How to Conduct a Community Health Assessment: Guidance for AmeriCorps Members

Author: Henry Stabler, PhD

INTRODUCTION

This guidance document is a resource for undergraduate and graduate students if asked to participate in producing a community health assessment (CHA). Its purpose is to synthesize available information on how to conduct a CHA, regardless of the type of organization(s) involved. This document is also meant to be flexible, providing sufficient information for students regardless of their level of involvement.

What is a Community Health Assessment (CHA)?
Per the Centers for Disease Control and Prevention ([CDC](#)), a community health assessment is "… a state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis."
Assessing the health of a community is a long-practiced public health tool for organizations looking to improve the health and well-being of the communities that they serve. The results of a CHA can be used to identify the most pressing health issues affecting a community and inform how best to allocate resources to address these issues. Often a CHA is a necessary first step for the development of a community plan to address certain health issues.

What is a Community Health Needs Assessment (CHNA)? Are there any differences between a CHA and a CHNA?
A CHA and CHNA are two very similar types of health assessments: both use available data to assess the health status of a particular region or community., but there are a number of differences to note (see Table 1, below). CHAs are generally the preferred terminology for the types of assessment conducted by health agencies, while CHNAs are more commonly conducted by hospitals and health systems. CHAs are entirely voluntary for health agencies to conduct, while completion of CHNAs is required for non-profit hospitals as a condition of their continued tax-exempt status. Assessment frequency is also different, with CHNAs conducted every three years and CHAs completed once within a five year period.

CHAs and CHNAs also differ in purpose. CHAs will generally 'profile' the health of the community, which can mean covering a range of different health domains; CHNAs, on the other hand, must prioritize the most urgent health issues. In practice, this final difference between CHAs and CHNAs is not relevant, because CHAs are often completed with a specific purpose in mind. For example, many CHAs will prioritize certain health issues as part of the process for developing a Community Health Improvement Plan (CHIP), which is a workplan for health agencies to follow based on the results of the CHA. In fact, it is not uncommon for health agencies and hospitals to partner on their respective assessments.

Table 1: Community Health Assessment (CHA) vs Community Health Needs Assessment (CHNA)

Topic	CHA	CHNA

Requirement	Public Health Accreditation Board (voluntary accreditation)	Internal Revenue Service (IRS) (required for tax-exempt hospitals)
Periodicity	w/in 5yrs of app. submission	Every 3yrs
Local Authority	Local / state/ regional/ tribal health departments	Non-profit hospital(s)
Jurisdiction	Jurisdiction served by applicant, interdependent jurisdictions served by multiple local health departments	"community served by hospital", "jointly defined community served by multiple hospitals" (may only capture part of a county or overlap multiple)
Focus	*Population Health*: population health needs, community health profile, available assets	*Health Needs*: "community health needs" (prioritizing their patients served)
Implementation	Community Health Improvement Plan (CHIP)	Implementation Strategy

Who Conducts CHAs (and/or CHNAs)?
CHAs and CHNAs have become commonplace within the past 10 years, in particular due to several regulatory changes that have compelled health agencies and hospitals to regularly conduct these assessments. Although the focus of this guidance document will be on completing a CHA, becoming familiar with the regulations motivating the conduct of both CHAs and CHNAs and the required components of each assessment type will be a key step for anyone involved.

Local Health Departments: In 2011, the Public Health Accreditation Board (PHAB), a national nonprofit organization committed to advancing best practices among health agencies, established a national accreditation program for state, local, tribal, and territorial health departments. As part of the standards and measures to achieve accreditation is the requirement for health departments to regularly conduct a comprehensive community health assessment within a five-year period (Domain 1, Standard 1.1).

Nonprofit Hospitals: Since 2011, all US hospitals that are classified as a "nonprofit organization" must comply with federal regulations in order to qualify for certain federal tax exemptions. Among these regulations is a requirement to conduct a CHNA every three years. These federal regulations are overseen by the Internal Revenue Service (IRS) and can be found here. This guidance document will refer to these regulations where applicable

(for example, who must be engaged as part of the CHNA process to be compliant with the IRS regulations).

Like health agencies, hospitals also are required to use the results of the assessment to plan an "implementation strategy", which is similar to a CHIP but lays out how the hospital plans to address the prioritized health issues.

Other organizations: Other types of organizations and agencies may also be interested in conducting a health assessment of their own and/or want to be involved in larger health assessment efforts. For example, a local United Way or another charitable foundation may want to use the results of a health assessment to decide where to allocate their resources.

Given that health assessments are conducted by different organizations, including both health agencies and hospitals, multiple organizations may collaborate to conduct a single assessment.,When working with partners, it is especially important to establish the goals and objectives of the assessment from the very beginning to ensure the final report meets the expectations of the supporting organizations.

PLANNING A CHA

An initial planning process wherein assessment-related goals, objectives, and an initial timeline are discussed with supporting organizations is a critical first step for conducting a CHA. Here are some key questions that should be answered by the end of this planning process:

What type of framework or model is being used to guide the assessment?
A number of different commonly-used frameworks are available to help guide organizations through the CHA process. These frameworks provide step-by-step guidance for health agencies to follow.

In Minnesota, local health agencies are expected to use the state-designed [framework](#) (discussed in more detail later). This framework provides an overall structure for the process and allows for the use of a more detailed framework to drive how the assessment is conducted. Some of these more detailed frameworks include:
- [Mobilizing for Action through Planning & Partnership (MAPP)](#)
- [Association for Community Health Improvement Assessment Toolkit](#)
- [Assessing and Addressing Community Health Needs from the Catholic Hospital Association of the U.S.](#)
- [Community Tool Box](#)

There are many, many other [models](#) and tools as well, from a range of different sources and agencies. For example, there are [tribal-specific assessment](#) tools that are meant to help tribal health agencies navigate a community health assessment process. Because of how common it is, this guidance document will also discuss some of the more commonly used models in more detail below.

The model or framework that a client organization chooses to follow is important because they must document and report on the process used for their assessment. See, for example, PHAB's Measure 1.1.1: "The health department **must document** the collaborative process to identify and collect data and information, identify health issues, and identify existing Tribal or local assets and resources to address health issues." We will discuss some of these models in more detail below.

What is the geographic area being assessed and how is it defined?
Defining the geographic area being assessed is a critical step. What are some common ways a geographic area might be defined?
- By state
- By county
- By municipality
- By ZIP code
- By census tract

A geographic area can be composed of different geographic units - for example, a county can be broken down into smaller geographic units, such as census tracts or zip codes. Other times, a geographic area might be defined based on a particular criteria, such being within a particular distance from a hospital. This can lead to a geographic area including partial geographic units, such as part of a county or municipality.

