

## Community Health Status Assessment

The Community Health Status Assessment (CHSA) answers the questions, “How healthy are our residents?” and “What does the health status of our community look like?” The results of the Community Health Status Assessment provide the MAPP Committee with an understanding of the community’s health status and ensure that the community’s priorities include specific health status issues (e.g., high lung cancer rates or low immunization rates).

The Florida Department of Health’s public health statistics website, Community Health Assessment Resource Tool System (CHARTS; [www.floridacharts.com](http://www.floridacharts.com)), provides the data elements for broad-based categories of health status and quality of life indicators. The categories include Population Characteristics, Chronic Diseases, Communicable Diseases, Maternal and Child Health, Environmental Health, Injury and Violence, Social and Mental Health and Health Resources Availability. Numerous reports are also available on CHARTS including county health profiles, major causes of death, county health status comparison, county birth data comparison and state county Behavioral Risk Factor Surveillance (BRFSS) results. For many indicators, trend lines, maps and bar graphs are available. CHARTS offers features such as exportability to Microsoft Excel and data sorting for custom comparisons. Data reports and graphics are readily exportable to Microsoft Word, a desirable feature for community partners preparing their community health status profile reports.

By reviewing the data for each of the categories on CHARTS and comparing county data to trend information, peer county and state data, local health issues can be identified and prioritized.

### Recommended Participants and Roles:

- **Subcommittee** — designs and prepares for the Community Health Status process, oversees the review and analysis of data, and compiles results.
- **MAPP Committee** — oversees subcommittee activities, provides recommendations for collecting additional community level data and community input.
- **Broad Community Involvement** —should already be incorporated into the committee membership; however, if additional participants are desired for this process they should be recruited.

### A Step-by-Step Overview of the Community Health Status Assessment Phase:

1. **Establish a subcommittee** and plan how the Community Health Status Assessment steps will be undertaken.
2. **Access health status data** and begin the review of county and state level data. Review previous assessment efforts and build from these, as needed. Health status data are available at [www.FloridaCharts.com](http://www.FloridaCharts.com)
3. **Organize and present the data** in understandable narrative, charts and graphs in a community health profile report. Widely disseminate the community health profile report.
4. **Establish a system to monitor the indicators over time.** Modify or add to the indicators periodically, as new information arises from other phases of MAPP.
5. **Identify challenges and opportunities** related to health status that should be considered during the next phase of MAPP, Identifying Strategic Issues.

## Introduction

### The Community Health Status Assessment

The Community Health Status Assessment answers questions such as, “How healthy are our residents?” “What are the leading causes of death and illness among residents? How do the lifestyle behaviors of our residents contribute to the community’s overall health status? “What are the socio-demographic and economic factors impacting the health and quality of life of our community? How does the health status of our community compare to that of ten years ago; to that of other communities; to that of the state and the nation?”

A Community Health Status Assessment is the process or work of collecting, analyzing, and reviewing public health data to describe population health status, develop priorities, and plan actions to improve public health outcomes. During the community health assessment process, community partners and local public health leaders review health and quality of life data to identify the health conditions, strengths, resources and health care needs of their community.

The results of the Community Health Status Assessment provide the MAPP Committee with an understanding of the community’s health status and ensure that the community’s priorities consider specific health status issues, such as high lung cancer rates or low immunization rates. The Community Health Status Assessment provides a list of core indicators in several broad-based categories. Communities may also select additional indicators.

A community health status assists public health and emergency management personnel with their readiness and preparedness plans, providing pertinent information about the population at risk. By gathering data for each of the categories and assessing changes over time or differences among population subgroups or with peer, state, or national data, health issues are identified.

### The Community Health Profile Report

The findings of a Community Health Status Assessment should be described in a written report, often referred to as a community health profile report. The community health profile report commonly includes information about the health of the community as it is today and about the community’s capacity to improve health status for the future.

The community health profile report includes indicators and narrative about the demographic and socioeconomic characteristics, health status, health risk factors, health resource availability, quality of life, and perceptions of health that are relevant to the community. The profile should contain a combination of narrative, data tables, comparison graphs, and trend lines. Finally, the priority issues identified by community partners should be listed and described.

