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Community Health Assessment, Prioritization and Planning Phase of the Community Health Improvement Process

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Course Objectives:

By the end of this session, you will be able to:

- define the terms ***Assessment, Prioritization and Planning*** in the context of the CHIP cycle.
- describe and reflect on the 5 steps of a Community Health Assessment (CHA)
- give details of each step including examples.
- list what factors inform prioritization and what to consider in session design.
- analyze an issue for its root cause(s)
- understand the basic principles of a quality planning process including evaluation preparation

The Community Health Improvement Process

Remember that the Community Health Improvement Process…

- Is ongoing
- Is deliberate
- Is evidence-based
- **Includes a Community Health Assessment (CHA) which informs the State Health Assessment (SHA)**
- **Informs a Community Health Improvement Plan (CHIP) which informs the State Health Improvement Plan (SHIP)**
- Leads to community change and health improvement via active partnerships and measurement of outcomes

Definitions First!

Assessment: A deliberate process of gathering data, both qualitative and quantitative to develop a snapshot and tell the story of a community's current health situation with Health Equity as a framing lens.

Prioritization: A community selection process by which the most pressing areas of concerns are lifted up for action planning during a given time frame.

Planning: The strategic development of effective action steps to improve policy, programming or implement projects. This can include root cause analysis to better address upstream issues.

Assessment, Prioritization and Planning

In the next section, we'll break down all the steps of a Community Health Assessment:

- Each step is color-coded and explained in greater detail.
- After most steps, there is a reflection activity.
- You'll get more out of this training if you:
  - go slowly enough to absorb the material,
  - write down your answers to the questions,
  - take notes on ideas that need exploration and
  - follow up with your council and/or Health Promotion Team to go deeper on the issues.

Community Health Assessment (CHA) Steps and Components

1. Gather Data

- Center Health Equity including diversity and inclusion.
- Describe geography demographics and community systems.
- Collect public sources of quantitative health data at population level.
- Conduct surveys, focus groups and/or key informant interviews to collect public's perspective on health issues (qualitative).

2. Identify Needs and Resources

- Center Health Equity including diversity and inclusion.
- Conduct Asset Mapping (show where and what services are available and to whom).
- Highlight any new problems, disturbing trends, or extra distressed parts of community.
- Experience and dialogue to clarify expressed needs may be warranted.

3. Analyze the Issues

- Center Health Equity including diversity and inclusion.
- Use comparative analysis to ensure accurate context.
- Root Cause Analysis here could be helpful to keep an upstream focus.
- Be open to discovering other related indicators and impacts.

4. Select Priorities

- Center Health Equity including diversity and inclusion.
- Gather stakeholders and people with lived experience to engage them in priority setting session(s).
- Consider prevalence, duration, frequency, burden, solutions available, community control, political realities, etc.

5. Write and Submit CHA

- Center Health Equity including diversity and inclusion.
- Using all the information gathered, tell the story of your community's health in a comprehensive way.
- Outline at least one priority, and its rationale, that your community will focus on in the next 1-3 years.

1. Gather Data:

- Be sure to center Health Equity including Diversity and Inclusion. (Who else needs to be present? – especially when gathering community input)
- Describe the community in terms of geography, population characteristics, and current systems of care.
- Collect public sources of quantitative health data at the population level parsed by equity factors when possible.
- Conduct surveys, focus groups and/or key informant interviews to collect the public's perspective on health issues (qualitative). There are better and worse ways to do these. Please research best practices first!

There are qualified experts to help health councils with this data collection process. The Dept. of Health and the Center for Health Innovation are ready to assist with data experts and facilitators that have been specially trained. Health councils may request this support or find other ways to gather the data.

1. Gathering Data: Reflection Activity

- Even if your council is long standing, why would a refresher on this step be useful?
- What are some of the downsides of only focusing on quantitative or qualitative data?
- How might you ensure that community members could attend input sessions equitably?

2. Identify Needs and Resources:

- Continue to center Health Equity including Diversity and Inclusion at this step.
- Conduct Asset Mapping (show where and what resources are present in a community). Video 1 . Video 2 . Sample 3.
- Highlight any new problems, disturbing trends, or extra distressed parts of community. What gets noticed (or not) gets attention (or not).
- Experience and dialogue to clarify expressed needs may be warranted. (Sometimes people with lived experience may have a very different and valid view of a service gap.)

Some resulting products of this step could be a resource directory, a service sector report that shows what is/ is not available, or storyboards that illustrate a community issue that is disproportionally affecting people in certain groups. There are many ways to show community assets. Get creative!

2. Identify Needs and Resources:

This process can be assets-based and also address gaps that are realized. Here's a sample of how an asset map can be organized.

