This is a sample of the instructor materials for *Population Health: Principles and Applications for Management*, by Rosemary M. Caron.

The complete instructor materials include the following:

- Test bank
- PowerPoint slides for each chapter
- Instructor guides for each chapter (with answers for discussion questions and exercises)

This sample includes the PowerPoint slides and instructor guide for Chapter 9, "Community Health Assessment."

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CHAPTER 9
Community Health Assessment

Professor Rosemary M. Caron, PhD, MPH

Department of Health Management and Policy

University of New Hampshire

Chapter Outline

1. Community health assessment
2. Community health assessment process
3. Community health improvement
   - CHA and CHIP examples
4. CHA and CHIP tools
   - MAPP
   - Community Tool Box
   - County Health Rankings & Roadmaps
   - Healthy People 2020 MAP IT
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5. Data sources
   - Challenges
6. Community benefit standard
7. Community benefit standard and public health
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Community Health Assessment Defined

"Community health assessment (CHA) is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues. A variety of tools and processes may be used to conduct a community health assessment; the essential ingredients are community engagement and collaborative participation."

(National Association of County and City Health Officials)

The CHA Process

NACCHO (2016) describes the CHA process as one "that uses quantitative and qualitative methods to systematically collect and analyze health data within a specific community." Health data include information on risk factors, quality of life, social determinants of health, determinants of inequity, mortality, morbidity, community assets, forces of change, and information on how well the public health system provides essential services. The design and implementation of community health assessments should include community stakeholders such as residents, businesses, nonprofit organizations, and government agencies. (Dever 1997; Cibula et al. 2003; Issel 2004; PHAB 2010)

The CHA Process

A CHA can be used to answer the following questions for a community:

- What are the health problems in a community?
- Why do health issues exist in a community?
- What factors create or determine the health problems?
- What resources are available to address the health problems?
- What are the health needs of the community from a population-based perspective?

(Dever 1997; IOM 2003; Issel 2004)

CHA Steps

- Describe the community and define the population.

- Engage the community and define their health priorities.

- Identify key partners and stakeholders.

- Identify community health indicators.

- Report the health priorities.

- Develop a community health improvement plan.

(McCoy 2010)

Community Health Improvement Process (CHIP)

NACCHO states that "A CHA should be part of an ongoing broader community health improvement process [CHIP]." A community health improvement process uses CHA data to identify priority issues, develop and implement strategies for action, and establish accountability to ensure measurable health improvement, which are often outlined in the form of a community health improvement plan (Durch et al. 1997). A community health improvement process looks outside of the performance of an individual organization serving a specific segment of a community to the way in which the activities of many organizations contribute to community health improvement.

CHA and CHIP Examples

NACCHO examples of high-quality CHAs and CHIPs
www.naccho.org/topics/infrastructure/CHAIP/guidance-and-examples.cfm

CHA and CHIP Tools

MAPP (WWW.NACCHO.ORG/TOPICS/INFRASTRUCTURE/MAPP/FRAMEWORK/MAPPBASICS.CFM)

"…a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems." (NACCHO 2015)

CHA and CHIP Tools

MAPP Elements

- MAPP emphasizes a community-driven and community–owned approach.
- MAPP builds on previous experiences and lessons learned.
- MAPP uses traditional strategic planning concepts within its model.
- MAPP focuses on the creation and strengthening of the local public health system.
- MAPP creates governmental public health leadership.
- MAPP uses the essential public health services to define public health activities.
- MAPP brings four assessments together to drive the development of a community strategic plan.

CHA and CHIP Tools

Community Tool Box
(HTTP://CTB.KU.EDU/EN/ABOUT-THE-TOOL-BOX)

"The Community Tool Box is a free, online resource for those working to build healthier communities and bring about social change. It offers thousands of pages of tips and tools for taking action in communities." (Community Toolbox 2015)

CHA and CHIP Tools

County Health Rankings & Roadmaps
(**WWW.COUNTYHEALTHRANKINGS.ORG/**)

The County Health Rankings & Roadmaps approach involves the measurement of "vital health factors, including high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income, and teen births in nearly every county in America. The annual *Rankings* provide a revealing snapshot of how health is influenced by where we live, learn, work and play. They provide a starting point for change in communities."

