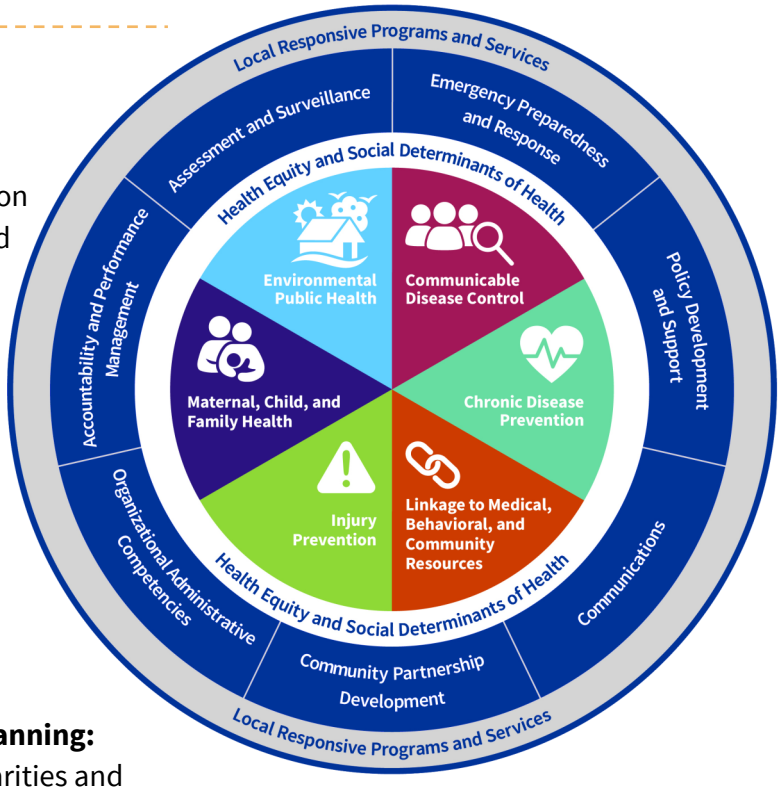
ASSESSMENT AND SURVEILLANCE

1 **AREA OF EXPERTISE FOCUS:**

2 Review health disparities data (sources on pg 4) among different demographic groups, related to this area of expertise. Then use the discussion prompts and resources below to identify action steps to increase capacity in the intersect between this capability and area of expertise.



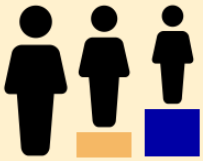
Assessment and Surveillance include the public health agency's ability to collect, access, analyze, and utilize data to guide public health planning and decision making. It includes the ability to prioritize and respond to data requests, translate data into understandable reports, identify data related to health inequities and social determinants of health, and prioritize public health work based on data.

#HealthierMO recommends three key steps in the assessment and surveillance process.

Prepare for a community health assessment: Identify key partners, an equitable framework, and the data necessary to assure systematic, comprehensive data collection and analysis.

Prepare for community health improvement planning: Consider how you will benchmark health disparities and priorities, identify key health indicators, and build shared power in decision-making.

Monitor through surveillance: Monitor population health issues and disparities in your community using surveillance for ongoing, systematic collection, analysis, and interpretation of health-related data.



INFUSING HEALTH EQUITY

Choose a community health assessment model that fosters shared power for informing and making decisions. Include the full range of community members in the community assessment process to hear diverse perspectives and experiences. Choose health indicators that account for inequality and social conditions. Advocate for a community health improvement vision that seeks to create the conditions where everyone can thrive.

Gary Zaborac, Clay County Public Health Center

"In 2009, the Supreme Court finally said the Affordable Care Act was here to stay. And there was a clause, an IRS 990 requirement that not-for-profit hospitals had to participate in community health assessments and they had to engage with their local health departments. Before that point, Vision North had been doing a community health assessment and hospitals had been doing their own. So we called a time-out and said, 'It doesn't make sense to be duplicating all of this work. Why don't we work together and just do one?' Once we started working together, we made some real traction. Now we create one community health improvement plan as well. It has evidence-based strategies for health equity and social determinants of health built into it."

Spotlight

PREPARE FOR A COMMUNITY HEALTH ASSESSMENT

The Public Health Accreditation Board (PHAB) recommends public health agencies participate in **community health improvement planning** at least every five years. This work begins with a **community health assessment**. The Affordable Care Act requires non-profit hospitals to complete a community health needs assessment and strategic implementation planning every three years to guide community benefit expenditures. Many jurisdictions have found significant benefit in collaborating on assessment and improvement planning.

Review the toolkits below to familiarize your team with the process of conducting a community health assessment. Refer back to these tools when you are ready to complete a community health assessment.

Mobilizing for Action through Planning and Partnerships (MAPP), NACCHO

Community Health Assessment Toolkit, Healthy Communities

1. Who should be engaged in the community health assessment processes to ensure diverse perspectives, inclusive representation, and lived experience?

