

**Community Health Assessment
Guidance and Format
2010 – 2013**

Introduction and Background

Community health assessment is a core function of public health agencies and a fundamental tool of public health practice. Its aim is to describe the health of the community by presenting information on health status including epidemiologic and other studies of current local health problems, community health needs, health care and community resources. It seeks to identify target populations that may be at increased risk of poor health outcomes and to gain a better understanding of their needs, as well as assess the larger community environment and how it can help play a role in addressing the health needs of individuals in the community. The community health assessment process also identifies those areas where better information is needed, especially information on health disparities among different subpopulations, quality of health care, and the occurrence and severity of disabilities in the population. Community health assessment is a continuous, interactive local process. The goal of producing a CHA and submitting it at one point in time is not the production of a static document. The process involves continuously scanning the local health environment for changes in conditions and emerging health issues.

The Community Health Assessment (CHA) should be the basis for all local public health planning, including that required by the Municipal Public Health Services Plan (MPHSP). PHL §602 describes community health assessment as one of the five basic service areas described by the MPHSP and conducted by each local health department (LHD). The CHA document should be programmatically linked with its corresponding MPHSP and submitted as part of the MPHSP for the same time period. Each program in the MPHSP must be supported by data, analysis, and statement of need in the CHA. This is especially important when a LHD is conducting a public health program that is not defined by Part 40 of Title 10 of the New York State Codes Rules and regulations.

An important aspect of the CHA is the interpretation and communication of community data by the LHD. LHDs are encouraged to use the data made available by the State Health Department via the public website or other sources, as well as to generate local data when appropriate and important to understanding local issues. The CHA requires that the LHD analyze and explain the meaning of the data and use this information in a meaningful way to plan for future public health services, which are described in the MPHSP.

PREVENTION AGENDA TOWARD THE HEALTHIEST STATE

A CHA gives LHDs the opportunity to identify and interact with other health care providers, key community leaders, organizations and interested residents about health priorities and concerns. This community/public health planning process can form the basis of improving the health status of the community. The Prevention Agenda toward the Healthiest State (“Prevention Agenda”), launched in April of 2008, is a public health initiative to focus the state and its communities on public health and primary and

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secondary prevention. It supports the goals of collaborative community health planning by establishing statewide public health priorities and asking LHDs and their health care and community partners to work together to achieve them. See reference 1.

LHDs have always been seen in the critical role as convener of community partners in collaborations aimed at improving the health of their community. The Prevention Agenda reinforces the LHD role and gives hospitals an equally important role as co-convener. LHDs and hospitals are required by PHL to assess the health of the community through the CHA and Community Service Plan (CSP), respectively. The Prevention Agenda solidifies this partnership by asking LHDs and hospitals to work with community partners to identify 2-3 priority areas on which they will focus their improvement efforts. These community collaborations should include health care providers and insurers; community-based organizations; businesses, labor and work sites; schools, colleges and universities; government; industry; and the media. In some parts of the state, a regional approach may be desirable. In this case, the LHD should reach out to other health departments and regional resources.

In addition to documenting the health of the community, the CHA can have several other purposes for local health departments and the NYS DOH:

- Planning for and evaluation of programs;
- Cataloging multiple health-related activities taking place within the community,
- Justifying budget appropriations and program development;
- Providing the public with information about community health needs;
- Determining staffing needs;
- Reporting on important health outcome measures;
- Providing technical assistance to other agencies;
- Providing needs assessment for categorical grants;
- Enabling LHDs to identify activities to be undertaken by community partners or in partnership with other agencies to demonstrate improvement in the health of the community; and
- Documenting fulfillment of legal and regulatory requirements.

Key Feature of the 2010-2013 Community Health Assessment

The term of the written CHA document is four years, which coincides with the four year term of the Municipal Public Health Services Plan.