CHA and CHIP Tools

County Health Rankings & Roadmaps
(**WWW.COUNTYHEALTHRANKINGS.ORG/**)

This initiative also provides the *Roadmaps* that provide guidance and tools to understand the data, and strategies that communities can use to move from education to action. The *Roadmaps* are helping communities bring people together from all walks of life to look at the many factors that influence health, focus on strategies that we know work, learn from each other, and make changes that will have a lasting impact on health.

(County Health Ranking 2015)

CHA and CHIP Tools

Healthy People 2020 MAP-IT (WWW.HEALTHYPEOPLE.GOV/2020/TOOLS-AND-RESOURCES/PROGRAM-PLANNING)

"No two public health interventions are exactly alike. But most interventions share a similar path to success: Mobilize, Assess, Plan, Implement, Track. Otherwise known as MAP-IT, this framework can be used to plan and evaluate public health interventions to achieve Healthy People 2020 objectives." (Healthy People 2020)

CHA and CHIP Tools

National Public Health Performance Standards Program (NPHPS) (**WWW.CDC.GOV/NPHPSP/**)

- The State Public Health System Assessment Instrument
- The Local Public Health System Assessment Instrument
- The Public Health Governing Entity Assessment Instrument

Data Sources

- **Quantitative data**: Quantitative data include the type of data that can be counted or expressed numerically—for example, vital records data (i.e., births, deaths), physician office and emergency room visits, BRFSS data, and US Census data. (Tutko 2013)

- **Qualitative data**: Qualitative data include information provided in a verbal or narrative form via key informant interviews, open-ended survey questions, or focus groups, for example. (Tutko 2013)

Data Sources

Primary data are data that are collected for a purpose. An example of quantitative primary data would be a seatbelt observation survey. Qualitative primary data would be personal interviews conducted about why a respondent does or does not wear a seatbelt. (Tutko 2013)

Data Sources

Secondary data are data collected for one specific purpose and potentially available to help address a problem or issue. An example of quantitative primary data would be an outpatient and inpatient hospital discharge dataset. Qualitative secondary data would include healthcare provider notes in an electronic medical record. (Tutko 2013)

Data Challenges

Challenges one may encounter in accessing data to help assess the health of a community include the following:

- Data of interest are not collected at all or at the required geographic level
- Data can not be released due to confidentiality concerns
- Data are out-of-date
- Small numbers (Tutko 2013)

Community Benefit Standard

The United States Internal Revenue Service developed the community benefit standard, which allowed nonprofit hospitals to maintain a tax-exempt status and also made them eligible for federal funding to provide services to the poor in their communities (IRS 1983). To qualify under the community benefit standard, nonprofit hospitals need to provide the following services to their community:

- Board made up of community members
- Qualified physicians in the area have medical privileges at the nonprofit hospital
- Emergency department
- No discrimination of patients admitted to the nonprofit hospital
- Funding directed to benefit the patients served by the nonprofit hospital

(Catholic Association 2010)

Community Benefit Standard and Public Health

The Public Health Accreditation Board (PHAB) is "a non-profit organization dedicated to improving and protecting the health of the public by advancing the quality and performance of Tribal, state, local, and territorial public health departments" (PHAB 2015). PHAB has developed national accreditation guidelines for local and state public health departments, of which conducting a CHA is required. Thus, a significant sector of the public health system will be assessing the health of the communities in which they serve.

Community Benefit Standard and Population Health

It will be important for the public health system to not only consider the major public health issues affecting a community's population but also the determinants contributing to the community's health status. Think about the Evans and Stoddart model of health and well-being.

Community Benefit Standard
and Population Health

"The implications for measuring the success of a given program are obvious; no single entity in a community can take full credit for 'preventing a disease,' because too many relevant factors are beyond the control of any single organization. This means that health-related organizations serving any target population must work together to impact the health status of that population, and no single entity can measure the impact of its activities without acknowledging the potential impact, positive or negative, of other entities affecting the same target population. Collaboration on needs assessment, interventions, and impact measurement become essential." (Turner and Evashwick 2014)

Questions?