Healthcare								Both /And	Education and Economic Development					Both /And	
Physical		Mental Health				Preventative Education and Services	Emergency Services	Built and Natural Environment	Education		Vocation	Business	Public Infrastructure	Family Support Services	Civic Grou
Basic Needs	Treatment	General	Substance Use Recovery	Developmental	Geriatric				Birth -18	18 +					
Food	Hearing	Suicide Prevention	Medical withdrawl	Adult Day Care	Residential Memory Care	DWI Program	EMS	Recreation Paths	Early Childhood Development Centers	Adult Basic Education	DVR	Small Business Assistance	Roads	Tax Assistance	Rotary Clut
Housing	Speech	Counseling	12-Step Programs	Community Living	Medication Management	My CD classes	Law Enforcement	Sidewalks	Childcare	Financial Literacy	Workforce Connection	Chambers of Commerce	Bus Service	Legal Aid	Elks Lodge
Clothing	Physical Therapy	Behavior Management	Support Groups	Respite Care	Senior Centers	Family Planning	Sexual Assault Response	Climate Resiliency Group	Public Schools	English as a Second Language	Internships	Workforce Connection	Train Service	Advocacy	Masons
Furnishings	Vision	Individual	Substance Use Counseling	Medication Management	Community Living	NM Crisis and Access Line	Animal Control	Recreation Centers	Private Schools	Parenting Classes	Job Shadowing	Internships	Bike Paths	Immigration Support	Pilot Clubs
Water/Plumbing	Home Health	Multi-Systemic Therapy	Substance Testing	Psychosocial Rehab	Support Groups	Harm Reduction	Protective Services - 0-18	Swimming Pools	Charter Schools	UNM-VC	Supported Employment	Farmer's Markets	Airport	Supervised Visitation	Kiwanis Clu
	STD testing/ treatment	Family Therapy	Community Living	Treatment Foster Care		STD testing	Protective Services 18 +	Wildlife Refuges	Free Afterschool Programs	Continuing Education	Work Opportunity Investment - YDI	Job Fairs	Public Library/Computing	Thrift Stores	Civitan
	Renal	Respite Care	Accupuncture	Supported Employment		Youth Health Literacy	Urgent Care Centers	Open Spaces	Public Library/ Computing	Job Readiness Classes	Job Fairs	Farmers and Ranchers	Free Public Spaces	Pregnancy Counseling	Blue Star Mothers
	Primary Care	Medication Management	Missing - Residential Treatment	Support Groups		Nutrition Counseling	Crisis Line	River	Special Needs to 21	Literacy Classes	Volunteer Coordinating Groups	Manufacturing	Internet Access	Public Health	American Legion Post
	Respiratory	Support Groups				Juvenile Diversion	Disaster Response	Ditches/Acequias	Extenstion Service	Extension Service	Extension Service		Electricity	Parenting Classes	Knights of Columbus
	Prenatal	LGBT supportive				Parenting Classes	Domestic Violence Shelter	Parks		Home Visiting			Water	Childcare Assistance	Moose Lodg
	Tobacco Cessation	Mental Health First Aid				Car Seat Safety Clinics	Missing-24 hr. Emergency Facility	Conservation Groups		Mental Health First Aid			Natural Gas	Home Visiting	Health Counc
	Assisted Living	Equine Therapy				Safety Education	Missing- Homeless and/or Youth Shelter for those not experiencing Domestic Violence	Extension Service		Nutrition Counseling			Solid Waste Collection	Juvenile Justice	Neighborhoo Association
	Walkin Clinic	Missing - Residential				Insurance Sign-up Assistance							Community Development		Juvenile Just

2. Identify Needs and Resources: A Reflection Activity

- How could the variety of participants that engage in this step have an impact on what is reported?
- What format can you imagine your Asset Map taking? Sample 4.
- How would you go about balancing the needs of multiple distressed communities?
- How comfortable is your health council acting as a convener for providers as well as people with lived experience?
- Would it be wise to have separate or mixed groups of various categories of stakeholders?

Take some time to really think about how powerful this process can be if done well and with intention! Again, there is plenty of support for this process!

3. Analyze the Issues:

- Continue to center Health Equity including Diversity and Inclusion (remember that who is viewing the data will impact the interpretation of those data.)
- Use comparative analysis to ensure accurate context. More data may be needed to see disparities relative to other communities.
- Root Cause Analysis may be helpful here but will also occur at planning step.
- Be open to discovering other related impacts and indicators.

This step can be done with a smaller group of community members who express an interest in or have skills in data analysis. This step can be facilitated by an in-house or outside facilitator.

3. Analyze the Issues: A Reflection Activity

How might personal bias creep into this process and alter a council's perspective?

Our state (NM) tends to rank poorly relative to the rest of the country.

How might that skew our perception of needs and assets?

