COMMUNITY HEALTH NEEDS ASSESSMENT TOOLKIT

Designed by GNYHA's Center on Community Health Equity Policy and Services

CONTENTS

INTRODUCTION

A community health needs assessment (CHNA) and its implementation strategy help hospitals and health systems understand the health needs of the community and the services and resources needed to address prioritized needs. The goal of the CHNA is to foster collaboration with the community to help hospitals identify and prioritize such needs and develop strategies to address them.

Since hospitals engage with the community on an ongoing basis, the work performed as part of the CHNA process can be integrated into current workflows. Both new and existing hospital community health activities can be included in a new CHNA report as programs that are tracked for progress and impact. In addition, ongoing meetings with community partners often lead to new insights that can help hospital staff conduct the CHNA.

This toolkit details the essential best-practice steps of the needs assessment and implementation process. Each step is designed to be scalable to a hospital or hospital system's available resources. GNYHA staff are available to provide technical assistance with planning activities, including how to manage the process with available resources.

This toolkit is *not* a compliance tool to conform with the Affordable Care Act's CHNA requirement, the Internal Revenue Service's CHNA regulations, or any state-specific CHNA requirement. Instead, it is a model template to provide guidance on how a CHNA can be conducted and how to draft a CHNA report and its implementation strategy. Hospitals should consult Federal or state requirements for any specific steps that may be required by the appropriate regulatory body.

The toolkit will be useful to all hospitals in GNYHA's membership, including hospitals and health systems in New York, New Jersey, Connecticut, and Rhode Island. Sources for the toolkit's content include the Centers for Disease Control and Prevention (CDC), the American Hospital Association, the Institute of Medicine, the Catholic Health Association, and the New York State Department of Health. Materials from these and other sources were compiled and organized to be useful—and actionable—by GNYHA members.

The toolkit is divided into two sections: *needs assessment* and *implementation strategy*. The needs assessment section provides guidance on how to conduct a CHNA, including planning and using publicly available data to describe the community and identify and prioritize the community needs that the institution will address. The implementation strategy section describes how to address the selected and prioritized needs through intervention selection, intervention design, and evaluation. Each section includes resources and examples to help hospitals through the process.

PLANNING FOR THE CHNA PROCESS[1]

Reviewing the previous CHNA report, implementation strategy, and community engagement process and developing a timeline are important starting points for a new CHNA process. Revisiting the previous work will help institutions to identify what processes were effective in their last CHNA submission and whether the implemented community health intervention programs met the desired outcomes.

We will detail the following steps:

- *Review the previous CHNA report*
- *Engage community members on an ongoing basis*
- *Develop a timeline*

REVIEW THE PREVIOUS CHNA REPORT

While conducting a CHNA is a separate process from designing and executing an implementation strategy, reviewing both sections of the previous CHNA report is an opportunity to recall lessons learned, what strategies should remain the same, and what should be changed. Consider these areas when reviewing the previous CHNA report:

- Review the identified needs of the community and how they were established. The needs identified in the previous report can be a reference point as the hospital begins its next needs assessment cycle.
- What progress has been made on previously selected priorities? What are the outcomes of existing programs that were noted in the CHNA's implementation strategy?
- Review the methods for data collection and the type of data that helped identify the needs of the community. Are there other data collection methods or publicly available resources to consider?
- What feedback did the community provide? How does this affect future planning and implementation of the needs assessment?

Using the previous report and processes will provide a baseline and create an informed strategic approach for the upcoming assessment.

ENGAGE COMMUNITY MEMBERS[2]

For hospitals, community engagement is a constant effort that involves many organizational levels. Hosting a town hall on a health issue, partnering with a community-based organization (CBO) to offer job training, or working with a local market on a healthy food initiative are examples of hospital community engagement efforts. While these kinds of relationships are generally helpful, finding engaged community partners to help with the specific activity required by the needs assessment process is important. Hospitals can begin the search for engaged partners by reviewing which individuals and CBOs participated in the last CHNA process and whether the same or new participants should be involved in the upcoming effort. The hospital should also ensure that the needs assessment process includes the perspectives of those who lack access to care or who face other inequities, including medically underserved populations. Such inclusive efforts should occur even if the hospital is participating in a larger collaborative process with other partners.

Input from new and existing community partners will help both hospitals and community members to prioritize needs and create implementation strategies. Various entities can be incorporated into the CHNA process, including CBOs, local government officials, public health experts, educational facilities, businesses, places of worship, members of community advisory bodies, or individual residents from the area. The American Hospital Association website provides further examples, including a list of individuals and organizations.

DEVELOP A TIMELINE

Develop a timeline to show how long it will take to conduct and complete the needs assessment process, including creating and drafting the implementation section. Don't forget to include time for the hospital board of trustees to approve the completed report. Inserting milestones to highlight progress and accomplishments is also helpful.[3] When the timeline is complete, present it to the hospital team and other stakeholders and request their feedback. Edit the timeline as appropriate based on the feedback.

Considerations

Whether the hospital is conducting the CHNA by itself as a standalone institution or as part of a large health system or local collaborative will influence the timeline. For example, obtaining consensus on what needs should be addressed as part of a large collaborative may take more time than working within a single hospital network and its community partners. Other activities that could take considerable time are working with the local health department and public health officials, community and partner engagement, information gathering, data analysis, and writing the report. Below is a sample timeline to help generate ideas.

Sample Timeline to Conduct the CHNA and Develop the Implementation Strategy

NA = Needs Assessment
IS = Implementation Strategy

NA Toolkit Planning, Step 1 & Step 2	NA Toolkit Step 1 to Step 4	NA Toolkit Step 4 to 6	NA Toolkit Step 6 to 7; IS Step 1 to 3	Toolkit Step 8; IS Step 2 and 3
Month 0 to 1	Month 1 to 2	Months 2 to 4	Months 5 to 8	Months 9 to 12
Review previous CHNA and community engagement efforts	Finalize hospital team leader and staff to conduct the CHNA; Begin to engage with senior leadership about the CHNA process and its report	Conduct primary data collection, analysis, and interpretation. This includes meetings with CBOs or other community members.	Prioritize and determine the needs that the hospital will address	Collect final evaluation or progress update for existing programs
Organize and plan team meeting	Begin to engage community stakeholders	Analyze and interpret secondary data collection	Finalize interventions and evaluation strategy to address needs and partners/ collaborators for the interventions	Draft and finalize CHNA report

NA Toolkit Planning, Step 1 & Step 2	NA Toolkit Step 1 to Step 4	NA Toolkit Step 4 to 6	NA Toolkit Step 6 to 7; IS Step 1 to 3	Toolkit Step 8; IS Step 2 and 3
Month 0 to 1	Month 1 to 2	Months 2 to 4	Months 5 to 8	Months 9 to 12
Begin working on the timeline for the CHNA process	Develop Advisory Committee	Begin to share findings with the community	Follow-up with advisory meeting to discuss findings	Present CHNA and IS to the board for approval
	Determine the community served and begin collecting data resources	Schedule meetings with Advisory Committee and hospital team	Begin to draft the CHNA and IS	Communicate results to partners and Advisory Board

CONDUCTING THE CHNA

The following section reviews the steps to conduct a CHNA:

- *Step 1: Develop a CHNA Hospital Team*
- *Step 2: Develop a CHNA Advisory Committee*
- *Step 3: Determine and Define the Community Served*
- *Step 4: Collect Data on the Health Status of the Community*
- *Step 5: Identify Community Assets*
- *Step 6: Analyze and Interpret Data*
- *Step 7: Determine Health Priorities*
- *Step 8: Document and Communicate Results*

STEP 1: DEVELOP A CHNA HOSPITAL TEAM[4]

When beginning the CHNA, select a hospital staff person to lead the process and establish a hospital team.[5] The team leader will develop the team and coordinate efforts. Examples of hospital staff roles that could be designated for this role include community affairs, community health, community engagement, strategic planning, or another staff person with the skill set and access to senior leadership to manage such a project. The leader's responsibilities include identifying community partners, communicating with senior leadership about progress, selecting resources, developing a budget, and creating the plan to set the priorities for the assessment process.

The hospital team should consist of staff members who engage with the community and relevant departments that engage in the health issues identified by the assessment. The staff members could include, but not be limited to, strategic planning, community health, ambulatory services, medical and nursing staff, finance, communications, social services, community benefit, and the appropriate clinical leads. A background in public health, epidemiology, and statistical analysis is helpful but not necessary.

The hospital team can be as large or small as the hospital or team leader determines based on available resources. The team should include those able to support the efforts of the needs assessment. The following roles and responsibilities are needed to adequately conduct the needs assessment:[6]

- Project oversight, including managing timelines and the overall methodology or approach to conducting the assessment
    - Includes deciding on the approach of the needs assessment such as performing it as a standalone hospital, part of a health network, or part of a local coalition
- Establish and maintain relationships with community partners
- Research and analyze primary and secondary data
- Analyze and interpret results of data collection activities
- Work with hospital departments to obtain community activity information

- Message needs assessment activities at various stages within the hospital and the community. These activities could include gathering community input or informing hospital staff that this is an activity the hospital is participating in as part of a larger effort to improve community health outcomes.
- Select interventions and/or policies that will address the community's needs
- Write the needs assessment
- Present the findings and the written report to hospital staff and leadership. A CHNA typically needs board approval so the hospital team should involve leadership along the way.

The hospital team leader will also select members of the team to participate in the CHNA Advisory Committee, which is discussed further in Step 2. Hospital staff on the Advisory Committee will liaise with the community to help engage them in the process.

STEP 2: DEVELOP A CHNA ADVISORY COMMITTEE

When conducting the needs assessment, use community stakeholders' expertise and insight to understand the priorities of the population the hospital serves. Establishing an Advisory Committee comprising hospital staff and community members can facilitate communication between the community and the hospital. Hospital staff on the committee should collaborate with the community directly and have working knowledge of hospital activities outside and inside the hospital. Community stakeholders should represent broad interests of the community, including medically underserved populations. The size of the committee can be scaled to available time and resources.

The Advisory Committee's main role is to gather information, prioritize needs, and reach consensus on approaches to engage the community for the needs assessment process. The committee also can contribute to the CHNA's implementation strategy by working on tactics to meet the needs of the community, plan for monitoring and evaluation, and work together on the agreed upon implementation steps. Implementation is discussed further in the second half of this toolkit.

When recruiting community members to join the Advisory Committee, hospital leaders must clearly describe the roles and responsibilities before beginning the work. Hospitals should consider the following questions when working with community organizations:[7]

- What role should the CBO or partner play in the needs assessment process? Will they be an advisor, an expert in a health or social issue, or will they help develop a current or future program?
- What population(s) does the organization represent and serve?
- What resources or knowledge can the hospital and organization share? Staff, a referral process, or other types of resources?
- What challenges, if any, exist for the community organization to participate in the needs assessment process as a committee member? What steps are needed to remove or work through the challenges?

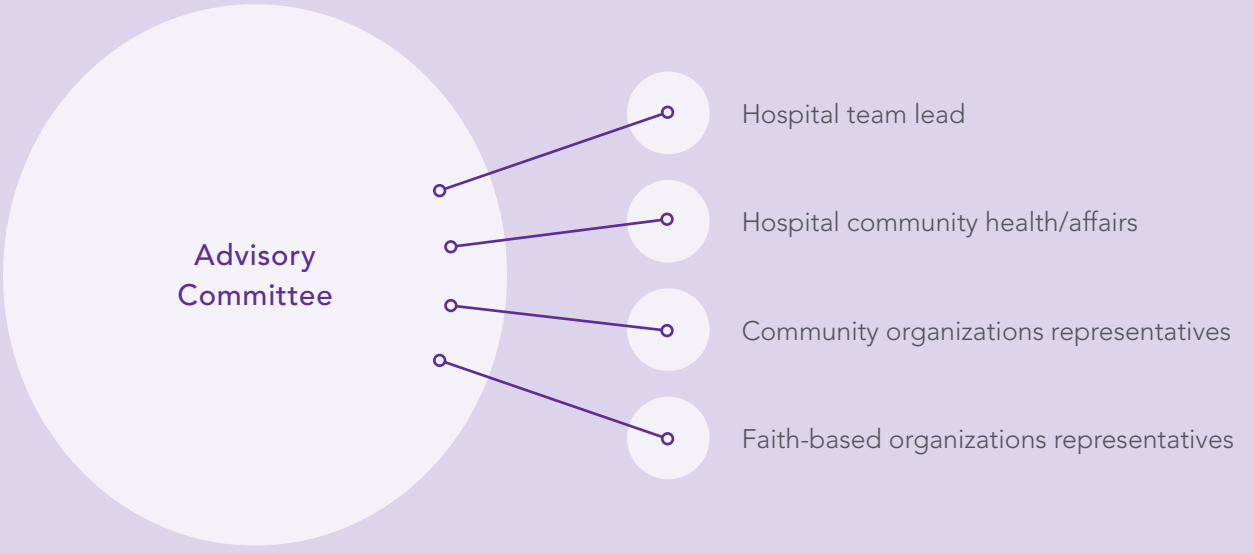
Community stakeholders who understand their role in the needs assessment process could then contribute according to their available resources and expertise. Such a partnership will give the hospital direct insight into a population and its needs and strengthen community relations.

Figures 1 and 2 highlight possible recruits for the Advisory Committee.

Figure 1: Large Advisory Committee

If resources dictate a committee of limited size, consider these core individuals to fulfill the Advisory Committee's key functions.

Figure 2: Small to Mid-Size Advisory Committee



STEP 3: DETERMINE AND DEFINE THE COMMUNITY SERVED

The hospital can define its community in terms of the physical service area of the hospital and/or individuals who seek care at the hospital (e.g., specialty hospitals may define "community served" both geographically and by the patients who present to the hospital who reside outside of the immediate geographic area). Often, hospitals note zip code data or maps in the written description of the community to provide context on where the community resides.