CHAPTER 9

COMMUNITY HEALTH ASSESSMENT

DISCUSSION QUESTIONS

1. What is a community health assessment? Briefly describe the CHA process.

The Public Health Accreditation Board (PHAB) utilized the definition of *community health assessment* (CHA) provided by Turnock (2009) to describe its goal and purpose: "Community health assessment is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues. A variety of tools and processes may be used to conduct a community health assessment; the essential ingredients are community engagement and collaborative participation."

The National Association of County and City Health Officials (NACCHO) defines a CHA as "a process that uses quantitative and qualitative methods to systematically collect and analyze data to understand health within a specific community. An ideal assessment includes information on risk factors, quality of life, mortality, morbidity, community assets, forces of change, social determinants of health and health inequity, and information on how well the public health system provides essential services. Community health assessment data inform community decision-making, the prioritization of health problems, and the development, implementation, and evaluation of community health improvement plans."

Thus, it should be clear based on these two definitions that a CHA is grounded in the core functions of public health: assessment, policy development, and assurance. NACCHO states that CHAs "provide information for problem and asset identification and policy formulation,

implementation, and evaluation. CHAs also help measure how well a public health system is fulfilling its assurance function" (IOM 2003; PHAB 2015).

The CHA Process

NACCHO (n.d.) describes the CHA process as one "that uses quantitative and qualitative methods to systematically collect and analyze health data within a specific community. Health data include information on risk factors, quality of life, social determinants of health, determinants of inequity, mortality, morbidity, community assets, forces of change, and information on how well the public health system provides essential services. The design and implementation of community health assessments should include community stakeholders such as residents, businesses, nonprofit organizations, and government agencies" (Dever 1997; Cibula et al. 2003; Issel 2004; PHAB 2010).

NACCHO (n.d.) states: "Assessment is one of three core public health functions. Data collected through community health assessments inform the other two core functions: policy development and assurance. Community health assessments provide information for problem identification, policy formulation, implementation, and evaluation. Well-informed policy development, in turn, fulfills the assurance function to ensure the conditions, programs, and interventions that maintain and improve health. Assessment also helps measure how well a public health system is fulfilling its assurance function." (IOM 2003; PHAB 2010)

According to NACCHO (n.d.), a CHA can be used to answer the following questions for a community:

- "What are the health problems in a community?"

- "Why do health issues exist in a community?"

- "What factors create or determine the health problems?"

- "What resources are available to address the health problems?"

- "What are the health needs of the community from a population-based perspective?"

  (Dever 1997; IOM 2003; Issel 2004)

The Minnesota Department of Health outlined the steps involved in a CHA (McCoy 2010):

Step 1: Describe the community and define the population. Consider what factors are necessary for you to be able to describe the community. For example, the types of information that would be helpful to describe the community of focus include, but are not limited to the following:

- Geography (e.g., urban, rural)

- Population size

- Racial, ethnic, gender, age distribution

- Socioeconomic status of the population (e.g., education, employment)

- Culture, religion, historical significance

- Environment (e.g., political, economic, built, housing) (McCoy 2010)

Step 2: Engage the community, and define their health priorities. It is important that the community be an active participant in the CHA. The community members know the issues that most affect their health and quality of life. However, it can take time for the local, state, county, or regional health department to develop the trust of a community and build a collaborative

relationship. For example, when working with community members on a persistent public health issue, an academic-community partnership identified the following four core values as being constructive: (1) adaptability, (2) consistency, (3) shared authority, and (4) trust (Serrell et al. 2009).

McCoy (2010) further identifies the following questions that are important to consider when working to know your community:

- "Who are they?"

- "Where do they live?"

- "How do they live?"

- "What do they do?"

- "What's important to them?"

- "Who are the formal and informal leaders?"

- "What do they know about you?"

NACCHO (n.d.) states that "Community representatives are an integral part of a community health assessment because they know community habits, customs, attitudes, social groups, and where things happen (Edberg 2007). Successful community health assessments build trust and community ownership of the process through active engagement of organizations and residents. Meaningful engagement involves the community in developing assessment protocols, identifying priorities, and implementing and monitoring community improvement efforts (Dever 1997). Moreover, community members help promote and bring visibility to community health assessment and improvement initiatives" (IOM 2003).

Step 3: Identify key partners and stakeholders. There are numerous factors to consider when building partnerships with key stakeholders. McCoy (2010) recommends considering the following:

- Who will be most impacted by the work being conducted?

