VERMONT
DEPARTMENT OF HEALTH

The How-to Guide for

Conducting a Community Health Needs Assessment

Center for Behavioral Health Integration, LLC

This toolkit was developed by the Center for Behavioral Health Integration, a Vermont-based company specializing in program evaluation, training, and program implementation services.

For more information on their work please visit: www.c4bhi.com

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What is a Community Health Needs Assessment?

A Community Health Needs Assessment (CHNA) is a systematic, comprehensive, and collaborative way of studying the key health needs and assets of a community, so that the community can leverage its available resources to address these needs.

It is required as part of the Affordable Care Act (the ACA), and the regulations that govern it are defined by the Internal Revenue System (IRS) as a requirement for tax exemption status. It entails that a non-profit hospital conducts a CHNA every three years and do so in a manner that must:

- Define the community it serves.
- Assess the health needs of that community.
- Solicit and consider input received from persons who represent that community's broad interests, including those with special knowledge of or expertise in public health.
- Document the CHNA in a written report adopted for the hospital facility by an authorized body of the hospital facility.
- Make the CHNA report widely available to the public.
- Have a written implementation strategy that describes both the plan for addressing significant health needs found, and if not planning to address any significant health need, the reasons for that.

Learn more about Community Health Needs Assessment for charitable hospital organizations

Why do a CHNA?

The CHNA process involves hospitals and their community partners, collaborating to assess and address high priority health needs in the community. As such, this process provides a foundation for engagement, collaboration and trust.

Other benefits include:

- Providing tax exemption.
- Maximizing available resources: sharing and better allocating resources when addressing needs, sharing administration costs.
- Reducing the duplication of efforts.
- Maximizing Collective Impact: sharing focus on health needs, coordinating planning, improving communication, gaining better support for initiatives.
- Promoting best practices for collaboration within a community and across communities by elevating community voices and eliciting community feedback throughout the process.
- Advancing health equity by addressing health needs affecting under-served communities.
- Cultivating community partnerships, advancing community engagement, and providing a way to build trust and gain wisdom from the community.
- Gaining useful data to guide decision making and know how to measure improvement.

The American Hospital Association divides the benefits into those of the health system and those of the community in the following manner:

Hospital/Health System Goals

- Increased trust between community and hospital, leading to increased collaboration around priority issues.
- Greater community collaboration toward shared stewardship of and commitment to community health.
- Strengthened relationships with individuals and organizations that are assets for improving community health.
- Healthier communities in which individuals have access to preventive care and seek care at the appropriate level.
- Increased understanding of the hospital's role and capacity to impact health issues.

Community Goals

- Increased trust between community and hospital, leading to increased collaboration around priority issues.
- Self-determination of the community's future health and well-being.
- Consideration of residents' day-to-day lives, experiences and knowledge of community health care improvement.
- Health care solutions and strategies that align with community values.
- Strengthened relationships with individuals and organizations that are assets for improving community health.
- Continued involvement and investment in the short- and long-range success of the CHNA process and any subsequent community coalitions or collaborative improvement efforts.

This table shows The American Hospital Association's goals of a CHNA.
Learn more at healthycommunities.org

How to conduct a CHNA

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Vermont Department of Health: Conducting a Community Health Needs Assessment

Step

1

Identify who should be involved in conducting a CHNA

Identify who should be involved in leading the CHNA work and what authority and responsibility each group holds.

Partnership examples:

A collaborative:
A group of local public health partners, which may include hospital and health systems, community organizations, health centers, and local government. This group advises the hospital and CHNA staff on the assessment process.

A Steering Committee:
This applies to collaboratives that choose to have representatives of the collaborative jointly make decisions, plan, and guide the work of the CHNA. The Steering Committee actively drives the assessment planning, implementation, and use.

A network:
Referring to a CHNA process conducted across multiple hospitals within one health system or across multiple health systems. The leadership group for this work has broad representation across several communities and works to balance local needs with a system-wide scope.

Consider the following factors:

- **Identify the people and organizations** with a vested interest in the results of a health needs assessment and in using the findings.

- **Identify key representatives** from hospitals, public health, and community organizations to form a community partnership team or steering committee. As you identify people, consider who are the decision makers, who can influence public opinions, who can provide information, who can engage others and inspire action, who can advocate for the project, and who know how to secure resources.

- **Ensure the diversity of the community is represented.** Organize the process in a way that allows for maximum participation by all members, with an emphasis on ensuring those who are medically marginalized can be a meaningful part of the process.

  For example, consider geographical representation such as rural and urban populations that are medically marginalized or experience disproportionate health inequities, or have less ability to directly and assertively communicate their needs—such as significant disorders like mental health or substance use, or people whose first language is not English.