The community health profile report should be distributed throughout the community to serve as the basis for discussion, strategizing and action planning. The report can help a community maintain a strategic view of its population’s health status and factors that influence health in the community.

Health profile reports can motivate community leaders to address specific health issues. For example, if a community has a higher than average rate of alcohol related motor vehicle injuries and deaths as well as evidence of binge drinking among younger men, this evidence may signal that community action may be needed by law enforcement, establishments that sell alcohol, and the school system. Or another indicator may be a low rate of influenza vaccination among a large population of persons over age 65. Local public health system leaders, senior centers and care providers may want to work together to improve the vaccination rate among those over age 65.

Community health profile reports serve as reference documents that can be used by community partner coalitions as they present their priority issues to the public at large. Community health profile reports can also be used to complete grant applications for funding of identified priorities.

## How to Conduct the Community Health Status Assessment

### ***Step 1- Establish the Community Health Status Assessment Subcommittee***

A subcommittee should be designated to oversee the Community Health Status Assessment. Members should include individuals who can assist with access to data as well as data collection, analysis, and interpretation. Community representatives also provide an important perspective. In addition, since it is critically important that data be monitored over the long term, select some members who can participate in future years. This is not just an ad hoc, one-time effort. Once the subcommittee is assembled, members should review the Community Health Status Assessment steps and identify the skills and resources needed to conduct the activities.

### **Recommended Participants and Roles for the Community Health Status Assessment and Community Profile Report**

- **MAPP Committee** — oversees subcommittee activities, provides recommendations for collecting data and gathering community input.
- **Community Health Status Assessment Subcommittee** — designs and prepares for the Community Health Status Assessment process, oversees the collection and analysis of data, and compiles results.
- **Broad Community Involvement** —should already be incorporated into the committee membership; however, if additional participants are desired for this process they should be recruited.

### ***Step 2 - Access [www.floridacharts.com](http://www.floridacharts.com) and Begin the Review of County and State Level Data***

Review previous assessment efforts and build from these, as needed.

- a. **Open the County Profile Report.** This report, found on [www.floridacharts.com](http://www.floridacharts.com), provides the basic set of indicators from which a community can begin its health status assessment. Reviewing the data in this report should be a starting point for the process. Printing this report and disseminating it among the MAPP subcommittee for the Community Health Status Assessment is a good starting activity. Once all committee members have had an opportunity to review the report, discussions on each of the health areas can begin.
- b. **Review each of the domains of CHARTS.** CHARTS is structured by the health topics rather than by specific health data sets. The topics were adopted from the health areas recommended by NACCHO for the MAPP process. CHARTS' domain categories are listed below. In the future, additional health topics may be added as they emerge as priority issues:
  - Population Characteristics
  - Communicable Diseases
  - Chronic Diseases
  - Maternal and Child Health
  - Environmental Health
  - Injury and Violence
  - Social and Mental Health
  - Health Resources Availability

- c. Conduct an analysis of the demographic and socioeconomic characteristics of the county including age structure, gender, race, population density, overall population growth trends, poverty levels and median income data.** Compare the county indicators with those of peer counties and the state. Note any differences and similarities.

Analysis of socio-economic and demographic data offers crucial insight into characteristics of the community that are important for understanding current or potential health concerns. Additionally, review of this data provides insightful information about factors such as economic resources, health care access, and education that contribute to health disparities among special population groups.

- d. Continue the data analysis by reviewing the other domains on CHARTS.**
- e. Review trend and comparison data.** The CHARTS website contains trend data and cartographic maps for most indicators. Florida CHARTS provides trend data over three- and ten-year periods. Some indicators have twenty- year trend lines available. Attempt to collect a minimum of five years of data to analyze trends over time. Comparison data — state, national, and peer community data — should also be reviewed during this phase.

Various county comparison reports are available on CHARTS. Look for connections between indicators in different categories. For example, smoking-related behavioral risk factors might correlate with high smoking- related cancer rates. Alcohol-related behaviors may be related to injury rates, motor vehicle accidents, crime rates or liver disease death rates

- f. Select additional data indicators to explore issues important to the community. Identify additional data indicators by developing locally relevant indicators.** Collect data for the additional indicators.