The next step is to consider the population's identity, including characteristics such as the following:

- Age (children and youth, adults, seniors)
- Gender
- Sexual orientation
- Race and ethnicity
- Socioeconomic status
- Education level
- Insurance status
- Language preference
- Health literacy level
- Disability
- Medically underserved areas

There are several ways to expand beyond the hospital's physical location to define the hospital's community. General resources to help describe the community at the hospital, state, and local level include:

- Hospital utilization data can provide patient demographic information such as zip code and regional information. (Use of this data can be especially important for specialty hospitals that, because of their nature, draw patients from beyond any geographic area.)
- US Census Bureau: The US Census Bureau provides statistical information about the nation's population, demographics, language use, and other data
    - American Community Survey: Yearly census data on the demographics of a population
    - US Bureau of Labor Statistics: Details labor economics, statistics, and local area unemployment statistics
- Community Toolbox's Understanding and Describing the Community (University of Kansas): Background on describing, defining, and assessing a community
- Local health department information on communities can provide further demographic information at the granular level
    - Connecticut
        - Connecticut Open Data
        - CT Data Collaborative
        - Connecticut Data Haven
    - New Jersey
        - New Jersey State Data Center
        - State of New Jersey NJOIT Open Data Center

- Rhode Island
  - Rhode Island Data Center and Census Data
  - Data Spark from the University of Rhode Island
- New York
  - New York Open Data
- New York City Department of Health and Mental Hygiene
  - New York City Community Health Profiles
  - New York City Neighborhood Health Atlas

The following provides an example of how to structure a written needs assessment report describing the community.

Description of the Community Served

When defining the community being assessed, highlight the service area and its population. Doing so helps describe the population's demographics and characteristics referenced below.

[HOSPITAL X]'s service area is defined by a broad community that spans several zip codes across Queens and Brooklyn. They cover the following population zip codes: [XXXXX], [XXXXX]... Areas designated as medically underserved are [XX] and [XX].

Population Characteristics

The population of the service area is approximately [XX].

- Age: Describe the average age of the population. Are most residents in the service area in a specific age range or is there a young or older population?
- Race and Ethnicity: Describe the racial and ethnic makeup of the community.
- Sex/Gender: Include any known sex/gender identities of the population.
- Sexual Orientation: Provide data on the sexual orientation of the communities if that data is available.
- Socioeconomic Status: Highlight the economic status of community members. This can include statistics on those below the Federal Poverty Level, median family incomes, unemployment rates, education level, and housing.
- Insurance: Include the number of those uninsured and Medicare and Medicaid enrollment.
- Language Preference: Note background on languages spoken in the service area. If there is information on a preferred language at your institution, it may be helpful for future implementation of programming.
- Disability: Note the population's disabilities, which can include those with physical impairments, deaf and hard of hearing, and those with visual impairments.

STEP 4: COLLECT DATA ON THE HEALTH STATUS OF THE COMMUNITY

Next, collect information on the health and social determinants of health (SDH) of the community. Consider the populations that represent the defined community and how to engage them during the assessment process. Various approaches can be used to gather this information, frequently including the collection of primary and secondary data sources that contain qualitative and quantitative information.[8] Qualitative data is descriptive and non-numerical. It can contain text that can be gathered through interviews and focus groups that elicits perceptions and opinions. Quantitative data is numerical information such as population data and the number of patients seen with a diagnosis (e.g., asthma).

Primary Data

Primary data is collected directly from the source. In a CHNA, the community often provides primary data via different communication modes such as surveys, focus groups, town hall meetings, and CBO feedback. Such methods provide information directly from the community and allow for a realistic comparison to local and state data. Below are brief examples of some methods that can be used to conduct primary data collection. Choose a method or combination of methods and scale the activity to the institution's ability and resources to gather credible and useful information.

- *Electronic health record (EHR):* Use the institution's medical records to gather health information about those who received care and the various health issues treated at the facility. For example, this information can show whether an institution sees high rates of patients entering the emergency department (ED) with an asthmatic attack.
- *Key informant interviews:* One-to-one conversations between a facilitator(s) and a community member. Consider selecting participants who are active in the community such as a faith-based leader or other community leaders. Include clinicians, community health workers, and social workers, etc., who will also have a sense of the health and social issues that are treated at hospital or ambulatory sites.
- *Community surveys:* Written questions that can be filled out on paper and/or shared online with groups or individuals who represent the defined community.
- *Community focus groups:* Group-based conversations with questions that are led by a facilitator. Groups can range from eight to 10 people.[9,10]
- *Community forums/town hall meetings:* Large meetings with community members that are led by a facilitator to solicit community perspectives.[11]
- *Observations:* Firsthand observance of the community environment to gather information/data without direct interaction. Observations can be recorded via notetaking, photos, video, and other creative means.[12]

Ultimately, determine which method to collect primary data best suits the community *and the hospital's capacity to perform that method.* A tool that can help make this work more manageable is the CDC's Community Health Assessment and Group Evaluation (CHANGE). It was developed as a planning resource to help community members collect information to identify areas of improvement and prioritize the community's needs. To help with method selection, the CHANGE tool action guide provides a chart noting various data collection methods, including their advantages and disadvantages. The CHANGE tool also recommends focusing on five sectors: the community at large, community organizations, health care, schools, and location of employment.[13] Below are additional resources to help hospitals develop and conduct surveys and focus groups. In addition, GNYHA created a model template survey (see Appendix A) that can be tailored to meet the hospital's community needs. *The survey is a starting point for hospitals that also may not have a large staff to assume the rigor of survey development.*

Suggested Resources on How to Develop and Conduct Surveys/Focus Groups

- Association for Community Health Improvement (ACHI) Community Health Assessment Toolkit
  - Collect and Analyze Data: Reviews the different modes of data collection
- National Association of County Health Officials (NACCHO)
  - Phase 3: Collecting and Analyzing Data section on Community Themes and Strengths Assessment

        - Subsection Survey Instruments
        - Subsection Conducting the Assessments: Focus group guidelines, example focus group guides, and focus group and community dialogue tips sheets
    - Phase 3: Collecting and Analyzing Data section on Community Health Status Assessment
        - Designing and Sharing Your Surveys: Example surveys
- Community Toolbox
    - Conducting Public Forums and Listening Sessions: Guidance on holding a town meeting and what questions to consider
    - Conducting Surveys: How to prepare and distribute a survey.; this section also includes how to analyze survey results
    - Conducting Focus Groups: Defines focus groups and provides steps on planning and conducting focus groups
    - County Health Rankings and Roadmaps
    - Community Assessment Tool: Rotary International tool that details surveys, conducting interviews, and hosting community meetings
- Greater New York Hospital Association Sample Survey 2019 (see Appendix A)

Secondary Data

Secondary data is health status and/or needs information collected and published by organizations other than the hospital from credible sources such as a local health department, Federal or state agencies, universities, or other reputable organizations. Focus on the most current local and state public health data available. Public health data takes time to collect and analyze, so there is often a one- or two-year lag before the findings are reported. Knowing the year(s) the data represents will ensure that it is the most current information.

The most helpful secondary data is local health data at the county level or, even better, the neighborhood level. Generally, local health data can be obtained from the local health department and other organizations that work with different populations and collect their own data. Such organizations can include colleges/universities, local advocacy groups, local businesses, schools, religious groups, and not-for-profit organizations.[14] These groups may have done their own needs assessments for the populations they serve. These reports can provide insight on the types of services provided to the community and additional health indicators to review when analyzing a group's needs. Examples of these reports are: Celebrating Strengths, Addressing Needs: Community Driven Solutions to Improve Well-Being in Northern Manhattan (the Citizen's Committee for Children of New York), and City Voices: New Yorkers on Health: Community Needs Assessment Overview, 2015 (the New York Academy of Medicine).

The primary and secondary data compiled on a community's health status provides a snapshot or description of the health of the population served by the hospital. The description will include health indicators, SDH, and health disparities that will help to identify and prioritize health issues.[15]

Health Indicators

Health indicators from secondary data sources can provide information on health outcomes, health care use, and health behaviors. One way to reach a consensus on which health indicators to select is to discuss the indicators with the Advisory Committee. Ensure that different points of view are considered. Looking at the indicators associated with current health initiatives can be especially helpful. For example, if a current diabetes self-management program is addressing Type 2 diabetes, reviewing key indicators such as diabetes and obesity rates in the community can help establish a baseline and indicate whether/what further interventions may be needed. Examples of key indicators and their definitions are:

- *Infant mortality:* Infant mortality is an indicator of a society's overall health. The infant mortality rate is the number of infant deaths in the first year of life for every 1,000 live births.[16,17]
- *Mortality:* Mortality data details the causes of death in a population. The mortality rate is calculated as the number of deaths per 100,000 of the total population. Use this data to identify trends and find comparisons across different geographic areas.[18]
- *Morbidity:* Morbidity is an illness or an amount of an illness in a population. For example, Alzheimer's disease is a morbidity.
- *Prevalence:* Prevalence measures the amount of disease and the likelihood of a person having a disease. The rate of prevalence is "calculated by taking the total number of cases of a disease existing in a population divided by the total population."[19]

General health indicators that detail health and quality of life can be categorized into the following areas:[20]

- Demographics
- Socioeconomic status
- Access to health care and health insurance
- Health status of the overall population
- Risk factors
- Health behaviors
- Leading causes of death
- Child health
- Infectious diseases
- Environmental factors
- Resources and assets

Health indicators provide benchmarks set by national and state initiatives that reveal health trends over time. Two well-known resources with benchmarking information are Healthy People 2030 and the County Health Rankings and Roadmaps. Healthy People 2030 contains Leading Health Indicator topics that range from clinical preventive services to substance and tobacco use. County Health Rankings and Roadmaps highlights indicators around health outcomes and factors that influence health. The New York State Department of Health Prevention Agenda Dashboard also provides goals and objectives around health indicators for the State.

Suggested Resources Containing Health Status and Indicator Information

National Data Sets with State, County, and/or Local Information

- Healthy People 2030: Leading health indicators with benchmarks for the United States
- CDC
  - Behavioral Risk Factor Surveillance System: Telephonic survey that collects health data on health-related risk behaviors, chronic health conditions, and the use of preventive services for all 50 states
  - Youth Risk Behavior Survey: Considers six types of health-risk behaviors that contribute to mortality among youth
  - Chronic Disease Indicators

    - CDC Wonder: Contains online health data sets of various health topics
    - Disability and Health Data System
- County Health Rankings and Roadmaps: Contains county data information on health outcomes, health behaviors, and health factors that include clinical care, social and economic factors, and the physical environment
- 500 Cities Project (2016-2019): Data on health outcomes, prevention, and unhealthy behaviors for the 500 largest cities in the United States
- CDC Places: Local Data for Better Health (extension of the 500 Cities Project): Provides city and census tract estimates on health indicators such as chronic disease, health outcomes, and clinical preventive services
- City Health Dashboard: Sponsored by NYU Langone Health and the Robert Wood Johnson Foundation, *City Health Dashboard* is an online national database that includes community health status data for 500 of the largest US cities, including where GNYHA members are located. Among the included cities are Albany, Buffalo, Mount Vernon, New Rochelle, New York, Rochester, Schenectady, Syracuse, and Yonkers in New York State; Elizabeth, Newark, and Paterson in New Jersey; Hartford, New Haven, and Stamford in Connecticut; and Providence in Rhode Island.

New York State
- DOH 2019-2024 Prevention Agenda
- New York State Prevention Agenda Dashboard
- New York State Health Equity Report 2019 (County Edition)
- New York State Community Health Indicator Reports (CHIRS)
- New York State Leading Causes of Death
- NYS Hospital Inpatient Quality Indicators
- DOH Statewide Planning and Research Cooperative System Data

New Jersey
- Healthy New Jersey 2020
- Healthy New Jersey 2030 (in development)
- New Jersey Department of Health: Governmental Public Health Partnership: Includes county CHIPS and CHNAs
- New Jersey State Health Assessment Data: Public health topics and indicators

Connecticut
- Healthy Connecticut 2025
- Data Haven: Free resource with over 1,000 indicators of community well-being

Rhode Island
- Rhode Island Department of Health: Provides data on various health indicators
- Rhode Island Healthy Aging Data Report

New York City Local Health Data
- EpiQuery
- New York City Youth Risk Behavior Survey
- Vital Statistics
- Community Health Survey
- New York City Community Health Profiles
- NYC Health and Nutrition Examination Survey
- Neighborhood Health Atlas
- 2019-2021 Community Health Assessment and Community Health Improvement Plan Take Care New York 2024