- Whose voices are rarely heard?

- Who has the most potential to affect change in a positive manner for the community (e.g., community leaders, those who have access to resources, decision makers)?

Step 4: Identify community health indicators. It is important to know the availability of the data that will identify health issues in the community. As the data are collected and analyzed, recall that issues affecting the data include the completeness, the timeliness, and the quality of the data. The data tell the community's story from a health perspective. For example, what is the cause-specific mortality rate for the community? What are the age-specific mortality rates? How do the mortality rates for the community compare to other communities? How do these rates compare to the state as a whole? What are the teenage pregnancy and birth rates for the community? Are these rates above or below national benchmarks, such as Healthy People metrics?

Step 5: Report the health priorities. Based on the analysis of available health data, report to the partners, stakeholders, and community as a whole the outcome of the process. What are the major health issues affecting the community? Report this information in a format that is respectful of varying levels of health literacy and preferences for receiving health information (e.g., social media, newspaper, radio, town meeting, etc.).

Step 6: Develop a community health improvement plan. Considering the significance of the health priorities identified, the partnership needs to develop a feasible plan that will improve the health of the community. Goals and objectives that can be achieved in a reasonable timeframe should be developed and required resources should be allocated to this process. How this work will take place needs to be discussed and agreed upon by the partners (action steps); and what measures will be used to know when the actions have been successful or not (performance measures) need to be identified (McCoy 2010).

> In summary, NACCHO (n.d.) states that "A comprehensive community health assessment process uses broad networks of data, mobilizes community members, and garners resources to comprehensively approach public health issues" (Issel 2004; PHAB 2015).

2. How are CHAs and CHIPs useful in improving the health of communities?

A community health improvement process (CHIP) uses CHA data to identify priority issues, develop and implement strategies for action, and establish accountability to ensure measurable health improvement, which are often outlined in the form of a community health improvement plan (Durch et al. 1997). A community health improvement process looks outside of the performance of an individual organization serving a specific segment of a community to the way in which the activities of many organizations contribute to community health improvement (Durch et al. 1997).

NACCHO (n.d.) states that although "many community health assessment and improvement planning processes have similar components, they differ in terms of scope and philosophies. Processes may focus on a programmatic area, agency division, local health

department, or public health system. Some models address one specific health condition, while others identify underlying factors that affect several or all health conditions. Processes may be based on a biomedical or a socio-ecological model of health. Some models are informed by health promotion theory, while others are informed by strategic planning and performance measurement theories. The philosophy and scope of a given process will affect overall assessment and improvement results."

3. Describe two tools used to conduct a CHIP.

The section of the chapter titled "CHA and CHIP Tools" provides information on several reputable tools useful in conducting a CHIP. Please refer to this section of the chapter to address this discussion question.

4. What types of data are useful in a CHA?

Quantitative data include the type of data that can be counted or expressed numerically—for example, vital records data (i.e., births, deaths), physician office and emergency room visits, BRFSS data, and US Census data. Qualitative data includes information provided in a verbal or narrative form via key informant interviews, open-ended survey questions, or focus groups, for example. Both types of data present certain advantages. For example, quantitative data can summarize events and allow for comparison to "benchmarks." On the other hand, qualitative data allows for explanation behind the data (i.e., "the hows and whys behind the numbers") Buy-in from stakeholders (those with a vested interest in an issue) can be achieved since they are directly asked about their experience and opinion. Furthermore, health issues can be further investigated where quantitative data is not available (Tutko 2013).

Data can also be classified as primary or secondary data. Primary data is data that is collected for a purpose. An example of quantitative primary data would be a seatbelt observation survey. Qualitative primary data would be personal interviews conducted about why a respondent does or does not wear a seatbelt. Secondary data is data collected for a specific purpose and is potentially available to help address a problem or issue. An example of quantitative primary data would be an outpatient and inpatient hospital discharge dataset. Qualitative secondary data would include healthcare provider notes in an electronic medical record (Tutko 2013).

Challenges one may encounter in accessing data to help assess the health of a community include the following:

- Data of interest is not collected at all or at the required geographic level.

- Data cannot be released due to confidentiality concerns.

- Data is out-of-date (Tutko 2013).

