CHAPTER 9

COMMUNITY HEALTH ASSESSMENT

"An understanding of the determinants of health and of the nature and extent of community need is a fundamental prerequisite to sound decision-making about health. Accurate information serves the interests both of justice and the efficient use of available resources. Assessment is therefore a core government obligation in public health."

—Institute of Medicine (1988)

Learning Objectives

After completing this chapter, you should be able to

- define the *community health assessment* (CHA);
- discuss the CHA process, its strengths, and its limitations;
- describe the types of health data that would be useful for the CHA;
- explain the relationship between the CHA and the community health improvement process (CHIP); and
- understand the CHA's role in improving population health.

Introduction

Every community is different. Therefore, when assessing community health, one approach does not fit all. This chapter highlights the importance of understanding a community's health status, and it describes a variety of approaches for determining whether a community is healthy or not. Assessing the health of a community is an essential public health service, and assessments provide key information for efforts to manage the health of populations.

A **community health assessment (CHA)**, as defined by the Public Health Accreditation Board (PHAB), is a systematic examination of health status indicators for a population, conducted for the purpose of identifying key problems and assets in a community and assisting with the development of strategies to address the community's health issues (PHAB 2011; Turnock 2009). A CHA is also known as a *community health needs assessment* (CHNA). The assessment involves a variety of tools and processes, but "the essential ingredients are community engagement and collaborative participation" (PHAB 2011, 8). The National Association of County and City Health Officials (NACCHO 2016b) further describes a CHA as follows:

> A community health assessment is 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.

community health assessment (CHA) A systematic examination of health status indicators for a population, conducted for the purpose of identifying key problems and assets in a community and assisting with the development of strategies to address the community's health issues.

As these definitions make clear, the concept of the CHA is grounded in the core functions of public health—assessment, policy development, and assurance. These core functions interact in such a way that the information gained through assessment will identify health issues and inform the policy development and assurance functions. The ultimate goal of a CHA is to measure how well the public health system assures the health of the population it serves. It assesses the health indicators for the community and evaluates the development and implementation of policies to promote a healthy population (Institute of Medicine 2003; PHAB 2011).

The Community Health Assessment Process

The CHA process incorporates both quantitative and qualitative methods to collect and analyze specific health data within a community. Health data include social determinants

of health, mortality and morbidity information, quality-of-life indicators, inequity measures, community assets, and an evaluation of how well the public health system conducts its work. With these data, a CHA can help answer the following questions (Dever 1997; Institute of Medicine 2003; Issel 2004):

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

The CHA process is carried out by community stakeholders, such as residents, business owners, and nonprofit organizations, in addition to the local public health department (Cibula et al. 2003; Dever 1997; Issel 2004; PHAB 2010). It uses broad networks of data, mobilizes community members, and garners resources to approach public health issues in a comprehensive manner (Issel 2004; PHAB 2010). The key steps in the process are described in the sections that follow.

Describe the Community and Define the Population

Consider what factors would need to be included in a description of the community. Such factors might include, for instance, population size; features of the geography (e.g., urban or rural characteristics); racial, ethnic, gender, and age distribution; socioeconomic status (e.g., education, employment); culture, religion, and history; and the surrounding environment (e.g., politics, economic conditions, housing) (McCoy 2010).

Engage the Community and Understand Their Health Priorities

Members of the community know the issues that most affect their health and quality of life, and they also know the community's habits, customs, attitudes, and social groups (Edberg 2007). Therefore, the community itself must be an active participant in a CHA. NACCHO (2016a) writes: "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." An additional benefit of community engagement is that community members help bring visibility to CHA and improvement initiatives (Institute of Medicine 2003).

However, developing trust and building collaborative relationships between the community and the local, county, state, or regional health department can take time. Serrell and colleagues (2009) identify four "core values" that are constructive when working in partnership with community members on public health issues: (1) adaptability, (2) consistency, (3) shared authority, and (4) trust. In addition, McCoy (2010) has provided a list of important questions to consider when getting to know the 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?

Identify Key Partners and Stakeholders

A number of factors should be considered when building partnerships with key stakeholders. McCoy (2010) recommends asking the following questions:

- 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, people with access to resources, decision makers)?

Identify Community Health Indicators and Collect Data

A crucial step in the CHA process involves knowing the data that are available to help identify health issues in the community (McCoy 2010). The data will tell the community's story from a health perspective. When collecting and analyzing the data, carefully consider any issues related to their completeness, timeliness, and quality. You might ask, for instance, what is the cause-specific mortality rate for a particular disease in the community? What are the age-specific mortality rates? How do the mortality rates for the community compare to those of other communities? How do the rates compare

to those of the state as a whole? What are the teenage pregnancy and birth rates for the community? Are these rates above or below national benchmarks?