Health Disparities

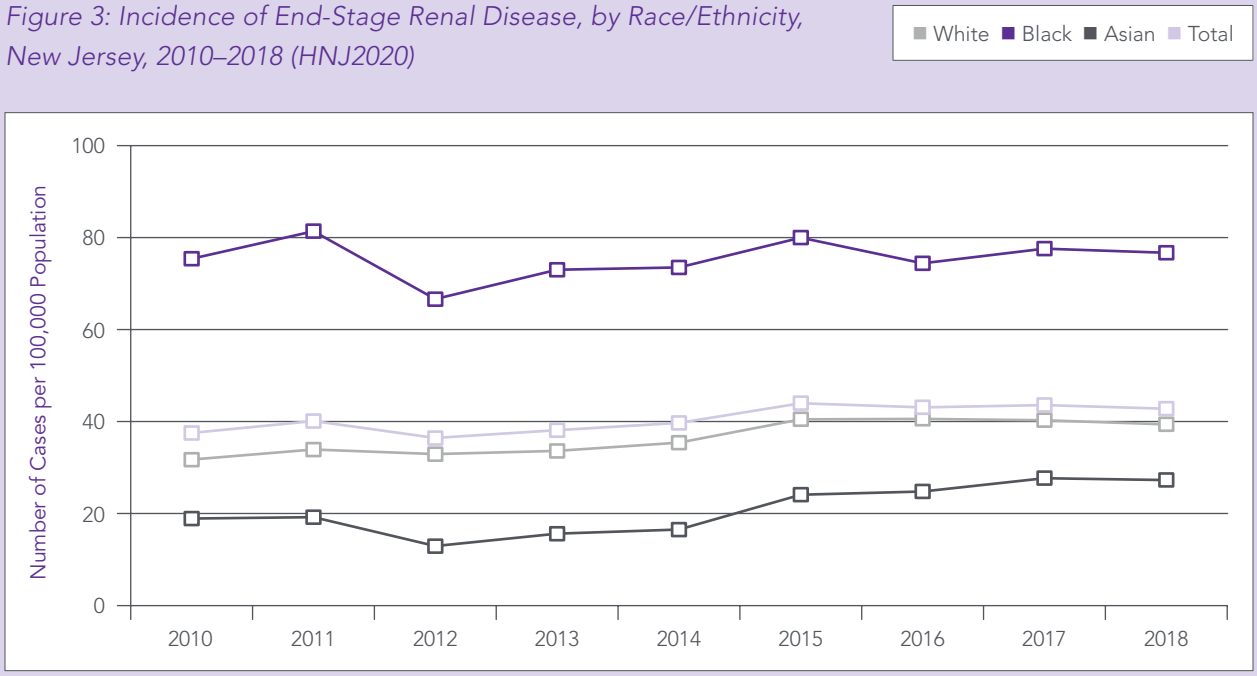
While reviewing the selected health indicators, examine disparities among groups and health issues. Health disparities are differences in health and health outcomes between different groups. They can negatively affect populations that experienced greater obstacles to health in relation to economic or social challenges. The U.S. Department of Health and Human Services' Healthy People 2030 initiative defines a health disparity as "a particular type of health difference that is linked with social, economic, and/or environmental disadvantage."[21]

Health disparities often arise from the following areas:[22]

- Economic status
- Race/ethnicity
- Age
- Disability status or special health care needs
- Gender
- Sexual orientation
- Geographic location (rural vs urban)

One example of a health disparity is the incidence of end-stage renal disease (ESRD) in New Jersey. From Figure 3, the incidence rate for Blacks is 76.7 per 100,000, for Whites is 39.4 per 100,000, and for Asians is 27.3 per 100,000.[23] New Jersey plans to address this via its Healthy New Jersey Initiative, which has the following objective for this issue: "Healthy New Jersey Objective Chronic Kidney Disease (CKD)-2: Reduce the incidence of ESRD per 100,000 population to 33.8 for the total population, 28.5 among Whites, 67.9 among Blacks, and 17.0 among Asians."

Figure 3: Incidence of End-Stage Renal Disease, by Race/Ethnicity, New Jersey, 2010–2018 (HNJ2020)



Another health disparity example is the rate of hospitalizations for asthma for different racial groups in New York. Those who are Black Non-Hispanic and Hispanic have the highest rates of asthma hospitalizations in New York State. The rate for Blacks is more than six times higher that the rate for asthma hospitalizations for Whites. This is shown in Figure 4, below.

Figure 4: New York State Health Indicators by Race/Ethnicity, 2016–2018

Health Indicator	Non-Hispanic			Hispanic	Total
	White	Black	Asian/Pacific Islander		
Respiratory Disease Indicators					
Asthma hospitalizations per 10,000 population, age-adjusted	3.8	23.1	5.2	15.4	10.8

Social Determinants of Health (SDH)

A needs assessment also uncovers how external factors can influence the health outcomes and well-being of a population. According to the CDC, SDH are "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes."[24] Healthy People 2030 categorizes SDH into five areas: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. The Kaiser Family Foundation categorizes SDH similarly but adds access to food as an additional category. Figure 5 provides further details and a visual for what falls into those categories.[25]

Figure 5: Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability Zip code/ geography	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination Stress	Health coverage Provider ability Provider linguistic and cultural competency Quality of care

Health Outcomes: Mortality, morbidity, life expentency, heath care expenditures, health status, funcational limitations

As the needs assessment process continues, SDH can be tied to health challenges faced by a community. For example, an assessment finds high asthma rates in EDs and notes that this is a key issue for a population. To address the root cause of ED visits, the assessment's community engagement reveals that the community is experiencing mold and other allergens in its housing units, which complicates efforts to control asthma. The hospital can incorporate a broader plan to address these SDH, even if the hospital focuses only on medication adherence and education. The hospital could also cite the SDH as a reason to implement an intervention. Working to eliminate these allergen issues and focusing on medication adherence are possible ways to reduce asthma exacerbations and preventable ED visits. Remembering these environmental factors or SDH during the assessment's implementation portion will inform future program development.

The needs assessment process uncovers SDH in many ways such as data gathered via surveys, interviews, and community engagement. Secondary resources can also highlight or support the findings revealed via primary data collection. Below are examples of resources that contain SDH data for a county or at the local level. GNYHA has also produced its Community Service Plan Tool on SDH versus Health Disparities to further detail how to integrate both concepts into hospital community needs assessments (see Appendix D).

Sample Resources for Social Determinants of Health

Summary of Datasets with Social Determinants of Health Indicators: Contains a list of datasets with SDH indicators across NYS.

CDC Social Vulnerability Index: Using US census data, the CDC has determined the social vulnerability of a census tract primarily to help communities prepare for emergency events or natural disasters. Social vulnerability refers to factors such as a lack of transportation access, poverty, and overcrowded housing. The Social Vulnerability Index groups 15 social factors into four domains: socioeconomic status, household composition, race/ethnicity/language, and housing/transportation. While its purpose is to help with emergency preparedness, this tool provides a social vulnerability score of the area and four domains that provide insight into where vulnerable populations exist and which social factors affect them. The information can be found using the interactive map and prepared county reports.

US Food Environment Atlas: Contains data on restaurant locations, markets, food prices, nutrition assistance programs, and community socioeconomic characteristics.

Healthy People 2030 Resources in Social Determinants of Health: Contains information about literature on specific SDH.

Map the Meal Gap: Created by Feeding America, a national organization focused on domestic hunger relief, Map the Meal Gap provides visual results of its food insecurity reports, which contain food insecurity rates, estimated eligibility for nutritional assistance, and additional funds required to meet food needs. One can filter the data by state, county, community district, and year. The map also includes food bank locations. The food insecurity reports describe food price variation, child insecurity, and food insecurity's impact on health and chronic disease outcomes. This resource also includes the Map the Meal Gap-Child Food Insecurity, a mapping tool that provides an estimate of children at risk for hunger by state and displays the relationship between child food insecurity and birthweight and health insurance.

Public Health Challenges

Circumstances beyond anyone's control such as natural disasters and pandemics can disrupt community health programming planning and operations. Resources often are redirected to emergency situations to fulfill urgent needs. When planning the CHNA process, consider these events and how they impact the community. Look to

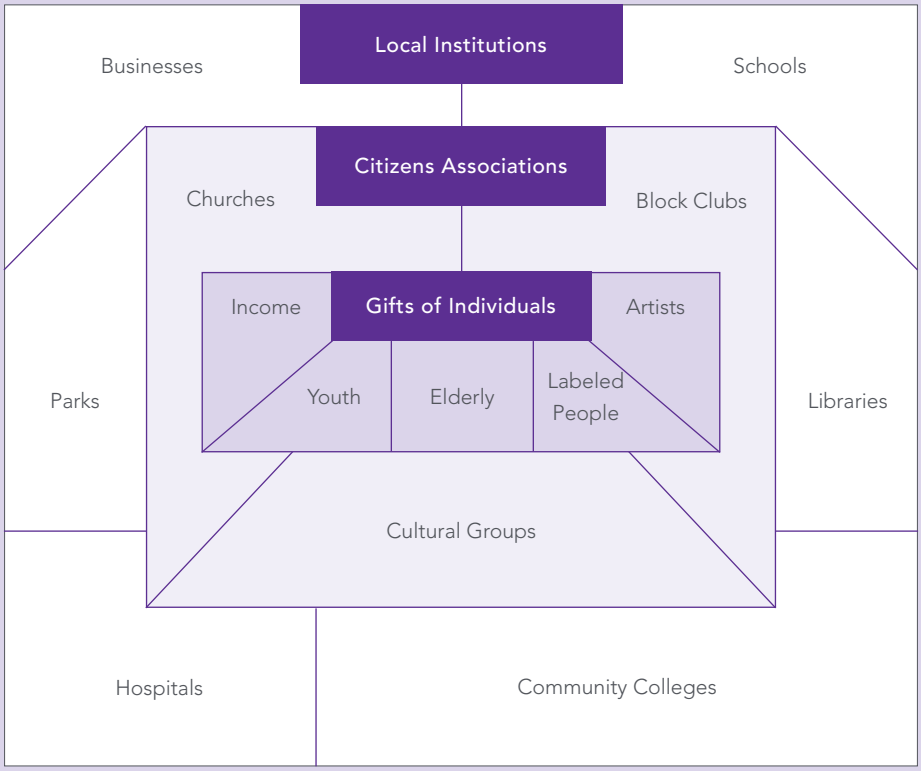
primary data resources or any recent data supplied by the government or other entities to capture information about these events. Real-time data allows the hospital to change the course of the CHNA if necessary. For example, the COVID-19 pandemic has affected not only health and mental health but social interactions and economic livelihoods due to job loss and remote education. GNYHA offers various resources to help hospitals address and understand the societal impact of COVID-19 on communities (see Appendix G).

STEP 5: IDENTIFY COMMUNITY ASSETS

Identifying community assets in the CHNA process provides the hospital with details on resources and efforts that can help address a community's health issues, including SDH. Any resource that improves the quality of life for a community is an asset. Assets can be a person, a physical infrastructure, a business, or community services.[26] Knowing the assets will help hospitals find and develop potential partnerships to address a need or avoid duplication of efforts by a hospital if there is an existing and successful community program. If resources are available, the hospital may wish to develop a program on its own or within its own walls, depending on the health issue it seeks to address. The assets can also help to mobilize resources to address the identified health needs. For example, hospitals unable to participate due to resource constraints can partner with active local health departments or other CBOs on an issue.

Figure 6: Community Assets Map

Provided by John Kretzmann and John McKnight,[27] this map visualizes how a community's assets are connected.



Consider the following examples of assets (strengths) in the community and within the hospital when gathering information:

Examples of assets in the community:[28]

- *Individuals who may be informal or formal leaders:* This could include a church pastor, a community organizer who advocates for a health issue, business leaders, elected officials, or a local schoolteacher
- *Physical buildings or places:* Such as a hospital, library, community center, university, elementary or high school, or local park. Knowing whether they are used or underused can provide insight into a community.
- *Organizations that provide services:* Such as public health departments, child care and senior centers, cultural centers, pharmacies, CBOs, faith-based organizations, and local businesses
- *Political resources:* Constituencies of elected officials and advocacy groups that influence change
- *Existing interventions:* Existing efforts in a community such as workforce development or violence prevention efforts led by CBOs

Examples of assets in the hospital:

- *Individual staff members:* Such as physicians, nurses, social workers, health educators, trustees, and executive leadership
- *Hospital departments:* Such as primary care, ED, diversity and inclusion, community health, population health, and finance
- *Hospital partnerships:* Knowing established partnerships can avoid duplication of efforts, and current relationships can be used to continue or broaden current projects. These partnerships will also help the hospital notice where there are gaps in its relationships.

The task of collecting and identifying community assets doesn't have to be overwhelming and can be scaled to the institution's level of staffing and resources. Hospital staff can obtain this information from the community members who are already engaged with the hospital in the needs assessment process. There may also be data sets that hospitals can use. For example, the New Jersey Community Asset Map includes a feature to display specific details such as which areas need rehabilitation, transportation access, walkability, medical facilities, etc. To keep track of the collected data, the information can be entered into a spreadsheet or Excel file with a list of organizations and the services they provide. The American Hospital Association's Association for Community Health Improvement also created a sample template that organizes information by individuals, groups, and organizations. It divides the assets by community and hospital resources.[29] Recording the strengths of the community will ultimately be a reference for both the needs assessment process and ongoing strategic planning.

STEP 6: ANALYZE AND INTERPRET DATA

Review data from the hospital's previous CHNA. Comparing and contrasting the same health indicators against the most recent data will help determine whether an indicator has changed at a population level—positively, negatively, or at all. Noting how indicators have changed over time will provide guidance on how to address health issues in the community. For example, if progress has been made on a specific health issue, it could provide support to continue addressing the issue with an existing intervention. Another way to consider this: The need to address the

health issue may no longer be as urgent as before, meaning the institution may not need to prioritize it in the new CHNA. Primary and secondary data gathered via recent research will highlight the most pressing needs. Comparing health indicators from the past CHNA with the present CHNA is a simple way to find a baseline for changes in the community.

Primary and secondary data can be interpreted in various ways once it is collected. The following reviews different ways to analyze and interpret the collected information in accordance with the data collection method.

Primary Data Review

The community's voice is a key component of the CHNA process. Responses from surveys, focus groups, and other types of engagement can help prioritize the health issues that need to be addressed. Considering health data without this type of direction is challenging, so community involvement can help guide the process by revealing the most important health areas. When reviewing the community responses, consider the following questions:

- What concerns are most frequently voiced by the community?
- What areas does the hospital have the position and capacity to address?
- What issues can be addressed through partnerships?
- Are the issues raised currently being addressed? What can be done better and how?

Survey

While survey replies can be useful, only those who answered the survey are represented. Consider whether those who responded represent the broader community or a certain population. Describing the group's characteristics such as a respondent's Zip code or other demographic information is helpful to understanding the survey results. It is important to not generalize for a whole population from these results.[30] How and where the survey was conducted should be documented in the analysis to detail the survey's reach.

The survey responses can be aggregated to create a summary of respondents' characteristics. When considering the survey results, the questions to raise are:

- Does this group represent a broad population of the community?
- What health issues were mentioned the most?
- How does this group view the health of the community generally?
- What are the strengths of the community from the respondents' perspective?
- What social and/or economic issues were ranked of the highest importance?