- **Consider the resources and capacity** each partner has available to support this work, where these resources will come from, and who holds responsibility for them. Resource categories include:

  - Funding
  - Staffing
  - Knowledge and expertise (IT, evaluation, research, grant writing)
  - Any resources such as meeting space

  To conduct and use CHNAs, staff time is needed to coordinate the collaboration leadership team, do community outreach at the local level, collect and analyze data, and do copy writing and reporting. Growing staff expertise and capacity in each of these roles would be an important goal towards sustainability.

  Relying on consultants when greater expertise is needed or when network capacity is insufficient should decrease over time. A potential resource gain can be found in partnering with local and state health departments to provide the necessary secondary data for the CHNAs. This model has been very successful in New York and similar opportunities exist in Vermont.

Decide on the governance structure to manage and guide the partnership. Specifically:

- **The types of agreements to establish between the organizations.** This can range from informal verbal agreements to formal MOUs, with the middle road being a standalone organization that is not hospital-led and allows for a shared leadership model.
- **The type of leadership model to establish.** Many times, leadership is largely egalitarian and done through a steering committee with all involved organizations represented. At times, veto power is held by the hospital.
- **How ongoing management is conducted.** For example, who manages the funds and how they are allocated over time.
- **Decide on key roles, the ownership of key processes, and if training should take place to carry out key processes.** Consider someone with expertise and experience in assembling and maintaining high performing teams to be in the facilitator-leader role.
- **Decide on shared agreements to facilitate trust, safety, engagement, commitment, and shared ownership.**

Further resources:

King County Community Health Needs Assessment (CHNA)

What makes teams high performing?

The New Science of Building Great Teams

Step

2

Establish the purpose of the partnership

Identify the goals of the assessment so that you have a defined focus and know what data you need to collect.

Discuss the assessment's primary purpose and focus, how broad or specific it would be, and how to ensure equity and diversity in who is represented in the process.

Determine if a specific health need is significant and needs to be explored in the assessment. The IRS gives examples of how to identify if a health need is significant by considering:

- Burden, scope, severity, or urgency of the health need
- Estimated feasibility and effectiveness of possible interventions
- Health disparities associated with the need
- Importance the community places on addressing the need

Learn more about Community Health Needs Assessment for charitable hospital organizations

Consider exploring topics such as:

- The impact of systematic oppression due to structural bias against communities being served
- Needs of specific populations or geographies
- How to prevent illness
- Gaps in treatments and services
- Resource limitations
- Assets in the community
- Social or environmental factors that influence health

Discussing what not to include is important in defining the boundaries and scope of the needs assessment. Document any specific topics that are excluded after discussion. Refer to Step 5: Prioritize the findings for further information.

Compile specific goals and detailed objectives for each goal to guide the needs assessment.

Establish a workplan in which goals, objectives, and activities are tied to a timeframe.

"The CHNA has become a source of community pride."

The Health Collaborative, Texas

Checkpoint

Once a team and purpose are established, it is important to take some time to plan for and discuss common challenges that may arise during the partnership.

These could include:

- Aligning visions and priorities
- Using time efficiently
- Leadership buy-in
- Building lasting collaborations
- Adjusting timelines for CHNA completion
- Lack of clarity on who holds responsibility and authority for CHNA activities
- Are formal agreements in place, if needed
- Dedicating staff time
- Balancing local data needs with regulatory requirements
- Not overburdening the community with data requests
- Tracking/using shared metrics

Step 3

Identify activities within the scope of the CHNA

Activities of a CHNA collaborative would most likely include:

- Leading the CHNA process
- Meeting regularly
- Engaging partner and community
- Collecting and analyzing data
- Reviewing collected data
- Reporting out to all involved parties
- Implementing strategies to address identified needs
- Aligning individual and collective actions
- Sharing results broadly

If the hospital system is a larger health system with multiple hospitals, it is also important to note if activities will be led locally or in a centralized way via the network. Balancing local and network needs for larger hospital systems becomes another activity.

Further resources

The Boston Community Health Collaborative is an example of a well-established model.

Step 4

Collect, analyze, and report on the data

It is a widespread practice to collect both primary data (data collected firsthand for the CHNA) and secondary data (publicly available data that already exists), and to use both quantitative and qualitative methods.

Establish timelines for data collection. Often primary collection will be done after secondary data has been analyzed and reported on. Note that qualitative data collection and analysis takes time, and its scope depends on what types of representations you identified as needing to take place as well as funding. The scope will also determine how many people to interview to get a good representation for each health issue or identified population.

Identify and review secondary data:

- Seek the assistance of the Vermont Department of Health when planning to collect secondary data, as the department has many data sources to share, such as How Healthy Are We? Data Resources | Vermont Department of Health (healthvermont.gov). Advise hospitals to contact Department of Health District Directors if they are looking for specific data.
- Other data sources could come from the organizations in the partnership, county health departments, vital statistics, schools, and universities, etc.
- Review, summarize, and report on the secondary data to identify gaps in what you know about the health of the community. This will inform further data collection needs.