Local level indicators might be selected related to community interest in a specific topic, demographics in the area (e.g., an aging population) or findings highlighted by the committee from the review of CHARTS. Some suggested activities include:

- Accessing previously conducted health assessments or reports that include data.
- Identifying committee members who may have access to community level data through their organizations.

Consider whether steps are needed to ensure that data are valid and usable. Sparsely populated communities and neighborhoods have the unique challenge of interpreting "low numbers or incidence" into usable information. For suggestions on how to address this issue, see the section on [Data Issues in Jurisdictions with Small Populations](#).

### ***Step 3 - Organize the Data and Present it in Understandable Narrative, Charts and Graphs in a Community Health Profile Report***

The findings of a Community Health Status Assessment should be described in a written report, the community health profile report. The community health profile report commonly includes information about the health status of the community as it is today and about the community's capacity to improve health status for the future.

The profile should contain a combination of narrative, data tables, comparison graphs, and trend lines. Finally, a list of the most compelling issues associated with the data findings from this assessment should be included. The most prominent findings should be organized and captured in a brief summary. Consolidating the findings from this assessment will help to organize and

identify key challenges and opportunities related to health status as well as assist in recognizing crosscutting issues from the other three assessments.

The community health profile report should be disseminated and shared with the community as the basis for discussion, strategizing and action planning. The health profile report can help a community maintain a strategic view of its population's health status and factors that influence health in the community.

If possible, also publish an executive summary report. If this is not feasible, a series of fact sheets or a central website may be equally useful. What is important is that the information is compiled, is easily understood by the general public and made available through one central location.

Develop a proactive dissemination strategy, including promoting the information through the media (newspapers, local television, or radio stations). This helps to reach a broad audience. See the Tip Sheet – [Engaging the Media](#) for more information.

### **Benefits of Having a Community Health Profile Report**

Health profile reports can:

- Highlight relationships between health status and determinants of health (social, environmental, behavioral and health care resources).
- Define comparisons with other communities, the state or nation
- Motivate community leaders to address specific health issues.
- Serve as reference documents that can be used by community coalitions as they present their priority issues to the public at-large.
- Assist community partnerships with decisions on how to allocate resources.
- Provide data driven information to assist individual community agencies with the development of their agency specific strategic plans.
- Assist community partners with grant applications for funding for desired interventions
- Bring community members together around issues of interest to build coalitions and collaboration.

### ***Step 4 - Establish a Process to Monitor the Indicators Over Time***

During this step, the subcommittee establishes a procedure for monitoring the selected indicators. This helps to ensure that continuous health status monitoring occurs and establishes baseline data upon which future trends can be identified. This process will also be instrumental in identifying the results of the MAPP process and evaluating the success of activities.

Sustainable monitoring systems require a clear definition of roles, including leadership, coordination, and communication. Data on CHARTS will be available on an annual basis in an easily downloadable format. The monitoring system should be responsive to new information that results from the other three MAPP assessments and from the selection of strategic issues. The monitoring system is especially important to the evaluation component of the MAPP Action Cycle.

### ***Step 5 - Identify Challenges and Opportunities Related to Health Status***

The Community Health Status Assessment should result in a list of challenges and opportunities related to the community's health status. Data findings should be reviewed to identify challenges, such as major health problems or high-risk behaviors and opportunities, such as improving health trends. Ideally, the final list will include 10-15 community health status issues that will be more closely examined in the next phase of MAPP, Identifying Strategic Issues.

## **Presenting Data**

The MAPP process will generate a great deal of data. It is important that these data are well understood throughout the community. Presenting data in a clear and concise manner helps emphasize the important findings and results of the MAPP Community Health Status Assessment process.

Data can and should be presented in variety ways. These include:

- written updates of the process (e.g., newsletters, reports, and summaries of findings);
- presentations made to the community and media, and
- the maintenance of an open and public process.