Another important point is the protection of individuals who may represent rare or unusual events. For instance, the reporting of a few number of cases of a rare condition may allow for the identification of those individuals. Reporting agencies, such as local and state health departments, will often suppress the reporting of events if they number fewer than, say, five cases so as to protect the potential identification of the affected individuals and their family members.

5. What is the community benefit standard?

The United States Internal Revenue Service developed the community benefit standard, which allowed nonprofit hospitals to maintain a tax-exempt status and also made them eligible for federal funding to provide services to the poor in their community (IRS 1983). In order to

achieve the community benefit standard, nonprofit hospitals need to provide the following

services to their community:

- Board comprised of community members

- Qualified physicians in the area have medical privileges at the non-profit hospital

- Emergency department

- No discrimination on patients admitted to the nonprofit hospital

- Funding directed to benefit the patients served by the non-profit hospital (Catholic

  Association 2010)

So, how is the community benefit standard related to the assessment of the health of a

community? The Patient Protection and Affordable Care Act (ACA) has attempted to

demonstrate the impact the community benefit standard has had on communities by requiring

hospitals to engage in conducting CHAs and developing CHIPs (IRS 2015; Turner and

Evashwick 2014).

In addition to the points listed above, hospitals can contribute to the health of their

community by not only providing charitable care but also by providing community-oriented

health promotion efforts (Turner and Evashwick 2014).

6. How can the community benefit standard be useful in improving population health?

The Public Health Accreditation Board (PHAB) "is a non-profit organization dedicated to

improving and protecting the health of the public by advancing the quality and performance of

Tribal, state, local, and territorial public health departments" (PHAB 2015). PHAB has

developed national accreditation guidelines for local and state public health departments, of

which conducting a CHA is required (PHAB 2015). Thus, a significant sector of the public

health system will be assessing the health of the communities in which they serve. Yet, it will be important for the public health system to not only consider the major public health issues affecting a community's population but also to develop feasible interventions addressing the determinants contributing to the community's health status. Think about the Evans and Stoddart model of health and well-being.

"The implications for measuring the success of a given program are obvious; no single entity in a community can take full credit for 'preventing a disease,' because too many relevant factors are beyond the control of any single organization. This means that health-related organizations serving any target population must work together to impact the health status of that population, and no single entity can measure the impact of its activities without acknowledging the potential impact, positive or negative, of other entities affecting the same target population. Collaboration on needs assessment, interventions, and impact measurement become essential" (Turner and Evashwick 2014).

In closing, Stoto (2013) states, "Population health is fundamentally about measuring health outcomes and their upstream determinants and using these measures to coordinate the efforts of public health agencies, the healthcare delivery system, and many other entities in the community to improve health… given the many factors that influence health, no single entity can be held accountable for health outcomes."

SUGGESTED WRITTEN ASSIGNMENTS

This chapter lends itself to written assignment more than multiple choice questions. In place of a test bank, the following discussion questions from the chapter are suggested for written assignments:

NACCHO Examples of High Quality CHAs and CHIPs,

http://www.naccho.org/topics/infrastructure/CHAIP/guidance-and-examples.cfm

East Central Kansas Public Health Region, CHA

1. Describe the CHA and CHIP processes based on the information provided in the excerpt.

The student should note the demographics of the population and the community as described. Also, the process for identifying the major health issues for the community was a collaborative effort involving various stakeholders in an organized process. In addition, the region was compared to the state of Kansas, as a whole—an example of a benchmark. The community had a voice in identifying and weighing the health issues to be addressed, as well as how they would be addressed.

Taken from the case directly: "Consideration was given to other projects, media, events, and collaborations occurring in the region, in addition to the statistical data and community interests found in the CHA. In the final analysis of priorities, the Core Team elected to address two priorities: Oral Health and Healthy Eating Behaviors. The impact of underemployment and poverty were not dismissed as a priority. Rather, the Core Team and community partners understand that this social determinant underlies many behaviors and ability to access care and thereby impacting individual and community well-being. It was a consideration in all strategies planned for the two priorities selected. The team believed that this first regional effort must remain manageable and not duplicate other efforts in the community.