Focus Groups/Interviews

Review the responses and comments collected during the focus groups and interviews. Sort the information by topics or themes.[31] Document who is participating in the focus groups or interviews, and the objectives of those meetings. As the data is collected, consider if any relationships or consistent topics align with the secondary data that is collected. This will help narrow the issues to address during the prioritization process. The primary information can support the secondary data and vice versa.

Community Forums/Town Hall Meetings

Similar to the approach to the focus groups/interviews noted above, identify themes and topics that arise from the community's feedback. Collect the notes or recordings gathered from community meetings and document which organizations and individuals attended the meeting(s). Compare different sessions and recognize who is providing the input so that it can be used to help determine important health issues. For example, one person or group may dominate the conversation and present only a certain issue as important to their group. But that viewpoint may not represent the most important issue to the entire community. Check with other colleagues on the hospital team who are present to ensure that the information is not subjective or biased.[32]

Secondary Data Review

Using primary data to narrow health indicators will help make the review of secondary resources—such as publicly available data and electronic medical records—manageable. There are several ways to review and analyze secondary data or quantifiable data points to highlight what needs are important in the community. The following methods provide options to analyze and interpret the information.

Community Comparisons

One way to review the collected data and indicators is to compare it with other communities nearby or across the country. When comparing indicators, knowing the date the data was collected—and if it is the most current data available—is critical. Common measures that allow for accurate comparisons are proportions, ratios, and rates.[33] Data that is misinterpreted can be misleading, so compare indicators appropriately by using the same timeframe for data collection and note any changes in how the data was collected that may or may not make the data comparable.

To compare data at the local level, use local health department data, not-for-profit organizations' assessment reports, or websites that compile data from multiple sources and present it in a user-friendly format. This data will include health indicators and SDH data. The level of granularity will vary by source. The following resources, which are available at the local level, allow for such comparisons:

- CDC Places: Local Data for Better Health (extension of 500 Cities Project)
- New Jersey State Health Assessment Data Small Area Data (NJ Department of Health)
- Connecticut State Department of Health Statistics and Research
- Rhode Island Healthy Aging Report: Community Profiles
- City Health Dashboard
- New York City Neighborhood Health Atlas
- New York City Community Health Profiles
- Take Care New York 2020
    - 2019-2021 NYC Community Health Assessment and Community Improvement Plan: Take Care New York
    - Executive Summary

At the county level, various databases allow for comparisons with nearby counties or counties across the country. When noting how the hospital's county compares to others, consider which counties are similar or are known as

"peer counties." County Health Rankings and Roadmaps and the CDC's Community Health Status Indicator teams have created a Peer Counties Tool to help find groups of counties that could be considered peers based on indicators such as social and economic factors. The following websites provide county-to-county comparisons and are visually helpful for this type of analysis:

- America's Health Rankings
- County Health Rankings and Roadmaps
- USDA Food Environment Atlas
- New Jersey Health Collaborative: County CHIP Strategies and Activities
- New Jersey Community Dashboard and Profile Reports
- Healthy Connecticut 2025: State Health Improvement Plan
- New York State Prevention Agenda Dashboard
- New York State Health Equity Report 2019 (County Edition)
- New York State Leading Causes of Death

These types of sites gather their information from publicly available data and usually note the data sources. Knowing the date the data was collected is the key to finding comparisons or trends.

National Standards/Benchmarks[34]

Benchmarks or other indicators of interest are another way to measure a community's wellbeing. It allows a hospital to see if its communities are doing better or worse than the considered standard or point of reference. If, for example, a community is not meeting an established benchmark, the resource may suggest the need to prioritize that indicator or topic area. Benchmarks also contain time-targeted goals that allow the hospital to see what indicators are being measured and prioritized at the national and local level. Ultimately, hospitals can use this information to help with future programming and measurement that support the broader public health improvement goals. The following are examples of data that include benchmarks:

- Healthy People 2030: Sets 10-year national objectives to improve American's health
- Healthy NJ 2020 Dashboard: State-level indicators with goals and objectives for the State's plan Healthy NJ 2020
- New York State Prevention Agenda Dashboard: State-level indicators with goals and objectives for the Prevention Agenda, the State's health improvement plan
- County Health Rankings and Roadmaps: Provides comparison between the healthiest and least healthiest counties

Trends

As noted, it is helpful to compare indicators from the previous assessment with the present one. Consider the same health indicators to make the comparisons meaningful. Comparing how trends evolve over several years will also help to account for population shifts. The timeframe period should match to allow comparisons over time. For example, comparing the diabetes rate from the last five-year period with the diabetes rate from the previous five-year period can provide insight into the rates over a longer period of time. This type of trend analysis can also help to identify special events such as a hurricane or policy change that may have influenced health outcomes seen in the

data.[35] When considering indicators, watch the trends to see whether there is an increase or decrease in their rates over time, and ultimately where more attention could be paid in the community.

The hospital's electronic medical records—which provide admissions, billing, and demographic data—also can help to identify trends. For example, one could review asthma-related hospitalizations and re-hospitalizations over time. Hospital data trends are useful because they highlight specific indicators for the population that the hospital is directly serving.

Resources that can provide trend information include:

- CDC Behavioral Risk Factor Surveillance System (BRFSS) Prevalence and Trends Tool
- Healthy NJ 2020 Dashboard
- Rhode Island BRFSS
- New York State Prevention Agenda Dashboard
- New York State Community Health Indicator Reports (CHIRS)
- DOH SPARCS Data
- New York State Hospital Inpatient Prevention Quality Indicators

Example of How to Use and Interpret Data

The following example shows how staff at the fictional Sample Hospital in Otsego County, New York, could review both primary and secondary data to reach conclusions or insights into the needs of the community. This is just one example. There are other ways to collect and interpret data.

Review of Primary Data

Sample Hospital identified diabetes as a top priority from evaluating the survey information. It also noted that the cost of medical care is too expensive for many members of the community because of a lack of jobs and job training. Next, the hospital considered the data collected via focus group sessions, which, in this example, included faith-based leaders, local YMCA leadership, public school staff, community members, and local CBOs. During the focus groups, a facilitator delved deeper into the needs of the community, and the discussions highlighted top health, social, and economic issues. The data was compiled into the chart below, which shows the top health issues that arose from the survey and focus groups.

Survey Top Health Issues	Focus Group Top Health Issues	Focus Group and Survey Social and Economic Issues	Common Top Issues
Diabetes	Suicide	Access to areas of play/gyms	Diabetes
Mental health	Diabetes	More job training needed	Exercise/area of play
Cancer	Physical activity		

Secondary Data Review of Information

Let's review the public health data collected on Otsego County to begin to understand the community's health issues from secondary health data.

This example's interpretation of data continues by noting New York State's leading causes of premature death in 2018—the year with the latest public health data available—in Otsego County. Using this data set for the county is just one way to review secondary data—again, there are other publicly available data sets to review for local data. Heart disease and cancer are the leading causes of premature death, followed by lower-respiratory diseases, diabetes, and cerebrovascular disease.[36]

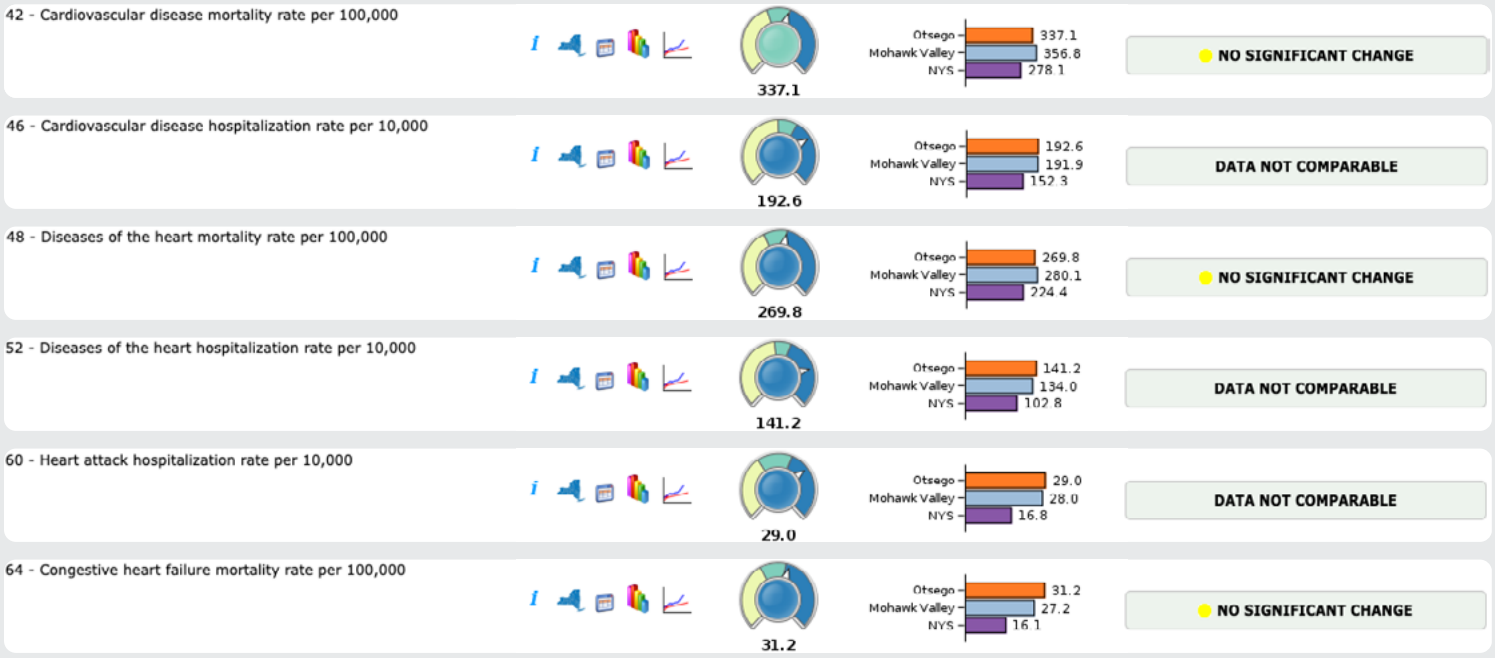
Number of Deaths and Age-Adjusted Death Rate (2018)					
Total Deaths	#1 Cause of Death	#2 Cause of Death	#3 Cause of Death	#4 Cause of Death	#5 Cause of Death
Total deaths 619 679.7 per 100,000	Heart disease 154 158.9 per 100,000	Cancer 133 146.9 per 100,000	CLRD 38 35.9 per 100,000	Diabetes 26 26.6 per 100,000	Cerebrovascular disease 23 23.2 per 100,000

The next step is to gather additional information on these health issues. Of interest are heart disease, cancer, and diabetes, with cancer and diabetes being the top issues that arose via survey and focus group discussions. Addi-

tional indictors within these issues include hospitalizations, diseases of heart mortality, congestive heart failure, heart attacks, cancer incidence rate, diabetes incidence, and mortality rates. Such indicators can be found in the-New York State Community Health Indicator Reports (CHIRS), which have data from 2016 to 2018 and provide trend data on that information as well as county and state comparisons.

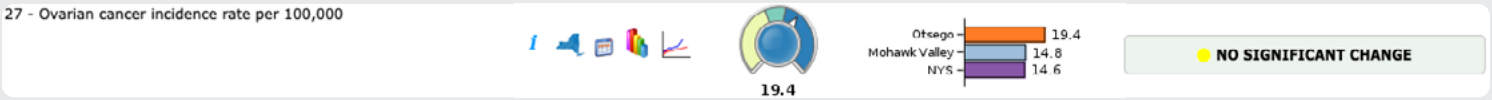
The below examples are snapshots of CHIRS data as it relates to varied cardiovascular, diabetes, and cancer indicators from the county. There has not been a significant change in the rates indicated in the snapshots below on the right side of the snapshot. Some data is also not comparable due to changes in disease classification and coding.

The information below provides the heart health or cardiovascular indicators.[37]



Below, there has been no significant change in the cancer incidence rate per 100,000 by county, region, and the rest of New York State.[38]

However, the ovarian cancer rate is higher than the State and county levels.



Diabetes was mentioned during primary data collection efforts. CHIRS data shows that the diabetes mortality rate is high compared to Mohawk Valley and the rest of the State. While there was no significant change in the trend over time, the diabetes rate is still high and should be noted.[39]

Using the 2021 County Health Roadmaps and Rankings, which have the same data collection timeframe as 2018, Otsego County overall ranks 25 out of 62 New York counties in this data set.[40] The county is in the middle-high range of New York counties for healthy outcomes. While there are relatively good health outcomes, air pollution and child poverty rates are high. Adult smoking (20%) is higher than in the top US counties (14%), and alcohol consumption is higher (19%) than the top US counties (14%). According to the data, individuals report higher amounts of poor physical health (4.1 days) and poor mental health days (4.5 days) compared to the rest of New York State, which is 3.6 days for both poor physical and mental health days. Adult obesity is increasing at 29% vs New York State at 26%. Obesity is also a risk factor for developing diabetes and should be considered a need to address. Poor physical health could relate to the need for physical activity noted from the community and another area to think about.

Next, review hospital data to identify areas with the highest preventable hospitalizations and the diagnosis rates for inpatient hospitalizations. Sample Hospital has high inpatient hospitalization rates for those diagnosed with cancer and diabetes. These two areas should be compared with the data above to measure overlaps. Consider claims data from 2018 and any recent claims data to assess current trends.

Based on the collected data regarding health concerns, diabetes is the frontrunner and should be addressed. Obesity, a related underlying issue, can be tied to the need for exercise, as noted by community members. Cancer is another top issue that should be further explored, especially in terms of screenings and early diagnosis. Again, these issues have been raised in community conversations and via secondary data sources.