Knowing how the geographic area being assessed is defined will have implications for your data analysis. Any secondary data set (and potentially primary data set if you are conducting a survey) you may use for analysis will rely on data that is reported for a certain geographic area. Secondary data is commonly presented at a county level (see for example, the County Health Rankings – more on this source, below), but other data sources, such as from the U.S. Census, can be disaggregated down to a census tract, which may be helpful if the area being assessed is more urban and has more people living in each square mile.

Other geographic units that are less commonly used to define geographic areas for the purposes of conducting a CHA, such as ZIP codes, may become relevant if the organization you are working for has sufficient resources to conduct any sort of address-based survey, or telephone-based survey where respondents are asked for their ZIP codes.[1]

Who should be involved and in what capacity?
While this is a question that those organizing the CHA should be responsible for answering, it still may be relevant to you as someone involved in some capacity for producing the assessment. For example, many assessments may rely on an advisory committee to help guide and review the CHA as it is conducted, and you may be expected to present to this group. Many CHAs also require conferring with certain stakeholders when determining the most pressing health issues. If you are asked to interview these stakeholders, you will need to know who the client organization would like you to interview.

What health domains are to be covered?
A key next step is discussing how the assessment report is to be organized, which requires knowing which broad health domains are to be included. Health domains are broad areas of health. Many times, these domains are organized around specific health issues, such as 'cancer' or 'infectious disease'. Many times, reporting organizations will also want to include non-health domains that influence health (often referred to as social determinants of health), such as economic status or food insecurity. Knowing which health domains are to be included in the assessment report will help determine the sources of data to be included in the report.

What data should be used?

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[1] This guidance document will not discuss the finer points of conducting a telephone-based survey, as it requires significant resources, time, years of expertise, etc. to complete – and the chances of a client organization asking you to conduct a randomized telephone survey for them is virtually non-existent. However, this document will discuss some basic concepts of survey analysis, as you may be expected to analyze survey data.

After determining the health domains that should be covered by the health assessment, the next step is discussing potential sources of data for each health domain. Potential sources of data are covered in more detail below, but it is important to discuss in this initial planning section.

Conducting a CHA usually requires both primary and secondary data sources. Primary data refers to data that has been collected firsthand by those conducting the assessment. This can include, for example, surveys, focus groups, and interviews. Secondary data are those datasets that are collected by external agencies or organizations. Many times, these data sources are collected by large governmental entities periodically. The data that comprise your assessment will likely be quantitative data, which are any data that are numeric in nature, and that can be counted and/or put into specific metrics or statistics.. Your assessment will also likely include qualitative data, which is data comprised of narratives that are more descriptive in nature. They can come from, for example, interviews or narrative responses to an open-ended survey question. While quantitative data may provide better answers to "What" or "How many" questions, qualitative data is often better suited to provide contextual answers to "Why" questions.

How will the assessment ensure existing health disparities in the community are accounted for?
While CHAs are meant to assess the health and well-being of the community-at-large, one must remember that within each community exist those who disproportionately suffer from poor health due to disadvantages related to who they are and what they are able to access. This includes those who live in poverty, those who endure the effects of racism, and those who are disabled and/or elderly. Determining how to best identify the issues that these marginalized community members face should be a point of discussion from the outset. For example, partners could discuss how to ensure the list of potential interviewees includes people from these communities. An assessment that has centered equity throughout its process and identifies health concerns that are relevant to the most marginalized is only possible when equity has been a point of discussion and focus from the very beginning of the assessment.

What is your scope of work and your deadlines?
If you are reading this document, it is assumed that you have been asked to participate in a CHA in some capacity. The organization(s) that are overseeing the assessment process will need to be clear about what is expected of you and what you are responsible for producing from the very beginning. When multiple individuals and organizations are involved in a joint assessment, it is common to put together a workplan or a schedule that lays out responsibilities and deadlines.

Assessment Guidance & Frameworks

Because you might need a clear understanding of the process involved, this section will detail some commonly used guidance models and frameworks for conducting a CHA.

Minnesota Department of Health Guidance
The Minnesota Department of Health (MDH) has outlined a series of steps that all local health agencies should follow when conducting a CHA that is especially helpful for delineating how the initial planning process should proceed. Within this guidance, health agencies should feel free to follow one of the many other CHA models available, including the two described in detail below (MAPP and the Community Tool Box).
The steps that MDH suggest include:
1. Organize: This step encompasses the initial phase of planning a CHA. As part of this phase, assessment organizers will want to: (1) review what has worked and what has not worked in previous assessments and develop a process that builds on these lessons; (2) recruit (or re-recruit) a broad, multisectoral partnership team to plan and implement the assessment process to ensure it is 'community-driven'; (3) choose or adopt a planning model such as MAPP or the Community Tool Box (see below) to ensure the assessment will meet your needs and the needs of your community; (4) establish a regular meeting schedule for your team; and (5) establish a plan for communicating your progress internally and to the community-at-large.

2. Plan assessment in partnership: Once an assessment team has been established, the next phase of the assessment process should be concerned with ensuring the team has consensus around how the process will function, i.e., how decisions are made, how will the assessment process unfold, etc. Internal organizers should first decide on an internal infrastructure to use - for example, organizers should decide if they will fully integrate partners into the minutiae of the assessment process or will there be a separate partnership team whose role is to advise throughout the process.

3. Hold facilitated planning sessions: This phase, which involves utilizing the expertise of your partners to help interpret your analyses, includes several interim steps. This includes: (1) gathering and compiling data from a variety of sources (both quantitative and qualitative data); (2) summarizing the data and analyzing the results in collaboration with your partners; (3) adding data as needed to complete as holistic a health profile of your community as possible; and (4) beginning discussions around prioritizing certain health issues based on the results of the data analysis.

4. Develop an action plan: Once you have exhausted your sources of data and analyzed the results, your focus should turn to sharing the results with the rest of your communities - in particular, via the networks of your partners.

5. Monitor and revise with partners: To ensure that the CHA is not the end of your multi-sectoral partnership, MDH recommends establishing a regular meeting schedule, in order to continue monitoring your community's health and ensure resources are directed where they are needed.

This MDH framework is purposely broad, which allows for the adoption of more in-depth models to inform how your CHA is conducted. This includes two that are recommended by MDH: Mobilizing for Action through Planning and Partnership (MAPP) and the Community Tool Box.