### **Presenting Data in Written Reports**

**Helpful Hints:** Use an attractive and colorful layout. Keep the community and media updated throughout the process. Consider launching a newsletter or publishing information in a report. Highlight only the important facts or findings. Don't waste space on details. Use clear, simple charts. The easier they are to understand, the better. Summarize major findings in as many places as possible. Write in a clear, simple style that can be understood by readers without a public health background. Acknowledge community perceptions of public health. If there is a specific area of interest, address it. Know your audience. Carefully select visual aids and language that will be understandable and interesting to participants. Double check all data and information presented. Incorrect data can affect the perceived credibility of the presenter and of the entire process.

In both graphic and narrative data reports make sure to include trend analysis, and comparisons. Compare community data to county data and compare county data to state data and to national data whenever such data points are available.

### **Oral Presentations**

**Helpful Hints:** Keep presentations brief — less than 30 minutes per issue. Invite special interest groups and representatives from all community organizations. Cover only the highlights. What is unusual, either in number or by trend? What finding may be of particular concern to the community? Use visual aids that highlight only important information. Clear, simple charts get the point across better than numbers. Stimulate interaction. Encourage discussion about areas of specific interest. Be organized. Have information on hand that may be of interest to participants. Use everyday language. Scientific or statistical jargon may be unnecessary and confusing. Keep it simple. Be clear and concise. Summarize. Spend the last two minutes reviewing the major findings so that participants don't get lost among all the facts. Give participants summary handouts and fact sheets. Check equipment in advance to ensure they function properly. Have back-ups available in case of equipment failure. Use maps of geographic areas to show what the information means to different communities or neighborhoods.

## Data Issues in Areas with Small Populations

Data collection is an integral part of the assessment function of public health. The challenge is to collect and convert data into useful information that provides a composite picture of the community's health.

Sparsely populated or small communities have the unique challenge of translating "low numbers or incidence" into usable information. Low numbers or incidence can produce unstable rates that greatly fluctuate from year to year. In addition, a "snapshot" view of one year may not adequately represent the true status of the community's health. Also, smaller communities may not have access to individuals with expertise in data analysis. For these reasons, the collection and analysis of data may be an especially large barrier to community health assessment in communities with small populations.

### Statistical Instability

There are two potential ways to avoid or address the statistical instability with which jurisdictions with low populations are faced. It is recommended that such communities consider one of the following approaches:

- Combine multi-year data (e.g., data for three years). A drawback to this option is that looking at multi-year data limits the ability of the jurisdiction to monitor program interventions and identify new trends. Rolling year averages (e.g., looking at data for 1997-2000 one year, and 1998-2001 the following year) may overcome this drawback and should be considered.
- Expand the geographic area by conducting a regional health assessment in collaboration with neighboring jurisdictions. A drawback to this option is that the community may then be looking at geographical areas over which it has no control. Analyzing data at the regional level may also mask interesting local variations in the data.

Both of these approaches increase the number of events under analysis. It is recommended that all indicators be based on 20 or more events (i.e., infant deaths, low birth-weight infants, etc.) In general, the higher the number of events, the more stable is the data. Confidentiality issues must also be considered when the number of events is small.

### Other Data Considerations

The following tips may be useful to communities that do not have access to epidemiological expertise in data analysis.

Data should be considered in light of the following questions: What are the sources of these data? Are the sources reliable? What are the issues raised by the data? Are key pieces of information missing and can they be obtained? Are there any other considerations regarding the health issue that need to be taken into account when analyzing the data? Can a summary statement be made about the numbers?

Consider the following issues:

- The manner in which the data are collected is very important. In analyzing communicable disease information, consider the reporting system that exists in the state or locality and the kind of data that would be produced.
- Consider the sampling frame used in gathering the data to ensure that all special high-risk populations are included. For example, university populations should be

included when looking at youth issues, while nursing home or retirement communities should be included to get a valid rate for aging issues.