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 (McCoy 2010). What are the major health issues affecting the community? Report this information in a format that is respectful of the varying levels of health literacy among community members, as well as the varying preferences for ways of receiving health information (e.g., social media, newspaper, radio, town meeting).

Develop a Community Health Improvement Plan

Once the health priorities have been identified and reported, the partnership needs to develop a feasible plan to improve the health of the community. The plan should specify goals and objectives to be completed within a reasonable timeframe. It should address how resources will be allocated and how the work will take place, and the partners should agree upon the action steps. The plan should also identify performance measures that will indicate whether the actions have been successful (McCoy 2010).

The Community Health Improvement Process

community health improvement process (CHIP)
A broad improvement effort that includes a community health assessment, builds from the assessment's findings, and provides a framework for addressing key health issues.

The **community health improvement process (CHIP)** is a long-term effort that encompasses a CHA, builds from its findings, and provides a framework for addressing key health issues (PHAB 2010). It has the primary goal of improving the health of communities. The CHIP uses CHA data to identify issues, develop and implement strategies for action, and establish accountability to ensure measurable improvement (Durch et al. 1997). These aspects of the process are often outlined in the form of a community health improvement plan (which is also sometimes known by the acronym *CHIP*). The community health improvement process looks beyond the performance of a single organization serving a specific segment of the community; instead, it focuses on how the activities of multiple organizations contribute to community health improvement (Durch et al. 1997).

Public health experts have developed a variety of CHA and CHIP models that share common elements but differ somewhat in scope or philosophy. Information about several of those models—PRECEDE-PROCEED, Healthy Communities, the Planned Approach to Community Health, the Assessment Protocol for Excellence in Public Health, the CHIP described by Durch and colleagues (1997), and Mobilizing for Action Through Planning and Partnerships (MAPP)—is presented in exhibit 9.1 (NACCHO 2016a). Note

Exhibit 9.1
Community Health Assessment and Community Health Improvement Processes

	Description	Principles	Notes
PRECEDE-PROCEED	A health promotion assessment and planning process in which communities "precede" by defining their desired outcome and conducting an assessment and then "proceed" with intervention and evaluation	Taking time to identify the desired outcome prior to implementing an approach; collaboration; community-based interventions	Usually addresses a single health issue; implements a medical model
Healthy Communities	A health improvement process "owned" by the community	Collective action involving multiple, diverse systems; community ownership; community empowerment; systems change	Influenced MAPP; used in Canada and Europe
Planned Approach to Community Health	Engagement of the community to plan, implement, and evaluate health promotion programs; process includes community health assessment	Data-informed program development; community participation; collaboration; strengthening of local community capacity	Focuses on chronic disease health promotion
Assessment Protocol for Excellence in Public Health (APEXPH)	Tool to help local health departments carry out the core functions of public health	Community involvement; capacity of the local health department	Precursor to MAPP
Community Health Improvement Process	Process with iterative cycles, including identification and prioritization of health issues, analysis, and implementation	Accountability by community collaborators; shared goals; performance measurement	Influenced community health profiles
Mobilizing for Action through Planning and Partnerships (MAPP)	Strategic planning process "owned" by the community, focusing on improving the health of the community and the local public health system; informed by four assessments	Strategic planning; community collaboration and "ownership"; identification of assets and needs	NACCHO's "gold standard" approach to improving community health

Source: Adapted from NACCHO (2016a).

that the processes may include action at a system or agency level, at a local health department level, or even at a specific programmatic level. Some address the underlying factors that affect one or more conditions, while others focus on one specific health condition. Further, some approaches use a socioecological model of health, whereas others use a biomedical model (NACCHO 2016a).

EXERCISE: EXAMPLES OF HIGH-QUALITY CHAS AND CHIPS

A collection of high-quality CHAs and CHIPs are presented on the NACCHO website at www.naccho.org/topics/infrastructure/CHAIP/guidance-and-examples.cfm. Explore the materials at the following links and answer the related discussion questions.

East Central Kansas Public Health Region: CHA/CHIP
http://archived.naccho.org/topics/infrastructure/CHAIP/upload/ECKPHC-CHA_CHIP_2012.pdf

1. Describe the CHA and CHIP processes based on the information provided.
2. Do you agree with the community's rationale for choosing which health issues to work on? Explain.