Mobilizing for Action through Planning and Partnerships (MAPP)
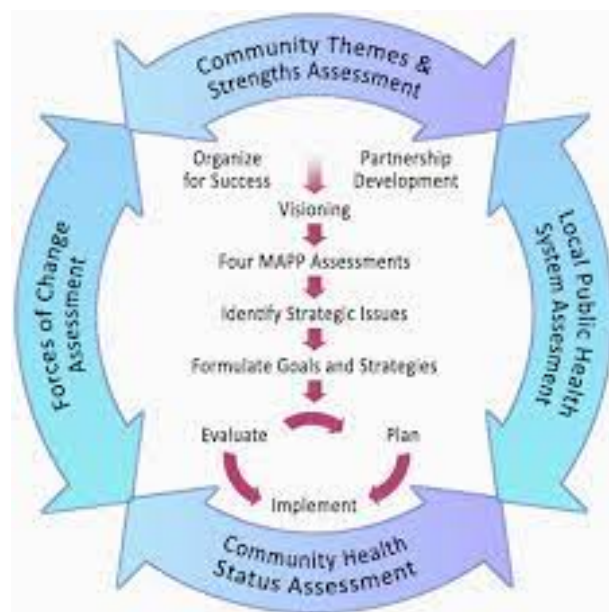
MAPP is a very common model (particularly among public health practitioners) for conducting a CHA and identifying community health issues. First developed by the National Association of County and City Health Officials (NACCHO), MAPP has been used for two decades to help organizations, particularly health agencies, conduct a health assessment. It lays out a community-wide strategic planning process that requires input from a range of community organizations and agencies to first prioritize health issues and then identify available resources to address these issues. Subsequent development of strategies to address these health issues is based on a comprehensive assessment of both the health of the community and an internal assessment of who is available to help improve community health.

MAPP is comprised of six phases:

-   Phase 1- Organize for Success and Partnership Development: This phase is the planning phase of the overall assessment and when organizers make decisions about who should be part of the process and how the assessment should be conducted
-   Phase 2 - the Visioning Phase: The phase when organizers collectively decide on an approach that ensures a shared community vision
-   Phase 3 - the Four Assessments: The most critical phase of the MAPP process; the aim of the four assessments is to provide a comprehensive, holistic, current view of the community.
    o   The Community Themes and Strengths Assessment: An assessment of the issues that community members feel are important
    o   The Local Public Health Systems Assessment: An overview of the local public health system, including all of the organizations that contribute to the delivery of public health services

o The Community Health Status Assessment: An assessment of priority community health and quality of life issues

o The Forces of Change Assessment: An assessment of the forces that will likely affect the operations of the local public health system and surrounding community, such as legislation or technology.

- Phase 4 - Identifying Strategic Issues: uses all of the information gathered from the four assessments and identifies the issues that the community must address.

- Phase 5 – Developing Goals, Strategies, and an Action Plan: During this phase, participants formulate goals in response to the issues identified in Phase 4, and then begin developing strategies and interventions that will enable the community to meet those goals.

- Phase 6 – Taking and Sustaining Action: The final phase of the MAPP process encompasses three action cycle activities – planning, implementation and evaluation of the chosen strategies and interventions.

While you may be involved in other phases in some capacity, Phase 3 is where you likely will be most involved. The link provided for Phase 3 has a wide array of examples and guidance documents that you can use to help guide you through the assessment process.

Community Tool Box (University of Kansas)
Another commonly used model for conducting a CHA is the Community Tool Box developed by the University of Kansas. The Community Tool Box is an extremely comprehensive CHA model that not only provides detailed information on how to conduct a CHA, but also includes a number of relevant, associated toolkits to help guide LHAs to develop associated skills, such as conducting program evaluation of your CHIP initiatives or community engagement.

The recommended steps of the Community Tool Box are very much designed for CHAs whose primary goal is to establish a list of prioritized health issues that are relevant to the community, and that can easily be worked into a CHIP. These steps include:

1. Describe the makeup and history of the community to provide a context within which to collect data on its current concerns.

2. Describe what matters to people in the community, including a description of:

3. Describe what matters to key stakeholders

4. Describe the evidence indicating whether the problem/goal should be a priority issue

5. Describe the barriers and resources for addressing the identified issue(s), including

Data Collection & Analysis

As should be obvious by now, CHAs rely on data. How, then, do we go about collecting data for our assessment? First, let us start with a discussion of secondary data and some of the types of measures you may encounter when compiling secondary data. We will then go into a discussion of primary data collection, and the many ways in which you can collect data yourself.

Secondary Data Collection
The types of data used for CHAs will vary, but can largely be broken down into some general categories, including: demographic information on the region being assessed; information that describe the health status of the community, both broadly and for more specific health domains; and information on different social and economic conditions within the community. Most (if not all) of your data will come from secondary sources – especially from federal, state, and local government agencies – and most of this data will likely be presented in the form of measures and statistics that have already been calculated for you. Some secondary data sources though may require you to calculate statistics yourself using data that has been downloaded or acquired.

Before getting into specific sources of data, what types of statistics might you encounter, or be asked to calculate?

An Epidemiologic Approach[2]
A basic understanding of key epidemiological concepts is helpful for understanding the various statistics and measures that are often used in a CHA. Per the CDC, the study of *epidemiology* is "… the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems". Measures that are used in CHAs can describe the distribution (i.e., the frequency and pattern of health-related events in the communities being assessed, such as the number of people with cancer) and determinants (i.e., the potential causes that influence the onset of disease, such as the number of people who visit their doctor every year or that have a regular exercise regimen). Very broadly, these measures: (1) count up the number of cases or events over a specific time period in a specific place, and/or among a specific set of people; (2) divide that number by a denominator, such as the total population residing in the geographic area being assessed, to come up with a rate; and (3) compare these rates with other geographic areas and/or groups of people.

Because we are attempting to summarize the health of a community in a CHA, you will typically encounter frequency measures, including proportions and rates.

A proportion is a comparison between the number of people afflicted with, or characterized by, some particular feature. Note that the denominator of a proportion (the bottom part) is inclusive of the top part (the numerator):

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[2] This section providing a brief, basic overview of important epidemiology concepts is based on the CDC's free introductory epidemiology self-study course and textbook. While the guidance in this section is meant to provide you with a sufficient understanding for the purposes of conducting an assessment, the CDC's course is a much more thorough and useful introduction to epidemiology.

$$\frac{Number\ of\ people\ or\ events\ with\ a\ characteristic}{Total\ number\ of\ people\ (inclusive\ of\ numerator)}$$

Proportions can also be expressed as a percentage - just multiple the above calculation by 100 – in addition to a fraction or decimal.

A <u>rate</u> is an expression of event frequency in a specific population over a period of time. Common types of rates that are often used in a health assessment include incidence rates, prevalence rates, birth rates, mortality rates, and clinical-related rates, such as hospital or emergency room admission rates. Rates are usually multiplied by either 1,000, 10,000, or 100,000 and expressed as a rate 'per 100,000 people'. Note that these rates can be cause-specific (for example, the number of cancer deaths per 100,000 people), all-cause (total number of deaths per 100,000 people), or specific to a population (infant mortality rate is typically the number of deaths among children <1 year old).