"The Core Team elected to align regional objectives with Healthy People 2020 Objectives. The goals, objectives, indicators, and strategies proposed for community effort are listed below. Many community partners from area agencies and many individuals participated in discussion groups within each county to identify roles and responsibilities for implementation of strategies that address the issues. Lead individuals and organizations who volunteered to lead the various interventions are identified in the plan that follows."

2. Do you agree with the community's rationale for addressing the identified health issues they selected to work on? Explain.

This will be an interesting question for the student to consider since only an excerpt of the case is provided. However, this case was selected as one of the best examples of CHAs and CHIPs by NACCHO, so one should consider this case as an example of a best practice.

NACCHO Examples of High Quality CHAs and CHIPs,

http://www.naccho.org/topics/infrastructure/CHAIP/guidance-and-examples.cfm

Alachua County, Florida Health Department

1. Describe how the Local Public Health System Performance Assessment complements the CHA and CHIP.

Taken from the case directly: "The NPHPSP is a partnership which is designed to improve the practice of public health and the performance of public health systems. The NPHPSP assessment instruments guide state and local jurisdictions in evaluating their current performance against a

set of optimal standards. Three assessment instruments have been designed to assist state and local partners in assessing and improving their public health systems.

"The instruments are based on the framework of the ten Essential Public Health Services. The Essential Services represent the spectrum of activities that should be provided in any jurisdiction to ensure the health of the residents. Therefore, the instrument itself is divided into ten sections– one for each of the Essential Services. Because many entities contribute to delivering the Essential Services, the focus of the NPHPSP is the 'public health system.' A public health system includes all public, private and voluntary entities that contribute to the delivery of the Essential Public Health Services within a given jurisdiction.

"The purpose for undertaking a performance assessment is to strengthen and improve the public health system. The rating tool includes a description of optimal functioning for each model standard and so it is expected that local health jurisdictions will see many differences between their own performance and the 'gold standard' described in the instruments. System partners should seek to address these weaknesses and also recognize and maintain areas in which they are strong."

The collaborative effort for this initiative is evident in that much of the public health system, including the community, were involved in this assessment process.

2. Comment on the potential reasons why the essential public health services ranked the way they did for this community. What factors would influence this rank order of essential public health services for a community?

Taken directly from the case: "These highest ranking essential services were Number 6: Enforcing Laws and Regulations that Protect Health and Number 2: Ensure Safety and Diagnose

and investigate health problems and health hazards. These essential services tend to rank well in most communities in Florida because they are funded and designated to a specific agency or group of agencies. The lowest ranked items are, in general, those which are diffused throughout the community.

"The community process of discussion and ranking both performance and priority included over 50 participants and resulted in identification of four essential services for further discussion. These were low performing, high priority services. The performance ratings of these services were based on scores that were recalculated using only those rated by the community wide process.

- **Essential Service 1**: Monitoring Health Status to Identify Community Health Problems
- **Essential Service 4:** Mobilizing Community Partnerships to Identify and Solve Health Problems
- **Essential Service 5:** Developing Policies and Plans that Support Individual and Community Health
- **Essential Service 7:** Link People to Needed Personal Health Services"

The intent of this question is to have the student think about how a community rationalizes what it will prioritize and that sometimes the factors that influence this decision are under the community's control and sometimes they are not. The above listed essential public health services are ones that the community deemed a high priority, yet the public health system was not succeeding, in the community's perception, in achieving the established goal. Potential reasons for this could include limited resources in terms of funding and an ill-prepared workforce, or workforce shortage; reluctant members of the public health system to collaborate on offering an essential public health service, because they believe the issue belongs to another

local agency (i.e., lack of ownership of the problem); and competing priorities for agencies and organizations preventing these four essential public health services from becominh action items.

MAPP and MAP-IT

1. Compare MAPP to MAP-IT. Discuss the similarities and differences.

This question is intended to have the student spend some time with these two assessment processes and understand that there is indeed a process that is followed to assess the health of communities and that this work can take time. MAPP works with the local public health system to improve the community's health via a strategic approach. Similarly, MAP-IT uses a strategic approach with the intent of developing and implementing interventions that will assist a community in reaching its identified Healthy People 2020 objectives.

NACCHO, in collaboration with the CDC, developed "Mobilizing for Action through Planning and Partnerships (MAPP) [which] is a community-driven strategic planning process for improving community health. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems" (NACCHO 2015).