What would be some benefits or downsides of having an in-house or outside facilitator for this process?

4. Select Priorities:

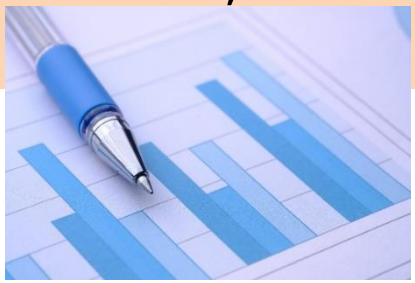
- Continue to center Health Equity including Diversity and Inclusion. If a small homogeneous group picks the priorities, the planning and action phases most likely will not adequately address the population's needs.
- Gather stakeholders and people with lived experience to engage them in priority setting session(s). There are good reasons for having joint or separate sessions for different audiences. Be thoughtful about the design and impact on participants.
- Consider prevalence, duration, frequency, burden, solutions available, community control, political realities, etc. One health council cannot fix everything at once and to try and do so can burn out key players. Careful selection of what the council will focus on for the next 1-3 years will help drive the work intentionally forward and keep partners more engaged.

Public Health Infrastructure & Systems (naccho.org) is an in-depth model for facilitating a prioritization process!

4. Select Priorities: Terms Defined

- **Prevalence**; number of cases over time per population (How much/many – usually expressed as a rate/ratio)
- **Duration**; how long over time endured (acute vs. chronic)
- **Frequency**; how often
- **Burden**; the hardships and losses associated with disease, disability and death. (This can be on considered on micro-individual or macro-community levels: also called impact.)

- Community capacity considerations:
  - Are solutions available; How much will it cost? Is there an evidence-based solution? Is there staff to implement?
  - Does the community control? Is there access to intervene?
  - What are the political realities, etc.? Timing of policy change matters!



4. Select Priorities: Reflection Activity

- How might you recruit diverse community in an equitable way to a priority selection process?

- What might a session include?
- What other human factors would you want to attend to outside of presenting data?

5. Write and Submit a Community Health Assessment (CHA)

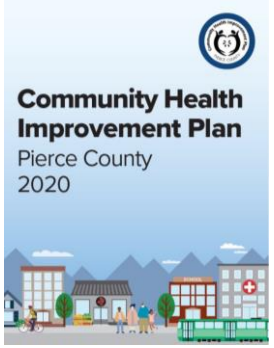
- Continue to center Health Equity: Consider consulting your Health Promotion Team to assist with language choices and help edit the document.

- Using all the information gathered, tell the story of your community's health in a comprehensive way. (You could contract out for this service, but best if created by people that have been involved in the whole process.)
  - Executive Summary
  - Community Description
  - Community Data
  - Community Assets and Needs
  - Summary of Analysis Leading to Priority Selection
  - Priorities
  - Continue to reach out for support if desired at this stage. We are here to help you! We have templates to get you started. Please submit any completed CHA to the Health Promotion Team.

And now for the CHIP!

An effective Community Health Improvement Plan:

