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Learning Objectives:
1. Describe what the New York State Prevention Agenda, its purpose and the role of community health assessments.
2. Describe requirements for communities (hospitals and LHDs) to conduct a community health assessment.
3. Describe what a community health assessment is.
4. List the major steps in the community health assessment process.
5. List the types of data that are appropriate for assessing the needs and assets of the population/community of interest.

NYS Prevention Agenda: Overview
- What is it?
- 5 priority areas
- Goals, objectives, interventions
- Tracking indicators
- Role of community health assessments
- Local planning
Prevention Agenda 2013-2017: New York State's Health Improvement Plan


Prevention Agenda 2013 Guidance

- Essential elements of CHA and CHIP
- Requirements for hospital CSP

PHAB Recommendations for Local Health Departments

• Conduct or participate in a collaborative process for completing a comprehensive community health assessment.

• Conduct a comprehensive planning process resulting in a “community health improvement plan, assess healthcare service capacity, identify and implement strategies to improve access to healthcare, and use a performance management system to monitor achievement of objectives.”

Released 2012

Affordable Care Act / IRS Rules

• Hospitals must “consult with members of their communities” and “take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.”

• Every three years, hospitals must “conduct community health needs assessments (CHNA) in conjunction with local health departments and others” and “develop an implementation strategy to meet the needs identified through their CHNA and a set of performance measures to track progress.”

Released 2013
Assessment is an essential public health service

1. Monitor health status to identify and solve community health problems

2. Diagnose and investigate health problems and health hazards in the community
What/who is ‘community’?

- A group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings.
- County covered by the LHD
- Catchment area for hospital

What is a community health assessment?

- A systematic way of identifying needs and resources by
  - Gathering statistical data
  - Soliciting perspectives of community members
  - Collecting information about community resources
- A process (in which community members/partners get invested in planning change)
- A product (baseline data that can be used to track changes)
Why do a community health assessment?

- Provides insight into the community context
- Ensures that collaborative partners have a common understanding of the issues
- Helps to make decisions about where to focus resources and interventions
- Understand where the community is and what kinds of things you want to track along the way in order to determine how your efforts are contributing to change
- Influences others in the community and builds support and resources for your efforts
- Ensures that interventions will be designed, planned, and carried out in a way that maximizes benefit to the community
- NYS laws and regulations require it!

A community assessment tells us:

- The main health issues in the community
- The main reasons for these health issues
- The strengths/assets in the community
- Where we might want to intervene to create change
Who is involved?

“Public health is a team sport”
-- Ross Brownson

Teams, coalitions, workgroups, consortia:
- Government
- Community members
- Private industry
- Health care provider groups
- Non-profit organizations
- Other relevant groups

What questions do you ask?

- What is important to our community?
- What is the health status of our community?
- What assets do we have that can be used to improve community health?
- What are the components, activities, competencies, and capacities of our local public health system (and its partners)?
- What affects the health of our community or the local public health system?
- What policies and environmental characteristics support or hinder our goal of improving health?
Ecological framework

The socio-ecological model recognizes the complex interplay that exist between individuals and factors in their environment (reciprocal determinism).
“The uncreative mind can spot wrong answers. It takes a creative mind to spot wrong questions.”

(Antony Jay)

Problem: Pediatric obesity/high sugar consumption

Question: What’s wrong with what parents are feeding their kids?
Case scenario

- County wants to know how best to serve the nutritional needs of low-income families.

- Research team provided results of data collected through BRFSS.

- The ‘county’ said these data were not helpful. What might be some of their concerns?

- Do these tell us about individual, social, governmental, organizational, or environmental factors influencing health?

Steps for Conducting a Community Health Assessment
Community Assessment Steps

1. Plan and organize
   - Establish the team / workgroup / coalition
   - Decide what to assess (What do you want to know?)

2. Design the data collection
   - Determine what information is already available and what you still need (what is essential) to answer your questions
   - Decide the best method to collect new data
   - Develop a work plan that identifies tasks to accomplish, roles and responsibilities, time frame

3. Gather the data

Community Assessment Steps

4. Review and analyze data.

5. Present a summary to the stakeholders – for feedback, clarification, buy-in.
   Note: Choose a format that fits the audience (or use multiple formats)
   - Pictures
   - Charts and graphs
   - Written or oral reports

6. Next steps …
What is already known?
Review existing (secondary) data

- Morbidity / mortality data
- Risk factor / behavior data
- Epidemiological studies / scientific literature
- Public or institutional records (e.g., hospital records, housing records, policies and their enforcement, etc.)
- Social indicators – particularly important as we move toward environmental and policy changes
  (More on this in Quantifying the Issue Module)

