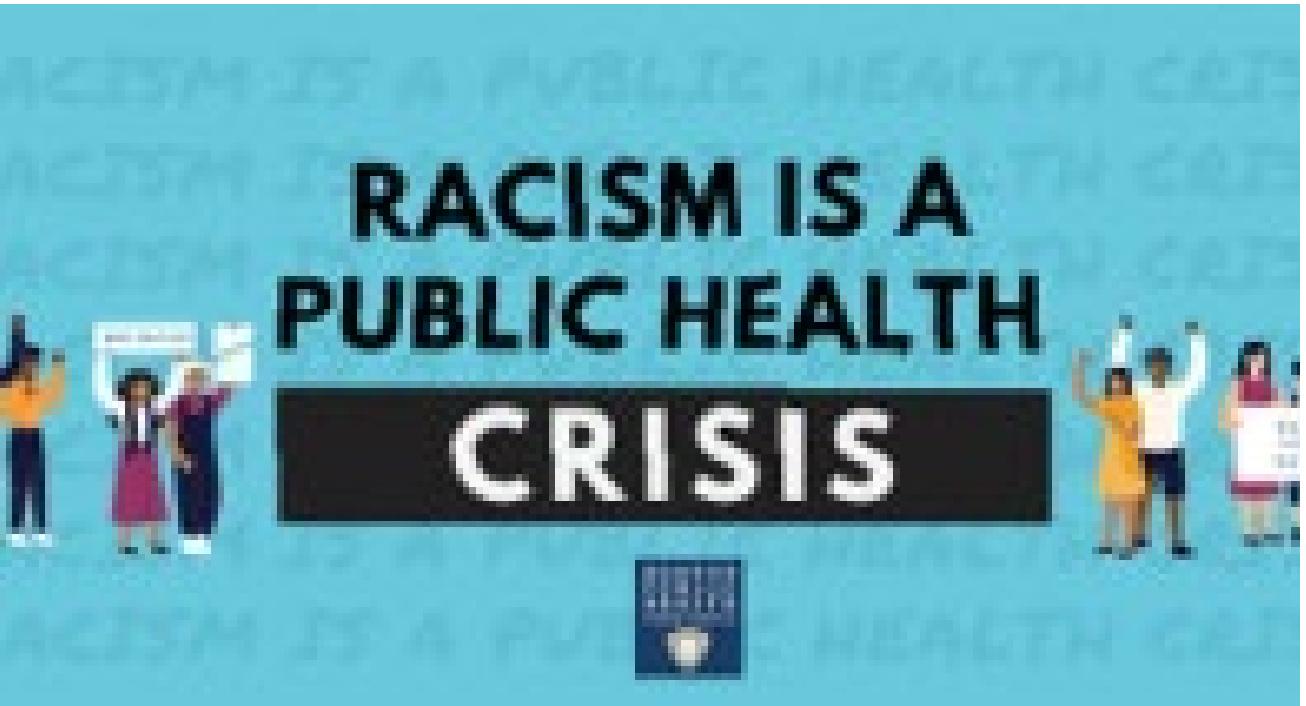
Conducting a Community Health Needs Assessment *using a Racial Justice & Health Equity Lens*

ALYSSA BENALFEW-RAMOS, MPH – ASSOCIATE DIRECTOR
OFFICE OF RACIAL EQUITY & COMMUNITY ENGAGEMENT
BOSTON PUBLIC HEALTH COMMISSION



Introduction*

Alyssa Benalfew-Ramos, MPH (she/hers)

- Associate Director, Office of Racial Equity & Community Engagement, Executive Office, Boston Public Health Commission.
- Career & Leadership Development Lead, Health Career Connection New England Alumni Chapter Leadership (volunteer)

*Views I share today are informed by my work however I am speaking as a public health practitioner

The BPHC Mission & Vision

The mission of the Boston Public Health Commission is to **protect, preserve, and promote** the health and well-being of **all Boston residents**, **particularly the most vulnerable.**

We achieve our mission by providing and supporting accessible high-quality community-based health and social services, community engagement and advocacy, development of health promoting policies and regulations, disease and injury prevention, emergency services, health promotion, and health education services.

Vision Statement

The Boston Public Health Commission envisions a thriving Boston where all residents live healthy, fulfilling lives free of racism, poverty, violence, and other systems of oppression. All residents will have equitable opportunities and resources, leading to optimal health and well-being.