Decide what primary data to collect, based on the review of secondary data.

- Primary data may include asset mapping, surveys, focus groups, and key informant interviews.
- Consider the output of each of these and how you would use these outputs to review needs and make actionable implementation plans to address them.
- Consider quantitative and qualitative data collection, and each method's benefits and challenges.
- Qualitative data complements quantitative methods by providing in-depth information about perspectives, meaning of experiences, and deeper insights, allowing unanticipated, contextual, and/or deeper information to emerge.

"The KC HHC collaborative allows hospitals/ health systems to come together to collaborate—not compete."

King County Hospitals for a Healthier Community, Washington

Advantages and disadvantages of data collection methods:

Method	Advantages	Disadvantages
Asset Mapping An inventory of community health assets, such as available resources, services, facilities, community-based organizations and associations. Usually represented by geographically mapped data.	• Builds on existing community assets • Can generate a lot of community participation • Mapping the inventory creates a visual depiction of existing and lacking assets • Data can be used to raise awareness about the availability of assets, develop or improve services and programs, or to apply for funding	• Finding the right maps can be difficult, and mapping software can be expensive and difficult to use • Some community assets will be difficult to map if they don't have a physical location • Needs community buy-in and collaboration to adequately inventory up-to-date community resources
Focus Groups A series of structured discussions involving 8-12 people, selected to share their perceptions of a defined topic.	• Flexible • Captures rich, in-depth data • Immediate results • Encourages and stimulates individuals to share more openly • Data can be combined with quantitative data to provide a complete picture about an issue	• May be challenging to recruit participants • Need to schedule at least 2-3 focus groups to capture diversity • Difficult to generalize results to the larger population because of small numbers of participants • Difficult to compare results across groups

This table shows advantages and disadvantages of data collection methods from the UCLA Center for Health Policy Research Health DATA Program

Advantages and disadvantages of data collection methods continued:

Method	Advantages	Disadvantages
Survey A survey conducted over the phone, in person or via mail with closed-ended or directed questions.	• Data can be collected from a lot of respondents easier than any other method • Can get a large enough sample that can be representative of the larger population • Findings can be generalized to the larger population • Can cover a lot of topics • Can easily compare different groups' data to each other	• Survey instrument must be carefully constructed to avoid leading questions, and to make sure the appropriate responses are available • Response rates can be low for self-administered surveys, especially mailed ones • Response will be low if survey is too long
Key Informant Survey A survey conducted over the phone, in person or via mail with short answers or other open-ended questions.	• Detailed and rich data can be gathered in a relatively easy and inexpensive way • Allows interviewer to establish rapport with the respondent • Provides an opportunity to build or strengthen relationships with important community informants and partners • Can raise awareness, interest, and enthusiasm around an issue • Can contact informants to clarify issues as needed	• Selecting the "right" key informants may be difficult so they represent diverse backgrounds and viewpoints • May be challenging to reach and schedule interviews with busy and/or hard-to-reach respondents • Difficult to generalize results to the larger population unless interviewing many key informants

This table shows more advantages and disadvantages of data collection methods from the UCLA Center for Health Policy Research Health DATA Program

For large hospital systems, data collection activities can be led either locally or in a centralized way via the network. When the network provides guidance or expectations for the data collection standards and methods to be used, there are less variations in the type and quality of data than when data collection is led locally. If data collection cannot be led fully by the network team for the current CHNA cycle, it is advised that data collection standards and methods are provided by the network and local leads are supported in implementing them. This will provide greater uniformity and is a good place for shared service to reduce the burden on local staff.

Quantitative and qualitative data collection and analysis techniques, along with data visualization techniques, help in gathering the needed data, making sense of the data, answering the original questions the steering committee set out to explore, and reporting on any new discovery the data shows. While these involve specialized training and skills, the following pages take a deeper dive into two main techniques:

1. **Planning and Organizing Focus Groups**
2. **How to Analyze Qualitative Data**

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"Emerging from the CHNA, the community had a single, accepted set of high-quality data, which created significant efficiency across organizations that had previously needed to each maintain and research their own distinct datasets for activities such as service planning and grant applications."

Columbia Gorge Regional Health Assessment and Improvement Process, Oregon

1. Planning and organizing focus groups

- **Develop an outreach list**. Include in this list the name of the outreach organization, the name of the person(s) in the organization you are reaching to, their contact details, and why this organization is of interest. Include who is doing the outreach, and any notes and updates on the status of planning and scheduling groups.

- **Develop a schedule list** of interviews. This may include date and time of interview, who is the contact person for the group being interviewed and their email address, information about why this group is being interviewed (what population, community, specific experiences, etc. they represent), and a physical address or virtual link of where the group would take place. A group of six to eight people is ideal.

- **The location** of focus groups is important. Participants should have sufficient room and privacy to be able to authentically engage. The location should be relatively easy to get to for participants.