New York Data

Will be covered in Quantifying the Issue Module
From NYS Prevention Agenda Website:

Secondary Data Sources: National Data Sources for NYS Information

- Behavioral Risk Factor Surveillance System (BRFSS) – queriable database for state level prevalence rates
  [http://www.cdc.gov/brfss/index.htm](http://www.cdc.gov/brfss/index.htm)

- American Fact Finder, US Census Bureau – population, housing, economic and geographic data on a national, state and county level

- County Health Rankings – show the rank of the health of nearly every county in the nation
  [http://www.countyhealthrankings.org/#app/](http://www.countyhealthrankings.org/#app/)

- Chronic Disease Indicators – facilitate and standardize surveillance for states, territories and large metropolitan areas. Includes links to additional data resources
  [http://www.cdc.gov/nccdphp/cdi/overview.htm](http://www.cdc.gov/nccdphp/cdi/overview.htm)

- Health Indicators Warehouse – single, user-friendly, source for national, state, and community health indicators
Recommended Resources for Assessments

County Health Rankings Roadmaps
Describes the community health improvement cycle and provides Effective Policies and Programs for Implementation.

CDC Community Health Improvement Navigator
Provides hospitals, public health agencies, and other community organizations, with help to identify evidence-based interventions for implementation.

What do you still need to know?
Collect new (primary) data

- Surveys – behavioral, organizational, partnership
- Individual or group inquiry
  - focus groups
  - community forums / listening sessions
  - interviews
  (more on this in next module – Qualitative Data)
- Observations
Things to consider

- Who is asking the questions?
  - DOH as regulatory agency
  - Personal biases and tendencies
- Did you participate in the discussions?
- Did you tell people you were observing them?

Community Assessment Resources

- New York State Prevention Agenda Community Planning Guidance
- Community Health Assessment and Group Evaluation (CHANGE)
  http://www.cdc.gov/healthycommunitiesprogram/tools/change.htm
- Community Toolbox
  http://ctb.ku.edu/en/tablecontents/chapter_1003.aspx
- Mobilizing for Action through Planning and Partnerships (MAPP)—NACCHO
  http://www.naccho.org/topics/infrastructure/mapp/index.cfm?&renderForPrint=1
- National Network of Libraries of Medicine
  http://nnlm.gov/outreach/community/planning.html
Prevention Agenda 2013-2017

Local Community Health Planning

Local Health Department Contacts
Directory of local health department community health assessment and health improvement plan liaison contact information.

New York State Department of Health Public Health Contractors
Map and listing of public health contractors that can support local Prevention Agenda activities.

Community Planning Guidance (PDF, 140KB, 7 pp.)
The Prevention Agenda 2013-2017 serves as a guide to local health departments as they work with their community to develop mandated Community Health Assessments including a Community Health Improvement Plan and to hospitals as they develop mandated Community Service Plans over the coming year. Guidance describing the essential elements of these reports was released by the NYS Department of Health in December, 2012.

Memo from Commissioner Shah (PDF, 27KB, 1 pp.)
Dr. Shah has asked local health departments and hospitals to work together with community partners to assess the health challenges in communities, identify key priorities and develop and implement plans to address them. The Department is expecting that each local health department and hospital will, together, with other partners, identify and develop a plan for addressing at least two priorities in the new Prevention Agenda. At least one of these priorities should address a health disparity.

Community Health Planning Webinars
Webinars were sponsored by the Healthcare Association of New York State (HANYS) for hospitals and local health departments.
- January 11 Webinar - Local Community Health Planning Guidance Overview (pdf, 62KB, 11pp.)
- January 29 Webinar - Local Community Health Planning Process and Data Tools (pdf, 3.41MB, 36pp.)

Frequently asked questions about CHAs, CHIPs and CSIPs
Questions and answers about the Community Health Assessments (CHAs), Community Health Improvement Plans (CHIPs), reports that have to be submitted by local health departments, and about the Community Service Plans (CSIPs), reports that have to be submitted by hospitals.

Community Health Data for Assessment and Planning
The data sources below can be used for community health planning and monitoring interventions:

New York State Prevention Agenda Dashboard
The New York State Prevention Agenda Dashboard is an interactive visual presentation of the Prevention Agenda tracking indicator data at state and county levels. It serves as a key source for monitoring progress that communities around the state have made with regard to meeting the Prevention Agenda 2017 objectives.

