insights into the health needs of patients in the hospital.

- Interview individuals representative of the community, including subgroups experiencing health disparities.

Supplement topic areas with sparse secondary data by interviewing community stakeholders knowledgeable in that area.

Find innovative ways to recruit for stakeholder interviews:

- Ask community leaders if they know and could provide connections to potential participants with the characteristics being targeted.
- Engage clinicians in hospitals or any associated medical groups and practices to identify patients for interviews.
- Talk to hospitals' patient and family advisory councils (PFACs).

Location	Make the location easily accessible; consider factors such as proximity to public transportation, time of day, availability of parking, child care, etc. Hold the interviews in a neutral space (i.e., not the hospital). Consider online or phone interviews to reduce barriers to participation.
Facilitator	Ensure that the interview facilitator is culturally competent and speaks the language(s) spoken by the interviewees. Use a facilitator who is well trained in moderating interviews, including keeping participants on topic and maintaining a neutral position.
Developing interview questions	Develop an interview guide so the same questions are asked across all interviews. Ask short and open-ended questions to encourage dialogue on various topics. Review the list of questions ahead of time with community members to ensure that questions are culturally appropriate and at a level that participants would be able to understand. Be aware that the interview facilitator cannot ask people to identify their health conditions. If possible, provide the questions to attendees ahead of time.
Conducting the interviews	Explain to participants how their input will be used. Establish confidentiality of the participants' responses. Especially in small communities, participants may be worried about their names being attached to their comments. Provide an estimated timeline of when final results will be shared. Ask whether the individual would like to be involved in future stages of the CHA and set the process for continued engagement. Establish realistic expectations for what the hospital and partners can do to address community needs.

FOCUS GROUPS

Participants	Consider whom to sample: a cross-section of the whole community and/or more targeted groups? Contemplate recruiting from existing groups (e.g., PFACs, church groups). Find innovative ways to recruit for focus groups where people live, learn, work and play (e.g., advertisements on social media, in newspapers, on the radio, at churches, local businesses, etc.). Engage clinicians to identify patients for focus groups. Consider members of the community who may not be easily reached and brainstorm how they can be recruited. Encourage attendance through reminder notices. Limit focus groups to 10 or fewer participants to ensure that everyone's opinions can be heard.
Location	Make the location easily accessible for community members. Consider factors such as proximity to public transportation, time of day, availability of parking, child care, etc. Hold the focus groups in a neutral space (i.e., not the hospital). Consider holding virtual or phone focus groups to reduce barriers to participation. Focus groups should typically last no longer than 90 minutes.

Facilitator	Use a facilitator who is well trained in moderating focus groups, including keeping participants on topic, maintaining a neutral position, and making sure that everyone participates and is listened to. Ensure the facilitator is culturally competent and speaks the language(s) spoken by attendees. Consider using a facilitator from a neutral third party, so participants feel more comfortable.
Developing focus group questions	Develop a focus group question guide, so the same questions are asked across multiple focus groups. Ask short and open-ended questions to encourage dialogue on various topics. Review the list of questions ahead of time with community members to ensure that questions are culturally appropriate and at a level that participants would be able to understand. If possible, provide the questions to attendees ahead of time. Refrain from asking very sensitive questions that individuals would not want to share in a group.
Conducting the focus groups	Establish confidentiality of the participants' responses. Especially in small communities, participants can be concerned about their names being attached to their comments. Explain to participants how their input will be used. Give participants an estimated timeline of when results will be shared. Establish realistic expectations for what the hospital and partners can do to address community needs. Ask whether the individual would like to be involved in future stages of the CHA and set the process for continued engagement.

TOWN HALL MEETINGS

Participants	Advertise the meetings where people live, work, learn and play using social media, newspapers, radio, announcements and flyers, local organizations, support groups, PFACs, etc. If possible, offer child care for participants. Explain why the CHA is relevant for the whole community.
Location	Make the location easily accessible for community members. Consider factors such as proximity to public transportation, time of day, availability of parking, child care, etc. Hold the meetings in a neutral space (i.e., not the hospital). Consider coordinating the meeting with existing community or town meetings.
Finding a facilitator	Ensure that the facilitator is culturally competent, speaks the languages spoken by community members and is sensitive to attendees' needs. The facilitator should be well trained in moderating community meetings, including keeping participants on topic, ensuring that louder voices do not drown out others, and maintaining a neutral position.
Developing an agenda and questions	Develop a draft agenda and questions and, if possible, distribute them to attendees ahead of time. Ask participants open-ended questions to encourage dialogue about various topics. Review the list of questions ahead of time with community members to ensure that questions are culturally appropriate and at a level that participants would be able to understand.

Meeting logistics	Tell all participants how their feedback will be used and when results will be shared. Consider using voting devices (clickers, cell phone apps, etc.) to gain input from more community members, especially those who may not feel comfortable speaking up in a public setting. Establish realistic expectations for what the hospital and partners can do to address community needs. Provide the option for participants to be contacted for further involvement in the CHA process; this is an easy way to identify individuals who desire increased engagement.

Source: Health Research & Educational Trust. (2016, July). Applying research principles to the community health needs assessment process. Chicago, IL: Health Research & Educational Trust. Accessed at https://www.aha.org/ahahret-guides/2016-07-15-applying-research-principles-community-health-needs-assessment-process (https://www.aha.org/ahahret-guides/2016-07-15-applying-research-principles-community-health-needs-assessment-process)

1. Hartwig, K., Calleson, D., and Williams, M. (2006). Unit 1, section 1.1: Definitions, rationale and key principles in CBPR. In *Developing and sustaining community-based participatory research partnerships: A skill-building curriculum*. Retrieved from https://depts.washington.edu/ccph/cbpr/u1/u11.php (https://depts.washington.edu/ccph/cbpr/u1/u11.php)

Key Resources

> **Community Health Assessment Toolkit**
> **Case Study: Yale University**

Community Health Assessment Toolkit Home (/resources/community-health-assessment-toolkit)

Community Engagement (/resources/toolkit/files/community-engagement)

Step 1: Reflect and Strategize (/resources/toolkit/files/step1-reflect-strategize)

Step 2: Identify and Engage Stakeholders (/resources/toolkit/files/step2-identify-engage-stakeholders)