Alachua County, Florida, Health Department: Community Health Profile
http://archived.naccho.org/topics/infrastructure/CHAIP/upload/Alachua-County-Community-Health-Profile-2012.pdf

1. Review the section titled "Local Public Health System Performance Assessment" (pages 8–10), and describe how that assessment complements the CHA and CHIP.
2. Comment on possible reasons that the "Essential Public Health Services" ranked the way they did for this community. What factors might influence this rank order for a community?

CHA and CHIP Tools

Mobilizing for Action Through Planning and Partnerships

The Mobilizing for Action Through Planning and Partnerships (MAPP) tool is a resource jointly developed by NACCHO and the Centers for Disease Control and Prevention

(CDC). It is a community-driven strategic planning process, facilitated by public health leaders, that helps communities prioritize public health issues, find resources to address them, and ultimately improve the performance of local public health systems (NACCHO 2016c). It centers on a vision of "Communities achieving improved health and quality of life by mobilizing partnerships and taking strategic action." MAPP emphasizes the need for communities to use their resources wisely, take into account their unique circumstances and needs, and form effective partnerships for action. No one approach will fit every community; tailored approaches are more effective.

NACCHO (2016c) lists seven main elements of MAPP:

1. "*MAPP emphasizes a community-driven and community-owned approach.*" The community's strengths, needs, and desires drive the MAPP process, which strengthens community connections and provides access to the community's collective wisdom (NACCHO 2016c).

2. "*MAPP builds on previous experiences and lessons learned.*" MAPP incorporates concepts from previous planning efforts and assessment tools, most notably the Assessment Protocol for Excellence in Public Health (APEXPH) that was released in 1991, but is more progressive in a variety of ways (NACCHO 2016c). See exhibit 9.1 for comparison.

3. "*MAPP uses traditional strategic planning concepts within its model.*" MAPP model includes such concepts as visioning, an environmental scan, identification of strategic issues, and formulation of strategies (NACCHO 2016c).

4. "*MAPP focuses on the creation and strengthening of the local public health system."* MAPP defines *local public health systems* as the "human, informational, financial, and organizational resources, including public, private, and voluntary organizations and individuals, that contribute to the public's health"—a definition from the Institute of Medicine's *Improving Health in the Community* (Durch et al. 1997). The MAPP tool aims to bring these diverse elements together to carry out public health activities in a collaborative effort (NACCHO 2016c).

5. "*MAPP creates governmental public health leadership.*" MAPP helps create a greater recognition of the roles governmental entities (e.g., local health departments, boards of health, environmental agencies) play in their communities (NACCHO 2016c).

6. "*MAPP uses the essential public health services to define public health activities.*" The essential public health services (EPHS) discussed in

chapter 1, as well as other public health practice concepts, are incorporated into MAPP, helping to link it with other public health initiatives (NACCHO 2016c).

7. "*MAPP brings four assessments together to drive the development of a community strategic plan.*" The four assessments are the Community Themes and Strengths Assessment, which focuses on themes of interest to the community, quality-of-life perceptions, and community assets; the Local Public Health System Assessment, which measures the ability of the local public health system to carry out essential services; the Community Health Status Assessment, which analyzes data about health status, quality of life, and risk factors; and the Forces of Change Assessment, which identifies forces that affect or will affect the community or local public health system (NACCHO 2016c).

Community Tool Box

The Community Tool Box is an online resource developed by the Work Group for Community Health and Development at the University of Kansas, along with collaborating partners. It offers a variety of educational modules and other tools in support of its mission to "promote community health and development by connecting people, ideas, and resources" (Community Tool Box 2016). "The vision behind the Community Tool Box is that people—locally and globally—are better prepared to work together to change conditions that affect their lives."

County Health Rankings & Roadmaps

The County Health Rankings & Roadmaps program, previously discussed in chapter 4, is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The program provides a variety of data—including information about education, employment, income, obesity, and quality of air and water—to help answer the question, "How healthy is your community?" The Rankings provide a "snapshot of how health is influenced by where we live, learn, work and play," and the Roadmaps offer guidance and strategies for moving from education to action (County Health Rankings & Roadmaps 2016).

The program's goals include building awareness of the various factors that influence health; providing reliable, sustainable source of local data to help communities find opportunities to improve health; engaging and activating local leaders from various sectors to create change; and empowering community leaders working to improve health (County Health Rankings & Roadmaps 2016).

Healthy People 2020 MAP-IT

Healthy People 2020, previously discussed in chapter 1, is an initiative of the US Department of Health and Human Services that helps guide health promotion and disease prevention efforts. An important part of the initiative is the Mobilize, Assess, Plan, Implement, Track (MAP-IT) tool, which helps the public health system plan and evaluate interventions aimed at achieving the Healthy People objectives. The MAP-IT tool operates under the premise that no two public health interventions are exactly alike, because no two communities are exactly alike (Healthy People 2016).