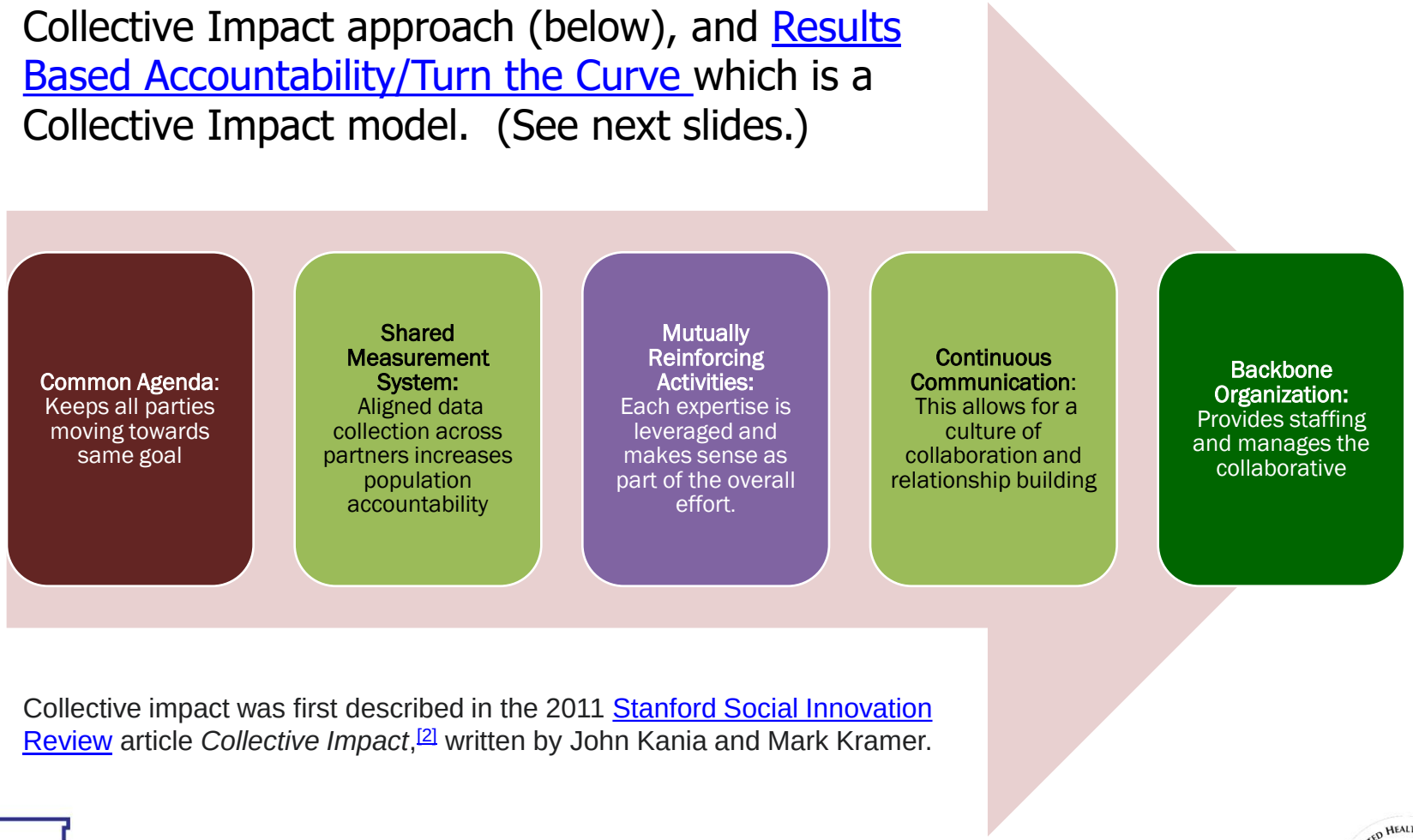
- follows the Community Health Assessment and focuses on the priorities/priority chosen
- is strategic and logical
- has an operational component
- centers Health Equity including Diversity and Inclusion (next slide)
- keeps root causes and upstream approaches in mind
- uses evidence-based approaches when possible
- builds in accountability and evaluation plans
- could use Results Based Accountability (RBA) as a model that is a Collective Impact approach. (outlined in future slides)



Sample CHIP from Tacoma, Washington

Ways to accomplish a CHIP

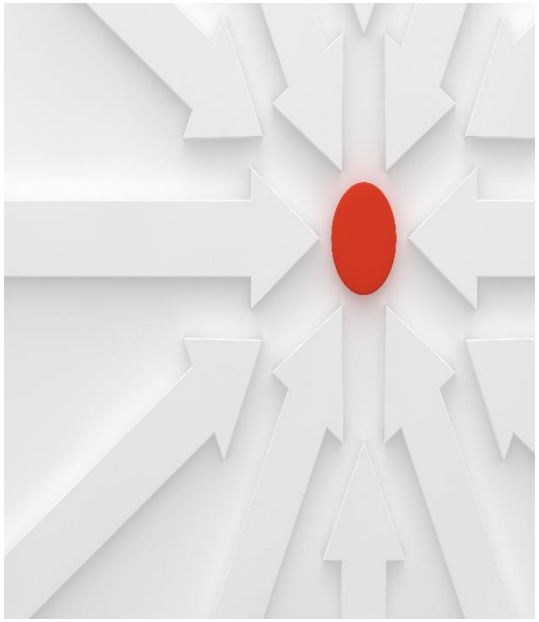
The CHIP framework can incorporate other models of community work. Health Councils are urged to use a Collective Impact approach (below), and Results Based Accountability/Turn the Curve which is a Collective Impact model. (See next slides.)



Collective impact was first described in the 2011 Stanford Social Innovation Review article *Collective Impact*,[2] written by John Kania and Mark Kramer.

The following slides detail the Results Based Accountability (RBA) model of planning with preparation for evaluation.

- This is just one model. You may choose to use any effective model that works for your council.
- The benefit of using RBA is that some of the Health Promotion Team has expertise in implementing RBA and can support you.