Step 3: Define the Community (/resources/toolkit/files/step3-define-community)

Step 4: Collect and Analyze Data (/resources/toolkit/files/step4-collect-analyze)

Step 5: Prioritize Community Health Issues (/resources/toolkit/files/step5-select-priority)

Step 6: Document and Communicate Results (/resources/toolkit/files/step6-document-community-results)

Step 7: Plan Implementation Strategies (/resources/toolkit/files/step7-plan-implementation)

Step 8: Implement Strategies (/resources/toolkit/files/step8-implement-strategies)

Step 9: Evaluate Progress (/resources/toolkit/files/step9-evaluate-progress)

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Community Health Assessment Toolkit

Step 5: Prioritize Community Health Issues

Purpose

Hospitals and community stakeholders go through a process to distinguish the most pressing community health needs based on the data collected. The identified priority health needs will be addressed through the implementation strategies.

Key Components

Identify criteria for prioritization
Hospitals are at their discretion to develop prioritization criteria and processes. A set of criteria should be determined to guide the prioritization process. Typically, three to six priorities are selected, based on:

- Magnitude of the problem

- Severity of the problem
- Need among vulnerable populations
- Community's capacity and willingness to act on the issue
- Ability to have a measurable impact on the issue
- Availability of hospital and community resources
- Existing interventions focused on the issue
- Whether the issue is a root cause of other problems
- Trending health concerns in the community

Additional prioritization criteria can include:

- The importance of each problem to community members
- Evidence that an intervention can change the problem
- Alignment with an organization's existing priorities
- Hospital's ability to contribute finances and resources to address the health concern
- Potential challenges or barriers to addressing the need
- The opportunity to intervene at the prevention level

Select community health priorities

Priorities can be selected as part of an established process informed by contributing partners, including community stakeholders, health departments, social service agencies, policy makers and hospital leadership. Action steps to be considered are:

- Select a prioritization committee – Members can be from hospitals, community stakeholder organizations and other organizations/institutions with specialized knowledge or constituents.
- Discuss the data – Present the qualitative and quantitative data to the prioritization committee. Make sure that the data are presented in a format that is accessible for the individuals on the committee. Foster an environment for open dialogue to discuss the identified health needs thoroughly.
- Review community assets – Reflect back on your asset map (/system/files/media/file/2019/09/asset-mapping-for-chna.pdf) to identify what resources exist in your community to address the need. Take stock of what resources (staffing, in-kind, financial, etc.) in your hospital could potentially be leveraged to address that need.
- Select priorities – Decide which approach you want to use to determine priority needs.

TECHNIQUES	DESCRIPTION
Multi-voting technique	Decide on priorities by agreeing or disagreeing in group discussions and continuing process/rounds until a final list is developed.
Strategy lists	Determine if the health needs are of "high or low importance" by placing an emphasis on problems whose solutions have maximum impact, with the possibility of limited resources.
Nominal group technique	Rate health problems from 1 to 10 through group discussion.
Hanlon method	List those health needs viewed as priorities based on baseline data, numeric values and feasibility factors.

Prioritization matrix	Weigh and rank multiple criteria for prioritization with numeric values to determine health needs with high importance.

- Build consensus around priority needs – If you select priorities that vary from community recommendations, justify the reasons for making those choices. Consider the consequences of not addressing an issue and how that can affect the community's well-being in the future. In the case of overlapping health needs, consider consolidating into a single priority.
- Validate selected priorities – Conduct discussion groups with members of your hospital's steering committee and community members for additional input. Make sure the selected priority needs align with hospital and community sentiment.
- Present priorities to senior leadership and the hospital's board of trustees for approval – Align your hospital's population health management strategy with the community health priorities.

Describe which needs were not prioritized

It may not be possible to address all community health needs at once. If there are significant needs that are not prioritized or will not be addressed, you should be able to describe what the needs are and why you have chosen not to address them.

Key Resources

Community Health Assessment Toolkit
Case Study: Childrens National

Community Health Assessment Toolkit Home (/resources/community-health-assessment-toolkit)

Community Engagement (/resources/toolkit/files/community-engagement)

Step 1: Reflect and Strategize (/resources/toolkit/files/step1-reflect-strategize)

Step 2: Identify and Engage Stakeholders (/resources/toolkit/files/step2-identify-engage-stakeholders)

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Step 5: Prioritize Community Health Issues (/resources/toolkit/files/step5-select-

priority)

Step 6: Document and Communicate Results (/resources/toolkit/files/step6-document-community-results)

Step 7: Plan Implementation Strategies (/resources/toolkit/files/step7-plan-implementation)

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Community Health Assessment Toolkit

Step 6: Document and Communicate Results

Purpose

Share the results of your assessment with both internal and external audiences. This step provides an opportunity for the many participating organizations and the community at large to see the final product. It serves as a reference point for future discussions and planning strategies to address community health needs.

Key Components

Publish the CHA process and results
Write and publish a public report documenting the process and findings of the community health assessment (CHA). The report should include:

> o Includes a description of the underserved, low-income and minority populations represented

o Includes names and qualifications of all persons/organizations involved in data collection and analysis
- A description of the service area and community served
- A description of the processes and methods
- Identification of all organizations or any other third parties that collaborated or assisted
- A description of how your hospital solicited and took into account input from the community
- The process for identifying and prioritizing needs, including prioritization criteria
- A prioritized list of health needs and a description of those priority health needs
- Potentially available resources and strategic measures to address priority needs
- An evaluation of impact for strategies implemented since the last assessment, if available

Present material in an accessible way

A written document representing your CHA process and results allows information to be shared with the community. Involving stakeholders during development allows them to provide valuable insights about how to present the information (e.g., length of document, language level, acronym use, font size, balance and use of pictures vs. words), what format to use (e.g., written, audio), if the document needs be translated into another language and which forms of communication would best reach the community.

Epidemiological data may be particularly challenging for community members to interpret. Presenting data in a clear yet comprehensive way can enable discussion and interest in community health improvement. Tips for organizing and presenting data include:

- Organize data, surveys, and findings based on topics/headings.
- Use graphs, maps, photos, tables and charts when necessary and applicable to the data.
- Select appropriate graphics or visualizations to display findings.
- Identify ways to present data that highlight health disparities.
- Use descriptive labels on all graphs and tables.
- Try to tell a story with the data.