The Healthy People (2016) website provide guidance for each of MAP-IT's components:

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.

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.

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).

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).

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.

National Public Health Performance Standards

The CDC's National Public Health Performance Standards (NPHPS) provide a tool with which to assess the performance of the public health system and related governing bodies.

The NPHPS framework assists with identifying areas for improvement in the system, building stronger partnership, and ensuring proper management of public health issues. Its tools are used to identify partners and community members in the public health system; engage those partners in health assessment and improvement planning; and promote improvement in agencies, systems, and communities (CDC 2016). The CDC (2016) identifies four key concepts that helped frame and inform the NPHPS:

- The ten essential public health services
- Focus on the overall public health system
- Focus on an optimal level of performance rather than on minimum expectations
- Supporting a process of continuous quality improvement

The standards incorporate three assessments: the State Public Health System Assessment Instrument, which focuses on state public health agencies and other partners at the state level; the Local Public Health System Assessment Instrument, which assesses the local public health system and entities that contribute to public health services in a community; and the Public Health Governing Entity Assessment Instrument, which focuses on governing bodies (e.g., boards of health, councils, or county commissioners) accountable for public health at the local level (CDC 2016).

Issues in Data Collection and Analysis for Community Health

The process of improving the health of a community starts with understanding the public health issues affecting the population and identifying those for which a feasible intervention can be implemented in a timely manner. Earlier in this chapter, we examined the steps of the CHA process. But once the community has been defined in terms of demographics, how do we know if the public health issues that were identified are indeed problematic? One way is by comparing the community's data with data from other areas that can serve as benchmarks. Common benchmarks include similar or nearby communities; state and national experiences; and state and national targets and goals (Tutko 2013).

quantitative data
Data that can be counted or expressed numerically.

Types of Data

qualitative data
Data provided in a verbal or narrative form.

Often, two types of data are collected about communities: **quantitative data**, which can be counted or expressed numerically, and **qualitative data**, which are provided in a verbal or narrative form. Quantitative data might include, for instance, vital records data, numbers of physician office and emergency room visits, Behavioral Risk Factor

Surveillance System findings, and US Census figures. Qualitative data might include information obtained via key informant interviews, open-ended survey questions, or focus groups. Both types of data present certain advantages. Quantitative data can quickly summarize events and allow for easy comparison with benchmarks. Qualitative data, meanwhile, can offer explanations behind the quantitative data—in other words, the "hows" and "whys" behind the numbers—and allow for investigation of matters for which quantitative data is not available. In addition, the collection of quantitative data can lead to increased buy-in from stakeholders who have been directly asked about their experiences and opinions.

Data can also be classified as either primary or secondary. **Primary data** are collected by investigators for their own specific purpose, whereas **secondary data** have already been collected by someone else but can be used by other investigators for their own purposes. For example, quantitative primary data might come from an observation survey of seatbelt usage, and qualitative primary data might come from personal interviews about why respondents do or do not wear seatbelts. Quantitative secondary data might be obtained from a hospital discharge data set, and qualitative secondary data might include healthcare provider notes in an electronic medical record (Tutko 2013).

primary data
Data collected by investigators for their own specific purpose.

secondary data
Data that have already been collected by others.

Obstacles to Data Collection

Accessing data for the assessment of community health can be challenging. Some data of interest might not be collected at the required geographic level, or even collected at all. Other data might be out of date or unable to be released because of confidentiality concerns. Another issue involves the privacy of individuals who represent rare or unusual events. For instance, if only a very small number of cases of a condition exist in a community, the reporting of health data might enable others to identify those individuals. To prevent personal identification in such cases, local and state health departments and other agencies will often suppress the reporting of events if they number fewer than, say, five cases.

The Community Benefit Standard and Population Health

In 1969, the US Internal Revenue Service (IRS) set forth the **community benefit standard**, which enables eligible nonprofit hospitals to maintain a tax-exempt status and receive federal funding for services provided to the poor in their communities (Miller 2009). To qualify under the community benefit standard, a nonprofit hospital must meet the following requirements (Miller 2009):

- It must have a board made up of community members.
- Qualified physicians in the area must have medical privileges at the hospital.

community benefit standard
A set of requirements for nonprofit hospitals in the United States seeking tax-exempt status and federal funding for services provided to the poor.

- It must have an emergency department.
- It must admit all types of patients without discrimination.
- Funding must be directed to benefit the patients served by the hospital.

