STANDARD 1.1

Participate in or lead a collaborative process resulting in a comprehensive community health assessment.

A community health assessment (CHA) paints a comprehensive picture of a community's current health status, factors contributing to higher health risks or poorer health outcomes, and community resources available to improve health. CHAs are comprised of data and information from multiple sources, which describe the community's demographics; health status; morbidity and mortality; socioeconomic characteristics; quality of life; community resources; behavioral factors; the environment (including the built environment); and other social and structural determinants of health status.

Development of a CHA involves a systematic process to collect data and information that provides a sound basis for decision-making and action. In order to alleviate health disparities among subpopulations, the CHA gleans data and information to understand the factors and root causes that contribute to higher health risks and poorer health outcomes to inform strategies and plans to enable all community members to attain their optimal health. The CHA can help frame the narrative to emphasize the conditions that create health and cause disparities in health outcomes. It is important that the community health assessment be developed by the community, for the community. For this reason, it is important that community members or organizations that represent populations who are at risk or have been historically excluded or marginalized, participate in the CHA and are provided with key findings from the assessment in a manner they understand.

Developing the CHA in partnership with other organizations and members of the community provides opportunities to develop a shared understanding among the public health system of the community's health needs and assets. The community health assessment provides valuable insight to inform the basis of community health improvement plan strategies.

The Standards use the term "community health assessment" to refer to assessment at the state, Tribal, or local level. For state health departments, this is often referred to as a state health assessment and will assess the health of all residents in the state. For local health departments, the CHA will assess the health of residents within the jurisdiction it serves. A local health department's assessment may also assess the health of residents within a larger region, but the submitted assessment will include details that address the requirements specific to the

jurisdiction applying for accreditation. Tribal health departments will define their community. The community health assessment is often referred to as a Tribal health assessment and will address the health of the community as defined by the Tribal health department. For example, it may address all residents residing within the Tribe's jurisdictional area, the Tribal residents residing within the Tribe's jurisdictional area, or the Tribal population as defined under Tribal sovereignty.

MEASURE 1.1.1 A:

FOUNDATIONAL CAPABILITY MEASURE

Develop a community health assessment.

Purpose & Significance

The purpose of this measure is to assess the state, Tribal, or local level health department's comprehensive community health assessment of the population of the jurisdiction served by the health department. The community health assessment tells the community story and provides a foundation to improve the health of the population. It is the basis for priority setting, planning, program development, policy changes, coordination of community resources, funding applications, and new ways to collaboratively use community assets to improve the health of the population.

A health assessment identifies disparities among different subpopulations in the jurisdiction, and the factors that contribute to them, in order to support the community's efforts to achieve health equity. Data within the community health assessment may include information about mortality and morbidity, quality of life, attitudes about health behavior, socioeconomic factors, environmental factors (including the built environment), social determinants of health, community narrative, assets, and stories. Data should be obtained from a variety of sources, using various data collection methods.

MEASURE 1.1.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 community health assessment	**Dated Within** 5 years
1. Community health assessment (CHA) that must include **all** of the following elements:	This may be referred to as a state health assessment, Tribal health assessment, health needs assessment, or other name. A community health assessment differs from a statistical report in that it is developed collaboratively and with the express purpose of using data collected to draw conclusions about the health status, challenges, and assets of the population served in order to inform the prioritization of policies, strategies, and interventions. As such, this process requires not only the collection but also the interpretation of data to inform plans and decision-making, in terms easily understood by its target audience – community members and stakeholders. The collaborative partnership may determine that the community health assessment be updated on a different schedule, such as every 3 years. Dynamic community health assessments (i.e., websites with continuously updated data) are acceptable, if they address required elements a-g. In these cases, the health department is building on past data that have been collected and adding to those data over time. The partnership would meet on a periodic basis to review the data that are being collected and determine if there are any changes in data collection or interpretation. A combination of webpage screenshots and other documentation and descriptions may be used to demonstrate the required elements. As dynamic community health assessments may be updated more frequently, a description of the method and frequency of updates can be provided to meet the timeframe requirement, as long as the last updated date is within 5 years. Similarly, other formats of a CHA will be accepted, as long as required elements a-g are included. The intent of required elements a and b is to describe who is involved in the collaborative process to assess the health of the community and how they are involved. This could be included within, for example, the health assessment, an appendix, a partnership charter, or provided as a memo. **It is not necessary for the process description to be within the health assessment document itself.**		