Publicizing CHA results

Publicizing the results of the CHA raises awareness about the health issues affecting the community served and promotes engagement and conversation between your hospital, partners and potential collaborators. The CHA can be publicized through various channels to gain a larger audience, such as:

- Websites of your hospital, partnering organizations, businesses and other stakeholders
- Social media accounts of your hospital, partnering organizations, businesses and other stakeholders
- Press releases in print, online and broadcast media
- Distribution of copies of your CHA in print and online format in and out of the hospital
- Email blasts of your hospital, partnering organizations, businesses and other stakeholders
- Newsletters of your hospital, partnering organizations, businesses and other stakeholders
- School ListServs
- Issue briefs
- Links to key findings on websites of local health departments, hospitals and community organizations

The CHA document can also serve as a repository of community assets by including a list of resources related to the identified health needs. Consider linking to websites of community resources and to upcoming health education and promotion events.

Develop a tracking system to assess how many individuals accessed your CHA through all forms of distribution. This will help determine which method drives the most interest and whether there are populations who are not receiving the information.

Engage the hospital and community around CHA results

Present the report to both internal and external audiences, such as staff members, patients, key stakeholders, collaborating partners and community organizations and residents to stimulate dialogue and comments on the assessment process and outcome. This can be done by:

- Conducting meetings with community members to gather their input on the CHA results
- Providing oral presentations about the CHA report in public meetings to promote more interaction and engagement
- Discussing the CHA findings with hospital staff members to raise awareness about health needs and other health issues in the community and workforce
- Providing takeaways on the identified health issues for hospital staff to implement in their personal and professional lives

A robust community discussion of the CHA results can open the opportunity for fostering partnerships around implementation strategies and future assessments.

Key Resources

Community Engagement Case Study: Childrens Mercy Kansas City PDF

Community Health Assessment Toolkit Home (/resources/community-health-assessment-toolkit)

Community Engagement (/resources/toolkit/files/community-engagement)

Step 1: Reflect and Strategize (/resources/toolkit/files/step1-reflect-strategize)

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Community Health Assessment Toolkit

Step 7: Plan Implementation Strategies

Purpose

Developing comprehensive, multifaceted strategies to address the community health needs prioritized in your assessment is crucial to improving community health. Regardless of whether you have been doing community health improvement work for many years or are new to this process, you can build or supplement services or programs to address the needs identified in your community health assessment (CHA).

Key Components

Engage strategic partnerships both within the hospital and with external stakeholders
Actively encourage involvement in the implementation strategies planning process to ensure widespread buy-in and to increase the odds of making an impact on community health.

Internal partnerships: Individuals and departments across the hospital may be able to assist with development and implementation of community health improvement strategies by helping to scale the strategies across the hospital or engaging clinicians who focus on the needs identified in your CHA. The support of hospital leadership can be crucial for securing funding and resources to implement desired strategies. Engage with C-suite executives and hospital trustees to share the CHA findings and discuss intervention approaches.

External partnerships: Develop a plan with community stakeholders to garner support for implementation efforts. You may want to form an implementation committee including individuals who participated in previous stages as well as new stakeholders who can offer fresh insight and resources. It is particularly important to involve members of the population who will be affected by the implementation strategies to ensure plans are culturally appropriate. Many hospitals are also engaging their local and state health departments in developing their CHAs. Reinforcing and strengthening these relationships can be important as hospitals move from the assessment phase to developing and implementing strategies to address identified community health priorities.

Align strategies with the hospital and other community stakeholder organizations

Part of engaging hospital leadership can include a discussion of how strategies around the identified priorities can be aligned with the hospital's population health management strategy to increase the odds of sustainability and commitment to success. Additionally, as you have conversations with other hospital departments and organizations, you may find there is already an alignment of interests and goals. Leverage this alignment so that there are multiple components addressing the health need.

Collaborative strategies increase potential for impact

The Collective Impact Framework posits that no single entity or sector alone can tackle our society's most complex problems[1]. The health needs identified in your CHA are likely the result of complex social, economic and environmental factors, making Collective Impact an appropriate model to apply to your implementation strategies. Widespread collaboration among community stakeholders around shared health challenges can catalyze positive change in the community. The Collective Impact Framework has five key elements:

- Participants have a common agenda with a joint approach for solving an agreed-upon problem.
- Data and results are measured consistently across participants.
- Action plans have mutually reinforcing activities.
- Open communication is necessary to build trust and ensure mutual objectives.
- A backbone organization coordinates the collaborative effort.

Consider adopting some or all of these elements as you shape your approach for addressing community health needs.

Determine your community assets

Assets in your community can be leveraged for your collective health improvement efforts. There is no need to duplicate services or programs that already exist. Reflect on your asset map (/resources/toolkit/files/step2-identify-engage-stakeholders#assetmap) to identify potential assets and partners within your organization and your community at large. Ensure that the partnership would be mutually beneficial for all stakeholders. It can also be helpful to develop a visual representation of where services are physically located in relation to each other, utilizing a tool such as the Public Health Foundation's Community Stakeholder Services Map.
(http://www.phf.org/resourcestools/Pages/Community_Stakeholder_Services_Map.aspx)

Identify the drivers of community health improvement

Developing a Population Health Driver Diagram
(http://www.phf.org/resourcestools/Pages/Developing_a_Population_Health_Driver_Diagram.aspx) tailored to each priority health area in your CHA can be useful for identifying primary and secondary drivers as well as specific interventions to which different community stakeholders can contribute that will achieve improvement in the priority area. A program logic model helps guide the theory and assumptions underlying the implementation strategies. It is a systemic way to visualize the relationships among the resources, activities, inputs and projected changes that you hope to achieve. The Population Health Driver Diagram framework can be thought of as an actionable logic model. This framework details the aim you are striving for, along with specific goals, primary drivers and secondary drivers. In addition, the driver diagram can help multiple stakeholders identify contributions they can make towards improving the priority health area and begin aligning their efforts with other stakeholders

Select strategies to address priority needs

Develop a strategy for each need prioritized in your CHA. Hospitals can select strategies that impact the clinical needs of their population (e.g., improved access to care, chronic disease management) and/or social determinants of the priority need (e.g., poverty, education, community safety). Both types of strategies are appropriate for a CHA. Below are some considerations as you develop the approach for your implementation strategies.