Learning objectives

1. To develop baseline understanding of the role a community health needs assessment (CHNA) can play in public health practice
2. To identify the process steps of a CHNA using a racial & health equity lens
3. To contextualize the need for community input and strategies for equitably engaging community members in meaningful ways
4. To identify multiple data sources and acknowledge the benefit of employing qualitative methods
5. To brainstorm process challenges and solutions for stages within a CHNA

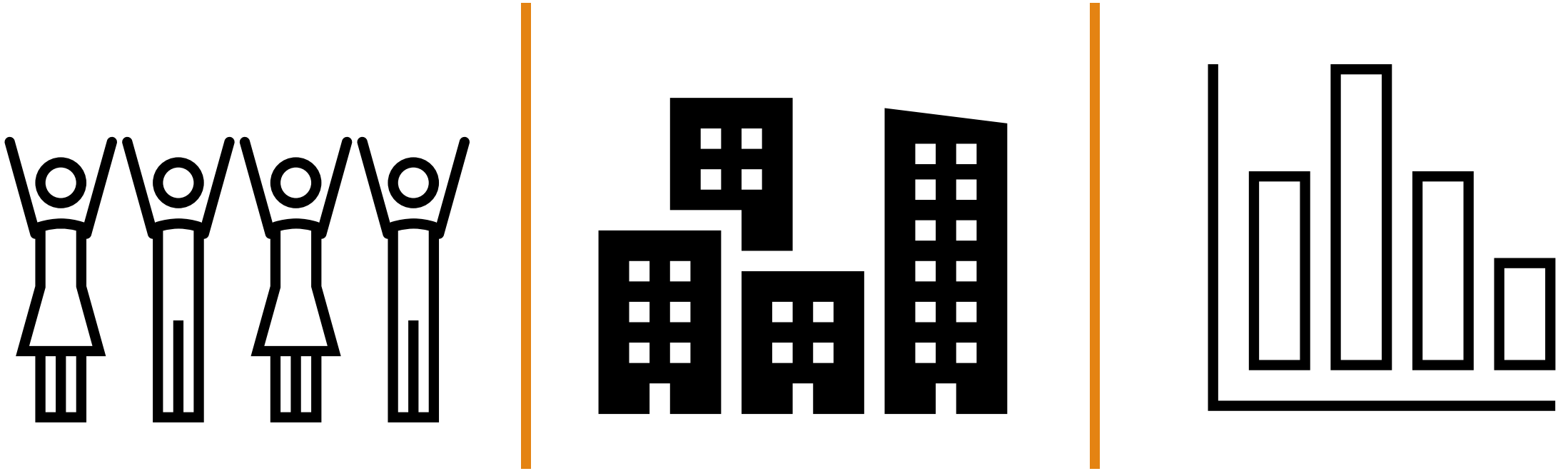
Term	Definition
Social determinants of health	Social determinants of health are the conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks, as well as access to health care. (KFF)
Health equity	The opportunity for everyone to attain their full health potential. No one is disadvantaged from achieving this potential because of their social position (class, socio-economic status) or socially assigned circumstance (race, gender, ethnicity, religion, sexual orientation, geography, and more). (BPHC)
Equitable community engagement	The practice of using multiple strategies to provide opportunities for all [Boston] residents – particularly those historically excluded, under-represented, or under-resourced – to be informed and to participate in public planning and decision-making to achieve an equitable outcome. (BPHC)
Stakeholder	Any individual, group, or organization with a vested interest (a stake) in a particular issue or decision – either they will be impacted, or they are able to affect change. Stakeholders can be residents, staff, business owners, or representatives of community-based organizations. (BPHC)
Qualitative methods	A means of understanding public health problems in greater depth by providing contextual information regarding a population's beliefs, opinions, norms, and behaviors. This type of information is difficult to capture using traditional quantitative methods, yet it can be vitally important for understanding the "why" for many health problems and also the "how" in terms of how to achieve improvements in health outcomes. (BUSPH)
Structural racialization	The cumulative and compounded effects of an array of factors such as public policies, institutional practices, cultural representations, and other norms that work in various, often reinforcing, ways to perpetuate racial inequity, and manifesting in structural factors that systematically support, reinforce or privilege white people and disadvantage people of color. (BPHC)

Shared Language & Definitions

Best Practice Approaches for a CHNA

- We use a racial justice & health equity lens
- We value lived experience and multiple sources of knowledge
- We center those most impacted (over intent)
- “There is no thing as a single-issue struggle because we do not live single-issue lives.” (Audre Lorde)
- We utilize the best available research and data
- We are mindful and communicative about our role and limitations
- We are all lifelong learners

What is a CHNA?



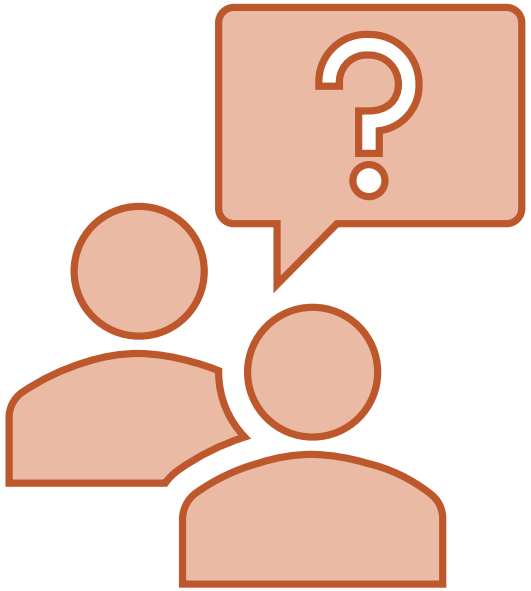
Have you led or participated in a Community Health Needs Assessment before?