- **Consider logistics** for this focus group to be successful and for all potential participants to be able to engage. This includes language and interpretation considerations, childcare, permissions to guardians if minors are participating, food and drink and any specific dietary needs, and any accommodation or accessibility features.

- **Assign a facilitation team**. It may be helpful to have one facilitator focusing on content and another attending to any extraneous items such as technological difficulties or questions outside of group discussion that come up. Once a focus group is completed, the facilitator can use a ‘completed interviews’ file to record the interview—recording file name, if a thank you note and incentives were sent, and any other information pertaining to the focus group.

Develop a detailed guide with the entire team of facilitators. Include:

Preparation notes or what needs to be accomplished before the focus group. For example, sending a letter to participants with information about the focus group, having a way to record the session, finalizing any accommodations and accessibility options available to participants, a sign-in sheet, food, or incentives.

Facilitation notes which include the different steps of the focus group, such as:

An introduction: Introduce facilitators, goal of the focus group, how long the meeting will take, voluntary nature of answering, agenda, boundaries, and any details such as how incentives would be provided. Include some ground rules of conversation, such as being respectful if differing opinions arise. If recording, you will need to ask for consent to record. Discuss how you are handling confidentiality of what is being said and any limits to it. Discuss how information will be used and by whom.

Ask the focus group questions. Keep questions open-ended (no 'yes' or 'no' questions).

Example questions:

The questions should address the scope and plan arrived at by your steering committee and build on what was learned from the secondary data reviews.

- *These were the health issues that have come up as being the most important health issues in your community (share the list, prioritize how to talk about them, choose the first one to talk about). What are the biggest barriers to fixing this problem for your community?*
- *Tell me about experiences (your personal, friends, family, co-workers, etc) using or attempting to use health care services in your community.*
- *If someone in your community needs mental health (or substance use, crisis, specific health need help, housing, etc.) do they know where to go?*
- *Are there other health issues you think are important that we have not discussed?*

Wrap up: Ask if any pertinent info has not been covered. Thank everyone for their time, supply incentives, make sure they have a way to follow up with facilitators if they have any further comments or questions. Discuss how to access results when available.

Post interview*:* All data from the interview is named according to naming conventions to be available to analyst(s).

Develop a budget tracking document: This list is where to track outreach efforts, supplies, travel expenses, participant incentives, transcription, facilitator compensation, interpretation and translation expenses, childcare, food, and other planning and administrative tasks associated with the focus groups.

Some notes on using incentives to encourage participation:

Asking people with lived and professional experience to participate in interviews and focus groups is a critical part of a CHNA and comes with it a responsibility on the part of the CHNA to those being interviewed. The request both requires a commitment from the interviewees to share openly to support your work and to make time to be involved. There are things the interviewers should work to do to make this commitment as easy as possible.

- Compensate people for their time. Unless participants cannot be paid for their time (which is common when they are participating as professionals during work hours), providing a stipend, often in the form of a gift card, is expected. Ensure that incentives are purchased with the goal of what is most easily accessed by participants. For example, online gift card websites often have an initiation fee but operate like traditional debit cards and can be used anywhere. The amount can vary, but it should be a reasonable contribution to demonstrate how much you value their time. $30-$50 is the norm, while anything below $20 can easily look like a token rather than true compensation.

  - There may be local rules about how incentives can be provided and who can receive them. Be sure to work with your local leadership about the options you have.

  - Gift cards can typically be purchased in bulk at numerous sites online and can be distributed electronically or by mail.

- Aside from monetary compensation, there are other important incentives to provide to reduce barriers to participation. These options should be offered whenever feasible. Not doing so will reduce involvement from many community members, especially those facing equity barriers, which are often underrepresented as it is.

  - Childcare and food for in-person group
  - In-person, virtual, and hybrid (virtual and in-person) options
  - Interpreters
  - Translation of needed documents

2. How to analyze qualitative data

The process of analyzing qualitative data requires resources to plan, conduct interviews, analyze, and report on the data. The following gives a brief description of how to conduct such an analysis. If there is limited capacity, budget, and technical expertise, consider an open-ended text question in a survey to arrive at some information, limit the scope of the interviews, and use software such as Word to summarize, assign and organize codes.

The qualitative analysis process is that of iteration and reduction. The input is raw qualitative data (transcribed interviews, focus groups, and other documents) and the output is a more concentrated form of this data that doesn't lose the essence of the information.

Once all interviews are transcribed, your files can be imported into qualitative software of choice, such as Dedoose or NVivo.

A codebook should also be created and imported prior to analysis. The codebook is a system of labels to assign segments of data, including each label's definition. You may also include inclusion/exclusion criteria and examples.