In Results Based Accountability,

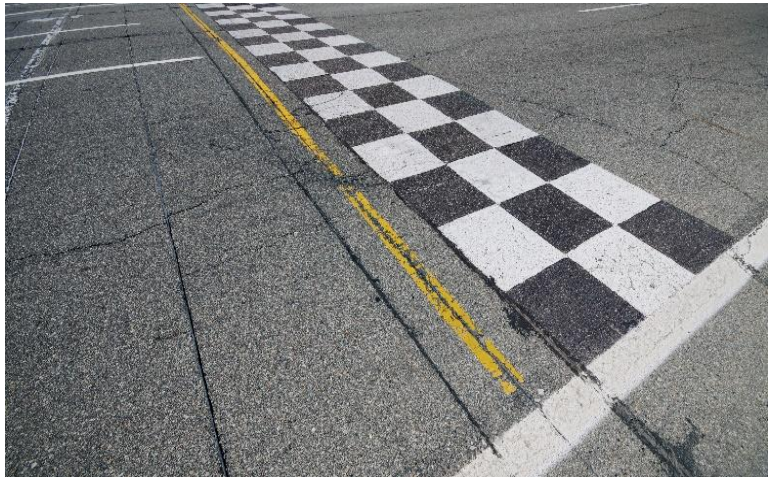
we start with the **END RESULT or vision** in mind.

What do we want our world, state, county, neighborhood to look like?

This could be one of your priorities stated in a positive result format or you can facilitate a visioning exercise for new coalitions.

RESULT = A condition of well-being for children, youth, adults or communities

- Healthy sustainable communities
- Safe neighborhoods
- Clean environment
- Stable healthy families
- Children born healthy
- Healthy adults
- Children/youth successful in school



Results-Based Accountability
has two kinds of accountability:

Population Accountability
about the well-being of
WHOLE POPULATIONS

For communities – cities – counties – states – nations

Performance Accountability
about the well-being of
CUSTOMER POPULATIONS

For Programs – Agencies – Service Systems

RBA continued: How do we know when we get there as a community? (population accountability)

RESULT =

A condition of well-being in the population

INDICATORS! =

A measure which helps quantify achievement of a RESULT

• Healthy sustainable communities	• Poverty rate
• Safe neighborhoods	• Crime rate
• Clean environment	• Air quality index
• Stable healthy families	• Unemployment rate
• Children born healthy	• Rate of low birthweight babies
• Healthy adults	• Obesity rate
• Children/youth successful in school	• Graduation rate

For each priority/result you choose, select a *population* indicator that is a good measure of that result.

RBA continued:

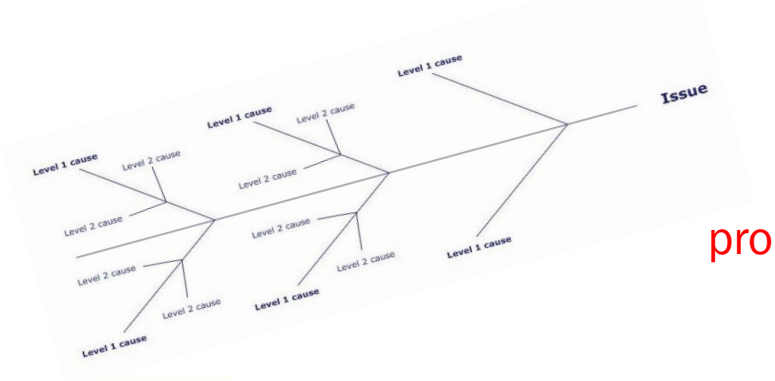
Baselines: How to forecast and plan to "Turn the curve".

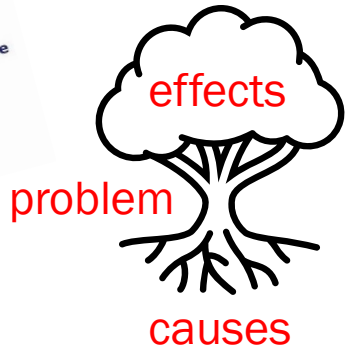
- For each indicator, plot the historical data including equity/ disparity breakdowns and ask if it's an "ok" situation. If it's not okay,:
- Project what will happen if nothing changes (forecast the curve).
- What's the story behind that baseline? This is also known as root cause analysis and can point to upstream interventions that would be impactful.

Watch this local skit that shows an upstream or root cause issue!

(RBA) Story Behind a Baseline or Root Cause Analysis (RCA)

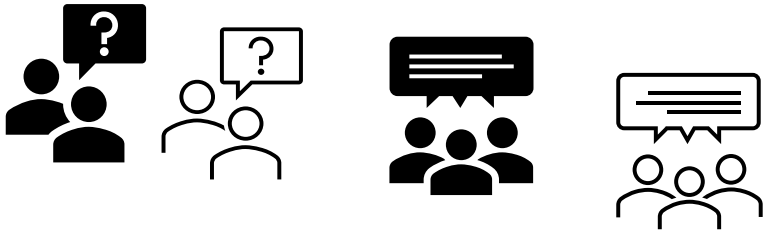
- This is a great time to explore the deepest reason why an indicator is trending in an unhealthy direction and discover which other data you may need.
- There are multiple ways to do Root Cause Analysis. The aim is to work as far upstream as possible so that your collective interventions have the biggest impact.
- There is often more than one root cause but trying to tackle more than one or two can be overwhelming. Select the few that the council with partners has the capacity to impact.
- There are many methods to accomplish root cause analysis like 5 Whys, Fishbone Analysis, and Problem Tree.