- Consider time-related issues when looking at certain health issues or diseases (i.e., the amount of time it may take for a program intervention to show results). For example, a decrease in cancer rates may be indicative of the success of program interventions that took place many years earlier.
- Years of Potential Life Lost (YPLL) is a good indicator that can provide additional information about the important causes of premature death in a community. For example, consider the number of deaths due to injuries in a community. Although the actual number of deaths due to injuries might be low, the impact of this problem could be highlighted if the YPLL is high (indicating that deaths due to injuries cause a disproportionate loss of potential productivity in younger populations).
- Consider that a substantial change in a single indicator (e.g., number of cancer deaths increasing from 20 to 30 [or a 50% rise] over one year) may not necessarily represent a trend or pattern. While troubling to the community, this may be a normal variation in reporting. Situations like this may present an opportunity to engage the community in the science of epidemiology. Exploring risk factors may increase the participants' appreciation for health planning, community health status assessments, and related activities.

**References:**

American Public Health Association. Healthy Communities 2000: Model Standards. Washington, DC: 1991, pp. 458-459.

## Terminology - Community Health Assessment

**Behavioral Risk Factors:** These are measures of behaviors that are believed to cause, or to be contributing factors to, accidents, injuries, disease, and death during youth and adolescence and significant morbidity and mortality in later life.

**Communicable Disease:** Measures within this category include diseases that are usually transmitted through person-to-person contact or shared use of contaminated instruments/materials. Many of these diseases can be prevented through the use of protective measures, such as a high level of vaccine coverage of vulnerable populations.

**Community:** The aggregate of persons with common characteristics such as geographic, professional, cultural, racial, religious, or socioeconomic similarities. Communities can be defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other common bonds.

**Community Health Improvement Process:** Community health improvement is not limited to issues classified within traditional public or health services categories, but may include environmental, business, economic, housing, land use, and other community issues indirectly affecting the public's health. The community health improvement process involves an on-going collaborative, community-wide effort to identify, analyze, and address health problems; access applicable data; develop measurable health objectives and indicators; inventory community health assets and resources; identify community perceptions; develop and implement coordinated strategies; identify accountable entities; and cultivate community "ownership" of the entire process.

**Community Health Profile:** A comprehensive compilation of measures representing multiple categories that contribute to a description of health status at a community level and the resources available to address health needs. Measures within each category may be tracked over time to determine trends, evaluate health interventions or policy decisions, compare community data with peer, state, nation, or benchmark measures, and establish priorities through an informed community process.

**Community Partnerships:** A continuum of relationships that foster the sharing of resources, responsibility, and accountability in undertaking activities within a community.

**Environmental Health Indicators:** The physical environment directly impacts health and quality of life. Clean air and water, as well as safely prepared food, are essential to physical health. Exposure to environmental substances, such as lead or hazardous waste, increases risk for preventable disease.

**Geocode:** Addresses matched and assigned to a corresponding latitude and longitude (Healthy People 2010, chapter 23-22). The process of assigning geographic location information to attribute data that are to be used for analytic purposes.

**Geographic information system (GIS):** Combines modern computer and supercomputing digital technology with data management systems to provide tools for the capture, storage, manipulation, analysis, and visualization of spatial data. Spatial data contains information, usually in the form of a geographic coordinate system, that gives data location relative to the earth's surface. These spatial attributes enable previously disparate data sets to be integrated into a digital mapping environment. (Healthy People 2010, chapter 23-22). Geographic information systems that are computer based processes for capturing, lining, summarizing, and analyzing data containing geographical location information. These systems are particularly useful in

supporting visual analysis and communication of data using maps that display the geographic distribution of data.

**Health Assessment:** The process of collecting, analyzing, and disseminating information on health status, personal health problems, population groups at greatest risk, availability and quality of services, resource availability, and concerns of individuals. Assessment may lead to decision making about the relative importance of various public health problems.

**Health Promotion Activities:** Any combination of education and organizational, economic, and environmental supports aimed at the stimulation of healthy behavior in individuals, groups, or communities.

**Health Resource Availability:** This category includes data on factors associated with health system capacity that may include both the number of licensed and credentialed health personnel and the physical capacity of health facilities. In addition, the health resources category includes measures of access, utilization, and cost and quality of health care and prevention services. Service delivery patterns and roles of public and private sectors as payers and/or providers may also be relevant. T

**Impact Objective:** An impact objective is short term (less than three years) and measurable. The object of interest is on knowledge, attitudes, or behavior.