This chart shows examples of codebook labels:

High-cost of living	Discussion of any items related to the high cost of living and making ends meet. Includes inflation, wage stagnation and any other economic trends impacting Vermonters. Excludes high cost of services and high cost of housing. Description of why it is a health concern.
Cost-emotional toll	Cognitive and emotional stress/ stakes of making financial decisions knowing something's going to give. The financial juggling is a health issue in itself. What gets bumped.
Cost-suggested actions	Discussion of actions or solutions suggested for the topic of the rising cost of living and economic security. Include anything that is being implemented already, regardless of success.

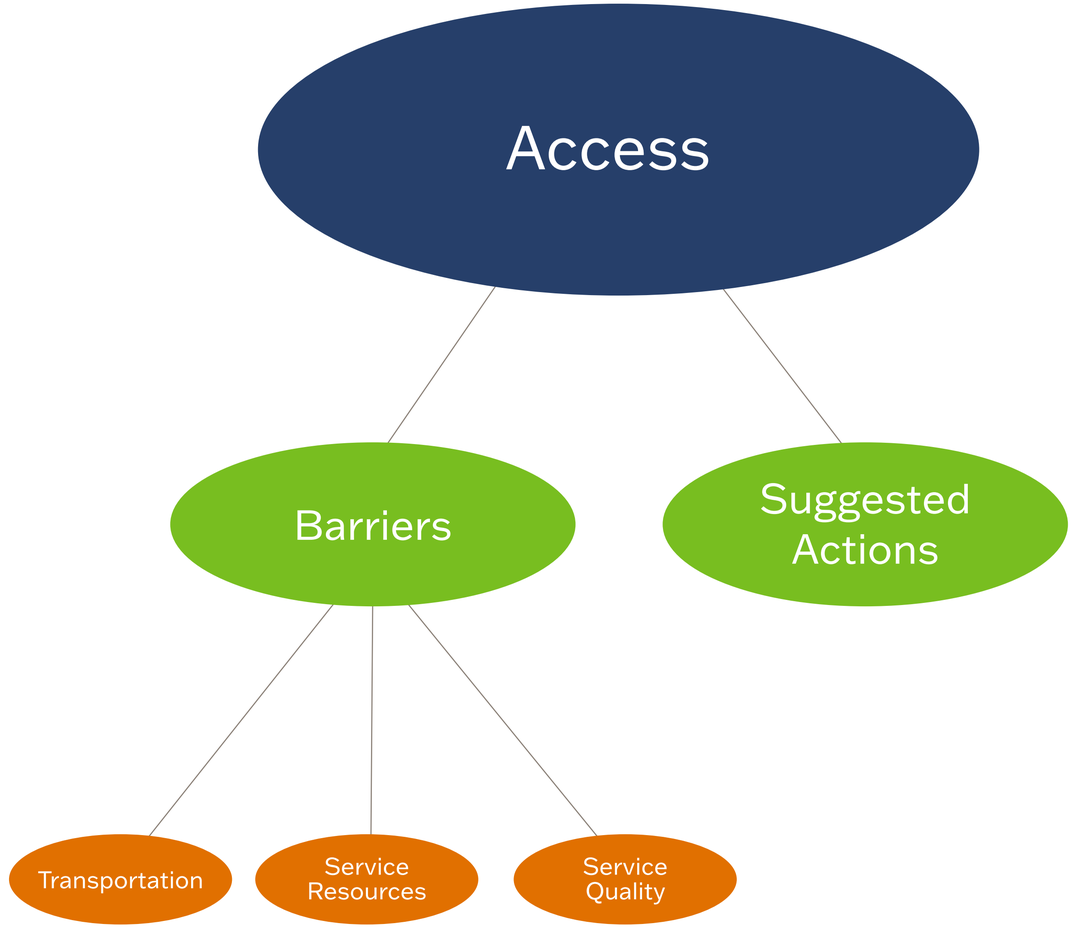
The codebook is derived from the focus group guide, reading through a representative number of focus groups, and discussion about reporting needs and project goals. New codes may emerge during coding. Code structure may be nested to allow for more detailed naming and classifications, as needed.

If there are further segmentations needed that are not devised through codes (for example, demographic descriptors or attributes), design how these would be filtered during analysis. For example, while you are collecting all access barriers under one code, you may need to further examine what these barriers look like for rural areas or for children. Plan how to filter the data.

- Using the established codebook, code the transcripts. In other words, assign the prepared labels to segments of data. Skimming the transcript first and then reading it in detail to assign codes is good practice. If multiple people are involved in analysis, form a system of communication to ensure consistency in coding and reporting. While coding, write notes about any impressions you are getting from the codes, any questions you may have, and any relationships and connections you see appearing.

- Once coding is completed, the analysis stage begins. Grab all the information for one code, read through it while taking notes on what the data is saying. Figure out themes, relationships, and be cautious to maintain the richness

An example of nested codes:



and depth of the original data. Are there relationships to other codes? Which codes were used most often and which least often? Are some codes overlapping? Is there a re-organization that may benefit? The answers become the building blocks for the report.