Type of strategy: There are multiple approaches you can take to address the identified need, but the overarching dichotomy is between a *practice* (a way of doing things) and an *intervention* (a program or initiative). Both are valuable and have the potential to make a significant impact on community health; however, instituting a practice may have longer-term sustainability as it becomes part of the daily workflow.

Level of intervention: Think critically about the level at which you are intervening and how your efforts can make the most impact. Will your strategy be clinically based, or will it take place in the community? Will you address the specific needs of individuals or the community as a whole? The following models may help you conceptualize how you want to target your strategies.
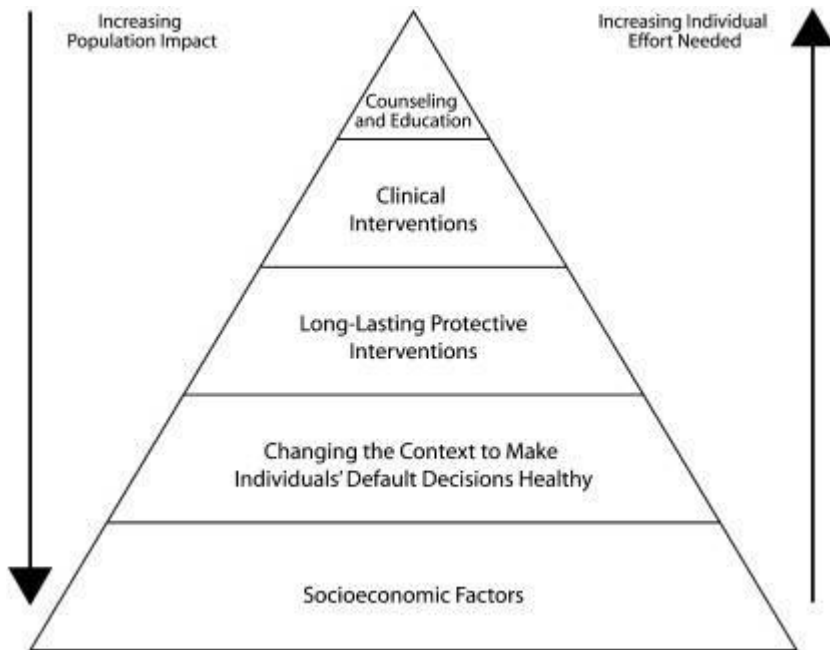
Which level of prevention will your strategy address?

- Primary: Targeting an entire population to prevent a problem by thinking upstream about the social determinants of health and fostering circumstances and environments that promote health and well-being for all.
- Secondary: Targeting at-risk populations to prevent escalation of a problem by identifying these populations and trying to address risk factors.
- Tertiary: Treating individuals diagnosed with the problem through intensive, individualized treatment or interventions.

What level of intervention are you targeting?

To make an impact at the population level, be sure that the strategy gets at the root of the identified need. Frieden's health impact pyramid (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/) (2010)[2] suggests that interventions to address socioeconomic factors and changing the context of individuals' decision-making may have a greater impact on population health than more traditional, clinically focused or educational actions.

Health Impact Pyramid

Increasing
Population Impact

Increasing Individual
Effort Needed

Counseling
and Education

Clinical
Interventions

Long-Lasting Protective
Interventions

Changing the Context to Make
Individuals' Default Decisions Healthy

Socioeconomic Factors

Source: Frieden, T. R. (2010). A framework for public health action: the health impact pyramid. American Journal of Public Health, 100(4), 590-595.

What type of intervention are you proposing?

CDC's 6|18 Initiative (http://www.cdc.gov/sixeighteen/) conceptualizes types of prevention into three buckets (https://nam.edu/wp-content/uploads/2016/05/CDCs-618-Initiative-Accelerating-Evidence-into-Action.pdf)[3]:

- Traditional clinical prevention: This type of prevention occurs in a clinical setting as part of a one-on-one patient-clinician encounter. Prevention activities in this bucket include vaccinations and screenings.
- Innovative clinical preventive interventions: Interventions in this bucket extend care from the clinical setting to the community, but these services are not historically paid for by insurance. Prevention approaches in this bucket include using community health workers to support chronic disease management.
- Total population or community-wide interventions: Activities in this bucket target entire populations in a given geographic area and are based outside of clinical offices in communities, schools or workplaces. Interventions are accomplished though policy or environmental changes.

How many facets of the health need does your strategy address?

To move the needle on community health, it is helpful to develop a comprehensive strategy that addresses multiple facets of each health need. This requires thinking of the big picture of health and the hospital and health care system's role in improving it. A comprehensive approach includes:

- Multiple strategies (e.g., educational, environmental, policy, programmatic)
- Various settings (e.g., schools, communities, workplaces)
- Multiple targets, including individuals, the community at large and at-risk subgroups
- Methods to address the medical and non-medical factors that contribute to the health issue

Identify interventions with evidence of success

A wealth of evidence exists regarding the efficacy of various approaches and interventions to guide your implementation strategies. Strategies need to be tailored to meet the unique characteristics of each community. By identifying the key elements of a program or intervention, you can adapt the rest of the program to meet your needs and goals. Strategic questions to consider include:

- What has been successful in the past?
- What does the research suggest is most effective?
- What is feasible to be implemented in our situation and circumstances?
- What research is appropriate to replicate?

Some organizations have synthesized studies on various community health needs to provide you with the most promising, evidence-based practices. Those are available at:

- The Guide to Community Preventive Services (The Community Guide) (http://www.thecommunityguide.org/) : Resource to help identify programs and policies proven to improve health and prevent disease.
- CDC Community Health Improvement Navigator (http://www.cdc.gov/chinav/): An interactive database of interventions to address socioeconomic factors, the physical environment, health behaviors and clinical care.
- CDC's 6|18 Initiative: Accelerating Evidence into Action (http://www.cdc.gov/sixeighteen/): Targeting six common health issues with 18 proven interventions.
- CDC's Health Impact in 5 Years (HI-5 (http://www.cdc.gov/policy/hst/hi5/)): Strategies for achieving health impact in five years.
- County Health Rankings and Roadmaps: What Works for Health (https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health) provides evidence of effectiveness strategies to address priority community health needs based on existing research.