This type of research will help narrow the topics to examine further. It will also help to support and focus the presentation to hospital staff, partners, and community members. Again, the example provides one means of looking at primary and secondary data. It also provides insight into how to begin to analyze and interpret data.

STEP 7: DETERMINE HEALTH PRIORITIES

Selecting issues to address that were highlighted via the assessment process can seem daunting. Now that the data is interpreted, the next step is to prioritize the needs and issues of greatest concern. There are various ways to prioritize such issues. Here are five prioritization methods from NACCHO:[41]

- *Multi-Voting Technique:* Rounds of voting to narrow health priorities
- *Strategy Grids:* Help to address the needs that will yield the most return or impact. This can be done by using a 2x2 matrix or grid, with the quadrants having criteria such as *high need/low feasibility, high need/high feasibility, low need/high feasibility, and low need/low feasibility.*
- *Nominal Group Technique:* Involves brainstorming for ideas, gathering several possibilities, having a group discussion, and then anonymously ranking the ideas
- *The Hanlon Method:* A method that defines criteria, baseline information, and feasibility factors
- *Prioritization Matrix:* A tool to help prioritize an issue or issues against several criteria established by the group. The criteria are weighted and then priority scores are calculated to rank the priorities.

A step-by-step process for each of these techniques, with examples, can be found on the NACCHO website.

Once the prioritization is completed, detail in the written report what steps were taken to narrow the priorities. This description should include how the community was engaged in the process, the criteria or technique used, and the result. The following are key takeaways to consider in this section of the report:

- Describe how priorities will be selected
- Link the process to State and Federal requirements. For example, priorities should align with New York State Prevention Agenda guidance.
- Choose measurable health priorities
- Choose priorities that the hospital has the capacity to perform either alone or via a CBO partnership

STEP 8: DOCUMENT AND COMMUNICATE RESULTS

The final report should note the CHNA process and its final results, including any interesting findings about the community and what needs the hospital will address. It is best practice to share the comprehensive report, usually by posting it on a website or offering physical copies in the hospital lobby for the community to access.

The box on the following page details what should be included in the report, with a suggested outline that includes the needs assessment and implementation strategy.

Suggested Community Health Needs Assessment and Implementation Strategy Report Outline

1. Executive Summary
2. Describe Hospital (e.g., mission, location, whether part of a health system)
3. Describe Community/Population Served (e.g., geographic, demographic, and socioeconomic information)
4. Health Needs Assessment Process
    a. Describe the community's health status and the resources used to determine status (e.g., public health department data, data from the RWJ Foundation's County Health Rankings)
    b. Community engagement for needs assessment process:
        i. Describe the process for engaging with the community while conducting the needs assessment
        ii. Who was involved? List community partners consulted, including local health departments, CBOs, other health care providers, and other organizations.
    c. Identify assets and resources to address the identified community health needs found
5. Prioritized Health Needs to be Addressed
    a. Describe the health needs identified through the community health needs assessment process
    b. Discuss which of the community health needs will be prioritized and addressed. Include a description of the criteria used to select the priorities and how community partners, including the public health department, were engaged in the process.
    c. Within these prioritized needs, are there health disparities that should be targeted?
6. Implementation Strategy (discussed in the next section)
    a. Describe how the hospital and other partners, including local health department and CBOs, will address the identified/prioritized needs. How will the hospital address any identified health disparities within the prioritized needs?
    b. Describe the evidence-based interventions to address the prioritized community health needs
        i. Provide goals and objectives for each intervention to measure and track progress over a three-year period
        ii. Include hospital resources committed to the interventions
        iii. Include information on partner collaborations such as the roles and resources of other participants and stakeholders such as the local health department and CBOs
    c. Discuss how partner engagement will be maintained
7. Describe How the Report Will be Shared with the Public
8. Indicate the Date the Governing Board Adopted the Report (Needs Assessment and Implementation Plan)

CHNA IMPLEMENTATION STRATEGY

The implementation strategy, which is the latter part of the CHNA, is the written plan describing how the institution will address the prioritized needs identified earlier. This section of the toolkit reviews the steps to develop the implementation strategy and how to measure progress and impact. While this section offers a model, the strategy need not be complex and should highlight the specific steps the hospital and its partners will take to address the priority needs. In some cases, regulatory agencies may request that the implementation strategy be shared as a chart or spreadsheet. Having the written plan or narrative description to work from will help the hospital complete the requested chart. The narrative will also enable the hospital to post the information in a manner that can be easily understood by the community and the public, and to have text available to insert into other reports.

Follow these key steps to design an implementation strategy:

- *Step 1: Plan for Implementation and Evaluation*
    - *Logic Model for Planning*
    - *Evidence-Based Interventions (EBIs) and Evidence-Informed Practices*
    - *Develop Goals, Objectives, and Measures*
    - *Plan the Evaluation*
    - *Logic Models for Evaluation*
- *Step 2: Write the Implementation Strategy for the CHNA Report*
- *Step 3: Evaluate*
- *Step 4: Share Findings and Updates on the Implementation Strategy*

The steps detailed below will help hospitals consider and implement strategies to address community needs. Many of the steps in the needs assessment—including known assets, partnerships, and what populations to serve—will also inform the implementation strategy. Reviewing the institution's activities is key to avoiding duplicating initiatives that may already be in place. Hospitals can also leverage or adapt ongoing initiatives that were not included in the previous CHNA report in the current CHNA report. For example, if a hospital hosts a farmer's market onsite for the community that includes an educational component, and the needs assessment highlights food insecurity as a priority issue for the community, the hospital could leverage its existing farmer's market to address the food insecurity need.

STEP 1: PLAN FOR IMPLEMENTATION AND EVALUATION

This first step highlights how to identify the needs that the institution plans to address. Throughout the planning process, involving external and hospital stakeholders is important. The questions and considerations below will help frame what type of intervention to select and develop and how to implement it.

- Review the asset inventory to gauge what the hospital and community are presently doing in the selected health issue to be addressed. Is there an intervention currently addressing an issue that can be leveraged within the hospital or the community to address the prioritized need? If so, has the intervention met its goals? Does the intervention need to be refined? Or is the next step to develop a new intervention because none currently exist in the community?

- Work with community and hospital stakeholders to plan how to address the community health needs. For example, which community groups should be involved in either an existing or new intervention? Are these groups part of the implementation or will they help to increase awareness in the community?
- Review what social determinants of health may be affecting or contributing to the identified health issue and what type of health disparities exist (see Appendix D).
- If developing a new initiative is under consideration to meet a need, and there are resources to do so, consider the following:
    - What type of intervention is needed? Will it be a clinical or community-based program? The CDC's Accelerating Evidence into Action initiative notes three types of prevention programs: traditional clinical prevention, innovative clinical prevention, and total population or community-wide interventions. See the CDC's discussion paper for definitions and details for each type of program.[42]
    - How will the initiative be implemented and who will implement it? Possible candidates could be department/staff within the hospital, a local health department, or other community partners.

Logic Model for Planning

The toolkit uses the logic model to approach implementation. Logic models are standard and a best practice for public health interventions. A logic model helps to visualize a program's path and can be used to plan the implementation. The CDC states that logic models depict "the shared relationships among the resources, activities, outputs, outcomes, and impact for your program."[43] Logic models can guide program planning, implementation, and evaluation.

A basic logic model generally includes the following columns: inputs, activities, outputs, outcomes (short-term and intermediate), and impacts. The contents of these columns are:[44]

- *Inputs:* Resources that planners and implementers use to carry out the program or evaluation
- *Activities:* Actions required to fulfill the plan
- *Outputs:* The products or results of the actions taken
- *Outcomes*:* Short- and intermediate-term changes in participants' knowledge, skills, attitudes, and behaviors that result from engagement in the program
- *Impacts*:* Long-term changes in health conditions and determinants of health that result from the program

Figure 7 is an example of a logic model used to plan a local community's nutrition program. This example is centered on teaching community members about healthy food options, with a kitchen demonstration and community outreach. It is based on an existing nutrition-focused EBI.[45]

*The columns for "outcomes" and "impacts" can be substituted with three columns labeled "short-term outcomes," "intermediate-term outcomes," and "long-term outcomes" if so desired.

Figure 7: Sample Community Nutrition Program Logic Model

As this sample logic model shows, *inputs* include human and supply resources, funding, and any other resources needed to complete the activities.

Activities to implement the program should be noted as separate actions. Therefore, write straightforward individual activities rather than combining them. Listing activities in chronological order—though some activities will likely overlap in the timeline—is also helpful.

Outputs are the direct results of the activities.

Outcomes reflect intended results based on the goals and objectives of the program. Short-term outcomes are results observed immediately after an intervention or program ends. Intermediate outcomes include changes occurring a few months or years after a program began. As the logic model is used for planning only and not as a representation of what has already happened, the outcomes list shows program planners and other stakeholders the behavioral and environmental changes that should result from the intervention.

Impact, also called long-term outcomes, includes intended transformation in public policy, population health, and other structural changes in the future—for example, one year after the intervention or if the intervention continues over years, then periodically over time.

EBIs and Evidence-Informed Practices

Programs implemented should always be based on interventions with an existing evidence base. EBIs and evidence-informed practices, or promising practices, can be identified via various sources. See Appendix C for resources on evidence-based and evidence-informed interventions. An EBI has proven to be effective based on a body of research built on rigorous evaluation, including replication. An evidence-informed intervention, or promising practice, has evidence of efficacy but likely isn't backed by a significant amount of research.

Crucially, when implementing, the program must be carried out as intended, particularly if it is an EBI. If program implementation deviates significantly from the original program design, then it is no longer an EBI. While an EBI can be adapted to fit a different focus population such as for cultural adaptation, it must be done carefully so that it does not lose the intervention's intended core components. Process evaluation will help to monitor and ensure that an intervention does not inappropriately deviate from the original EBI. NACCHO has provided guidance on adapting EBIs to fit the community served.[46] The guidance describes various forms of adaptation, including cultural, cognitive, affective-motivational, environmental, program content, and program form. See Appendix E for more information on how to adapt interventions.

Develop Goals, Objectives, and Measures

Whether with an existing or new program, the goals, objectives, and measures of the interventions must be clearly stated. Goals are broad statements that describe the program's desired long-term outcomes such as increased cancer screening rates. Each goal can include multiple objectives. Objectives are statements of desired outcomes. Objectives should be specific, measurable, achievable, and time sensitive. For example, an objective might state that by December 2022, cancer screening rates for all patients in a clinic will increase from 65% to 85%. See Appendix B for more details on the differences between goals and objectives and how to write them. Also useful is NACCHO's Mobilizing for Action through Planning and Partnerships tool, which cites three types of objectives: process, outcomes, and impact.[47]

Measures provide a means to monitor the progress of an intervention toward achieving the planned goals and objectives. Different types of measures can be looked at in the short- or long-term. Process measures mark the progress of the program. An example of a process measure is the number of ER providers that have been screening patients for suicide. Outcome measures should examine whether the program's short- and intermediate-term goals and objectives have been met. An example of an outcome measure is the average percentage of patients screened for suicide in one day in the past four months. For more examples of process and outcome measures and how to write them, see Appendix B. Impact measures are essentially outcome measures but measure long-term change. An example of an impact measure is the monthly average number of hospitalizations due to asthma in children measured regularly over three years.

Plan the Evaluation

Planning how the institution will evaluate the intervention is critical and will help align goal-setting and decision-making for the implementation process. Evaluations should occur throughout program implementation—and after the program concludes. As noted, using logic models to guide the planning and completion of the evaluation is best practice.

The following sections detail best practices for program evaluation. These include an overview of different types of evaluations, a framework for evaluation (with a walkthrough on how to use it), and how to evaluate using logic models.

Types of Evaluation

The three forms of evaluation used in the implementation plan are process evaluation, outcome evaluation, and impact evaluation.

Process evaluation measures the progress of the intervention as it is being implemented. When planning a process evaluation, be sure to consider questions that must be answered and what the answers will be.[48] Once questions are posed, it will be easier to develop tracking indicators or measures. If indicators reveal that the program may not be proceeding as intended, then it is time to consider midcourse corrections.

Core components of process evaluation questions include context, reach, delivery, reception, fidelity, implementation, and recruitment.[49] Consider the following questions to guide program evaluation:

- Context: What is happening in the environment that affects the program? Are external factors impacting it?
- Reach: Is the intended population engaged? To what extent?
- Delivery: How much of the program has been delivered? Is it on target? Is it being delivered as intended?
- Reception: To what extent are participants engaged in the program?
- Fidelity: Is the program being implemented as intended?
- Implementation: To what extent has the program been implemented?
- Recruitment: How were participants recruited? Are there any recruitment issues?

Process Evaluation Example

An intervention is designed to address healthy eating in the community. The intervention involves partnering with a local community center to offer nutrition classes taught twice weekly by two community health workers from the hospital. Below are examples of how to apply the core components of process evaluation to this program.

- Context: Observe and note external factors that could affect indicators for the program's progress or outcomes. For example, if there is an issue with the community center room where the class takes place and the class needs to be moved outside, then note this as an external factor. Did the change in setting affect how the program was run that day? If so, how?
- Reach: Who and how many participants were in the program?
- Delivery: For this nutrition class, evaluators might want to know how much of the curriculum has been delivered by the end of each session
- Reception: Evaluate how the participants received the program activities. What lessons did they learn from the nutrition class? Did the participants meet each learning objective by the end of the session?
- Fidelity: Did the session follow the planned curriculum for that day? If the delivery of the curriculum deviated from the plan, it should be noted and corrected.
- Implementation: Track the progress of the program by noting the dates and lengths of the sessions
- Recruitment: How were participants recruited to the program? Did recruitment reach the program's intended population? Did the method of recruitment exclude participants who could have been reached another way?