MEASURE 1.1.1 A: Required Documentation 1	Guidance	Number of Examples 1 community health assessment	Dated Within 5 years
a. A list of participating partners involved in the CHA process. Participation must include: i. At least 2 organizations representing sectors other than governmental public health. ii. At least 2 community members or organizations that represent populations who are disproportionately affected by conditions that contribute to poorer health outcomes.	Participating partners may engage in the CHA in a variety of ways. Participation could include, for example, serving on a steering committee or workgroup for conducting the CHA, contributing to data collection, or contributing to data interpretation. Involving impacted communities in the assessment will inform decisions about what data are collected and how they are interpreted in order to better understand the issues facing those communities, as well as resources or assets to address needs. The collaborative assessment will lay the groundwork for continued engagement in identifying and prioritizing potential solutions to improve community health (addressed in Measure 5.2.1 about the state/Tribal/community health improvement plan). **For required element a:** Partners that represent various sectors of the community could include, for example: hospitals, behavioral health, community clinics, and other health care providers; mortality review committees or boards; environmental public health groups; community foundations and philanthropies; volunteer organizations; religious organizations; community organizers and advocates; unions; parent-teacher associations, tenants, or volunteer organizations; or real estate representatives. The partnership will include community members directly or include organizations representing those populations who are disproportionately affected by conditions that create poorer health outcomes or for whom systems of care are not appropriately designed. Individuals or organizations that represent populations who have lived experiences with or are disproportionately affected by conditions that contribute to poorer health outcomes could include, for example: historically excluded or marginalized population groups, communities of color, indigenous communities, LGBTQ populations, individuals with limited English-speaking abilities, individuals with disabilities, immigrants, refugees, aging populations, or individuals who are blind, deaf, or hard of hearing. Organizations that represent populations or have expertise addressing inequities could include, for example, local, state, or regional networks and agencies, not-for profits, or civic groups representing specific issues or subpopulations. (If it is unclear from the documentation who participants are, it may be indicated in the Documentation Form—for example, to clarify who are community member representatives.)		

MEASURE 1.1.1 A: Required Documentation 1	Guidance	Number of Examples 1 community health assessment	Dated Within 5 years
b. The process for how partners collaborated in developing the CHA.	Partners in the CHA process may also include other public health entities, such as public health institutes, other health departments, or military installation departments of public health located in or near the health department's jurisdiction. Some examples of partners specific to the Tribal setting include other divisions within the Tribal government that may be outside the public health department division (e.g., environmental health, health care, or mental health). There may also be key partners who are external to the Tribal government, such as Tribal Epidemiology Centers; state or local health departments; or businesses. Tribal health departments may self-determine who the partners are and the number of partners that are most appropriate to include in the development of a community health assessment. **For required element b:** The process will describe how partners engaged, which could include, for example, recruitment of participants, roles of participants, frequency of meetings or other methods of convening partners, or use of engagement strategies such as stakeholder analysis or power mapping. The process could also describe, for example, the timeline for the assessment, or how data were assessed to draw conclusions about health issues and needs. The process may follow a national model; state-based model; a model from the public, private, or business sector; or other partnership and community participatory process model. Models could include, for example, Mobilizing for Action through Planning and Partnership (MAPP; NACCHO), Association of Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US), SHIP Guidance and Resources (ASTHO), or the University of Kansas Community Toolbox.		