The social determinants of health can positively or negatively influence population health. Intentionally instill an equity frame into community health assessment and improvement planning processes, beginning with assuring involvement from a diverse group of partners, stakeholders, and community members with lived experience.

2. What kinds of data do we need to collect and analyze in order to ensure we truly understand health inequities through our community health assessment?

Refer to the Community Partnership section of this workbook to draw ideas from a list of credible data sources.

PREPARE FOR COMMUNITY HEALTH IMPROVEMENT PLANNING

Review the tools below to better understand the overall process of developing a community health improvement plan that focuses on **priority health issues** informed by **data** from your community health assessment. Refer back to these tools when you are ready to complete a community health improvement plan.

Community Health Assessment and Health Improvement Planning, CDC

Community Health Improvement Toolkit, Health Resources in Action

3. How can we prepare to benchmark health disparities and health priorities as we analyze community health assessment data? What might the most important indicators be for our community?

Review benchmarks from the credible sources below.

Healthy People 2030, US Department of Health and Human Services (DHHS)

County Health Rankings and Roadmaps, Robert Wood Johnson Foundation

Missouri Kids Count Data Book, Annie E Casey Foundation

Data and Benchmarks, CDC

4. How might we build shared power to guide and make decisions through the community health improvement planning process?

Embracing Equity in Community Health Improvement, Health Resources in Action
Learn how to comprehensively integrate equity into the community health improvement planning process.

Spectrum of Participation, IAP2 International Federation
Review this model to determine the level of public participation you will commit to embrace.

Refer also to the Community Partnership Development section of this workbook for additional information.

MONITOR THROUGH SURVEILLANCE

Surveillance contributes to better prevention and management of diseases. Data collection and monitoring improves public health capacity by equipping agencies to set priorities and develop targeted interventions to prevent, slow, and stop disease transmission. This protects everyone, especially the most vulnerable community members.

5. How might we more effectively collect data from multiple sources to illuminate health disparities?

6. How might we more effectively arrange and analyze data by age, gender, race/ethnicity, gender, and other socioeconomic and environmental factors?

7. How might we more effectively use surveillance to monitor health disparities in our community?

8. How might we more effectively use the data we have to guide planning and decision-making?

Data Sets and Mapping Tools, Build Healthy Places Network
Use these mapping resources to sort data by zip code and demographic and socioeconomic factors.

9. How might we more effectively share and communicate data with our partners, stakeholders, and communities?

10. What additional training would enhance surveillance activities around this area of expertise?

TRAINING RESOURCES

Introduction to Public Health Surveillance, CDC

Public Health Foundation's Modified Competency Assessment
Ask each staff member to complete the Analytical/Assessment Skills section (pg 4).

NEXT STEPS

When you are ready to complete a community health assessment and community health improvement plan, revisit the tools below.

Mobilizing for Action through Planning and Partnerships (MAPP), NACCHO

Community Health Assessment Toolkit, Healthy Communities

Community Health Assessment and Health Improvement Planning, CDC

Community Health Improvement Toolkit, Health Resources in Action

Spotlight

Kelley Vollmar, Jefferson County Health Department

"Jefferson County does not have a lot of diversity, so our health inequities tend to fall along the lines of access to care. We have about four main highways that go throughout the county, and basically all of our medical facilities are on the eastern portion of our county. All the western portion, especially southwest, lacks access to medical care – access to a lot of services in terms of food deserts and others. What we try to do with our programs is look at how we manage to take care to those areas, whether that's through our mobile units – dental and wellness units – but also going to do onsite visits and onsite services when we can at churches and schools to be able to better ensure that those populations have just as much access to important services of prevention and treatment as individuals living on the eastern side of our county."

3 ASSESSMENT AND SURVEILLANCE: OUTCOMES AND ACTION STEPS

Included in the Potential Outcomes column below are the capacities required to fully assure this foundational capability. Refer to your Capacity Assessment Snapshot or Toolkit reports to review your agency's most recent self-assessment findings. Then use the table below to identify action steps you will take to close gaps and achieve full capacity to assure the FPHS model in your community. Edit the table or use your own planning tool to prioritize next steps. Refer back to tools provided in this workbook to support action steps.

Potential Outcome	Action Steps	Timeline	Resources	Assigned To
We collect primary public health data				
We access, analyze, use and interpret data from a number of credible sources				
We access, analyze, use and interpret data from the universal chart of accounts				
We conduct a community health needs assessment				
We contribute local health needs assessment findings to a statewide health needs assessment				
We identify health priorities arising from a community health needs assessment, including identifying health outcome disparities				
We respond to data requests with meaningful reports				
We report data stratified by age, race/ethnicity, gender, and socioeconomic status				
We develop and maintain electronic health information systems				
We access and utilize electronic health information systems				
We access 24/7 laboratory resources capable of providing rapid detection of disease				

RESOURCE

Fillable Logic Model template