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CHA Format Guidelines

1. An e-mail request for submission of the CHA will be issued by the Article 6 program of the Office of Public Health Practice of the SDOH. This request will contain instructions for electronic and hard copy submission of the document.
2. Materials needed to complete the CHA (Guidance and Format document, templates, request for submission, etc.) and data will be posted on the SDOH website on the Prevention Agenda Page.
3. Submitters are encouraged to use the headings, as written and in the order they are presented below in the body of the document and in the table of contents for the document. However, CHAs containing the required information but following a different order and format are also acceptable. Each submission should include a Checklist/Index, so that reviewers can locate the information contained in the CHA.
4. CHAs that reflect collaboration between two or more counties (e.g., regional CHAs) are acceptable. The submissions should be clearly written so that the data and needs of each individual LHD/county can be clearly discerned by the reader/reviewer.
5. Within each section, relevant data should be integrated within or referenced in the text. Detailed data may be placed in an appendix at the end of each program-specific section. County level data should be compared to national, statewide and/or New York State data, and /or regional data, where appropriate. County-to-county comparisons may be illustrative, but are not required. Consider using LHD program enrollment data to provide insight into the health status of the community (recognizing selection bias). Statistical information should be explained in simple narrative form, describing health issues, and current and projected statistical trends.
6. LHDs and hospitals are not required to incorporate their information into one document. Each entity should submit their required document to the SDOH: CHAs from LHDs and CSPs from hospitals. LHDs and hospitals may include data, analysis and problem statements that reflect the work of each other and the other community partners. This can illustrate their collaborative efforts and describe their selection of Prevention Agenda priority areas.
7. The CHA should describe the 2-3 local priorities identified by the LHD in collaboration with its local partners, and identify the indicators that will be used to benchmark progress using the areas identified in the Prevention Agenda. The community collaborative process to identify 2-3 priority health areas from the Prevention Agenda should also be described. The form, “CHA – Prevention Agenda Description and Priority Areas” has been incorporated into the CHA checklist for ease of summarizing this information.

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Suggested Format

Cover Sheet – A cover sheet is provided as part of the CHA format and should identify the document as, “the Community Health Assessment” and name the county. The name, address, phone and fax numbers and e-mail addresses of the LHD should appear on the cover page as well.

Section One – Population at Risk

A. Demographic and Health Status Information

This section should provide a narrative and statistical description of the county population. A comprehensive description would include overall size and breakdowns by age, sex, race, income levels/socioeconomic indicators, percent employed, educational attainment, housing and any other relevant characteristics. Data provided by the State Department of Health, local data and/or other reliable sources of data may be used. Natality, morbidity, mortality and relevant demographic data should be compiled and analyzed, using small areas, such as minor civil divisions, zip codes or census tracts within counties, wherever possible and meaningful. Particular emphasis should be on interpreting demographic trends for their relationship to poor health and needs for public health services.

B. Behavioral Risk Factors

Statewide, community-specific and/or locally-developed estimates for the prevalence of health risk behaviors can be used to identify and discuss population subgroups that are at increased risk due to unhealthy behaviors. Local circumstances related to priority health concerns identified in the Prevention Agenda should be considered.

C. The Local Health Care Environment

Identify and discuss aspects of the physical, legal, social, and economic environment that influence the attitude, behavior and risk of community residents for poor health. Components of the health-related environment include institutions (e.g., schools, work sites, health care providers), geography (e.g., transportation), media messages (e.g., TV, radio, newspapers), and laws and regulations (smoking policies). There is no requirement for a community health assessment to describe established regulatory environmental programs. However, programs that are unique to specific LHDs and included in the MPHSP as a Part B and for which reimbursement is requested via the State Aid Application must have corresponding CHA data and analysis to support the need for the program.

This section should contain a statement regarding how the completed CHA will be distributed in the community.

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Section Two – Local Health Unit Capacity Profile

This section should profile staff and program resources that are available for public health activity in the county. It is suggested that the CHA include a profile of local agency's infrastructure, including organization, staffing and skill level, and adequacy and deployment of resources, as well as the agency's expertise and technical capacity to perform a community health assessment.

Other tools like APEX *PH*, a model for assessment and planning includes an Organizational Capacity Assessment, and MAPP, Mobilizing for Action through Planning and Partnerships can assist you in this process. The APEX *PH* process enables the agency to assess and improve its internal organizational structure. It focuses on administrative capacity, basic structure, and the role of the agency in the community. The National Association of County and City Health Officials (NACCHO) website describes both tools:

“The Assessment Protocol for Excellence in Public Health (APEXPH) is a flexible planning tool developed to be used by local health officials to:

- assess the organization and management of the health department;
- provide a framework for working with community members and other organizations in assessing the health status of the community; and
- establish the leadership role of the health department in the community.”