The next slide is an example of the "5 Whys"

5 Whys for RCA



What is the 5 Whys?

The 5 Whys is an exercise designed to help organizations or individuals find a potential root cause of an issue. It was developed in the business sector to address manufacturing concerns. It has since been used to address other topics in other areas of life and can be a helpful way to drill down to an actionable and meaningful solution or way to reduce harms. The 5 Whys is just ***one*** way to arrive at ***one*** root cause. It can be repeated to find additional root causes as there are frequently more than one – especially for social ills.

Why do the 5 Whys?

Its benefit lies in the process of staying disciplined and keeping the focus on one issue and following it to its deep cause. It helps communities do more impactful work as opposed to "tinkering around the edges" of a problem. It can make strategic planning more exciting to community when they see that systems can be changed within a chosen priority area.

5 Whys Guidance Continued…

How to do the 5 Whys?

The 5 Whys exercise is vastly improved when applied by a team and there are five basic steps to conducting it: This is a quality improvement strategy.

1. Write down the specific issue. Writing the issue helps you formalize the problem and describe it completely. It also helps a team focus on the same problem.
2. Ask "Why" the issue happens and write the answer down below the issue.
3. If the answer you just provided doesn't identify the root cause of the issue that you wrote down in Step 1, ask "Why" again and write that answer down.
4. Loopback to step 3 until the team agrees that the problem's root cause is identified. Again, this may take fewer or more times than five Whys.
5. After settling on the most probable root cause of the problem and obtaining confirmation of the logic behind the analysis, develop appropriate corrective actions to remove the root cause from the system.
6. If the action step at the end is not within your control, go back one step and select a different reason why.

5 Whys Guidance Continued…

Some Caveats to the 5 Whys:

- Occasionally more "whys" are needed to get to the root cause, but 5 is usually enough. Sometimes just a few whys are sufficient.
- Just as with anything in the realm of human experience, bias or lack of knowledge can creep in and influence each step of the process.
- If done as a group, consider the tendency of the most vocal people having the most sway in making decisions at each step. It may be useful to have individuals come up with their ideas on paper first and then have a process for sharing with the group as well as a process for arriving at consensus at each step.
- It is important to repeat this process to make sure that all the root causes are found. A group may want to focus their efforts on the root cause that impacts multiple issues, the root cause that creates the most trauma, or the root cause that creates the most inequity.

And now an example of a 5 Whys exercise…

Identify the Root Cause of a Priority Challenge

5 Whys Worksheet

Define one priority challenge: Many children are showing up to school with fewer basic early learning skills.

Why is this challenge happening?
Some adults in the home aren't providing enough of those learning opportunities.

Why is that? ↓

Some parents don't see themselves as a capable child's first teacher.

Why is that? ↓

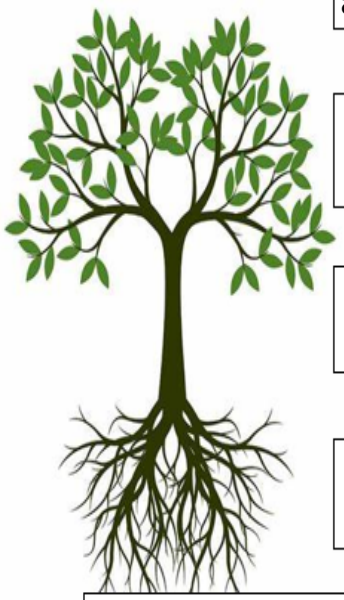
Society hasn't reinforced that all languages and oral traditions are valuable and equally good at brain building.

Why is that? ↓

Schools aren't teaching youth their role in early learning of children

Why is that? ↓

Schools need adjusted curriculum to reinforce this idea of capable 1st teacher.