Table 2: Common Rate Calculations

Metrics	Calculation
Crude Incidence rate	$\frac{Number\ of\ new\ cases\ during\ time\ period}{Average\ population\ during\ time\ period}\ x\ 10^n$
Prevalence rate	$\frac{All\ new\ and\ pre-existing\ cases\ \ during\ time\ period}{Population\ during\ time\ period}\ x\ 10^n$
Birth rate	$\frac{Number\ of\ new\ cases\ during\ time\ period}{Average\ population\ during\ time\ interval}\ x\ 10^n$
Crude mortality rate	$\frac{Number\ of\ deaths\ during\ time\ period}{Population\ during\ time\ interval}\ x\ 10^n$

Incidence and mortality rates can also be expressed as crude (as seen in Table 2 above) or age-adjusted. Crude rates, while a reflection of the true burden of disease or mortality, are affected by the underlying age distribution of a population because of the higher probability of disease burden and death among older adults. This makes it difficult to compare, for example, cancer incidence between two geographic areas if one area happens to have more older adults than the other. An age-adjusted rate accounts for this, by standardizing the crude rate to a larger population. In the U.S., this typically means standardizing rates to the U.S. population age groups. If you are asked to standardize the mortality and/or incidence rates, there are several different tutorials that will walk you through the process. See, for example, the National Cancer Institute's <u>tutorial</u>.

Presenting both crude and age-adjusted measures are appropriate to use in your assessment, as both provide critical information; however, if you are making comparisons between different populations and/or communities, you will need to use age-adjusted measures, especially for any measure that expresses a burden of disease.

A final type of measure you might encounter is a composite index measure. This is a measure that consolidates multiple measures into one, in order to describe an important concept, such as 'socioeconomic status'. Some common index measures include:

- The food security index , which includes measures related to the average distance to grocery stores or supermarkets, where people can buy healthy foods, and how affordable food is, in order to capture a community's ability to access food.
- The social vulnerability index, which uses 15 different measures of social conditions such as unemployment, prevalence of disability, and access to transportation to rank a community's vulnerability to hazardous events.
- The community need index is a community health need composite measure that aggregates different socioeconomic indicators that contribute to disparities in health.
- Hospital admissions for acute or chronic ambulatory care-sensitive condition composite measures capture the rate at which Medicare beneficiaries are hospitalized for various acute or chronic conditions that are preventable, such as urinary tract infections or bacterial pneumonia (for acute care patients) or complications from diabetes or heart failure (for patients with chronic conditions). These two composite measures are often used to characterize the quality of care patients are receiving.

Common Health Domains & Measures
Now that we have established the general types of measures we might use for an assessment, let us now turn to common data and measures that we might use across different health domains.

A good place to start is the County Health Rankings & Roadmaps, a program of the University of Wisconsin Population Health Institute. The County Health Rankings provide comparable health-related statistics on every county and state in the U.S., using a wide array of data sources. For many CHAs, the quantitative data analysis begins (and sometimes ends) with looking up their geographic area and using the set of statistics available for their county or counties. The County Health Rankings model, seen in Figure 1, is often used by CHAs as a framework for organizing the assessment and identifying categories of health issues to prioritize (seen on the right-side of the model), such as tobacco use or access to care. This is one way to organize the assessment and final report, although more specific health-related domains, such as 'diabetes' or 'infectious disease' can also be used or incorporated into this framework.

One thing to pay attention to when using the County Health Rankings: the dates of the underlying data. Some measures will use more recent data, such as any estimated measure

that uses data from the Behavioral Risk Factor Surveillance System (BRFSS) or from the Census (more on these data sources, below). Others will be older or averaged across multiple years. An unfortunate fact of working with data is that it is rarely recent. It takes a significant amount of time, effort, and resources to collect into a workable database that can be used for analysis. Acknowledging that the secondary data you use in your assessment is likely at least several years old is important, especially if the story that it tells about the health in your community is different from the story that you might hear directly from residents (if you are collecting primary data).

Some measures may also combine years of data together in order to have sufficient sample sizes to estimate measures, such as the 5-year estimates from the American Community Survey. Another unfortunate fact about data is that it requires a sufficient enough sample size to produce an estimate that can accurately represent that population. Thus, counties in rural communities with fewer people will have difficulty calculating certain measures. Combining data from multiple years is an appropriate method for building up a sufficient sample size to estimate measures.
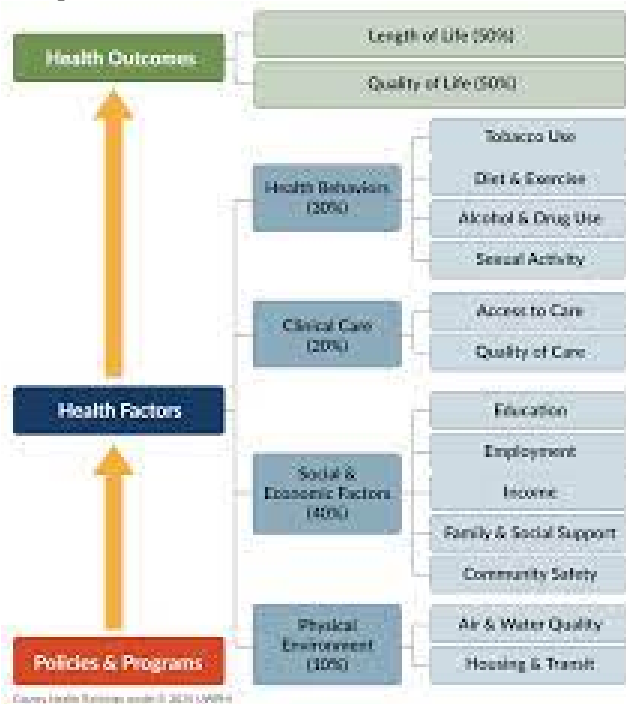
This brings us to a final fact about data: it uses intimate information about peoples' lives. Almost all of the measures in the County Health Rankings are calculated using private databases that are collected directly from individuals, and are produced by the agencies that control the data. As part of the assessment process, you may be asked to calculate similar measures using proprietary databases collected by state or municipal agencies; while this may be possible if the data has been sufficiently deidentified or you have special permission to view identifiable data, it is often very difficult (and sometimes costly) to access these databases.

Table 3 displays examples of different measures that can be used to describe different domains, and sources of data for each. This table is based on guidance provided by the Minnesota Department of Health (MDH) and displays county-level measures, as well as sources of data for each measure. The domains (or 'themes') used to categorize this data are also based on those used by MDH. Many states and their state health agencies will have similar resources available for their constituents to use for their own assessments.