- Describe the data in detail, its meaning, and its significance for reporting purposes. Paraphrase, filter, condense into key points that are representative of the larger set. Use quotes to exemplify what has been found.

- Produce the visualized and reported outcomes of the assessment. Communicating data effectively will tell the story of the community, ease comprehension, and allow strategizing and action to take place from a deep level of understanding.

Further resources for specific data:

SparkMap is a great place to start, particularly 'Make a Community Needs Assessment'. You can choose location, data indicators, and level of reporting for the county or state. Various visualizations are used to show when data indicators are of concern for the geographical location. Resources from which the data are clearly marked and include but are not limited to US Census Bureau, American Community Survey, Center for Disease Control and Prevention, Department of Transportation, Federal Bureau of Investigation and many more.

County Health Ranking and Roadmaps summarizes info by state or county and gives comparisons to other geographical areas (for example, if you would like to compare a county to VT in general or VT to the Unites States). It gives health outcomes, health factors, health behaviors, social and economic factors, physical environment factors. Methodology and sources can be found on their site.

Vermont Department of Health gives access to many of its reports on its site. You can find reports and data on chronic disease, health promotion, substance use and more. Beyond the sites, district directors have access to many more data sources that could be of immense help.

Applying Research Principles to the CHNA Process (aha.org) provides insights on community engagement and data collection method selection when doing CHNAs.

Step 5

Prioritize the findings

The partnership reviews the findings in detail and prioritizes the significant health needs found in the CHNA.

- **Review criteria established in Step 2:**
  Establish the purpose of the partnership on how to prioritize (e.g., feasibility, importance, urgency, cost of delay, or any other criteria used). Additional information on prioritization criteria and exercise can be found on page 27

- **Identify which health needs are most significant and what criteria and process was used to make this determination.** Document each health need: describe it, rank it, add notes on how rank was achieved, and reasons why rank was higher and/or lower than other selections.

- **Socialize decisions and incorporate feedback.** It is important to socialize the decisions and understand further partners' goals, requirements, and constraints as they hear the decisions. You also want their buy-in and commitment as you progress. This is crucial to gain a shared understanding, engagement, motivation, knowledge, and collaboration. Socialization is a discussion, and much can be learned from it. Do this through:

  - Lunch and learns
  - Department meetings
  - Small group meetings
  - One on one conversations
  - Surveys
  - Water cooler conversations
  - Emails, blogs, internal office communication channels
  - Visualizing decisions (e.g., posters) in hallways, lunchroom, etc.

Prioritization exercises

Step 1: Identify criteria for prioritization.
Before beginning the exercises, the group should brainstorm and develop prioritization criteria. This set of criteria will guide the prioritization process. Typically, three to six priorities are selected, based on:

- Magnitude of the problem
- Severity of the problem
- Need among marginalized populations
- Community's capacity and willingness to act on the issue
- Ability to have a measurable impact on the issue
- Availability of hospital and community financial and people resources
- Existing interventions focused on the issue
- Whether the issue is a root cause of other problems
- Trending health concerns in the community

Additional prioritization criteria can include:

- The importance of each problem to community members
- Evidence that an intervention can change the problem
- Alignment with an organization's existing priorities
- Potential challenges or barriers to addressing the need
- The opportunity to intervene at the prevention level

Step 2: Arrive at your priority list.
You may select exercises from *Committee Exercises for Prioritization* on page 28 to assist in the process. It is encouraged to do more than one exercise to view priorities from different perspectives and to have robust and deep thought process justifying rankings and selection.

Step 3: Consider the rankings you achieved.
Take a step back from specific exercises. You are now considering the forest rather than the trees. While the rankings arrived upon are not exactly what every individual in the group wanted, they are a consensus the group achieved from all the differing perspectives and considerations.

Discuss:

- *Are these similar or different to community recommendations?*
- *Does it "feel right"?*
- *Does the team stand behind reasons for making these choices? Is there anything that needs to be discussed again or is an outlier?*
- *Consider the consequences of not addressing some of the issues and how that can impact community well-being in the future.*
- *If needed, repeat, or include another prioritization technique exercise to learn more about your choices.*

Committee Exercises for Prioritization: Multi voting

(Information from "Module 3: Decision Making Tools" on balancedscorecard.org)

This is a great exercise to take the initial long list of community health needs and reduce it to a more manageable list for discussion and a deeper dive.

This technique is used to reduce a long list of items to a top few by voting. It will show you what the most important items on this list are. There will not be a ranking. Decide before you begin how many items you want your final list to be.

How to:

Step 1: List all the community health needs on a white board, assigning a letter to each (e.g. A: food distribution B: foster care housing etc.)

Step 2: Each participant works on their own to select the most important 1/3 of all the ideas via letters. (e.g., if there are 30 community health needs, each participant will have 10 letters for their top priority items).

Step 3: Collect all the votes and tally the votes together by placing a check mark next to the item for each vote it received.