Some interventions may be promising but do not yet have a body of data to qualify them as "evidence-based." This does not mean that such interventions may not be beneficial. By implementing similar interventions in your community and measuring their success, you could contribute to building that evidence base.

Assess the impact the strategies would have on health in your community
Health Impact Assessment (HIA) (https://www.cdc.gov/healthyplaces/hia.htm) is "a systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population. HIA provides recommendations on monitoring and managing those effects."[4] This is a tool to use when evaluating prospective strategies. The major steps in an HIA include:

1. Screening (identifying plans, projects or policies for which an HIA would be useful)
2. Scoping (identifying which health effects to consider)
3. Assessing risks and benefits (identifying which people may be affected and how they may be affected)
4. Developing recommendations (suggesting changes to proposals to promote positive health effects or to minimize adverse health effects)
5. Reporting (presenting the results to decision makers)
6. Monitoring and evaluating (determining the effect of the HIA on the decision)

Set goals and objectives for the implementation strategies
Set goals for each of the strategies you decide to adopt. What do you want to change? Are you seeking a quantitative change in disease morbidity or a qualitative change in social norms or attitudes? Defining your specific goals and objectives will help focus the strategies. Make sure to set "SMART" objectives[5]:

Specific

Measurable

Achievable

Realistic

Time-bound

Strive for quantifiable measures, but do not neglect critical issues whose importance may justify the development of non-standardized measures and/or new data sources. Do not shy away from challenges or setting audacious goals—this is your opportunity to tackle the most pressing health issues facing your community. If possible, work with community stakeholders to develop community-wide metrics to measure the collective impact of the strategies. Hospitals should also have separate metrics to measure the impact of their specific strategies.

Tailor strategies to community culture

Strategies should be unique to your community based on its needs, the demographics of individuals in the community, the capacity of the hospital and the community partners you decide to work with. Be aware of how the culture and environment of your community fits with an intervention. This is an area where engaging external stakeholders can be extremely valuable, as they can provide guidance regarding which strategies would be socially and culturally acceptable.

Consider evaluation from the start

Evaluation should be built into the planning process of your implementation strategies, including how evaluation activities will be funded. You will need to be able to describe the anticipated impact of the implementation strategies and report on the evaluation of the impact. If your CHA does not contain the baseline data needed, collect baseline measures now so that you will be able to tell the extent that your strategy is working and make sure you are measuring the right things in the right way.

Evaluation can look at short- and long-term outcomes as well as process metrics. The short-term measures are most likely to be process measures (how many people used a service or attended a program), while long-term outcomes will monitor changes in health status—a process that takes more time. Intermediate goals and benchmark metrics in the evaluation process will help you know if you are going in the right direction and will be important when discussing progress with executives, leadership and other internal teams, as well as external stakeholders. More information about evaluation can be found in Step 9 (/resources/toolkit/files/step9-evaluate-progress).

Identify funding sources and opportunities

New interventions or strategies require resources—both human and financial—to succeed. As you plan your strategies, consider what funding you have available and how it may need to be increased through grant funding. Reflect on these questions:

- How can this intervention be sustainably funded? What funding within the hospital or health system might be available? What grant opportunities are available?
- Does the hospital have a foundation that would be interested in supporting this?
- What community foundations may want to invest? Are there community development financial institutions that you could partner with?
- How much of your community benefit spending can go toward the strategy?
- Are there any collaborative grant opportunities?
- What in-kind resources from the hospital or community can be tapped?

Because these strategies will take time to make a population level impact, secure funding sources that will allow the strategy to be sustainable.

Document the implementation strategies

Document your implementation strategies, including:

- Strategies for each need for each hospital
- Actions to address prioritized health needs
- Anticipated impacts of the strategies
- A plan to evaluate the impact of the strategies

1. Hanleybrown, F., Kania, J., and Kramer, M. (2012). Channeling change: Making collective impact work. Retrieved from http://jcisd.org/cms/lib/MI01928326/Centricity/Domain/218/Making%20Collective%20Impact%20Work%20Stanford%202012.pdf (http://jcisd.org/cms/lib/MI01928326/Centricity/Domain/218/Making%20Collective%20Impact%20Work%20Stanford%202012.pdf)

2. Frieden, T. R. (2010). A framework for public health action: the health impact pyramid. *American Journal of Public Health*, *100*(4), 590-595. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/ (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/)

3. Hester, J., Auerbach, J., Seeff, L., Wheaton, J., Brusuelas, K., and Singleton, C. (2016). *CDC's 6|18 Initiative: Accelerating evidence into action*. Retrieved from https://nam.edu/wp-content/uploads/2016/05/CDCs-618-Initiative-Accelerating-Evidence-into-Action.pdf (https://nam.edu/wp-content/uploads/2016/05/CDCs-618-Initiative-Accelerating-Evidence-into-Action.pdf)

4. National Research Council (U.S.). Committee on Health Impact Assessment. (2011). *Improving health in the United States: The role of health impact assessment*. Washington, DC: The National Academies Press, p. 5. Retrieved from http://www.nap.edu/read/13229/chapter/1 (http://www.nap.edu/read/13229/chapter/1)

5. Centers for Disease Control and Prevention. (2011). Develop SMART Objectives. Retrieved from http://www.cdc.gov/phcommunities/resourcekit/evaluate/smart_objectives.html (http://www.cdc.gov/phcommunities/resourcekit/evaluate/smart_objectives.html)

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Step 8: Implement Strategies

Purpose

This step puts into action the plan selected and developed in Step 7 (/resources/toolkit/files/step7-plan-implementation) to address prioritized community health needs. This is an ongoing process where you are working to improve health by turning strategies into concrete, actionable steps. If you have developed Population Health Driver Diagrams to address priority health areas identified in your community health assessment (CHA) (Step 7), these driver diagrams can continue to be used and updated as you implement strategies with multiple stakeholders. Teams can be formed around each of the primary drivers, and these teams can determine specific secondary drivers to address.