Table 3: Available Example Measures by Health Domain

Domain / Measure	Original Source	Location
People & Places		
Population by age and sex	U.S. Census	[MN County Health Tables](#)
Percent of people living at or below 200% of poverty	U.S. Census	[MN County Health Tables](#)
Percent of housing occupied by owner	ACS (5-year estimates)	[MN County Health Tables](#)
Percent of kindergarten through 12th grade students by race/ethnicity	MDE	[MN County Health Tables](#)
Total population by race/ethnicity	U.S. Census	[MN Vital Statistics](#)
Birth rate	MN MCHS	[MN Vital Statistics](#)
Death rate	MN MCHS	[MN Vital Statistics](#)
High School graduation rate	MDE	[MN Vital Statistics](#)
Unemployment rate	MN DEED	[MN Vital Statistics](#)
Opportunity for Health		
Percent of uninsured adults (under age 65)	U.S. Census	[MPHDA](#)
Number of physicians per 10,000	Atlas Online	[MDH ORHPC](#)
Health Living		
Percent of 9th graders who were physically active for a total of at least 60 minutes	MSS	[MSS](#)
Percent of 9th graders who attempted suicide during the last year	MSS	[MSS](#)
Percent of children up to date with immunizations	MDH MIIC	[MPHDA](#)
Teen birth rate per 1,000 females	MDH MCHS	[MN Vital Statistics](#)
Percent of births that were born premature	MDH MCHS	[MN Vital Statistics](#)

Domain / Measure	Original Source	Location
Chronic Diseases and Conditions		
Percent of 9th graders who are obese	MSS	MSS
COPD hospitalizations per 10,000	MNHDD	MPHDA
Asthma hospitalizations per 10,000	MNHDD	MPHDA
All cancer incidence per 100,000	MDH MCSS	MPHDA
Breast cancer incidence per 100,000	MDH MCSS	MPHDA
Injury & Violence		
Suicide deaths	MDH MCHS	MN County Health Tables
Premature Death Rate per 100,000 (age-adjusted)	MDH MCHS	MN County Health Tables

Note: ACS = American Community Survey; MDE = MN Dept of Education; MCHS = MN Center for Health Statistics; MPHDA MN Public Health Data Access System; MCSS = MN Cancer Surveillance System; MSS = MN Student Survey; MN DEED = MN Department of Employment and Economic Development; MIIC = MN Immunization Information Connection; ORHPC = Office of Rural Health and Primary Care

There are many other ways of organizing the various measures that will inform your assessment. For example, some assessments may want to organize data by disease domain (such as heart disease or cancer) that encompasses prevention-related measures, as well as disease prevalence/incidence, management, and mortality. The Catholic Health Association offers the following broad health domains as a possible framework for your community health profile:
- Demographics and socioeconomic status
- Access to health care (including access to mental health and dental services)
- Health status of overall population and priority populations
- Risk factor behaviors (such as use of tobacco and other substances)
- Conditions related to top 10 causes of death
- Child health
- Infectious diseases
- Natural environment
- Social environment
- Resources/assets.

Appendix A has a list of suggested measures for each of these health domains. While these domains offer one option for organizing your assessment, the final set of health domains should really come from the sponsoring organization(s) of the assessment.

Common Data Sources

There are some common data sources that most, if not all, assessments will include. The following is a broad list and description of the common data sources you are likely to encounter.

U.S. Census Data

You will need an estimate for the number of people living in the community being assessed, as well as information on the socioeconomic status of those people, such as their educational status or household income. All of this data comes from the U.S. Census Bureau and can be expressed as a county or as a census tract (which can be aggregated into a county). States (such as Minnesota) will also often have population estimates available for you to use as the basis of your assessment.

The census of the U.S. population is conducted every 10 years in the U.S. This is a time-intensive process that involves gathering data on race/ethnicity, age, sex, and housing status directly from every person residing in the U.S. In between the 10-year population counting, the Census Bureau will also estimate and project yearly changes in populations. The U.S. Census Bureau also conducts an annual survey, the American Community Survey (ACS), that asks a sample of residents a range of questions about their jobs, income, educational attainment, housing, language use, disability status, and many other topics as well. Again, this data can be presented at a county level or census tract level, although data from multiple years may be combined to produce estimates with sufficient sample size, referred to as 3-year or 5-year ACS estimates.

Behavioral Health Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) is another common source of data for assessments. BRFSS is a cross-sectional health survey that is run by state health agencies, with significant oversight and support at the national level from CDC. A slate of questions is asked of all sampled residents regarding their health status and health-related behaviors, such as exercise routines, diet, use of seatbelts. Many states also have state-specific questions that they ask their sampled residents.

BRFSS county-level data can be downloaded from the CDC's BRFSS website or queried via the CDC's web-based data tools; most states also maintain a selection of county-based measures and statistics.

Data Comparisons

Now that you have collected a range of data, what can you do with it? Generally, assessments will want to make comparisons, either within their geographic area being assessed (i.e., identifying trends by comparing multiple years of data) or with other geographic units, to determine how their community is doing relative to others and/or if certain health issues have worsened or improved. When comparing your geographic area with others, you also will have the option of making comparisons:

- With your area and other areas within your state, such as other neighboring counties;

- With your area and the state averages;
- With your area and national averages;
- With your area and national benchmarks, such as Healthy People 2030

All of these comparisons will allow you to make inferences about how your area is doing relative to others or relative to an optimal level of health. It may also be possible to make comparisons between subpopulations in your community, such as between different age groups, different race/ethnicities, and different income levels. Identifying potential disparities that might exist between the community-at-large and those who are likely to have experienced barriers to good health is a critical step to developing future interventions that improve community health. However, this may not be possible with secondary data sources due to sample size constraints, so identification of health disparities may need to come via primary data collection and analysis.

Primary Data Collection
Assessments will often undergo a process of collecting primary data from residents, as there are a number of benefits. Collecting data directly from community members is an excellent way of engaging with local residents; primary data can also augment our understanding of community health beyond what collected secondary data.
Many times, organizations are required to collect primary data. For hospitals, for example, a key requirement of their CHNA process is putting together an inventory of health resources available in the local community. Gathering this information by asking people about where they might go for specific services via interviews is a common approach.

Survey Data
A survey of local residents is one in which a range of questions are asked of a sample of residents. These questions might be based on a validated, well-known survey instrument or one in which the organizing entities developed their own questions; they might be a mix of different types of questions that can produce both quantitative or qualitative responses. It might be one that takes respondents a few minutes to complete, or an hour. All of these decisions about the content and length of a survey instrument have strengths and drawbacks, and should be made after careful consideration by those in charge of decision-making of your assessment.

Sometimes, those conducting an assessment will have the means and resources to conduct a randomized telephone- or mail-based survey directly from residents. These surveys can be prohibitively expensive and require extensive human resources to conduct, but they can also produce exceptionally detailed, actionable information across a range of health-related topics. Such data is invaluable because if the sample is truly random, it provides the most up-to-date information on a community's health and is therefore ideal for planning effective interventions to address contemporary health issues.

Sampling Design
As stated earlier, almost all surveys are collected by an outside firm or agency that specializes in survey data collection. These surveys will be collected from a sample of residents. If you are asked to analyze this survey data, you will need to understand the

survey design, which characterizes how the residents were selected into the survey sample. The complexity of the survey design can range from a simple randomized design, to more complicated stratified or clustered sampling.