Outcome evaluation assesses whether the intervention addressed the health issue and the goals and objectives were met. The main goal of outcome evaluation is to gauge how the program affected its participants. This is often measured in terms of changes in knowledge, attitudes, skills, behaviors, and beliefs. Outcome evaluation can be done at the end of a program, or if the program is ongoing, at regular intervals to assess short- and intermedi-

ate-term outcomes. For example, if a program is planned to run for three years, outcome evaluation can be done at the end of each year to assess progress toward the program objectives.

Outcome Evaluation Example

The following examples of outcome evaluation are based on the same healthy eating program described above for process evaluation:

- Knowledge: What did participants learn from the program? Did participants meet the program's learning objectives?
- Skills: Did participants learn new skills? Did they improve existing skills?
- Behaviors: Did participants change their at-home nutrition behaviors such as eating more fresh produce after the program?
- Attitudes: Did participants' attitude toward healthy eating change by the end of the program? How did participants approach discussions of nutrition after the program versus before? Did participants believe they were able to integrate new eating habits into their everyday life?
- Beliefs: Did the participants believe that healthier food habits would change their health status?

Impact evaluation measures the long-term impact of the program once it ends. Like outcome evaluation, impact evaluation also measures whether and how the program met its goals and objectives. Impact evaluation could measure health status and behavioral, environmental, educational, social, or other changes.

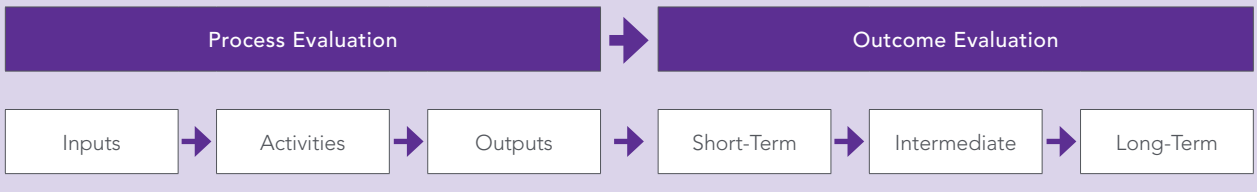
For example, a program seeking to reduce violence in a community concludes, and evaluators want to know if one year later and biannually thereafter injuries due to violence decreased in the targeted community. To find this out, one could examine hospital ED admissions for violence-related injuries and deaths. Impact evaluation shows stakeholders the bigger picture on how the program impacted the health issue in the community.

Logic Models for Evaluation

As with planning for implementation, a logic model can help to evaluate a structured approach. The following reviews the use of logic models for evaluation, which components to include in the evaluation plan, and considers the questions above.

The logic model for evaluation looks the same as the logic model for planning. The difference is in the content. Inputs, activities, and outputs should address how the evaluation will be conducted. Outcomes and impacts should reflect evaluation questions. Figure 8 depicts how the columns of the logic model align with the types of evaluation.[50]

Figure 8: CDC Logic Model Diagram



The program's goals and objectives will guide the evaluation plan, so planning should begin early. In the example below, the contents of the outcomes and impacts columns reflect things that will be measured via pre and post surveys before and after the intervention.

Evaluation Example

The following provides an example of applying a logic model for evaluation of an EBI within the 2019-2024 New York State Prevention Agenda priority "Promote Well-Being and Prevent Mental and Substance Use Disorders" and the focus area "Promoting Well-Being."[51] EBI 1.1.5 is to "enable resilience for people living with chronic illness: strengthening protective factors include independence, social support, positive explanatory styles, self-care, self-esteem, and reduced anxiety." To align with this intervention, a hospital could choose to offer community sessions on building resilience from the evidence base provided. These sessions could include meditation and mindfulness classes and self-care and anxiety management sessions—skills that the evidence base shows contribute to resilience. How would this program be evaluated?

The New York State Prevention Agenda provides an example of a specific intermediate-level measure for the 1.1.5 intervention. The measure is the percent of people who use tools and strategies learned from the program who have had documented discussions about how they have used them to help cope. A logical method for evaluating this would be to survey the participants before and after. The example logic model below assumes that for this intervention, one session is provided for each topic of resilience in the program.

Inputs	Activities	Outputs	Outcomes (Short-Term and Intermediate)	Impact (Long-Term Outcomes)
Pre-session surveys (printed and electronic) Post-session surveys (printed and electronic) Follow-up surveys Pens and pencils Evaluators/people to administer the surveys (same people who delivered the intervention/ implementers) Someone to compile and analyze the data	Evaluators/ implementers offer the surveys before and after the class Paper surveys given on the day of the session are entered into a database Follow-up surveys are electronically sent to the participants three and six months post-intervention An evaluator enters, reviews, and analyzes the data	At least 90% of participants submit pre- and post-surveys on the day of the session At least 80% of participants submit surveys sent three and six months post-intervention Analyzed data is reported to stakeholders	*(Depends on the survey questions)* Examples: Participants report lessened anxiety levels in the past three months Participants report using the skills they learned in the session at least once Participants report a higher sense of self-efficacy after participation	*(Depends on the survey questions)* Examples: Participants feel better able to cope with their chronic disease Participants score higher on resilience measures Participants regularly employ the skills they learned Participants have lower levels of general anxiety

STEP 2: WRITE THE IMPLEMENTATION STRATEGY FOR THE CHNA REPORT

The implementation strategy has the following key components in the written CHNA report:

- Identified and prioritized community need to address
- State or local objectives related to the prioritized need
- Intervention description
    - What actions will be taken?
    - Objectives, goals, and measures of the intervention
    - Where it will take place and the population it will serve
    - Describe the role of implementation partners in the intervention
    - If fully implemented before the current needs assessment, note results of progress so far
    - Provide a timeline for the intervention's development and progress. As the Federal CHNA is in a three-year cycle, hospitals can plan for three years.
    - Evaluation plan for the program

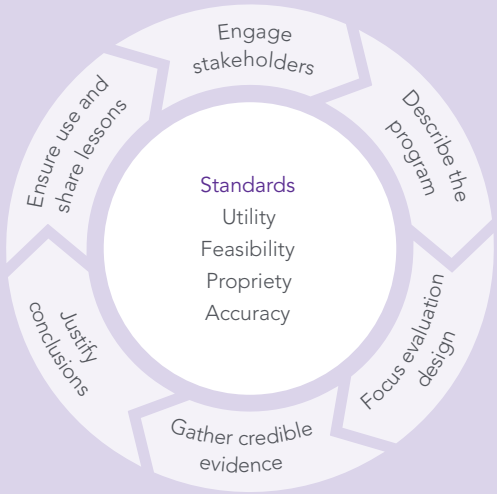
STEP 3: EVALUATE

The next section reviews how to conduct an evaluation based on best-practice approaches. It walks through a framework and details methods for evaluating an intervention.

Steps for Evaluation

The CDC has a framework for evaluation (Figure 9), with steps to guide the evaluation process from planning through sharing the results.[52] The CDC also provides more detailed descriptions and checklists for each of the framework's six steps.[53] Steps one through three are part of the planning process, and steps four through six describe how to conduct the steps in the evaluation. The following sections provide guidance on how to use the inner and outer circles of the CDC framework and follow the steps for program evaluation.

Figure 9: CDC Framework for Evaluation



The inner circle of the CDC framework depicts evaluation standards to consider while going through the process. The following four areas encompass standards to guide the development of a well-designed and effective evaluation plan:[54]

- Utility refers to usefulness in terms of information, services, and other relevant values for stakeholders
- According to the CDC, feasibility standards indicate whether the evaluation is "realistic, prudent, diplomatic and frugal." This encompasses effectiveness and efficiency.
- Propriety standards indicate ethical, fair, and just treatment and consideration in the evaluation

- Accuracy describes a standard of truth and dependability in conducting and reporting on the evaluation

According to the CDC framework for evaluation, the first three steps can occur in any order or concurrently. Steps four through six describe implementing evaluation plans, gathering data, and sharing results.

Step 1: Engage stakeholders

As previously noted, engaging stakeholders from the outset and throughout every step is best practice. Because evaluation planning is part of overall program planning, the stakeholders for evaluation will likely be the same as for implementation. For example, individuals who directly participate in running a program will be stakeholders in the evaluation process. Leadership involved in the needs assessment and program planning will also be involved, for example, to approve the plan before its enactment and to review the results before the report is published.

Step 2: Describe the program

This step of the evaluation can overlap with program planning as long as there are descriptions of the program components, activities, and desired outcomes. Focus on the program's goals and objectives and how they will be achieved. This is the best time to use the logic model, which will help visualize the path of the evaluation, starting with the required resources. It is a simple way to list and view the actions needed to carry out the evaluation plan. The logic model comprises inputs, activities, outputs, outcomes, and impacts.[55] See the previous section for planning guidance on creating and using a logic model. Including a summary to supplement the logic model with additional, more detailed information on the components of the logic model would be helpful.

Step 3: Focus evaluation design: Questions and Evaluation Method

In this step, the intent is to review goals and objectives, formulate questions that will be answered by the evaluation, and select an evaluation method. By this step, the type of evaluation, process, outcome, or impact should already be selected. A further description of this two-step process is provided next.

Evaluation Questions

Robust questions will guide the evaluation process. The questions will depend on the type of evaluation that is being conducted. Core components of evaluation questions, according to Grembowski (2016),[56] are:

- Does it work?
- How does it work?
- Why does it work?
- When does it work?
- For what groups does it work?
- Under what conditions does it work?
- What attributes make it work?
- How do the benefits compare with the costs?
- Can it be replicated?

These questions will guide the design of the evaluation. For example, if the question is whether participants learned the necessary tools of a program, a desired outcome may be to increase the knowledge of each participant. Sending participants surveys before and after the program to test their knowledge would be one way to measure whether the program accomplished its goal.

Evaluation Methods

Once the evaluation questions are formulated, then establish the evaluation method, which could be qualitative or quantitative. Qualitative methods can include focus groups, interviews, observations, and surveys with open-ended questions. Quantitative methods can include surveys with multiple-choice answers. In the previous example in the paragraph above, the evaluation method uses surveys to test for an increase in knowledge.

Choosing the right evaluation method involves reviewing what information needs to be gathered, the method's feasibility based on the available resources, and what ethical concerns are raised.

Below are evaluation methods to consider:

Evaluation Method	When Best to Use	Benefits
Open-ended survey	• Outcome evaluation • Impact evaluation • Request self-reported feedback • Qualitative method	• Details participants' self-reported changes in perceptions, attitudes, and health status • Can be used with large group of people • Can be submitted anonymously from participants • Multiple methods of administration (e.g., online, in person) • Can be inexpensive
Focus groups	• Outcome evaluation • Impact evaluation • To gather participant perspectives via facilitated discussion • Qualitative method	• Provide narrative data and testimony • Gather more detailed information directly from participants
Interviews	• Outcome evaluation • Impact evaluation • To gather participant feedback directly from individuals • Qualitative method	• Provide narrative data and testimony • Gather more detailed information directly from participants
Observation	• Process evaluation • To observe how programs are running in real time and if they are being implemented as intended • To see if any course corrections should be made • Qualitative method	• Reveals exactly how programs are running in the moment • If changes or course corrections are needed, observation can inform where and how those changes could be most effective
Close-ended survey	• Outcome evaluation • Impact evaluation • To measure changes in participants over time • Quantitative method	• Well-defined, specific questions and answers; usually multiple choice • Can be used with a large group of people • Can be submitted anonymously from participants • Multiple methods of administration (e.g., online, in person) • Can be inexpensive

Evaluation Method	When Best to Use	Benefits
Pre- and post-tests	• Outcome evaluation • To test changes in knowledge, attitudes, and skills pre- and post-intervention • Quantitative or qualitative method	• Observe changes in participants over the course of the intervention • Can be submitted anonymously from participants • Multiple methods of administration (e.g., online, in person) • Can be inexpensive
Documents and records (e.g., participant attendance lists, EHRs)	• Process evaluation • Outcome evaluation • Impact evaluation • To use existing data to determine progress of the program or changes over time • Quantitative method	• Review point-in-time records • Data already collected • Observe change over time • Can be collected from a large group of people

Step 4: Gather credible evidence

This step involves writing measures and carrying out the evaluation plan, which includes properly collecting the data.

When designing evaluation measures, make sure that the results will provide stakeholders with important information about the program. What will stakeholders gain from this effort? How is it useful? Be sure to follow the established plan to complete the evaluation.

Step 5: Justify conclusions

Review and analyze the data. Use appropriate methods of analysis and summarize the findings. Compare the results to the original goals, objectives, and intended outcomes to determine whether they were met. Interpret the significance of the findings to present them to the stakeholders.

Step 6: Ensure use and share lessons

Sharing the findings is essential to a successful evaluation and to demonstrate the effectiveness of the program. When reporting, interpret and summarize the data in a way that is suitable for the intended audience. Make sure that the results of the evaluation are shared with stakeholders in a timely manner and that stakeholder feedback and approval are obtained.

For further information on evaluation design and methods, see Appendix H.

STEP 4: SHARE FINDINGS AND UPDATES ON THE IMPLEMENTATION STRATEGY

Once the initiative is underway, continue to monitor progress and document the results according to the evaluation plan. Monitoring progress will help communicate to leadership, policymakers, and the community about the work the hospital is doing. Keep in mind the audience for this information and tailor it to what matters most to them.

The implementation strategy may need to be updated along the way due to the results of the evaluation, shifts in community needs and priorities, or changes in hospital resources to run the program.

Examples: A natural disaster or public health emergency (e.g., COVID-19) strikes and impacts the community's priorities. The hospital focuses on helping the community recover and pauses previous interventions to provide additional resources to help address the impact of the emergency.

Example components to consider when sharing a progress report on the program include:

- Did the program achieve its goals and objectives?
- What changes were made to the program and why?
- How many participants did the program serve?
- What is the outcome so far on each participant's health or other measures?
- Does the intervention continue to align with the community's needs?
- What are key learnings and recommendations going forward?

As a final task, request feedback on the report from community members and partners. Their feedback will generate new ideas and ways to improve the process for the next needs assessment cycle. Feedback can be gathered via discussions with community partners or through other means to interact with the community (e.g., anonymously through an electronic suggestion box).