**Injury:** Injuries can be classified by the intent or purposefulness of occurrence in two categories, intentional and unintentional injuries. Intentional injuries are ones that are purposely inflicted and often associated with violence. These include child abuse, domestic violence, sexual assault, aggravated assault, homicide, and suicide. Unintentional injuries include only those injuries that occur without intent of harm and are not purposely inflicted.

**Local Public Health System:** The human, informational, financial, and organizational resources, including public, private, and voluntary organizations and individuals that contribute to the public's health.

**Maternal and Child Health:** A category focusing on birth data and outcomes as well as mortality data for infants and children. Because maternal care is correlated with birth outcomes, measures of maternal access to, and/or utilization of, care is included. One of the most significant areas for monitoring and comparison relates to the health of a vulnerable population: infants and children. Births to teen mothers is a critical indicator of increased risk for both mother and child. This is a category of data recommended for collection within MAPP's Community Health Status Assessment.

**Outcome Objective:** An outcome objective is long term (greater than three years) and measurable. The objects of interest are mortality, morbidity, and disability.

**Population Characteristics:** Population characteristics include measures of total population as well as percent of total population by age group, gender, race and ethnicity, where these populations and sub-populations are located, and the rate of change in population density over time, due to births, deaths and migration patterns.

**Process Objective:** A process objective is short term and measurable. Process objectives may be evaluated by audit, peer review, accreditation, certification, or administrative surveillance. Objects of evaluation may include adherence to projected timetables, production, distribution, and utilization of products, and financial audits.

**Public Health:** "...the science and the art of preventing disease, prolonging life, and promoting physical health and mental health and efficiency through organized community efforts toward a sanitary environment; the control of community infections; the education of the individual in principles of personal hygiene; the organization of medical and nursing service for the early diagnosis and treatment of disease; and the development of the social machinery to ensure to every individual in the community a standard of living adequate for the maintenance of health." (C.E.A. Winslow) The mission of public health is to fulfill society's desire to create conditions so that people can be healthy (Institute of Medicine, 1988).

**Quality of Life:** A construct that "connotes an overall sense of well-being when applied to an individual" and a "supportive environment when applied to a community" (Moriarty, 1996). While some dimensions of quality of life can be quantified using indicators that research has shown to be related to determinants of health and community-well being, other valid dimensions of QOL include the perceptions of community residents about aspects of their neighborhoods and communities that either enhance or diminish their quality of life. This is a category of data recommended for collection within MAPP's Community Health Status Assessment.

**Sentinel Health Event:** Sentinel events are those cases of unnecessary disease, disability, or untimely death that could be avoided if appropriate and timely medical care or preventive services were provided. These include vaccine-preventable illness, late stage cancer diagnosis, and unexpected syndromes or infections. Sentinel events may alert the community to health system problems such as inadequate vaccine coverage, lack of primary care and/or screening, a bioterrorist event, or the introduction of globally transmitted infections. This is a category of data recommended for collection within MAPP's Community Health Status Assessment.

**Social and Mental Health:** This category represents social and mental factors and conditions which directly or indirectly influence overall health status and individual and community quality of life. This is a category of data recommended for collection within MAPP's Community Health Status Assessment.

**Socioeconomic Characteristics:** Socioeconomic characteristics include measures that have been shown to affect health status, such as income, education, and employment, and the proportion of the population represented by various levels of these variables. This is a category of data recommended for collection within MAPP's Community Health Status Assessment.

#### **Bibliography:**

Centers for Disease Control and Prevention, National Public Health Performance Standards Program, [www.phppo.cdc.gov/nphpsp](http://www.phppo.cdc.gov/nphpsp)

National Association of County and City Health Officials, Mobilizing for Action through Planning and Partnerships (MAPP), [www.naccho.org](http://www.naccho.org)

Turnock, B.J., Public Health: What it is and How it Works, Aspen Publishers, Inc., Gaithersburg, MD, 1997.

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2010, [www.healthypeople.gov](http://www.healthypeople.gov)

## Health Domain Definitions

The definitions below describe the focus areas or domains of the MAPP process. These are also the domains of the Florida public health statistics website, CHARTS.