To help you with the analysis of survey data, here are some basic [definitions](#) of key survey characteristics that you may need to be aware of:

- [Weights](#): Survey weights are adjustments made to survey data after it has been collected to help improve its accuracy. Weights are applied to account for differing probabilities in being selected to participate in the survey, as well as to adjust for how often selected participants did not respond to the survey.
- [Sampling Unit (PSU)](#): The defining unit to be sampled. Sampling units are the population elements that are used to group population elements. PSUs are sampling units that are chosen in the first part of a multi-stage survey. For example, if a survey is selecting households as elements, then counties may serve as the primary sampling unit.
- [Strata](#): Stratification is a method of dividing the sampled population into groups, often by demographic variables such as gender and/or race. Once you have defined these groups, surveys are then collected from each group as if it were independent from other defined groups. If, for example, you want your sample to be stratified by sex, men and women should be sampled independently, with separate sampling weights for each group.

A more detailed discussion of sampling design and analysis is outside the scope of this guidance, as entire textbooks have been written about the intricacies of survey methodology. However, there are several free resources available to help you with analyzing survey data, including:

- UCLA maintains a series on important statistical concepts and definitions. This includes several [survey methodology explainers](#), such as different [analyses](#) depending on the type of survey design and separated by statistical software.

Non-Random Sampling
There may be times when organizers forgo any sort of randomization of their sample and collect data from whomever is willing to respond to their survey, such as via a link on a health agency's website or from patients visiting their doctor. ***This is technically discouraged, but also may be unavoidable when there are limited resources available.*** While these efforts can also lead to valuable information on the health and well-being of residents, it should be noted that there are limits to what can be inferred from this information. Randomizing who responds to your survey ensures that the results are less biased than they would be otherwise. For example, if you conduct a survey at a farmer's market or a doctor's office, the people who are willing to respond to the survey are probably not representative of the entire community. In the case of the farmer's market participants, the respondents are likely both healthier and wealthier because they are more likely to eat (and be able to afford to eat) fresh fruits and vegetables, so their responses about health issues probably differ from the community-at-large.

At the same time, there are several benefits to soliciting survey responses from a sample of conveniently-located respondents. For one, it is cheaper and easier, while still collecting relevant information for your assessment. For another, meeting people where they are can

be a critical step for your assessment, especially when asking for survey responses from marginalized communities. Health agencies have an obligation to engage those from underserved communities through the CHA process, and this can include those that are difficult to reach via a randomized survey. Not everyone residing in your community has a telephone or an address, but their opinions on community health matter just as much as any other resident. Finding out what respondents from a food shelf or a homeless shelter think about health in their communities will undoubtedly provide you with information that you might not otherwise get via conventional means, as well as make your assessment all the more representative of the community being assessed.

Interviews, Focus Groups, & Community Forums
Surveys are not the only means by which you can collect primary data. Simply talking directly to individuals who have some particular insight into the health of the community is another invaluable way of assessing the health of the community. In addition to collecting qualitative data via survey (which was already discussed, above), there are three primary methods of collecting testimony from local residents: individually (often referred to as key informant interviews), in small groups (referred to as focus groups), and in large groups (often referred to as community forums). Because both hospitals and health agencies are required to talk to certain members of their communities as part of their CHAs, holding conversations with these community members is a straightforward, cost-effective way of meeting this requirement.

Key informant interviews: One-on-one interviews with individuals with specific expertise, such as public health experts or community leaders of underserved communities, are a common way to gather critical information on the health of the community that otherwise is not apparent in the quantitative data. Interviews can either be conducted over the phone or face-to-face.

Focus groups: A focus group is simply a group discussion with select individuals - usually comprised of 6-12 individuals. While a key informant interview is typically done for ease (one person's schedule is easier to manage than multiple people) and to ensure privacy, there are a number of benefits from conducting a focus group. When discussing topics in a group, you will be able to gauge whether there is consensus or disagreement around a certain topic. Group discussions can also instigate responses that otherwise might not have been uncovered because of the availability and interaction of different viewpoints. Focus groups can include a cross-section of individuals from different backgrounds or have some unifying characteristic, such as coming from a particular group or population.
Community forums or dialogues: Community forums or community dialogues are larger meetings of community members that are ideal for soliciting a wide array of viewpoints and finding consensus on certain issues all at once. They are similar to focus groups, but require more effort to manage since the number of people is larger.
NACCHO has a very helpful walk-through of the advantages and disadvantages of each of these approaches:

Table 4: Advantages and Disadvantages of Qualitative Data Approaches

	Advantages	**Disadvantages**
Key Informant Interviews	- Very easy way to gather needed information - Allows for the most control over who participates - Flexibility in the level of structure during the interview process	- No group dynamics to respond to - May result in biased results due to participants' particular experience (e.g., mental health providers can only respond to issues of mental health) - May be limited in sample size due to time/resource constraints
Focus Groups	- Participants can respond to a particular issue or discussion point together and build off of one another. - May be more enjoyable for participants - and more informative for the assessment - if grouped with people with similar experiences - Can be a quick process, especially relative to interviews; focus groups can provide detailed, valuable information from many people all at once	- Harder to control than interviews; one or more people's views may dominate the conversations - Group conversations may lead to less honesty from participants if they feel they will be judged for their opinions - Requires a fair amount of preparation and a good facilitator.
Community Forums / Community Dialogues	- Allows for extensive discussion with a large number of people at once - When effectively promoted, can ensure the assessment process is known among community members - Useful for engaging more difficult-to-reach communities (again, if effectively promoted)	- Requires significant promotional efforts to inform the wider community of the event - Also requires significant planning to prepare for (for example, what happens if too many people show up?) - Difficult to control effectively; requires a very strong facilitator who can control adverse group dynamics

Key Informant Interview Process

1. Developing an Interview Guide

Among the first steps you will need to take is deciding what to ask your participants - what sort of information are you hoping to gain from their input? Ideally, the information provided by your participants will give you a clearer picture of the health and well-being of the residents in your community, especially among marginalized members and neighborhoods.

The timing of when you conduct your interviews as part of the overall assessment process is also important to consider. For example, conducting interviews or focus groups after gathering and analyzing quantitative data would allow you to ask for your participants' opinions about what the data is saying, and perhaps offer some critical contextual information. Alternatively, you may want to avoid "queuing" your participants towards discussing certain health issues at the expense of others. For example, showing them data that suggests residents are disproportionately leading sedentary lives will bias them towards talking about a lack of opportunity for exercise in the community, rather than other factors that are also likely affecting health. In particular, the latter approach may be preferred if you are interviewing someone(s) with knowledge of a particular subgroup and their health [issues](.).

Key informant interviews can be more flexible than other types of qualitative data collection methods in terms of their chosen structure, ranging from informal conversation to highly structured [interview](:):

- ● Informal interview structure: A conversational approach to eliciting information with very little prepared to guide the interview process. This type of approach allows more flexibility in terms of the topics covered but makes comparisons between participants much harder.
- ● Semi-structured interview structure: Some prepared materials help guide the conversation to ensure certain topics are covered. The specific wording or order may change between interviewers, however.
- ● Standardized interview structure: A very structured interview protocol with a specified question order and wording. This type of interview structure allows for the easiest comparison between interview participants.