CONCLUSION

This toolkit is designed to serve as a guide for completing the CHNA, its implementation planning process, and the narrative report. As stated in the introduction, it is not designed to be a guide for compliance with Federal or state requirements, although most requirements align with the best practices outlined here.

GNYHA staff can help with the planning for each of the steps outlined in this toolkit, including how to scale the work to correspond with available staffing and resources.

Please contact Lloyd C. Bishop or Benjamín González with any questions.

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APPENDICES

APPENDIX A: MODEL SURVEY TEMPLATE

NEIGHBORHOOD HEALTH NEEDS ASSESSMENT

[Hospital Name] is interested in learning about your neighborhood's needs to improve the health of its residents. Your answers are anonymous and confidential. Thank you for your help and participation.

Health of Residents in Your Neighborhood

The following questions in this section ask about the health of your neighborhood and what actions would improve the health of its residents. Please mark your responses below with an "X" or checkmark.

1. How would you rate the overall health of the residents of your neighborhood?

   - ○ Excellent
   - ○ Very good
   - ○ Good
   - ○ Fair
   - ○ Poor

2. How important are the following issues to the health of the residents of your neighborhood?

	Not at all Important	Somewhat Important	Important	Very Important	Extremely Important
Access to healthy/nutritious foods					
Arthritis					
Asthma/breathing problems					
Cancer					
Dental care					
Diabetes					
Fall prevention among elderly and small children					
Heart disease					
Hepatitis C					
High blood pressure					
HIV/AIDS					
Mental health/depression					
Obesity in children and adults					
Sexually Transmitted Diseases (STDs)					

	Not at all Important	Somewhat Important	Important	Very Important	Extremely Important
Smoking/tobacco use/vaping					
Substance use (including alcohol and drug use)					
Violence					
Women's health and prenatal care					
Other, please specify: _____					

3. Many things outside of medical care can impact daily health where you live. What are the top three changes that you believe would improve the health of the residents of your community the most? Please select the top three items from the list below.

- ○ More local jobs
- ○ Reduced cigarette/vaping smoke
- ○ Reduced air pollution
- ○ Improved housing conditions
- ○ Reduction in homelessness
- ○ Cleaner streets
- ○ More parks and recreation centers
- ○ Reduced crime
- ○ Mold removal
- ○ Lead paint removal
- ○ Reduced speeding on neighborhood streets
- ○ Reduced traffic on neighborhood streets
- ○ Increased public transportation
- ○ Increased number of places where older adults can live and socialize
- ○ Other: _____

Personal Health and Support

The following questions are about your health, health behaviors, and support network. Your answers are anonymous and confidential. Please mark your responses below with an "X" or checkmark.

4. How would you describe your physical health?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

5. How would you describe your mental health?

   - ○ Excellent
   - ○ Very good
   - ○ Good
   - ○ Fair
   - ○ Poor

6. When is the last time you visited a health care provider for a routine checkup? Please select only the most recent period that applies.

   - ○ In the past year
   - ○ In the past two years
   - ○ In the past five years
   - ○ Five or more years

7. In the past 12 months, did you receive care in the emergency room?

   - ○ Yes
   - ○ No

   If yes, what was the reason: _____

8. In the past 12 months, how many times were you admitted to the hospital?

   - ○ None
   - ○ One
   - ○ Two
   - ○ Three or more

9. For which of the following reasons would you avoid getting medical care from a health care provider? Please select all that apply.

   - ○ Nothing; I make time to go
   - ○ High cost of care (e.g., copay, deductible)
   - ○ Do not have insurance
   - ○ Doctor's office doesn't have available appointments
   - ○ Lack of transportation
   - ○ Difficult to find child care
   - ○ Not enough time to go
   - ○ Don't understand the benefit of seeing a provider
   - ○ Don't like to go
   - ○ Other, please specify: _____

10. Where do you go most often when you are sick? Please select one choice below.

- ○ Doctor's office
- ○ Hospital emergency room
- ○ Urgent care center (e.g., CityMD, MedRite, Urgent Care)
- ○ Other, please specify: _____

11. Where do you go most often when you need health advice? Please select one choice below.

- ○ Doctor's office
- ○ Local health department
- ○ Hospital emergency room
- ○ Urgent care center (e.g., CityMD, MedRite, Urgent Care)
- ○ Community-based organization
- ○ Internet/websites
- ○ Religious group or leader
- ○ Other, please specify: _____

12. How likely is it for you to attend a community health program on topics like the ones below? Please select how likely you are to participate in each program.

Program	Not at all Likely	Somewhat Likely	Likely	Very Likely	Extremely Likely
Healthy nutrition/cooking class					
Diabetes self-management program					
Asthma self-management program					
Stress-reduction class					

13. How much stress do you feel on a regular basis?

- ○ None
- ○ Some
- ○ A fair amount
- ○ A lot
- ○ A tremendous amount

14. Do you have a support network (e.g., family members, neighbors, support groups, faith-based groups, community-based organizations) during times of stress and need?

- ○ Yes
- ○ No

15. How many support networks are near you that can help you during difficult times?

- ○ 0
- ○ 1
- ○ 2-5
- ○ 6-10
- ○ More than 10

16. How often in the past 12 months would you say you were worried or stressed about having enough money to buy nutritious meals?

- ○ Always
- ○ Usually
- ○ Sometimes
- ○ Rarely
- ○ Never

17. In the past 30 days, did you provide care or assistance to a friend or family member who has a health problem or disability?

- ○ Yes
- ○ No
- ○ Not sure

If you answered "Yes" to question 17, please continue to question 18. Otherwise, skip to question 19.

18. How long have you provided care or assistance to a friend or family member with a health problem or disability?

- ○ Less than one month
- ○ One month to less than six months
- ○ Six months to less than two years
- ○ Two years to less than five years
- ○ More than five years

Demographic Information

Please tell us about yourself by answering the questions below. Your answers are anonymous and confidential. Please mark your responses below with an "X" or checkmark.

19. Zip code where you live: _____

20. What is your age? _____ years

21. Are you of Hispanic or Latino descent?

- ○ Yes
- ○ No

22. Which of the following best describes your race? Please select all that apply.

- ○ White
- ○ Black or African American
- ○ American Indian or Alaskan Native
- ○ Asian
- ○ Native Hawaiian or Other Pacific Islander
- ○ Other: _____

23. Do you think of yourself as…?

- ○ Female
- ○ Male
- ○ Transgender female
- ○ Transgender male
- ○ Genderqueer
- ○ Prefer to self-describe: _____
- ○ Prefer not to say

24. Do you think of yourself as…?

- ○ Bisexual
- ○ Gay
- ○ Lesbian
- ○ Queer
- ○ Straight/heterosexual
- ○ Prefer to self-describe: _____
- ○ Prefer not to say

25. What is the primary language you speak?

- ○ Cantonese
- ○ English
- ○ Haitian Creole
- ○ Italian
- ○ Korean
- ○ Mandarin

- ○ Russian
- ○ Spanish
- ○ Other, please specify: _____

26. In what language do you prefer to receive medical information?

- ○ Cantonese
- ○ English
- ○ Haitian Creole
- ○ Italian
- ○ Korean
- ○ Mandarin
- ○ Russian
- ○ Spanish
- ○ Other, please specify: _____

27. What is your highest level of education?

- ○ Less than high school
- ○ High school diploma/GED
- ○ Technical school
- ○ Some college
- ○ College graduate/Bachelor's degree
- ○ Graduate/professional degree (i.e., Master's, JD/MD)
- ○ Other, please specify: _____

28. What is your current employment status? Please choose all that are applicable.

- ○ Full-time employed
- ○ Self-employed
- ○ Not employed
- ○ Part-time employed
- ○ Homemaker
- ○ Student
- ○ Retired
- ○ Unable to work

29. Do you have health insurance?

- ○ Yes
- ○ No
- ○ Not sure

If you wish to be updated on the survey results, please include your contact information below. This information will be stored separately from your responses. You may choose one or all of the options below. Thank you!

Name: _____

Mailing address: _____

_____

E-mail address: _____

Thank you for completing the survey! Please return your completed survey to [Name of contact].

APPENDIX B: WRITING GOALS, OBJECTIVES, AND MEASURES

GOALS AND OBJECTIVES

What Is a Goal?

A GOAL is a broad statement that describes the desired long-term outcome of an intervention.[i]

Examples:

Intervention	Sample Goal
Cancer screening	Increase cancer screening rates
Tobacco cessation	Reduce tobacco use in adults
Nutrition education	Increase knowledge of healthy food options

What Is an Objective?

An OBJECTIVE is a specific statement that defines the desired outcome of an intervention and the method by which the goal will be achieved. Multiple objectives align with a goal. Objectives can relate to the process or outcome—short-, intermediate-, and long-term—of the intervention.

Examples:

Intervention	Sample Objective
Cancer screening	By December 31, 2019, the percentage of patients who receive cancer screening will increase from 50% in December 2019 to 65%
Tobacco cessation	By December 31, 2019, 75% of patients referred to the hospital's tobacco cessation program will have completed the full program
Nutrition education	After one year, participants in the nutrition program will increase by 40% from the previous year

PROCESS AND OUTCOME MEASURES

What Is a Process Measure?

A PROCESS MEASURE evaluates the implementation of the intervention. These types of measures answer questions such as: Was the intervention implemented as intended? Did the intervention reach its intended target population?

Examples:

Intervention	Sample Process Measure
Cancer screening	The percentage of patients who received cancer screening each year

i https://www.cdc.gov/std/program/pupestd/developing%20program%20goals%20and%20objectives.pdf

Intervention	Sample Process Measure
Tobacco cessation	The percentage of patients who were referred to the tobacco cessation program who fully completed the program
Nutrition education	The percentage of participants in the nutrition program throughout the year

What Is an Outcome Measure?

An OUTCOME MEASURE evaluates the effects of the intervention based on short-, intermediate-, and long-term goals and objectives. Outcome measures should observe changes in knowledge, skills, attitudes, behaviors, and health status.

Examples:

Intervention	Sample Outcome Measure
Cancer screening	The percentage of early detection and treatment of cancer by December 2019 compared to baseline
Tobacco cessation	The percentage of patients who self-report use of tobacco cigarettes by December 2019 compared to the baseline
Nutrition education	The percentage of participants who self-report a healthy-eating lifestyle at the end of one year compared to the baseline

CASE EXAMPLE

Intervention

After conducting a needs assessment and examining health disparities in the service area, a hospital's ambulatory site decides to implement an intervention to address chronic diseases. The site seeks to focus on preventive care and management for cardiovascular diseases based on the community's feedback and local data. The intervention will focus on early detection of cardiovascular disease and self-management of cardiovascular health. The intervention is based on an evidence-based model to have providers screen patients for cardiovascular disease and train staff to teach self-management principles. The intervention was initiated on January 1, 2021.

Goals

1. To screen all high-risk patients for cardiovascular disease
2. To increase care management for patients with cardiovascular disease
3. To increase patient confidence in managing their cardiovascular health
4. To reduce health disparities in early detection and care management of cardiovascular disease

Objectives

1. In the first year, all primary care providers/staff will complete the training on screening and self-management skills. Training will be tailored to a specific population with a high risk for cardiovascular disease and will include concepts of cultural sensitivity for staff delivering the program.

2. By December 31, 2023, high-risk patients will be routinely screened for cardiovascular disease at a rate of 100%
3. By December 31, 2023, there is an increase in care management for all patients who screened positively for cardiovascular disease risk
4. By December 31, 2023, all patients who were positively identified as high risk for cardiovascular disease were educated on self-management for cardiovascular health (e.g., self-management of high blood pressure)

Measures

1. At the end of Year 1, the number of providers/staff who completed the training (process)
2. At the end of each year (2021, 2022, and 2023), the number of patients screened for cardiovascular disease in that single year (process)
3. By December 31, 2021, 2022, and 2023, the percentage of high-risk patients, who were screened for symptoms of cardiovascular disease (outcome)
4. By December 31, 2021, 2022, and 2023, the percentage of patients, who received care management after screening positive for cardiovascular disease who self-report better health six months after their care management began (outcome)
5. By December 31, 2021, 2022, and 2023, evaluate the percentage of patients who showed improved cardiovascular health through clinical indicators such as blood pressure or cholesterol levels (outcome)
6. By December 31, 2021, 2022, and 2023, evaluate the percentage of patients who showed improved cardiovascular health through clinical indicators aggregated by race and ethnicity and compare changes over time (outcome)

USEFUL RESOURCES

- American Public Health Association, CEPH Technical Assistance Session, *Outcome measures for assessing progress of meeting PHP or SPH Goals Presentation* (2007). https://media.ceph.org/wp_assets/Outcome-Measures_pres.pdf.
- Belmont University, *Writing Effective Outcome Statements*. https://www.belmont.edu/oair/assessment-support/pages/writingeffectiveoutcomestatements.html.
- Centers for Disease Control and Prevention, Division for Heart Disease and Stroke Prevention, *Evaluation Guide: Writing SMART Objectives*. https://www.cdc.gov/dhdsp/docs/smart_objectives.pdf.
- Centers for Disease Control and Prevention, *Evaluation Briefs: Goals and Objectives Checklist* (2008). https://www.cdc.gov/healthyyouth/evaluation/pdf/brief3.pdf.
- Centers for Disease Control and Prevention, *Evaluation Briefs: Writing Good Goals* (2018). https://www.cdc.gov/healthyyouth/evaluation/pdf/brief3a.pdf.
- Centers for Disease Control and Prevention, *Evaluation Briefs: Writing SMART Objectives* (2018). https://www.cdc.gov/healthyyouth/evaluation/pdf/brief3b.pdf.
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, *Developing Program Goals and Measurable Objectives*. https://www.cdc.gov/std/program/pupestd/developing%20program%20goals%20and%20objectives.pdf.