“MAPP is a community driven strategic planning tool for improving community health. Facilitated by public health leaders, this tool helps communities apply strategic thinking to prioritize public health issues and identify resources for addressing them.” Read more about these tools on the NACCHO website at: NACCHO.org.

Section Three – Problems and Issues in the Community

A. Profile of Community Resources

This section includes a profile community resources that are available to help meet the health-related needs of the county. Include all groups that may have the capacity and interest to work either individually or in collaboration with the LHD to improve the health status of the community. If possible, assess for availability, accessibility, affordability, acceptability and quality and what issues may surround utilization of these services such as hours of operation, transportation, sliding fee scales, etc. Discuss any significant outreach or public health education efforts and whether they are targeted to the general population or identified high-risk populations. A summary of the available clinic facilities and private provider resources for Medicaid recipients should be discussed.

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B. Access to Care

Access to care is an important component of safeguarding the health of communities. This section should discuss health resources in a general way. Describe the availability of hospitals, clinics and private providers, and information about access to health care providers. This section may also discuss actual utilization of primary care and preventive health services, if the information is available. The Behavioral Risk Factor Survey (BRFSS) or the Expanded-BRFSS are also excellent sources of local data on access to health care and if available, should be included in the CHA. Discuss whether any of the following commonly-identified barriers exist and any subgroups disproportionately affected:

- a. Financial barriers – inadequate resources to pay for health care, inadequate insurance, Medicaid eligibility vs. Medicaid enrollment vs. access to providers.
- b. Structural barriers – insufficient primary care providers, service sites or service patterns.
- c. Personal barriers – the cultural, linguistic, educational, or other special factors that impede access to care.

These data may be anecdotal or documented following an anecdote.

C. Profile of Unmet Need for Services

Identify and discuss additions to and changes in services that will improve the health of the identified at-risk groups. Discuss which types of changes would best serve the target group (e.g., lower/no cost, better hours, transportation assistance, increase sensitivity to population in need, language, increased acceptance of Medicaid, and integration and/or co-location of services). Identify the gaps in services and their location (e.g., township, city or census tract). Discuss problems that might be encountered in providing these services. This identification of needed services may also serve as a blueprint for other providers in the pursuit of federal, state, and local financial support.

Section Four – Local Health Priorities

This section should list the 2-3 local public health Prevention Agenda priorities identified through collaborative efforts among LHDs, hospitals, and other community-based organizations, health care providers, and consumers. Any other priorities identified by the LHD as part of its CHA or the Prevention Agenda process may also be included. This section should include a summary of the process (i.e., how recent, who was involved, how were priorities determined) by which the LHD(s) local hospital(s) and community partners identified these priorities. This section should mention collaborative efforts on the development of hospital CSPs. Collaborative assessments and planning processes with other community partners

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may also be described if they fall outside of a comprehensive community assessment process.

This section may also be used to discuss note-worthy accomplishment for both the LHD and other community public health partners in areas other than the 2-3 priorities selected for action. Cite efforts that have fostered new partnerships at the community level among schools, health agencies, etc. to maximize local assets which contribute to successful outcomes.

Section Five – Opportunities for Action

Building on all of the above sections, identify those opportunities that the local health department can pursue, either individually or in partnership that could alleviate the priority public health problems. A description of any current strategies, a general evaluation of their effectiveness, and their applicability to these priority areas is acceptable. This section should briefly describe the initial plan for action to be taken by the community and should describe the partners involved. These actions do not have to be implemented by the LHD alone. They can and should contain steps that other organizations in the community will take to begin to address the priority public health issues selected.

This section can be seen as a link between the priorities and community needs identified in the CHA and the more specific detailed information contained in the MPHSP.

Appendix A – Community Report Card

A LHD may attach its community public health report card and explain the distribution of the document.

References

1. PREVENTION AGENDA TOWARD THE HEALTHIEST STATE 2008.
2. Article 6 of the Public Health Law; specifically sections: 600,602,and 603,
3. Part 40 of Title 10 of the New York State Codes, Rules and Regulations; specifically: 40-1.10, 1.52, 1.53, 2.150 and 2.151