MEASURE 1.1.1 A: Required Documentation 1	Guidance	Number of Examples 1 community health assessment	Dated Within 5 years
c. Comprehensive, broad-based data. Data must include: i. Primary data. ii. Secondary data from two or more different sources.	Required elements c-g are the data and information that comprise the assessment itself. **For required element c:** Primary data are data for which collection is conducted, contracted, or overseen by the health department or CHA partnership. The CHA will indicate which data are primary by, for example, describing the methodology for data collection or listing the health department or CHA partnership as the data source. Data collection methods could include, for example, asset mapping, community forums, community listening sessions, surveys (e.g., surveys of high school students or parents), or focus groups (e.g., sessions discussing community health issues). Such information often provides additional context or details to help interpret secondary data sets. Non-traditional and non-narrative data collection techniques are acceptable forms of data collection. For example, an assessment could include photographs taken by members of the Tribe or community in an organized assessment process (e.g., photovoice) to identify environmental (including the built environment) health challenges, causal loop diagrams, iceberg models, or use of empathy mapping or ethnographic interviews to gather an understanding of current and historical inequities and their impact. Secondary data sources might include federal, Tribal, state, and local data. If the data collection is conducted, contracted, or overseen (i.e., the data collection instruments are designed) by the health department or the CHA partnership as a whole, it would not meet the intent of the element. However, data collected by a single partner of the collaborative (e.g., EHR data from a hospital that is part of the CHA partnership) would be appropriate. Specific secondary data sources could include, for example, Behavioral Risk Factor Surveillance Survey (BRFSS)/Youth Risk Behavior Surveillance (YRBSS) (if not collected by the health department), County Health Rankings, CDC Disability and Health Data System, CDC Social Determinants of Health (SDOH) and PLACES Data, US Census American Community Survey or Factfinder, AHRQ Social Determinants of Health Database, HRSA Area Health Resource Files, Dartmouth Atlas of Health Care, National Health Indicators Warehouse, CDC Wonder, PH WINS, SAMHSA's Behavioral Health Barometer, CityHealth, or Tribal Epidemiology Center data. Other secondary sources could include: vital statistics (if not collected by the health department); notifiable conditions data; clinical and administrative data collected by hospitals and/or health care providers, such as hospital discharge rates or insurance claims; local and state chart of accounts; data from local schools, academic institutions, or other departments of government (e.g., recreation, public safety, environment, housing, transportation, labor, education, or agriculture); or data from community not-for-profits (e.g., Aging and Disability Resource Centers), 211 data, community narrative, or other sources of nontraditional community information.		

MEASURE 1.1.1 A: Required Documentation 1	Guidance	Number of Examples 1 community health assessment	Dated Within 5 years
d. A description of the demographics of the population served by the health department, which must, at minimum, include: i. The percent of the population by race and ethnicity. ii. Languages spoken within the jurisdiction. iii. Other demographic characteristics, as appropriate for the jurisdiction.	**For required element d:** In addition to ethnic and racial composition and languages spoken, demographic information could also include, for example, gender, age, socioeconomic factors, income, disabilities, mobility (travel time to work), educational attainment, home ownership, employment status, immigration status, or sexual orientation.		
e. A description of health challenges experienced by the population served by the health department, based on data listed in required element (c) above, which must include an examination of disparities between subpopulations or sub-geographic areas in terms of each of the following: i. Health status. ii. Health behaviors.	**For required element e:** The intent of required element e is to present a summary of themes and findings based on the data in required element c, above. To examine what disparities may exist in the health status in the community, the CHA could include differences in rates of, for example, illness, death, chronic conditions, self-reported health and well-being, and other types of health outcomes in relationship to demographic factors (e.g., race, ethnicity, gender, sexual orientation, disability status or special health care needs, or geographic location). Similarly, the CHA will examine differences in health behaviors, for example, smoking or vaping rates, eating or exercise habits, or high-risk sexual behavior. Examples of ways the data could be presented include, for example, a table, or cross-tabulation that demonstrates differences in chronic disease morbidity by race and ethnicity; differences in smoking rates by age; or a map showing poorer health outcomes by zip code. It could also include a description of how themes from focus groups or townhalls varied based on neighborhood or demographics of participants.		

MEASURE 1.1.1 A: **Required Documentation 1**	**Guidance**	**Number of Examples** 1 community health assessment	**Dated Within** 5 years
f. A description of inequities in the factors that contribute to health challenges (required element e), which must include social determinants of health or built environment.	**For required element f:** Health equity relates to social justice in health; that is, everyone has a fair and just opportunity to be as healthy as possible. The description of factors that contribute to inequities may relate to conditions that vary by population, for example, the availability of affordable housing for low- and middle-income families; availability of culturally and linguistically appropriate services for limited English-speaking populations; or how conditions vary by neighborhood such as school funding or access to health services. Inequities related to the built environment might include vulnerability to climate change, or the availability of grocery stores, parks, sidewalks, or transportation. As part of identifying factors that contribute to health challenges within the community, the description may also address related policies (e.g., taxation, education, transportation, or insurance status), social or structural determinants of health, or other the unique characteristics of the community that impact health status. Social determinants of health include factors in which people are born, live, and grow that influence health beyond a person's control. Social determinants **may** include structural determinants or "root causes" of health inequities. Structural determinants include factors such as the political, economic, or social policies that affect income, education, or housing conditions. The structural determinants affect whether the resources necessary for health are distributed equally in society, or whether they are unjustly distributed according to race, gender, social class, geography, sexual orientation, or other socially defined group of people. The description could include equity indicators, for example, the Social Vulnerability Index or the Index of Concentration at the Extremes.		
g. Community assets or resources beyond healthcare and the health department that can be mobilized to address health challenges. The CHA must address the jurisdiction as described in the description of Standard 1.1.	**For required element g:** The intent of this required element is to ensure that when assessing the health of the community, the partnership is also learning about the assets and resources that can enhance community well-being. The CHA does **not** need to include an exhaustive list of all assets. A section may be dedicated to assets or resources, as a list or narrative, or they may be woven throughout the document. Examples of assets and resources could include, for example, local parks or recreation centers, farmers' markets, public facilities available at a school, or mutual aid groups or support circles. Intangible assets and resources could also be included. The CHA could spotlight strengths including, for example, stories that demonstrate community leadership, examples of social cohesion, or indications of social capital (e.g., number and diversity of civic organizations).		