Start out your interview with an introduction: who you are, who you represent, and why you are asking for this participant's input (e.g., goals of the assessment, how their information will be used, etc).

Generally, 5-10 questions is an ideal length for an interview. The questions asked of participants should revolve around three separate community health domains: (1) community health needs; (2) what the current efforts to address these needs look like; and (3) what else needs to be done to address these needs.

Example questions:
- ● What do you consider the strengths of our community as it pertains to health?
- ● What are some challenges or barriers to good health in our community?
- ● What do you see as the most pressing needs of our community that are not being addressed? Why are they not being addressed?

Finish the interview by reiterating how this information will be used in the assessment and thank them for their time.

Once you have developed your questions, practice reading them, preferably to other people. If you are going to be talking to people from different cultures and backgrounds, make sure that the questions are culturally appropriate, and if possible, review questions with people with the necessary cultural knowledge to ensure the questions' appropriateness.

2. Identifying participants
When choosing who to interview, it may be helpful to remember that these should be <u>key</u> informants, i.e., that they have some critical perspective or knowledge pertaining to the community's health. That may be an insight into a certain group of community members, for example, and/or expertise in specific health issues.

The people you ask to participate in a key informant interview should ideally represent varying backgrounds and expertise that are able to speak to the current health status of the community. Clinical viewpoints from healthcare providers and/or patients are frequently included, as are public health and community perspectives. If you are having difficulty getting people to participate, you might consider "snowball sampling" in which you ask any initial participants to help identify other potential participants they know who might be willing to participate and/or have an interesting perspective.

3. Conducting the interview
Prior to conducting the interview, make sure you are comfortable with your pre-specified interview process. This also includes deciding how you will record people's responses somehow: either with a recording device or with notes you take yourself. Also make sure people are okay with being recorded. Practice using your recording device (for example, if you are using Zoom, make sure you know how to record your interactions).

Along these same lines, privacy and consent is very important. Make sure your participants are comfortable with how their narratives are going to be used. For example, are they comfortable with being quoted in the assessment if they are deidentified? Are they comfortable being named in the report as a participant?

4. Analysis
Once interviews are complete, you will next need to analyze them.   To keep things organized, plan how you will analyze your interviews ahead of time. You may want to transcribe the entirety of each interview (if you have recorded your interviews), which would allow for more in-depth analysis of what was said - or simply summarize the key points.

Review all of your collected narratives at least once to gain a general understanding of what was said by your participants. After that, consider annotating your transcripts as you reread them and are able to identify common themes and/or unique observations across

narratives. If given permission by your participants, identify illustrative quotes that clarify these themes.

Additional Resources for conducting interviews:
[UCLA Center for Health Policy Research](#)
[Community Tool Box](#): guide for conducting interviews

Focus Group Process
Many of the same principles that were described as part of the key informant interview process will also apply to planning and implementing a focus group. Rather than reiterate those principles, we will note where the process is materially different from conducting interviews.

1. Developing a focus group guide
Focus group questions are very similar to key informant interview questions, but they are (1) generally longer (focus group sessions can last up to an hour) and more in-depth; (2) more conducive to instigating conversations between participants; and (3) more likely to be open-ended (key informant interview questions can be open-ended, but may also be more structured, depending on the preferences of those conducting the interviews).
As with key informant interviews, you will need to start with an introduction: who you are, why these questions are being asked of them, and how you will be recording their responses. The number of questions can vary, but should incorporate prompts to help the focus group facilitator manage the conversations and focus on the topic being discussed.

A general guide for the structure of the questions:
  ● Start with a general set of open-ended questions that helps to introduce the topics and get participants thinking about how they feel.
  ● Transition to a more specific set of questions that may be specific to the participants; for example, if focus groups are from a particular community, questions that may be specific to concerns of that community.
  ● A final set of questions that helps to wrap up the conversation and get participants thinking about any additional thoughts or recommendations.
You may also want to collect some basic demographic information on participants that could be used to help inform your analysis to track who said what (since most focus groups will de-identify their participants).

2. Identifying participants
As mentioned, focus group participants are often from the same community and/or have similar backgrounds. Determining how best to reach these participants may require careful planning and relationship-building, particularly among participants from harder-to-reach, marginalized communities. Existing community groups, such as church groups or social clubs, might be an effective way to recruit participants.

3. Conducting the focus group

Managing a focus group requires a number of moderation skills: good communication, a solid understanding of the topics being discussed, and the patience to remain neutral and respectful of participants. Focus group moderators also need to have a good understanding of group dynamics and can ensure quieter participants are not overpowered by those who are more outgoing and talkative, while also keeping the group on track to make sure all questions are answered.

As with key informant interviews, having the moderator practice the focus group questions will help with getting comfortable with the questions and identify any potential issues. You will want to have an additional person help with the focus group, e.g., to assist with note taking or recording - or to help track which participant said what.

4.   Analysis

As with key informant interviews, focus group conversations can be incredibly detailed and yield lots of valuable, relevant information, so you will want to have a strategy for how you will analyze the data. Developing a set of recurring themes or categories of discussion topics as you read through transcripts or review notes is a particularly good way of identifying what was said. It can also help compare and contrast if you conduct more than one focus group.

Community Forum Process

Community forums are similar to focus groups, but usually involve more participants. As a result, it may also require significant planning and work to implement, particularly if there are more than 40 participants.

1.   Developing a community forum implementation plan

Because community forums require more work to plan and implement, it is highly recommended that more than one person is responsible. It is preferable to form a committee or task force that is charged with conducting the community forum.

Think about what you and the assessment team are trying to accomplish with a community forum: what is/are the goal(s) and objective(s)? Any questions developed should speak to these goals and objectives. The questions can be limited in number and broad in topic, given the larger numbers of people involved. In fact, if more than 40 people are expected, you may want to consider dividing participants into smaller groups.

Because forums tend to involve more people, privacy is more difficult to maintain, and you may want to warn your participants of this. You may also want to structure your questions accordingly by, for example, including less invasive questions.

Finally, you may want to develop a set of ground rules for participants to follow to ensure everyone is respectful and can be fully heard.

2.   Identifying participants

As with focus groups, much thought and consideration should be taken to recruitment of participants. Ideally, you are able to attract participants that are representative of the broader community. Publicizing the community forum should be done well in advance, so participants can plan their participation ahead of time.

Since community forums usually invite the community-at-large to participate, implementing the community forum at a time and place that is convenient to most people is recommended. This means determining if, for example, it would be better to host the community forum during after-work hours or on the weekend, as well as finding a location that can accommodate a large number of people.