Step 4: Retain the items with the most votes for the next round. Repeat.

Repeat until only a few items remain. There should be several items left in the end—not just one.

Nominal group technique

This method can be used if a clear list of community health needs to prioritize is not clear yet. It allows for input from multiple team members regardless of authority or rank. The output from this technique is a list of ideas with a total priority score attached to each.

A facilitator is needed.

How to:

Step 1: Silent individual brainstorming. The data was presented already. Each person brainstorms on which community health needs should be the focus of a project. Each idea should be written on a separate sticky note.

Step 2: Facilitator collects all ideas and generates a list on a whiteboard/flip chart. All similar ideas should be grouped.

Step 3: Group discussion on ideas presented. The goal of the discussion is to elaborate on this idea, ask questions about it, and make it as familiar to everyone as possible.

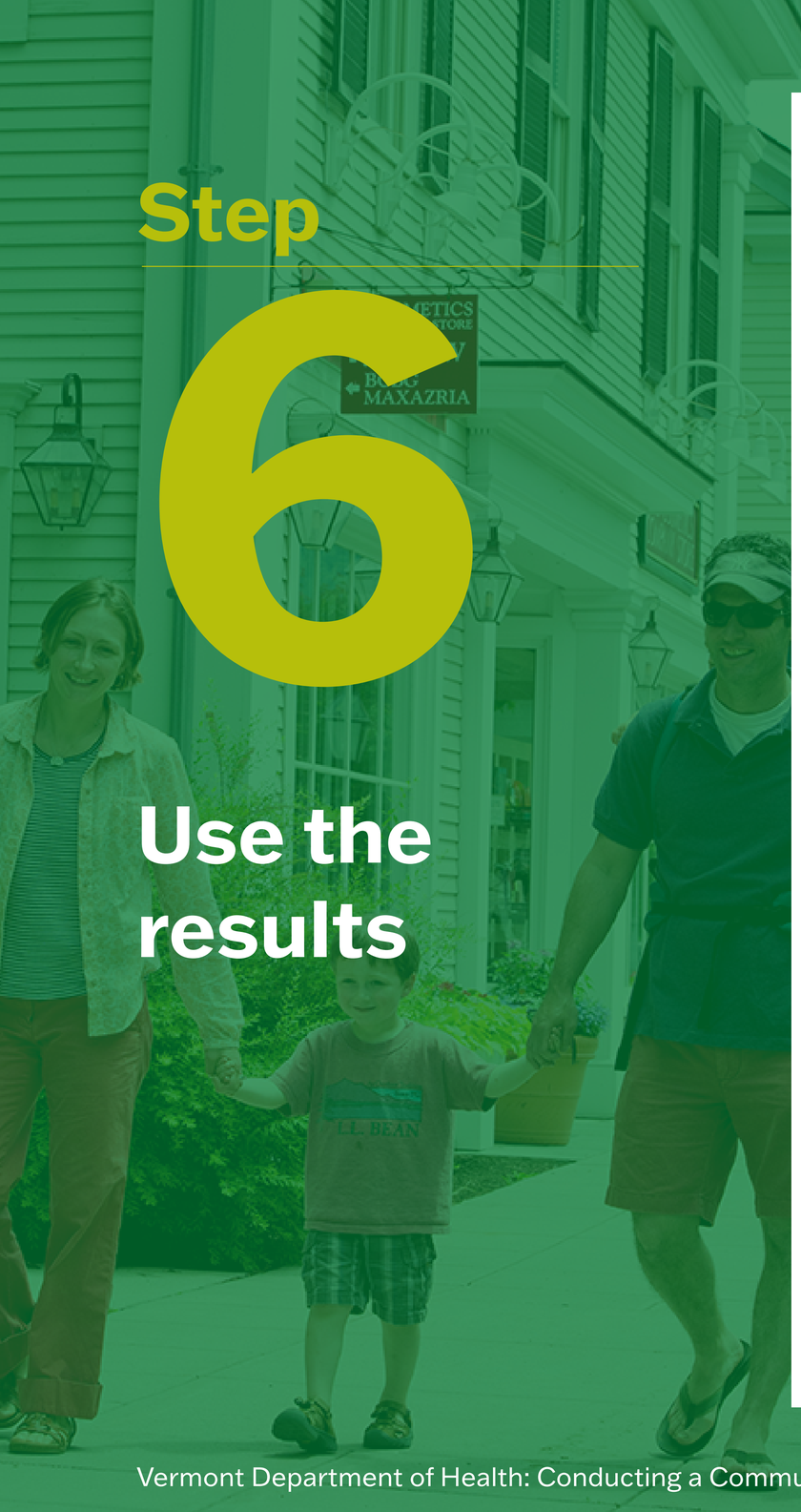
Step 4: Voting. Each individual votes for their top three items by putting a 1 (top), 2 or 3 next to their choices. A total priority score is calculated for each.