Community Health Indicator Reports
This site links the previous Community Health Data Set (CHDS) and Community Health Assessment Indicators (CHAI). Many new indicators have been added to this site. Nearly 200 health-related indicators are now available. State and county trend data are available for the majority of these indicators.
In addition, nearly 20,000 tables, maps and trend graphs of health-related indicators are available for community health assessment and planning.
The top part of this site allows you to access indicator data for all counties in the state by health topic areas. The bottom part of this site provides access to individual county profiles of these topic areas with direct links to county historical trend data.

Other Data Sources for Community Health Assessment and Planning
This list provides data sources that have been used to measure the progress made in the Prevention Agenda 2008-2012 priority areas. They have also been used to gather data and information on the current health status and health related factors (socio-economic status, environment, behaviors) affecting New York State residents. These data sources will be useful for community health assessment and planning.
Data Sources for Prevention Agenda 2013-17 Community Assessment, Planning and Implementation

This list provides data sources that have been used to measure the progress made in the Prevention Agenda 2013-2017 priority areas. Furthermore, they have been used to gather data and information on the current health status of New York State residents and health-related factors. These data sources will be very useful for community health assessment and planning.

New York State Prevention Agenda Tracking Indicator Dashboard

The New York State Prevention Agenda Dashboard is an interactive visual presentation of the most current Prevention Agenda tracking indicator data at state and county levels. It serves as a key resource for monitoring progress that communities around the state have made with regard to meeting the Prevention Agenda 2017 objectives.

Baseline Data - State and County Tracking Indicators for the Priority Areas

This page provides state and county-level baseline data (2007 - 2012) for the Prevention Agenda tracking indicators and the 2017 state objectives for the indicators.

Asthma Surveillance Data

Asthma surveillance data includes all inpatient and emergency department (ED) visit data from the Statewide Planning and Research Cooperative System (SPARCS) and death data at the state, county, and ZIP code level. Data on county-specific asthma death rates, both crude and age-adjusted, are available by region within New York State as well.

Centers for Disease Control and Prevention - Community Health Status Indicators (CHSI)

Promoting healthier communities is greatly enhanced by information on the health status of the population and information on a range of modifiable factors that have the potential to influence health outcomes. The Community Health Status Indicators (CHSI) 2013 is an online web application that produces health status profiles for each county.

A key feature of CHSI 2013 is the ability for users to compare the value of each indicator with those of demographically similar “peer counties,” as well as to the U.S. as a whole, and to state 2020 targets.

Community Health Indicator Reports

This site includes previous Community Health Data Set (CHDS) and Community Health Assessment Indicators (CHAI). Here you can find data on the health status of New York State residents and how it compares to state and county trends. Data are available for the majority of these indicators. From here, nearly 20,000 tables, maps, and trend graphs of health-related indicators are available for you to conduct community health assessment and planning. The top part of this site allows you to access indicator data for all counties in the state by health topic areas. The bottom part of this site provides gives you access to individual county profiles of those health topic areas with direct links to county historical trends data.

County Health Indicators by Race/Ethnicity (CHIRE)

CHIRE provides selected public health indicators by race/ethnicity for New York State and counties. Data related to births, deaths, and hospitalizations are presented.

County ZIP Code Portrat Data Profile

This site provides annual reports containing data tables and charts presenting information extracted from birth, death, and fetal death certificates. Data such as pregnancies and births by age, race/ethnicity, educational attainment, and birthweight as well as deaths by selected causes, race, and age are included. Data are presented for New York State by county. Limited statistics are available for school districts and cities and villages with populations of 10,000 or more.

Leading Causes of Death in New York State

This site provides annual reports containing data tables and charts presenting information extracted from birth, death, and fetal death certificates. Data such as pregnancies and births by age, race/ethnicity, educational attainment, and birthweight as well as deaths by selected causes, race, and age are included. Data are presented for New York State by county. Limited statistics are available for school districts and cities and villages with populations of 10,000 or more.

Cancer Registry

Cancer registration data are provided for both incidence and mortality by county, New York State and New York City. Site (tissue) of the cancer is available by the above geographical areas and by races and females.

Expanded (County Level) Behavioral Risk Factor Surveillance System

The Expanded Risk Factor Surveillance System (Expanded BRFSS) augments the CDC Behavioral Risk Factor Surveillance System (BRFSS), which is conducted annually in New York State. The Expanded BRFSS collected county-specific data on preventive health practices, risk behaviors, injuries and preventable chronic and infectious diseases. This survey was conducted in New York State during 2005-2005 and 2006-2006.