MAPP Elements

(from http://archived.naccho.org/topics/infrastructure/mapp/framework/mappbasics.cfm)

1) MAPP emphasizes a community-driven and community-owned approach. Because the community's strengths, needs, and desires drive the process, MAPP provides the framework for

creating a truly community-driven initiative. This creates stronger connections throughout the community and provides access to the collective wisdom necessary to addressing community concerns.

2) MAPP builds on previous experiences and lessons learned. Information from previous planning efforts and established assessment tools was used in the development of MAPP. Most notably, MAPP builds on the Assessment Protocol for Excellence in Public Health (APEX*PH*). Released in 1991, APEX*PH* has guided hundreds of local health departments through internal organizational capacity assessments and collaborative community health assessment processes. While building on the familiar concepts of APEX*PH*, MAPP is more progressive in a variety of ways:

APEX*PH*	MAPP
Build LHD leadership	Build LHD leadership, but also promote community responsibility for the health of the public
Assess LHD capacity for delivering public health services	Assess capacity of entire local public health system
Operational planning	Strategic planning
Focus on health status	Focus on health status, community perceptions, forces of change, and local public health system capacities
Develop plans to address needs	Strategically match needs, resources, ideas, and actions

3) MAPP uses traditional strategic planning concepts within its model. Strategic planning assists communities in more effectively securing resources, matching needs with assets, responding to external circumstances, anticipating and managing change, and establishing a

long-range direction for the community. The MAPP model includes basic strategic planning concepts, such as visioning, an environmental scan, the identification of strategic issues, and the formulation of strategies.

4) MAPP focuses on the creation and strengthening of the local public health system. Local public health systems are defined by MAPP as the "human, informational, financial, and organizational resources, including public, private, and voluntary organizations and individuals, that contribute to the public's health." This focus is important because "the public's health depends on the interaction of many factors; thus, the health of a community is a shared responsibility of many entities, organizations, and interests in the community" (Institute of Medicine, *Improving Health in the Community*). The MAPP process brings these diverse interests together to collaboratively determine the most effective way to conduct public health activities.

5) MAPP creates governmental public health leadership. While MAPP focuses on the local public health system, it is anticipated that governmental public health entities will take leadership roles in initiating MAPP in their communities. Thus, MAPP will help to create a greater recognition of the important roles governmental entities—such as local health departments, boards of health, and environmental agencies—play in their communities.

6) MAPP uses the Essential Public Health Services to define public health activities. The Essential Public Health Services and other public health practice concepts have been incorporated into MAPP, providing much-needed links with other public health initiatives. The

Essential Public Health Services are a list of 10 public health activities that should be undertaken in all jurisdictions.

7) MAPP brings four assessments together to drive the development of a community strategic plan. Four unique and comprehensive assessments gather information to drive the identification of strategic issues.

- *The Community Themes and Strengths Assessment* identifies themes that interest and engage the community, perceptions about quality of life, and community assets.

- *The Local Public Health System Assessment* measures the capacity of the local public health system to conduct essential public health services.

- *The Community Health Status Assessment* analyzes data about health status, quality of life, and risk factors in the community.

- *The Forces of Change Assessment* identifies forces that are occurring or will occur that will affect the community or the local public health system" (NACCHO, 2015).

MAP-IT

"No two public health interventions are exactly alike. But most interventions share a similar path to success: Mobilize, Assess, Plan, Implement, Track. Otherwise known as MAP-IT, this framework can be used to plan and evaluate public health interventions to achieve Healthy People 2020 objectives" (Healthy People 2020 2015).

Mobilize

(from https://www.healthypeople.gov/2020/tools-and-resources/program-planning/Mobilize)

Questions to Ask and Answer:

- What is the vision and mission of the coalition?

- Why do I want to bring people together?

- Who should be represented?

- Who are the potential partners (organizations and businesses) in my community?

Start by mobilizing key individuals and organizations into a coalition.

Look for partners who have a stake in creating healthy communities and who will contribute to the process. Aim for broad representation.

Next, identify roles for partners and assign responsibilities.

This will help to keep partners engaged in the coalition. For example, partners can:

- Facilitate community input through meetings, events, or advisory groups.