Key Components

Continue engaging stakeholders

Engage internal and external stakeholders throughout implementation to support ongoing community buy-in. Refer to the Community Engagement (/resources/toolkit/files/community-engagement)section for additional information about how to engage stakeholders in this process.

Assemble an implementation committee and team for each strategy

Over the course of your CHA, it is likely that many committees and work groups will have convened to address components of the process. These groups may develop into more official bodies or formal partnerships to implement strategies for addressing the priority needs or conduct the next CHA.

The implementation team can meet periodically to assess progress and challenges and make any modifications to the action plan. The team should include individuals from the hospital as well as community stakeholders and organizations. As you consider who should be part of the implementation team, reflect on these questions:

- Are there existing committees established earlier in the CHA process that can provide oversight? A separate or augmented group may need to be assembled to monitor implementation.
- Is the committee representative of the community served?
- Are there community efforts already under way?
- Who will be doing the work? Are all partners clear on their roles in the strategy?
- What skill sets are needed to make the strategy a success?
- Are there gaps in staffing and skills that need to be filled? Can those gaps be filled by people in your organization and/or community partners? Will you need to hire any new staff?

Develop an action plan

Develop an action plan for each strategy that addresses a priority need with a detailed description of specific activities, roles and timelines. The following questions should be addressed:

- What specific, concrete actions need to be taken to achieve the stated objectives?
- What specific changes need to occur?
- What organizations or individuals will take the lead on each action step, and who will be responsible for ensuring completion? Who else will participate, and what roles will they play?
- What is a realistic time frame for the implementation of each step?
- When will the implementation strategies be completed? How will they be maintained?
- What metrics—outcomes and process—will you be measuring? How often? Set benchmarks to measure progress along the way. Make sure this matches your evaluation approach and that metrics measure the outcomes you want to see.
- Is the plan flexible enough to adapt to changing circumstances or challenges?

The following are action plan templates that can be adapted for each priority need. Download the action plan templates here. (/sites/default/files/achi/SampleCHNAImplementationPlanningTemplate.xlsx)

Action Plan: Goals and Objectives

Priority Area:						
Implementation Plan		**From CHA Research**			**From Asset Mapping**	
Goal	S.M.A.R.T. Objective	Identified Community Need	Population at Risk	Disparity & Root Causes	Existing Community Asset	Potential Partner

Action Plan: Anticipated Impact

Priority Area:						
Goal:						
Objectives:	Strategy (Programs, Services, Partnerships)	Target Population	Tactic (Specific Action Step)	Anticipated Impact	Outcome Measure
Objective 1					
Objective 2					

Action Plan: Responsibilities and Timelines

Priority Area:					
Goal:					
Objective:	**Tactic (Specific Action Step)**	**Partner**	**Resources Needed**	**Responsible Individual(s)**	**Timeline**
Strategy 1					
Strategy 2					

Develop a budget

Go through a budgeting process to estimate how much the strategies will cost to implement. Remember to include resources for both the programs and the staff who implement them. Once a budget is in place, you will need to determine where the funding will come from. Your hospital may be willing to financially back the entire strategy, or you may piece together resources from your organization, grants, in-kind support and community partners. Consider the long-term sustainability of the project when you are budgeting; improving community health takes time, and any initiative will likely require multiple budget cycles.

Step 7: Plan Implementation Strategies (/resources/toolkit/files/step7-plan-implementation)

Step 8: Implement Strategies (/resources/toolkit/files/step8-implement-strategies)

Step 9: Evaluate Progress (/resources/toolkit/files/step9-evaluate-progress)

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Step 9: Evaluate Progress

Purpose

Evaluation should be planned throughout the community health assessment (CHA) process to assess the impact of your strategies and progress toward your goals. This step suggests a modified version of CDC's evaluation guidelines (http://www.cdc.gov/eval/framework/), and may be used as a starting point to tailor an evaluation for a particular community health improvement effort, at a particular point in time.

Key Components

Find your baseline
Determine your baseline to understand the impact of your strategies. This can include measuring a number of things such as knowledge and attitudes; community norms; biometric measures such as BMI or HbA1c levels; health

behaviors like tobacco use, physical activity and eating healthy foods; or health-promoting policy and system changes. The evaluation should focus on the CHA priority areas being addressed and their associated goals, objectives and strategies. Refer to your driver diagram (see below) to review how you are addressing the primary and secondary drivers that can positively impact the health priority being addressed.

Engage stakeholders

Include stakeholders from your hospital and community, including those involved in program operations, those involved in previous CHA steps, those served or affected by the program and primary users of the evaluation. View the Community Engagement (/resources/toolkit/files/community-engagement)section to see different ways that stakeholders can be involved in the process.

Focus the evaluation design

The evaluation should be designed to assess the issues identified as priorities in your CHA. If you developed Population Health Driver Diagrams for the priorities identified in your CHA (/resources/toolkit/files/step5-select-priority), (/Education/toolkit/files/step7-plan-implementation.shtml)once interventions associated with secondary drivers have been selected for action, your implementation team(s) can establish metrics (i.e., measures and targets) for each of the interventions. These metrics can be used for determining progress and evaluating the impact of your strategies. Consider the purpose, users, uses, questions and methods. Key questions include:

- What will be evaluated?
- What framework will be used?
- What criteria/metrics will be used? How will you ensure that those are the metrics that matter?
- What metrics will indicate success?
- What process metrics or indicators will suggest progress toward the goal?
- What conclusions will you be able to make based on the criteria/metrics being measured?

Gather credible evidence

Accurate, high-quality data are required to strengthen your evaluation's credibility and any recommendations that follow. These aspects of evidence gathering typically affect perceptions of credibility: indicators, sources, quality, quantity and logistics. Evidence should be gathered to support:

- **Process indicators:** Metrics to provide evidence that the action steps are being implemented according to plan.
- **Short-term impacts:** Intermediate outcomes of the action plan indicating progress toward the ultimate outcome objectives.
- **Outcomes:** Long-term goals such as change in health status that you are hoping to achieve from your strategies.