**Behavioral Risk Factors:** Behaviors that are believed to cause, or to be contributing factors to, accidents, injuries, disease, and death during youth and adolescence and significant morbidity and mortality in later life.

**Communicable Disease:** Measures within this category include diseases that are usually transmitted through person-to-person contact or shared use of contaminated instruments/materials. Many of these diseases can be prevented through the use of protective measures, such as a high level of vaccine coverage of vulnerable populations. This is a category of data recommended for collection in MAPP's Community Health Status Assessment.

**Population Characteristics:** This domain of data includes socioeconomic and demographic indicators from the U.S. Census Bureau. Population characteristics include measures of total population as well as percent of total population by age group, gender, race and ethnicity, rates of change in total populations over the ten year census period and mean age per population. Population Characteristics also includes measures such as income, education, employment and other indicators based on the U.S. Census. This category of data is recommended for collection within MAPP's Community Health Status Assessment.

**Environmental Health Indicators:** The physical environment directly impacts health and quality of life. Clean air and water, as well as safely prepared food, are essential to physical health. Exposure to environmental substances, such as lead or hazardous waste, increases risk for preventable disease.

**Health Resource Availability:** This category includes data on factors associated with health system capacity that may include both the number of licensed and credentialed health personnel and the physical capacity of health facilities. In addition, the health resources availability category includes measures of access, utilization, and cost and quality of health care and prevention services. Service delivery patterns and roles of public and private sectors as payers and/or providers may also be relevant.

**Injury:** Injuries can be classified by the intent or purposefulness of occurrence in two categories, intentional and unintentional injuries. Intentional injuries are ones that are purposely inflicted and often associated with violence. These include child abuse, domestic violence, sexual assault, aggravated assault, homicide, and suicide. Unintentional injuries include only those injuries that occur without intent of harm and are not purposely inflicted. Unintentional home, workplace, or recreational injuries affect all age groups and may result in premature disability or mortality.

**Maternal and Child Health:** Birth data and outcomes as well as mortality data for infants and children are the focus of this domain. Because maternal care is correlated with birth outcomes, measures of maternal access to, and/or utilization of, care is included. One of the most significant areas for monitoring and comparison relates to the health of a vulnerable population: infants and children. Births to teen mothers is a critical indicator of increased risk for both mother and child.

**Social and Mental Health:** This category represents social and mental health factors and conditions that directly or indirectly influence overall health status and individual and community quality of life.

## Example Community Health Survey

Please take a minute to complete the survey below. The purpose of this survey is to get your opinions about community health problems in (name of jurisdiction). The (name of jurisdiction) Community Health Committee will use the results of this survey and other information to identify the most pressing problems which can be addressed through community action. If you have previously completed a survey, please ignore this. Remember... your opinion is important! Thank you and if you have any questions, please contact us (see contact information on back).

1. In the following list, what do you think are **the three most important factors for a “Healthy Community?”** (Those factors which most improve the quality of life in a community.)

Check only three:

- |  |  |
|--|--|
| <input type="checkbox"/> Good place to raise children                | <input type="checkbox"/> Excellent race relations          |
| <input type="checkbox"/> Low crime / safe neighborhoods              | <input type="checkbox"/> Good jobs and healthy economy     |
| <input type="checkbox"/> Low level of child abuse                    | <input type="checkbox"/> Strong family life                |
| <input type="checkbox"/> Good schools                                | <input type="checkbox"/> Healthy behaviors and lifestyles  |
| <input type="checkbox"/> Access to health care (e.g., family doctor) | <input type="checkbox"/> Low adult death and disease rates |
| <input type="checkbox"/> Parks and recreation                        | <input type="checkbox"/> Low infant deaths                 |
| <input type="checkbox"/> Clean environment                           | <input type="checkbox"/> Religious or spiritual values     |
| <input type="checkbox"/> Affordable housing                          | <input type="checkbox"/> Other _____                       |
| <input type="checkbox"/> Arts and cultural events                    |  |

2. In the following list, what do you think are **the three most important “health problems”** in our community? (Those problems which have the greatest impact on overall community health.)