Action Needed (If the last answer is out of your control, go back to the previous answer):
This step would be decided in the next process

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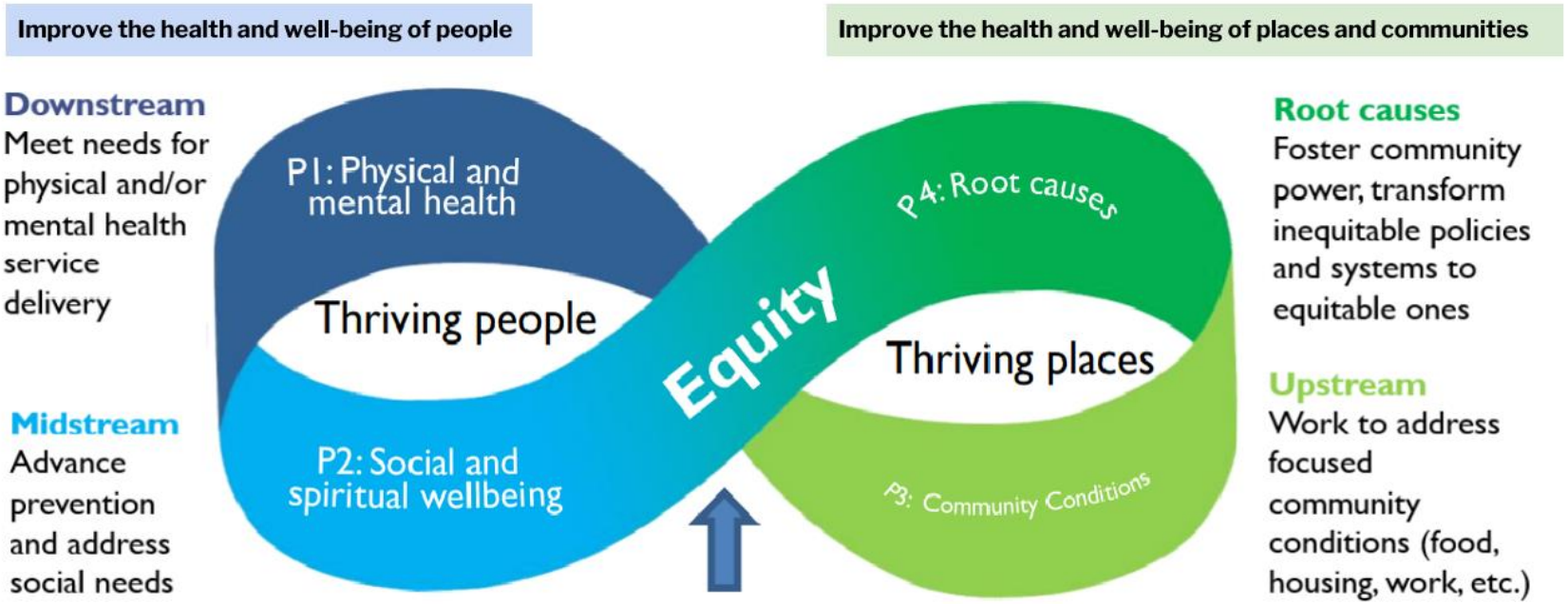
Once you've discovered at least one Root Cause, the next step is to figure out how to address it effectively.

In the next slides, we'll continue to center Health Equity and resume with Results Based Accountability as an option for planning interventions.

Keep Centering Health Equity

Pathways to Population Health Equity



Transforming inequitable structures and systems together with those who experience inequities

Adapted from [Framework | Pathways to Population Health Equity (publichealthequity.org)]

RBA Continued: What works? (What would it take to "Turn the Curve"?)

- What works/what doesn't?
- What is each partner's contribution (and how will it be measured at the program level)?
- What are some no cost/ low-cost ideas?
- What is the group's information/research agenda?

RBA Continued:

What are the means (strategies) that we use?

- **Programs**
- **Projects**
- **Policies**

OF

- **Agencies**
- **Organizations**
- **Coalitions/collaborations**
- **Service systems**

This is why health councils should organize the larger community of providers, systems and agencies to do this work ***together*** as partners. Health Councils are not expected to move the needle on population health by themselves! A health council could certainly work on policy alone, but probably not as effectively as with a coalition. The same is true for projects. How much more impactful if multiple agencies implement a new strategy at the same time together? Health Councils rarely provide direct services or programming which is another reason to have buy-in from community providers.

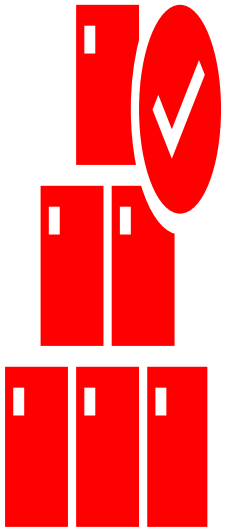
RBA Continued:
Programs, Policies, Projects

- This is where you decide what interventions/ preventions will be effective at accomplishing your result (goal).

- For each priority/result you are working on, select at least one **evidence-based or emerging best practice** program, policy or project that will improve the community health result selected.

Evidence-Based & Emerging Practices

- "Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research." Sackett et al., 1996
- Emerging practices are **interventions that are new, innovative** and which hold promise based on some level of evidence of effectiveness or change that is not research-based and/or sufficient to be deemed a 'promising' or 'best' practice.