Data sources for evaluation may include:

- Epidemiological community health status data
- EHR data
- Community surveys
- Program attendance
- Policies enacted
- Partnership quality assessments

Measure progress on each priority early and often

Measuring the extent to which metrics were achieved and progress toward goals was made should be done regularly. A practical, ongoing evaluation process will allow you to correct your course if the implementation is not eliciting the intended outcomes. Embedding a Plan-Do-Study-Act (http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx) approach will allow your team to regularly check how the intervention is going and how it could be modified to be more effective.

Justify conclusions

Link your conclusions to the evidence gathered and judge them against agreed-upon values or standards set when you planned your implementation strategies. How do your results fit with the metrics established to accompany your Population Health Driver Diagram? Justify conclusions using standards analysis/synthesis, interpretation, judgment and recommendations.

Use the results to improve or modify programs

The evaluation should point to what elements of your program are working and what could be altered. Use this feedback to expand or change the program arc at any point; you do not have to wait until the next CHA cycle to make improvements on the implementation strategies.

Communicate results

Share the results and lessons learned with stakeholders in the hospital and community. Prepare it in a format that stakeholders and community members will be able to easily access and understand. You may also use the evaluation of your strategy to contribute to the evidence base related to the impact of interventions to address a community health issue. Be prepared to state the impact of your implementation strategies as part of your next CHA.

Key Resources

Sample CHNA Implementation Planning Template

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Community Engagement (/resources/toolkit/files/community-engagement)

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Step 3: Define the Community (/resources/toolkit/files/step3-define-community)

Step 4: Collect and Analyze Data (/resources/toolkit/files/step4-collect-analyze)

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Step 1. Reflect and Strategize

COMPONENT	RESOURCE/TOOL	DESCRIPTION
Framework	Agency for Healthcare Research and Quality: Prevention Quality Indicators (http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx)	Resources to help identify potential health care quality problems in the community
	Catholic Health Association: Assessing and Addressing Community Health Needs (https://www.chausa.org/communitybenefit/assessing-and-addressing-community-health-needs)	Overview of required and recommended steps for assessing community health needs and developing implementation strategies
	Community Commons: Community Health Needs Assessment Tool (http://www.communitycommons.org/chna/)	Platform to help hospitals identify health needs and conduct measurable improvements
	Community Preventive Services Task Force: The Guide to Community Preventive Services (http://www.thecommunityguide.org/toolbox/index.html)	Collection of tools such as case studies, fact sheets, evaluations and templates to help collect data and implement prevention strategies

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Step 2. Identify and Engage Stakeholders

COMPONENT	RESOURCE/TOOL	DESCRIPTION

Asset Mapping	Health Research & Educational Trust: Asset Mapping Template (/system/files/media/file/2019/09/asset-mapping-for-chna.pdf)	Asset mapping template to help answer key questions about the community and hospital
	Healthy! Capital Counties: Asset Mapping (https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CD0QFjAA&url=http%3A//www.naccho.org/topics/infrastructure/CHAIP/upload/Asset-Mapping.docx&ei=2R9OUKTiEe630QHc5YHIBA&usg=AFQjCNGDBoW9EIeLJp5DLFBPRG6IvyyYSg)	Worksheet used to identify community assets
	Northwestern University: Asset-Based Community Development Institute Toolkit (http://www.abcdinstitute.org/toolkit/index.html)	List of resources collected from a variety of individuals and organizations, in three categories: talking points, asset mapping and facilitating

Step 3. Define the Community

COMPONENT	RESOURCE/TOOL	DESCRIPTION
Framework	Public Health Institute: Supporting Alignment and Accountability (http://nnphi.org/wp-content/uploads/2015/08/SupportingAlignmentAndAccountabilityInCommunityHealthImprovement.pdf) (http://nnphi.org/wp-content/uploads/2015/08/SupportingAlignmentAndAccountabilityInCommunityHealthImprovement.pdf)in Community Health Improvement (http://nnphi.org/wp-content/uploads/2015/08/SupportingAlignmentAndAccountabilityInCommunityHealthImprovement.pdf)	Report that examines the community health assessments and implementation strategies of tax-exempt hospitals with a focus on how community is defined

Step 4. Collect and Analyze Data

COMPONENT	RESOURCE/TOOL	DESCRIPTION
Framework	The Examining Community-Institutional Partnerships for Prevention Research Group: Developing and Sustaining Community-Based Participatory Research Partnerships: A Skill-Building Curriculum (https://depts.washington.edu/ccph/cbpr/index.php)	Framework and resources for community-based participatory research
	University of Wisconsin/Robert Wood Johnson Foundation: County Health Rankings & Roadmaps Approach (http://www.countyhealthrankings.org/our-approach)	Description of health-related factors in a community that can be identified and improved to establish the highest potential of health and well-being
	University of Wisconsin/Robert Wood Johnson Foundation: County Health Rankings & Roadmaps (http://www.countyhealthrankings.org/)	Framework for collecting information based on health indicators reflecting the health of a community
Data Collection Tools	Community Tool Box: Conducting Needs Assessment Surveys (http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/conducting-needs-assessment-surveys/main)	Detailed processes of survey development and execution, and type of data to collect

Data Sets	Community Commons: Vulnerable Population Footprint (https://www.communitycommons.org/2014/11/what-does- the-vulnerable-population-footprint-mean/)	National health data set
	Centers for Disease Control and Prevention: Community Health Status Indicators (https://wwwn.cdc.gov/communityhealth)	National health data set
	Dignity Health: Community Need Index (http://cni.chw-interactive.org/)	National health data set
	United States Census Bureau: American FactFinder (https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml)	National health data set
	United States Department of Health & Human Services: HealthData (https://www.healthdata.gov/)	National health data set
	University of Wisconsin: Area Deprivation Index (https://www.hipxchange.org/ADI)	National health data set
Community Engagement	Health Research & Educational Trust/Association for Community Health Improvement: Applying Research Principles to the Community Health Needs Assessment Process (http://www.hpoe.org/Reports- HPOE/gate/2016/hpoe-applying-research-principles-to-the- CHNA-process.pdf)	Report identifying tools and research principles to support CHAs, including patient- and community-centered practices and evidence-based resources to integrate into data collection during the CHA process
	Health Research & Educational Trust/Association for Community Health Improvement: Engaging Patients and Communities in the Community Health Needs Assessment Process (http://www.hpoe.org/resources/hpoehretaha-guides/2846)	Report that highlights ways patients and communities can be involved in the development of their hospital's CHA