The community benefit standard relates to community health assessment in a number of ways. First, the Affordable Care Act (ACA) of 2010 included provisions to more closely tie the community benefit standard to community health, and these provisions require hospitals to conduct CHAs and develop CHIPs (IRS 2016; Turner and Evashwick 2014). In addition, the IRS, in monitoring compliance with the standard, has recognized that hospitals can benefit their communities not only by providing charitable care but also by providing community-oriented health promotion efforts (Turner and Evashwick 2014). Furthermore, the Public Health Accreditation Board has developed national accreditation guidelines for local and state public health departments, and these guidelines also include a CHA requirement (PHAB 2015). As a result of these and other developments, a significant sector of the public health system will be assessing community health.

In conducting assessments and developing feasible interventions, the public health system should recall the Evans and Stoddart field model of health and well-being (discussed in chapter 8), which emphasizes the wide range of determinants contributing to a community's health status. Turner and Evashwick (2014, 159) highlight the complex nature of the work:

> 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.

Stoto (2013) summarizes, "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." He concludes: "Managing a shared responsibility, however, is challenging; given the many factors that influence health, no single entity can be held accountable for health outcomes."

Key Chapter Points

- A community health assessment (CHA) is a systematic examination of health status indicators for a population. It is conducted for the purpose of identifying key problems and assets in a community and assisting with the development of strategies to address the community's health issues. The concept of the CHA is grounded in the core functions of public health—assessment, policy development, and assurance.
- The steps involved in the CHA include the following: (1) describe the community and the population; (2) engage the community and understand their health priorities; (3) identify key partners and stakeholders; (3) identify community health indicators and collect data; (4) report the health priorities; and (5) develop a community health improvement plan.
- The CHA is part of a broader community health improvement process (CHIP). The CHIP uses CHA data to identify issues, develop and implement strategies for action, and establish accountability to ensure measurable improvement.
- Public health experts have developed a variety of CHA and CHIP models that share common elements but differ somewhat in scope or philosophy.
- The Mobilizing for Action through Planning and Partnerships (MAPP) tool was jointly developed by the National Association of County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). It provides a strategic planning process to help communities prioritize public health issues, find resources to address them, and ultimately improve the performance of local public health systems.
- NACCHO (2016c) describes the key elements of MAPP: It is community-driven and community-owned, builds on previous experiences and lessons learned, uses traditional strategic planning concepts, focuses on the creation and strengthening of the local public health system, creates governmental public health leadership, incorporates the essential public health services, and brings four assessments together to drive the development of a strategic plan.
- The Community Tool Box is an online resource developed by the Work Group for Community Health and Development at the University of Kansas, along with collaborating partners. It offers a variety of educational modules and other tools.
- The County Health Rankings & Roadmaps program is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. Its goals include building awareness of the factors that influence health; providing a reliable, sustainable source of local data for communities; and engaging and empowering community leaders to improve health.

- The Mobilize, Assess, Plan, Implement, Track (MAP-IT) tool helps the public health system plan and evaluate interventions aimed at achieving the objectives of the US government's Healthy People initiative.
- The CDC's National Public Health Performance Standards (NPHPS) provide a tool with which to assess the performance of the public health system and related governing bodies. They incorporate three assessments: the State Public Health System Assessment Instrument, the Local Public Health System Assessment Instrument, and the Public Health Governing Entity Assessment Instrument.
- Quantitative data can be counted or expressed numerically, whereas qualitative data are provided in a verbal or narrative form. Both types of data present certain advantages. For example, quantitative data can summarize events and allow for comparison to benchmarks, whereas qualitative data can offer useful explanations.
- Accessing data for the assessment of community health can be challenging. Some data of interest might not be collected at the required geographic level, or even collected at all. Other data might be out of date or unable to be released because of confidentiality concerns.
- The community benefit standard, set forth by the US Internal Revenue Service (IRS), enables nonprofit hospitals, if they meet certain requirements, to maintain a tax-exempt status and receive federal funding for services provided to the poor in their communities.
- The Affordable Care Act (ACA) of 2010 included provisions to more closely tie the community benefit standard to community health, and these provisions require hospitals to conduct CHAs and develop CHIPs. In addition, the Public Health Accreditation Board (PHAB) has developed national accreditation guidelines for local and state public health departments, and these guidelines include a CHA requirement.

Discussion Questions

1. What is a community health assessment? Briefly describe the CHA process.
2. How are CHAs and CHIPs useful in improving the health of communities?
3. Describe two tools used to conduct a CHIP.
4. What types of data are useful in a CHA?
5. What is the community benefit standard?
6. How can the community benefit standard be useful in improving population health?

7. Using a diagram, show the relationship between community health and the systems that deliver healthcare.
8. What are the similarities and differences between MAPP and MAP-IT?

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