- Centers for Disease Control and Prevention, Public Health Professionals Gateway, *Develop SMART Objectives*: https://www.cdc.gov/phcommunities/resourcekit/evaluate/smart_objectives.html.
    - Supplemental resources on this page: SMART Objectives Template.
- Community Tool Box, *Creating Objectives*. https://ctb.ku.edu/en/table-of-contents/structure/strategic-planning/create-objectives/main.
- Office of Disease Prevention and Health Promotion, Healthy People 2020, *Program Planning: Pl*an. https://www.healthypeople.gov/2020/tools-and-resources/program-planning/Plan.
    - Supplemental resources on this page:
        - Defining Terms: Vision, Goal, Objective, Strategy
        - Potential Health Measures
        - Setting Targets for Objectives

APPENDIX C: EVIDENCE-BASED AND EVIDENCE-INFORMED INTERVENTION RESOURCES

- Association of State and Territorial Health Officials Programs: Evidence-based and evidence-informed programs for various health issues
- Agency for Healthcare Research and Quality Tools: Research-based interventions and policies with tools for implementation for hospitals and health systems
- Campbell Collaboration Better Evidence: Evidence and systematic reviews of promising interventions by topic
- CDC Community Health Improvement Navigator: Contains tools for community health improvement efforts and a resource list for evidence-based interventions
- CDC Public Health Prevention Status Reports: Provides health status information by topic and by state, and programs and policies to address health issues
- Selected CDC-Sponsored Interventions for Reducing Health Disparities: Selected health promotion efforts in diabetes, asthma, colorectal cancer, hepatitis A, HIV, violence prevention, and disability
- Cochrane Library: Systematic reviews of evidence-based interventions browsable by topic
- County Health Rankings and Roadmaps Evidence-Based Resources: Compendium of evidence-based and evidence-informed programs
- The Community Guide: A compendium of evidence-based intervention for population health, searchable by topic
- Health.gov: Resources for health promotion on food and nutrition, physical activity, health literacy, and health care quality, including national action plans and initiatives
- National Association of County & City Health Officials: A library of health programs and policies.
- National Cancer Institute Evidence-Based Cancer Control Programs (formerly RTIPS): Evidence-based interventions for cancer and cancer-related topics
- National Institute for Health and Care Excellence: A library of evidence-based recommendations and guidance for public health programs
- New York State Prevention Agenda Dashboard: Compendium of evidence-based and promising practices by Prevention Agenda topic areas
- Rand Corporation Programs that Work, from Promising Practices Network on Children, Families and Communities: A compendium of evidence-based programs and promising practices for health care and other sectors
- Substance Abuse and Mental Health Services Administration Evidence-Based Practices Resource Center: Resource list of mental health and substance use programs and policies
- Surgeon General Report on Alcohol, Drugs, and Health Resource Guide: Resource list of evidence-based interventions on preventing and treating substance misuse or substance use disorders
- US Department of Health and Human Services Healthy People 2030 Evidence-Based Resources: A compendium of interventions and research organized by health conditions, health behaviors, populations, settings and systems, and social determinants of health
- US Preventive Services Task Force Published Recommendations: Resource list of evidence-based counseling, preventive medication, and screening interventions for various health issues
- GNYHA Prevention Agenda Toolkit: List of evidence-based hospital community health improvement interventions
- GNYHA Obesity Reduction and Prevention Best Practices: Community Interventions: List of evidence-based and evidence-informed community health improvement interventions focused on obesity prevention and physical activity

APPENDIX D: SOCIAL DETERMINANTS OF HEALTH (SDH) VS HEALTH DISPARITIES

SDH DEFINITION

Non-medical factors or "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes"[i]

Examples of SDH:

- Access to health care
- Health literacy
- Access to education and level of attainment
- Economic stability
- Food security
- Housing
- Transportation
- Air quality

SDH impact daily life and influence health outcomes.

HEALTH DISPARITIES DEFINITION

- Differences in health status in one population compared to other populations. This is often described as a lack of health equity in a population or group.
- The Centers for Disease Control and Prevention's Healthy People initiative defines a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage"[ii]
- Examples of health disparities
    - Higher mortality among Black adults with heart disease compared to White adults with heart disease
    - Obesity is more prevalent (31.2%) in American Indian and/or Native Alaskan children compared to White children (15.9%)[iii]
    - "Hispanic women are 69% more likely to be diagnosed with breast cancer at an advanced stage than white women"[iv]
    - "LGBT (lesbian, gay, bisexual, and transgender) youth are 2 to 3 times more likely to attempt suicide."[v]

i Centers for Disease Control and Prevention. About Social Determinants of Health. https://www.cdc.gov/socialdeterminants/about.html.

ii Centers for Disease Control and Prevention. Healthy People. Disparities. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities#6.

iii Isong, I. A., Rao, S. R., Bind, M., Avendano, M., Kawachi, I., Richmond, T. K. (2018). Racial and ethnic disparities in early childhood obesity. *Pediatrics*, 141. https://doi.org/10.1542/peds.2017-0865.

iv American Association for Cancer Research. (n.d.). *Cancer health disparities*. https://www.aacr.org/patients-caregivers/about-cancer/cancer-health-disparities/.

v Office of Disease Prevention and Health Promotion. (n.d.). *Lesbian, gay, bisexual, and transgender health.* https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health#:~:text=Research%20suggests%20that%20LGBT%20individuals,%2C2%2C%203%20and%20suicide.

CONNECTING SDH TO HEALTH DISPARITIES

Example 1:

- SDH: Poor air quality can lead to health problems such as asthma
- Health disparity: According to the Asthma and Allergy Foundation of America, "Black Americans are nearly 1.5 times more likely to have asthma"[vi]

Example 2:

- SDH: Limited English proficiency is a barrier to quality health care
- Health disparity: A large percentage of Asian Americans are foreign-born and have limited English proficiency. According to the National Institute on Minority Health and Health Disparities (2016), Asian Americans have the lowest cancer screening rates, and cancer is the leading cause of death for this population.[vii]

INCORPORATING CONCEPTS INTO YOUR COMMUNITY NEEDS ASSESSMENT

- Discuss and describe the SDH that influence the community's health
    - Prioritize major issues negatively affecting health outcomes
    - How do these factors affect the health of the community?
    - Provide examples
- Next, relate this to existing health disparities in the community you are describing
    - Describe data and health disparities identified
    - Consider how the health disparities influence the identified needs of the community
    - Do the interventions/programs that address community needs also address specific health disparities?
        - Describe how health disparities will be addressed. For instance, is the intervention addressing a particular population? How is the intervention tailored to them?
        - Incorporate measures for evaluation that address reducing health disparities
        - How are the SDH addressed within the intervention?

vi Asthma and Allergy Foundation of America. (n.d.). *Asthma disparities in America*. https://www.aafa.org/asthma-disparities-burden-on-minorities.aspx.

vii National Institute on Minority Health and Health Disparities. (n.d.). *The Center for Asian Health engages communities in research to reduce Asian American health disparities*. https://www.nimhd.nih.gov/news-events/features/training-workforce-dev/center-asian-health.html#:~:text=Asian%20Americans%20face%20health%20disparities,the%20leading%20cause%20of%20death.

APPENDIX E: RESOURCES FOR ADAPTING INTERVENTIONS

- CDC, Advancing Health Equity, General Adaptation Guidance: Describes adapting a program using an example of adapting and evidence-based sexual health curricula
- Community Tool Box, Adapting Community Interventions for Different Cultures and Communities: Describes adapting a program specifically to fit different cultural traditions and groups
- Department of Health and Human Services, Making Adaptations Tip Sheet: Describes evidence-based programs and how to plan and implement an adaptation while maintaining core components
- National Association of County and City Health Officials, Guidance for Adopting and Adapting Global Health Approaches for US Local Health Departments: Describes forms of adaptation, when it is appropriate and not appropriate to adapt an intervention, and steps for adaptation. Contains examples of interventions that have previously been adapted and a list of additional tools and resources.
- Rural Health Information Hub, Considerations When Adapting a Program: Outlines forms of adaptation, acceptable and unacceptable changes, and modifiable and non-modifiable components

APPENDIX F: GNYHA RESOURCES FOR IMPLEMENTATION

Data Collection and Evaluation of Obesity Prevention Programs Webinar (March 28, 2017)

- Webinar Recording
- GNYHA Slides: CHNA/CSP Support Webinar: Evaluation of Obesity-Related Community Programs
- DOH Slides: Evaluating Progress in Chronic Disease Prevention Initiatives in the New York State Prevention Agenda 2013-18

Evaluation of Community Health Improvement Programs Webinar (December 7, 2017)

- Webinar Recording

Evaluation of Hospital Community Health Improvement Programs Webinar (May 29, 2019)

- Webinar Recording
- DOH Slides: Evaluating Progress of NYS Prevention Agenda Initiatives

APPENDIX G: COVID-19-SPECIFIC DATA RESOURCES

GNYHA collected COVID-19-related resources that can assist hospitals to conduct their community health needs assessment. Community activities and priorities will shift as the pandemic continues and hospitals will need up-to-date information on their communities to strategize and plan their own community health programs. The resources below will be helpful in collecting secondary data on the impact of COVID-19 in your community. The resources cover case counts, vaccine rates and vaccine hesitancy information, racial disparities, identifying at-risk populations, and information on the societal impact from COVID-19.

TRACKING AND CASE COUNT

COVID-19 Data Tracker, Centers for Disease Control and Prevention (CDC): Tracks cases, deaths, and trends of COVID-19 in the United States. The information is updated daily by 8:00 p,m. ET.

National Environmental Public Health Tracking Network, CDC: Data explorer with COVID-19 data that allows you to select a variety of indicators that includes deaths, mask mandates, socioeconomic status, reopening information, medical infrastructure, and more. The search also allows you to select a certain time frame to give you the appropriate data.

State COVID-19 Data and Policy Actions, Kaiser Family Foundation: Provides state metrics on the number of cases, deaths, hospitalizations, vaccinations by race and ethnicity, and cases and deaths at long-term care facilities. This data is updated regularly.

Johns Hopkins Coronavirus Research Center US Map, Johns Hopkins University of Medicine: This map provides COVID-19 data by county with all US counties reported. Status reports include: county case data, state statistics (confirmed deaths and fatality rate), number of cases in last 14 days, new cases since previous day, county case per 100,000 population, and county fatality rate. Status reports also include: health insurance facts, population race, ethnicity and age, hospital bed facts, and American Community Survey statistics (people in poverty, total population, and population aged 65+). This data is updated daily.

VACCINATION AND VACCINE HESITANCY INFORMATION

US COVID-19 Risk and Vaccine Tracker: State and county-level data on COVID-19 cases, deaths, hospitalizations, test positivity, intensive care unit occupancy, and vaccination rates. It provides a vulnerability level as well as a comparison across states, counties, and metro areas. The tracker was developed by Covid ActNow in partnership with Georgetown University, Stanford University, and Harvard University.

COVID Collaborative, Institute for Health Metrics and Evaluation: Provides the percent of survey respondents who would be likely or less likely to accept a COVID-19 vaccine. The data provides information by county and zip code. The survey is from the Delphi Group at Carnegie Mellon University's *U.S. COVID-19 Trends and Impact Survey.*

COVID-19 Vaccine Monitor, Kaiser Family Foundation: Research tracking the public's attitudes and experiences with COVID-19 vaccinations.

COVID-19 RACIAL DISPARITIES

Other & Belonging Institute's Showing Racial Disparities in COVID-19 Cases, UC Berkeley: A visual map of disparities in COVID-19 rates by state.

National Center for Health Statistics (NCHS) COVID-19 Data Center, Centers for Disease Control and Prevention: NCHS provides the most recent data available on COVID-19 related deaths, births and pregnancy, telemedicine access, and hospital data and long-term care facility information. The data is taken from the vital statistics system, NCHS Research and Development Survey, and through a partnership with the US Census Bureau.

IDENTIFYING AT-RISK POPULATIONS

City Health Dashboard: COVID-19 Local Risk Index, NYU Langone Health: Provides neighborhood-level COVID-19 risk data as well as health, social, economic, environmental, and clinical measures for populations over 50,000 in the United States.

IMAGE: NYC's Identifying At-Risk Populations During COVID-19: The New York Academy of Medicine's interactive map that identifies neighborhoods with a higher risk of infections, with a focus on the 65+ population.

Minority Health Social Vulnerability Index (SVI), US Health and Human Services' Office of Minority Health: An extension of the CDC's Social Vulnerability Index that includes racial and ethnic data within factors associated with COVID-19 outcomes as well as the top five languages spoken by populations with Limited English Proficiency at the county level. The website offers a visual data platform to toggle different indicators by accessing Minority Health SVI through the CDC's website.

SOCIETAL IMPACTS FROM COVID-19

Household Pulse Survey, US Census Bureau: Measures household experiences during the COVID-19 pandemic. State level data provided on employment, food security, housing security, and mental and physical well-being during the pandemic.

APPENDIX H: RESOURCES FOR EVALUATION

EVALUATION DESIGN

- Community Toolbox Selecting an Appropriate Design for the Evaluation: Guidance, examples, and a checklist for evaluation design
- Rural Health Information Evaluation Design: Basic overview of types of evaluation and evaluation designs
- Better Evaluation Guidance on Choosing Methods and Processes: Guidance and steps for forming an evaluation design

EVALUATION METHODS

- CDC:
  - Program Evaluation Tip Sheet: Constructing Survey Questions
  - Evaluation Methods: Described various quantitative and qualitative evaluation methods

DATA COLLECTION AND ANALYSIS

- Northwest Center for Public Health Practice Data Collection for Program Evaluation: Thorough descriptions and guidance for evaluation design, methods, data collection, and analysis

DISSEMINATING RESULTS

- Family & Youth Services Bureau Tip Sheet for Disseminating Evaluation Results: Describes methods and steps for presenting and disseminating evaluation results and provides examples

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