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Step 5. Prioritize Community Health Issues

COMPONENT	RESOURCE/TOOL	DESCRIPTION
Prioritization Tools	Community Commons: Kaiser Permanente Community Health Needs Assessment Platform (https://www.communitycommons.org/groups/community-health-needs- assessment-chna/chna-data-platform/)	Kaiser Permanente's platform for community health assessments
	National Association of County and City Health Officials: First Things First: Prioritizing Health Problems (http://archived.naccho.org/topics/infrastructure/accreditation/upload/Prioritization- Summaries-and-Examples.pdf)	Detailed descriptions of how to prioritize health needs based on prioritization methods

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Step 6. Document and Communicate Results

COMPONENT	RESOURCE/TOOL	DESCRIPTION

Data Presentation Tools	Data Therapy: How to Make a Data Mural (https://datatherapy.org/data-mural-gallery/how-to-make-a-data-mural/)	Framework for developing a data mural to show community impact
	Public Health Foundation: Planning Before You Communicate Tool (http://www.phf.org/resourcestools/Pages/Planning_Before_You_Communicate_Tool.aspx)	Tool to help with designing consistent and clear communications both internally and externally
	S.D.H. Evergreen Effective Data Visualization: The Right Chart for the Right Data (https://www.amazon.com/Effective-Data-Visualization-Right-Chart/dp/1506303056)	Book on the importance of captivating readers with interactive methods of displaying qualitative data
	S.D.H Evergreen: Presenting Data Effectively: Communicating Your Findings for Maximum Impact (https://www.amazon.com/Presenting-Data-Effectively-Communicating-Findings/dp/1452257361/ref=sr_1_2?s=books&ie=UTF8&qid=1465841634&sr=1-2)	Book that offers guiding principles on how to effectively present data

Step 7. Plan Implementation Strategies

COMPONENT	RESOURCE/TOOL	DESCRIPTION
Framework	Collaboration for Impact: The Collective Impact Framework (http://www.collaborationforimpact.com/collective-impact/)	Approach that highlights the importance of building a greater impact on the community's health through collaboration
	Public Health Foundation: Community Stakeholder Services Map (http://www.phf.org/resourcestools/Pages/Community_Stakeholder_Services_Map.aspx)	Tool that assists with identifying services affiliated with a community health issue
	Public Health Foundation: Population Health Driver Diagram Framework (http://www.phf.org/programs/driverdiagram/Pages/Using_Driver_Diagrams_to_Improve_Population_Health.aspx)	Tool that helps identify primary and secondary drivers of an identified community health objective and serves as a framework for encouraging health care and public health sectors to collaborate and align community health efforts or interventions
	T.R. Frieden: The Health Impact Pyramid (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/)	Framework that describes the impact of incorporating different public health interventions based on community needs
Tools and Evidence-Based Programs	Community Preventive Services Task Force: The Guide to Community Preventive Services (http://www.thecommunityguide.org/toolbox/index.html)	Collection of tools such as case studies, fact sheets, evaluations and templates to help collect data and implement prevention strategies
	Centers for Disease Control and Prevention: 6|18 Initiative (https://www.cdc.gov/sixeighteen/)	Initiative focusing on the implementation of 18 evidence-based interventions that target six high-burden conditions
	Centers for Disease Control and Prevention: Community Health Improvement Navigator (https://www.cdc.gov/chinav/)	An interactive database of interventions to address socioeconomic factors, the physical environment, health behaviors and clinical care
	Centers for Disease Control and Prevention: Health Impact in 5 Years (HI-5) (https://www.cdc.gov/policy/hst/hi5/)	Strategies for achieving health impact in five years.
	University of Wisconsin/Robert Wood Johnson Foundation: County Health Rankings & Roadmaps What Works for Health (http://www.countyhealthrankings.org/roadmaps/what-works-for-health)	Provides information to help select and implement evidence-informed policies, programs and system changes

Health Impact Assessments	Centers for Disease Control and Prevention: Health Impact Assessment (http://www.cdc.gov/healthyplaces/hia.htm)	Overview of health impact assessments, including links to resources
	Human Impact Partners: New to Health Impact Assessments? (http://www.humanimpact.org/new-to-hia/)	Resources and tools to develop health impact assessments
	Human Impact Partners/Group Health Research Institute: Community Participation in Health Impact Assessments (https://www.grouphealthresearch.org/files/9614/5383/5392/CommunityParticipationInHIA_EvaluationSummary.pdf)	Information related to community participation in health impact assessments
	National Research Council: Improving Health in the United States: The Role of Health Impact Assessment (http://www.nap.edu/catalog/13229/improving-health-in-the-united-states-the-role-of-health)	Publication that provides guidance on conducting health impact assessments
	Society of Practitioners of Health Impact Assessment: Health Impact Assessment Guidance and Tools (https://sophia.wildapricot.org/HIA-Guidance-and-Tools)	Resources and tools to develop health impact assessments

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Step 8. Implement Strategies

COMPONENT	RESOURCE/TOOL
Action Plan	South Dakota Department of Health: Writing a Community Health Action Plan (http://goodandhealthysd.org/communitytoolkit/communitytoolkit/communitytoolkit/communitytoolkit/communitytoolkit/#Step_7__Create_a_Community_Health_Improvement_Action_

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Step 9. Evaluate Progress

COMPONENT	RESOURCE/TOOL	DESCRIPTION
Evaluation Tools	Catholic Health Association: Evaluating Your Community Benefit Impact (https://www.chausa.org/communitybenefit/evaluating-community-benefit-programs)	Resource to help community benefit leaders evaluate the quality and importance of their community benefit programs and report and use findings
	Centers for Disease Control and Prevention: Framework for Program Evaluation (http://www.cdc.gov/eval/framework/)	Tool that summarizes and organizes steps and standards for effective program evaluation
	Institute for Healthcare Improvement: Plan-Do-Study-Act (http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx)	Framework to guide improvement work

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