Check only three:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Aging problems (e.g., arthritis, hearing/vision loss, etc.) | <input type="checkbox"/> Heart disease and stroke                        | <input type="checkbox"/> Rape / sexual assault                |
| <input type="checkbox"/> Cancers   | <input type="checkbox"/> High blood pressure                             | <input type="checkbox"/> Respiratory / lung disease           |
| <input type="checkbox"/> Child abuse / neglect                                       | <input type="checkbox"/> HIV / AIDS                                      | <input type="checkbox"/> Sexually Transmitted Diseases (STDs) |
| <input type="checkbox"/> Dental problems   | <input type="checkbox"/> Homicide  | <input type="checkbox"/> Suicide                              |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Infant Death                                    | <input type="checkbox"/> Teenage pregnancy                    |
| <input type="checkbox"/> Domestic Violence   | <input type="checkbox"/> Infectious Diseases (e.g., hepatitis, TB, etc.) | <input type="checkbox"/> Other _____                          |
| <input type="checkbox"/> Firearm-related injuries                                    | <input type="checkbox"/> Mental health problems                          |   |
|  | <input type="checkbox"/> Motor vehicle crash injuries                    |   |

3. In the following list, what do you think are **the three most important “risky behaviors”** in our community? (Those behaviors which have the greatest impact on overall community health.)

Check only three:

- |   |  |
|---|--|
| <input type="checkbox"/> Alcohol abuse                          | <input type="checkbox"/> Racism                                    |
| <input type="checkbox"/> Being overweight                       | <input type="checkbox"/> Tobacco use                               |
| <input type="checkbox"/> Dropping out of school                 | <input type="checkbox"/> Not using birth control                   |
| <input type="checkbox"/> Drug abuse                             | <input type="checkbox"/> Not using seat belts / child safety seats |
| <input type="checkbox"/> Lack of exercise                       | <input type="checkbox"/> Unsafe sex                                |
| <input type="checkbox"/> Poor eating habits                     | <input type="checkbox"/> Other _____                               |
| <input type="checkbox"/> Not getting “shots” to prevent disease |  |

4. How would rate our community as a “Healthy Community?”

Very unhealthy     Unhealthy     Somewhat healthy     Healthy     Very healthy

5. How would rate your own personal health?

Very unhealthy     Unhealthy     Somewhat healthy     Healthy     Very healthy

6. Approximately how many hours per month do you volunteer your time to community service? (e.g., schools, voluntary organizations, churches, hospitals, etc.)

None     1 - 5 hours     6 - 10 hours     Over 10 hours

**Please answer questions #7-15 so we can see how different types of people feel about local health issues.**

7. Zip code where you live: \_\_\_\_\_

8. Age:     25 or less  
 26 - 39  
 40 - 54  
 55 - 64  
 65 or over

9. Sex:     Male     Female

10. Ethnic group you most identify with:

African American / Black  
 Asian / Pacific Islander  
 Hispanic / Latino  
 Native American  
 White / Caucasian  
 Other \_\_\_\_\_

11. Marital Status:

Married / co-habiting  
 Not married / Single

12. Education

Less than high school  
 High school diploma or GED  
 College degree or higher  
 Other \_\_\_\_\_

13. Household income

Less than \$20,000  
 \$20,000 to \$29,999  
 \$30,000 to \$49,999  
 Over \$50,000

14. How do you pay for your health care? (check all that apply)

Pay cash (no insurance)  
 Health insurance (e.g., private insurance, Blue Shield, HMO)  
 Medicaid  
 Medicare  
 Veterans’ Administration  
 Indian Health Services  
 Other \_\_\_\_\_

15. Where / how you got this survey: (check one)

Church  
 Community Meeting  
 Grocery Store / Shopping Mall  
 Mail  
 Newspaper  
 Newsletter  
 Personal Contact  
 Workplace  
 Other \_\_\_\_\_

Please return completed surveys to the address below by (date). If you would like more information about this community project, please contact us at the number below.

contact name  
organization name  
address  
phone / fax

Thank you very much for your response!