- Develop and present education and training programs

- Lead fundraising and policy initiatives.

- Provide technical assistance in planning or evaluation

(Healthy People 2020 2015).

Assess

(from https://www.healthypeople.gov/2020/tools-and-resources/program-planning/Assess)

Questions to Ask and Answer:

- Who is affected and how?

- What resources do we have?

- What resources do we need?

Assess both needs and assets (resources) in your community.

This will help you get a sense of what you can do, versus what you *would like* to do.

Work together as a coalition to set priorities.

What do community members and key stakeholders see as the most important issues? Consider

feasibility, effectiveness, and measurability as you determine your priorities.

Start collecting State and local data to paint a realistic picture of community needs.

The data you collect during the assessment phase will serve as baseline data. Baseline data

provide information you gather before you start a program or intervention. They allow you to

track your progress

(Healthy People 2020, 2015).

Plan

(from https://www.healthypeople.gov/2020/tools-and-resources/program-planning/Plan)

Questions to Ask and Answer:

- What is our goal?

- What do we need to do to reach our goal? Who will do it?

- How will we know when we have reached our goal?

A good plan includes clear objectives and concrete steps to achieve them.

The objectives you set will be specific to your issue or community; they do not have to be exactly the same as the ones in Healthy People 2020.

Consider your intervention points

Where can you create change?

Think about how you will measure your progress.

How will you know if you are successful?

When setting objectives, remember to state exactly what is to be achieved.

What is expected to change, by how much, and by when? Make your objectives challenging, yet realistic.

Remember: Objectives need a target. A target is the desired amount of change (reflected by a number or percentage). A target needs a baseline (where you are now—your first data point). (Healthy People 2020 2015)

Implement

(from https://www.healthypeople.gov/2020/tools-and-resources/program-planning/Implement)

Questions to Ask and Answer:

- Are we following our plan?

- What can we do better?

First, create a detailed workplan that lays out concrete action steps, identifies who is responsible for completing them, and sets a timeline and/or deadlines.

Make sure all partners are on board with the workplan.

Next, consider identifying a single point of contact to manage the process and ensure that things get done.

Be sure to share responsibilities across coalition members. Do not forget to periodically:

- Bring in new partners for a boost of energy and fresh ideas.

- Check in with existing partners often to see if they have suggestions or concerns.

Get the word out: develop a communication plan.

Convene kick-off events, activities, and community meetings to showcase your accomplishments (and partners).

(Healthy People 2020, 2015)

Track

(from https://www.healthypeople.gov/2020/tools-and-resources/program-planning/Track)

Questions to Ask and Answer:

- Are we evaluating our work?

- Did we follow the plan?

- What did we change?

- Did we reach our goal?

Plan regular evaluations to measure and track your progress over time.

Consider partnering with a local university or State center for health statistics to help with data tracking. Some things to think about when you are evaluating data over time:

- Data Quality: Be sure to check for standardization of data collection, analysis, and structure of questions.

- Limitations of Self-Reported Data: When you are relying on self-reported data (such as exercise frequency or income), be aware of self-reporting bias.

- Data Validity and Reliability: Watch out for revisions of survey questions and/or the development of new data collection systems. This could affect the validity of your responses over time. (Enlist a statistician to help with validity and reliability testing.)

- Data Availability: Data collection efforts are not always performed on a regular basis.

Do not forget to share your progress—and successes—with your community.

If you see a positive trend in data, issue a press release or announcement.

(Healthy People 2020, 2015)

RESOURCES

1. Community Tool Box. (2015). http://ctb.ku.edu/en/about

2. County Health Rankings and Roadmaps. (2015). http://www.countyhealthrankings.org/

3. Healthy People 2020 (HP 2020). (2015). *MAP-IT*: *A Guide to Using Healthy People 2020 in Your Community*. http://www.healthypeople.gov/2020/tools-and-resources/Program-Planning

4. National Association of County and City Health Officials (NACCHO). (2015). *MAPP Basics*

    – Introduction to the MAPP Process.

    http://www.naccho.org/topics/infrastructure/mapp/framework/mappbasics.cfm

5. National Public Health Performance Standards Program (NPHPSP).

    http://www.cdc.gov/nphpsp/