MEASURE 1.1.2 A:

Collaborate on and use the community health assessment process.

Purpose & Significance

The purpose of this measure is to assess both how the community health assessment partnership has evolved to deepen its focus on diversity, equity, and inclusion; and how the community health assessment has been used to support efforts to improve population health. The partnership engaged in the assessment process will change over time to develop a thorough understanding of the health needs and assets throughout the jurisdiction. The CHA is a resource for all members of the public health system and the population at-large. It serves as a foundation for collaboration, priority setting, planning, program development, funding applications, coordination of resources, and new ways to collaboratively use assets and resources to improve population health.

MEASURE 1.1.2 A: Required Documentation 1	Guidance	Number of Examples Narrative description	Dated Within 5 years
1. Evolution of the community health assessment partnership's membership with a diversity, equity, inclusion lens.	The intent of this requirement is to describe how participation in the state/Tribal/community health assessment partnership has evolved since the previous accreditation cycle in a way that, for example, intentionally seeks to be inclusive of diverse perspectives and stakeholders from groups that have been historically excluded or marginalized, considers how power dynamics are addressed in a manner that shifts power to community voices, considers how members of the partnership can better understand inequities in the community, or partners with community members and people with various lived experiences and expertise. This could include, for example, adding new or different members to provide additional perspectives or working to retain or more actively engage members. Health departments can consider a range of approaches in their efforts to intentionally elevate the voices of those that have been traditionally disenfranchised, such as the use of frameworks or models (e.g., Ladder of Participation) or using power mapping as they consider who is included in the CHA partnership. New members can provide additional data sources, information, resources, and different perspectives to the community health assessment. Potential partnerships may be shaped based on health disparity data. For example, if the data show disparate outcomes among individuals with disabilities, the CHA partnership may wish to obtain representation from community leaders or local or regional aging or disability agencies, or to engage an Inclusive Health Coalition (composed of community members, self-advocates, families, community or faith leaders, and health care providers with disability health expertise). It is **not** necessary to increase the total number of members. The narrative could describe efforts to change the composition of the partnership to better represent or learn about the community. Additional sectors could include, for example, local or state government (e.g., elected officials, law enforcement, correctional agencies, housing and community development, economic development, parks and recreation, planning and zoning, school boards, family and child services, or homeless services); businesses and industries; chambers of commerce; or academic institutions. Efforts to increase inclusiveness could help the partnership retain or more actively engage existing members or could potentially encourage participation from new and more diverse members. Efforts could include, for example, providing stipends, addressing barriers to participation (i.e., lack of childcare), or meeting in locations that are more accessible to community members. In smaller or rural communities, efforts might entail adding only one new partner (e.g., community-based organization or community college) or expanding the reach to include county, regional, or state partners. Regional partnerships may help rural jurisdictions with sparse populations to tackle common issues, such as gaining a better understanding of inequities and strategies to address them.		

MEASURE 1.1.2 A: **Required Documentation 2**	**Guidance**	**Number of Examples** 1 example (narrative of an example is acceptable)	**Dated Within** 5 years
2. Use of the community health assessment by either the health department or partner(s). The example must go beyond how the health assessment was used in the development of the health improvement plan.	The state/Tribal/community health assessment provides a foundation for efforts to improve the health of the population. In addition to being the basis for development of the health improvement plan, it could be used, for example, as a basis for setting priorities, planning, program development, funding applications, policy changes, and coordination of community resources and collaborative use of assets. While the example could include how the assessment was used in developing the health improvement plan, it will also include a specific use beyond planning purposes. For example, the example could show how using the assessment data, as part of the planning process, also led the health department to pursue a funding opportunity with its planning partners.		