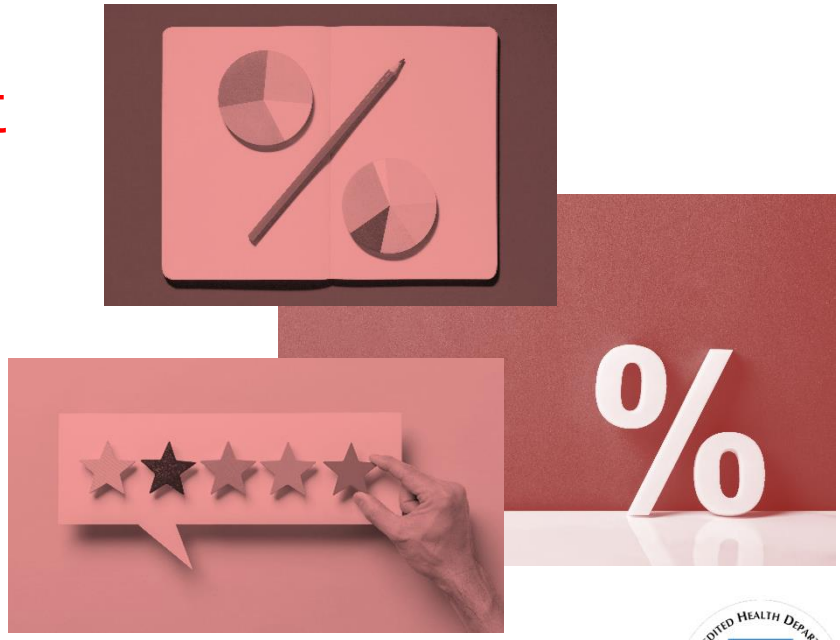
Evidence-Based & Emerging Practices Considerations

- What resources are required and what are available?
- Does it fit our mission and other efforts?
- Is it sustainable?
- Is it culturally relevant and/or can it be modified and still be implemented to fidelity?

One of the most important considerations when implementing an evidence-based practice is fidelity (sometimes called adherence or integrity) to the original approach. Preserving the components that made the original practice effective can directly impact the success of desired outcomes.

RBA Continued:
How do we know the means (strategies) are working?

- **PERFORMANCE MEASURE** = A measure of how well a program, agency or service system is working
- Three types of measurement
  1. How much did we do?
  2. How well did we do it?
  3. Is anyone better off?



RBA: Performance Measurements are for programs, policies or projects. Each participating partner should collect this data if they are providing an intervention.

So, to Recap Results Based Accountability: FROM ENDS TO MEANS...

POPULATION

RESULT

INDICATOR

We start here with what we want to see happen.

ENDS

Then we figure out what and how to measure that result at the community level.

PERFORMANCE

PERFORMANCE MEASUREMENT

Then all partners decide what they will track at the program level. (How much did we do?, how well did we do it?, Is anybody better off?)

Then all partners commit to what they are going to do to impact the population result/indicator.

MEANS

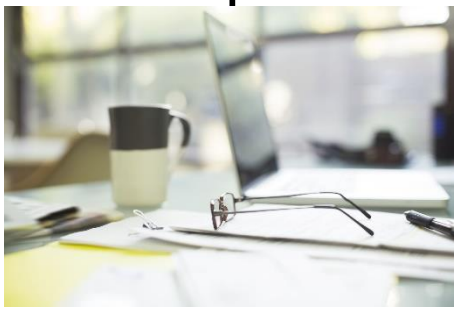
For increased accountability, create SMART Goals

(Specific, Measurable, Attainable, Resourced and Time-limited)

- Once you decide what you are going to do (that is attainable),
- make sure it's clear WHO is going to be doing what…
- by which date…
- with what resources.
- Example: "By Dec. 30th, 2022, Susie Q. will have purchased the XYZ training curriculum with funding from grant ABC"
- 2 bonus features:
  - How will you acknowledge or celebrate each task accomplished?
  - Do you have a back-up plan?

Write it up and get ready to act!

- Collect all the information gathered from the sessions with partners and present to community in the form of a Community Health Improvement Plan (CHIP).
- You may create your own or ask for a template to help guide you.
- Submit the final product to the New Mexico Dept. of Health; Health Promotion Team.
- Continue to move your coalition toward implementing the plan (Action Phase)!



What's next?

- Please fill out the training record provided to you and submit to your Health Promotion Team
- Following modules will take a deeper dive into each of the CHIP processes and define in greater detail what is meant by each item. Please view these.
- Consider what pieces of this process your health council needs to grow in. What support do you need? Feel free to reach out and ask!