This chart illustrates the total priority score calculation.

Idea/ community health need	1st choice score (give 3 points to each)	2nd choice score (give 2 points to each)	3rd choice score (give 1 point to each)	Total
Increase foster care housing for adolescents	4 (x3)	6 (x2)	6 (x1)	30
Have 5 mobile shower units operating by x	1 (x3)	2 (x2)	10 (x1)	17

Calculating the total priority score:

- Give three points to every first choice score, two points to every second choice score, and one point to every third choice score
- Add up the total score for each
- The higher the total score, the higher the priority



The work in the community from the CHNA rolls into development and implementation of the Community Health Improvement Plan (CHIP).

Sharing CHNA results: The IRS requires that reporting on the CHNA be communicated to partners and the community broadly by placing it on a website and that a paper copy be made available with no charge to the public.

Developing CHIP strategies: For each health need identified and prioritized during the CHNA process, it is important to identify strategies for how the community will address those needs. Strategies are a coherent selection of actions or approaches implemented to improve or achieve the objectives, goals, or results of a program or plan. In developing strategies, consider questions such as:

- ***What efforts are already in place to address the health need?*** Consider current programs or initiatives being implemented and determine which are working and could be continued or expanded.

- ***What strategies will meet the needs of populations experiencing inequities?*** Prioritize strategies that are tailored to the unique strengths and needs of the most marginalized populations in your community, such as people of color, Indigenous people, or people with disabilities.

- ***What strategies does the evidence support?*** Consider strategies or interventions for which there is evidence that they can improve the health need.

  - Evidence-Based Resources—Healthy People 2030
  - What Works for Health | County Health Rankings & Roadmaps

- ***What strategies advance systems change?*** Consider strategies that shift the conditions that are holding the problem in place. Systems change occurs at three levels:

  - Structural change (policy, practices, resource flows)
  - Relational change (relationships and connections, power dynamics)
  - Transformative change (mental models, or deeply held beliefs and assumptions that influence one's actions)

To ensure accountability for implementing the strategies as planned, it is recommended to create a detailed workplan that further documents the activities and tasks associated with each strategy. Work plans should include what is being done, by who, and by when.

"Aristotle said, 'The whole is greater than the sum of its parts,' and that was certainly true in this collaboration. While each partner organization brings value to our community, that value was multiplied when these individual organizations became connected through the CHNA process."

Sioux Falls Health Department, South Dakota

Evaluating and monitoring progress of the CHIP
The IRS regulations require monitoring progress of the CHIP implementation. Hospitals need to track progress annually by using measures they establish at the beginning. They also need to report on the collection, tracking, and utilization of meaningful measures when they do their next CHNA.

Identify performance measures to know if the work is effective over time. Performance measures are a quantitative or qualitative indication of how well a process, program, service, or entity is working to meet or accomplish its goals, strategies, or objectives. Consider how data for the performance measure is collected, aggregated, synthesized, and shared, and by whom.

It is important to select meaningful performance measures. Results-Based Accountability (RBA) is a disciplined way of considering desired outcomes as the starting point to guide data the selection of performance measures and performance improvement and accountability. The Sharecare Community Well-Being Index is another resource that could be of help when thinking through potential measures.

- *Strong health performance* measures should be directly tied to the CHIP strategies. Where possible, they should focus on community-level change (such as the number of people participating in a diabetes prevention program) rather than population-level change (the number of people in the state with diabetes). This reflects that the work of the CHIP over three years can have a more meaningful impact at the program or small group level than it can at the entire population level.

- *Choose performanc*e measures for which it is feasible to collect data. Data should either be already available or be collected simply and repeatedly over time. If data collection requires involved instrument development and data collection processes it is much less likely that data collection will happen reliably.

- *Creating systems* for data collection, basic descriptive analysis, and tracking over time are important for sustaining feedback loops and showing progress.

- *Reflecting on* and using this data are keys to success. Standard parts of the work include sharing data with your steering committee and internally, identifying factors contributing to desirable or undesirable trends, and making adjustments to build on success or improve undesirable trends. Continuous improvement and ongoing course corrections contribute to adaptability, to being mindful of addressing the community's needs, and to maintaining focus on meeting goals.

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From a capacity perspective, managing evaluation effort should be planned and discussed. How deeply to engage in evaluation is also a decision that needs to be made according to available resources and needs. Some options include community-level process evaluation, summative evaluation with ongoing data tracking, or process-outcome evaluation throughout. Occasionally, there are adequate in-house resources to manage evaluation. More often, it is helpful to engage with an external evaluator to get the work started and to help build internal capacity, with an eye towards eventual internal management.

Further resources

Turn the Curve Exercise Instructions (RBA)

A scoping review of community health needs and assets assessment: concepts, rationale, tools and uses

Sharecare Community Well-Being Index

Beyond CHNAs: Performance Measurement for Community Health Improvement