3. Conducting the community forum
On the day of the community forum, you will want to track who has participated, so consider having a sign-in sheet at the door.
While community forums tend to be less formal than focus groups, it is still recommended to have one or more moderators help guide the conversations, particularly if you have enough people to break into smaller groups.
Introduce the ground rules to your participants and make sure everyone understands what is expected of them.

4. Analysis
As with focus groups and interviews, community forums have the potential for very data-intensive qualitative narratives from many different people and perspectives, so plan accordingly. Again, identification of common themes is a suggested approach for analysis.

Examples of questionnaires
There are innumerable examples of materials for conducting interviews, focus groups, and community forums available to reference as you develop your own qualitative data collection instruments.. Not all of them will have the actual instrument (i.e., the specific procedures and questions asked) used for their assessments, but some will.

IDENTIFYING AND PRIORITIZING HEALTH ISSUES

Based on the data you have helped to collect, you may be asked to contribute to the identification of the most pressing health issues facing your community.,. As stipulated at the beginning of this document, prioritization is typically associated with conducting CHNAs, but such a process is also common to CHAs when deciding what to focus on via a CHIP. While these decisions are usually made by multiple individuals once all data has been collected and reviewed, there may be a request for you to participate in the process. In this section, we will discuss some commonly-used approaches for identifying priority health issues.

The prioritization of health issues may encompass two separate processes – one where the most pressing health issues are first identified, and a subsequent process where the assessment organizers choose which health issues to address based on their available resources. Other times, the feasibility of addressing each identified health issue in a successive CHIP is part of the prioritization process.

Prioritization may be a simple and straightforward process that is conducted without an overriding framework to help inform decision-making – that is, a prioritization process that considers all of the data collected and votes on which health issues <u>seem</u> like the most critical to address. Other times, there are specific approaches that are used to help guide decision-makers through the process, such as the MAPP process that accounts for the four assessment components (see MAPP discussion, above).

Other, more systematic criteria for identifying priority health issues include (from CHA):
- Magnitude
- Severity
- Historical trends
- Alignment of the problem with the community / organization(s) strengths and priorities
- Impact on vulnerable communities and populations
- Importance of the problem to the community
- Available resources
- Relationship of the problem to other community issues
- Ability to affect change
- Immediate need

Again, your involvement in this process may range from helping to organize meetings with other organizations, to presenting your findings at these meetings, to having a vote in deciding which health issues are the most important to address.

Reporting & Disseminating

You will likely be asked to contribute to the writing of a final CHA report. You may also be asked to help disseminate key findings from the report to community organizations and residents, for example by holding community forums to share and discuss findings. You may even be asked to help plan possible interventions to address the issues identified. This section offers guidance around writing up the assessment report.

<u>Writing the CHA Report</u>:
The language used in writing the final assessment report should be clear and accessible. Adhering to plain language principles - that is, writing to ensure the assessment is able to be widely understood by all - is recommended. There are a number of plain language guidance documents that might be helpful as you write the report, including those disseminated by the [U.S. government](). Always remember the audience for the assessment report: your community members!

Tables & Graphs
Assessments often include tables and figures to display key findings, and these again should also be easy to understand
Some important recommendations for tables and graphs include:
- The table or graph stands on its own and is understandable and interpretable without any additional information.
- The title is succinct and represents the contents of the table/graph well (for example, making clear the time period and geography).
- For graphs, the axes are also labeled and are easily understandable..
- Limit the use of too many decimal points.
- Where appropriate, use confidence intervals.
- Be compliant with any stipulated requirements for hospitals and/or health agencies. The outline described below will note where certain components are required depending on the stakeholder(s) commissioning the assessment.

Assessment Report Sections
The following are recommended sections that should be included in the final assessment report:

1. Background: What is this report about and why was this assessment conducted? You may also want to include some basic background information on any requirements that led to the assessment being conducted.

2. Description of the community: Includes a description of the community being assessed and any other relevant information that describes the community. For hospitals, it is important to include a description of how the community was defined.

3. Assessment process: How you and your colleagues went about conducting the assessment. What was the model or framework used to guide the assessment? What sort of primary and secondary data sources were compiled and analyzed? Who was involved in conducting the assessment?

    If hospitals are involved in the assessment process as part of their own CHNA, it is especially important to note how you accounted for the input from persons who represent the broad interests of the community served, especially from medically underserved, low-income, and minority communities (or the organizations that represent these communities).

4. Results: This is where you will discuss what you have learned, based on the analyzed data. You will likely want to discuss all health domains that were examined, not just those health issues that were determined to be priorities.

5. Identified health priorities: This section is where you will let your audience know what health issues were prioritized and why: How did you and your partners go about identifying which health issues were a priority? What criteria were used? Who had a say in deciding which issues should be prioritized?

6. Other potential sections: Some assessments may also include a community health improvement plan as a final section of the report, although this may also be presented separately. You may also want to include other sections, such as an Executive Summary at the start of the report that succinctly summarizes the assessment.

The assessment report should also not just be narrative, but include relevant tables, graphs, and/or maps to help present your findings and make them easier to understand.

Examples of CHAs
There are many examples of CHAs and CHIPs to refer to as you plan your own. In Minnesota, most LHAs will maintain their own website where they will post their assessments (see here for a list of Minnesota LHAs). For example, here is the Rice County CHA produced in 2019, as well as the CHIP. There are also examples of CHAs for more urban communities.

Appendix A: Catholic Health Association's Suggested Assessment Health Domain

Please note that not all of these measures will be available for your area.

Demographics and socioeconomic status
- Community overview, age, sex, race, socioeconomic status and academic attainment
  - Poverty by age and racial/ethnic subgroups.
  - Unemployment rate.

Access to health care
- Health staffing shortages by Health Professional Shortage Area (HPSA), Primary Care HPSA, Dental HPSA.
- Physicians (MDs and DOs), Primary Care per 10,000 population
- Hospitals and number of beds per 10,000 population.
- Percent uninsured
  - Uninsured adults (Ages 18+)
  - Uninsured children (≤17)
- Percent Medicaid and Medicare

Health status of overall population and priority population (uninsured, low-income and minority groups)
- Leading causes of death (age-adjusted rates if available)
- Inpatient admissions rates, top 10 causes
- Rates of "preventable" hospitalization (CHF, asthma, diabetes, COPD, and pneumonia).

Risk factor behaviors and conditions related to top 10 causes of death
- Tobacco use, obesity rates, and related behaviors
- Screenings utilization rates

Child health
- Infant mortality rate
- Low birth weight rates
- Proportion of women who receive late or no prenatal care
- Teen pregnancy rate

Infectious diseases
- Sexually transmitted infection incidence rates (chlamydia, gonorrhea, syphilis)
- HIV incidence rate
- Tuberculosis incidence rate

Natural environment
- Air quality annual rating

Social environment

- Violent crime rate
- Child abuse rate
- Housing affordability rate

Resources/Assets
- Resources available to address community health needs (such as federally qualified health clinics, school clinics)