Discussion questions

What have been some challenges or barriers you've experienced while conducting a CHNA or community engagement effort?

How did you or your team overcome these challenges or barriers? (mitigation or solutions)

What were wins or successes you've experienced doing a CHNA or conducting a community engagement effort?

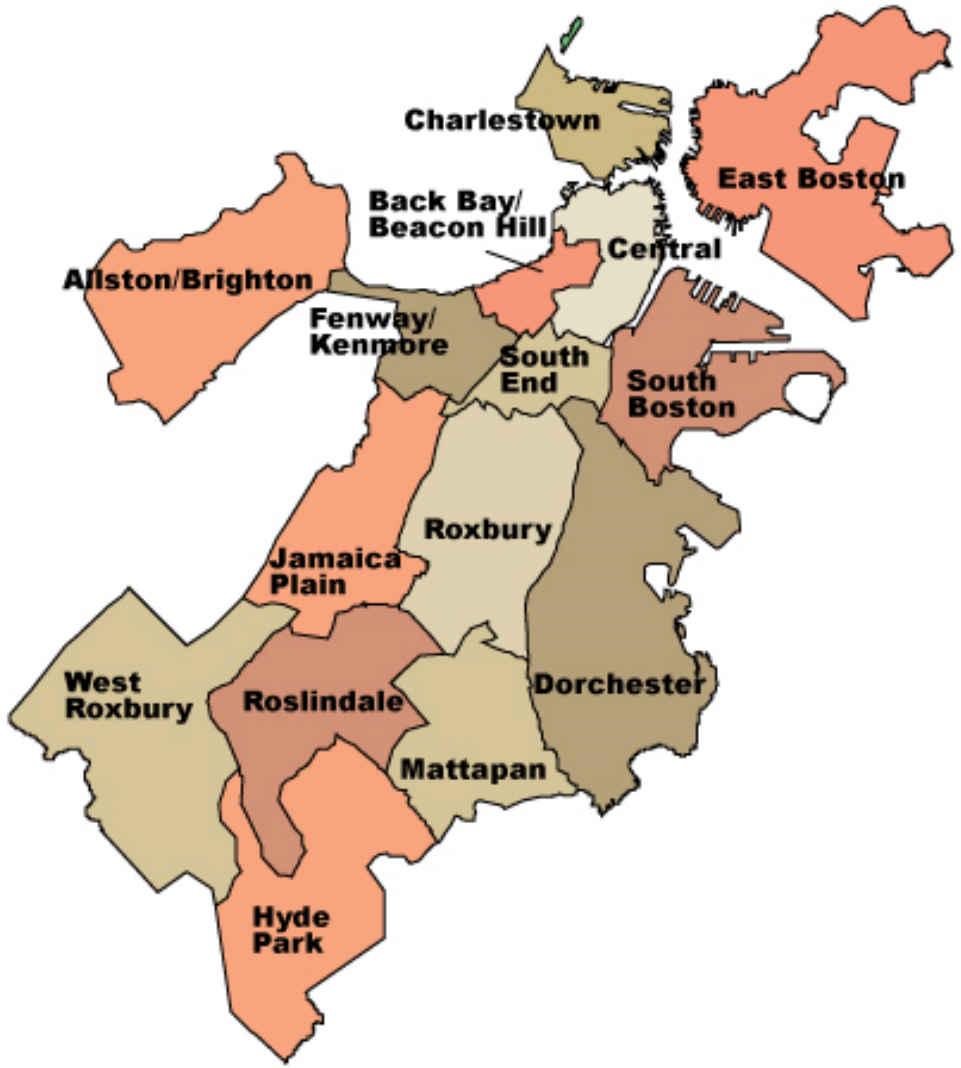


What is a Community Health Needs Assessment?

A community health needs assessment (CHNA), refers to a state, tribal, local, or territorial**health assessment** that **identifies key health needs and issues** through systematic, comprehensive **data collection and analysis**. (CDC)

- A specific community or population (ex: Asian Americans; people experiencing homelessness)
- A geographic area (ex: East Boston)
- Health statuses (ex: quality of life for people with diabetes)
- Health outcomes (ex: morbidity and mortality data)
- Social determinants of health (ex: environmental exposure to pollutants in Chinatown)
- Community priorities (ex: to focus on youth substance use prevention re: vaping)
- Community assets (ex: sense of connectedness)
- Available resources (ex: mental health providers)

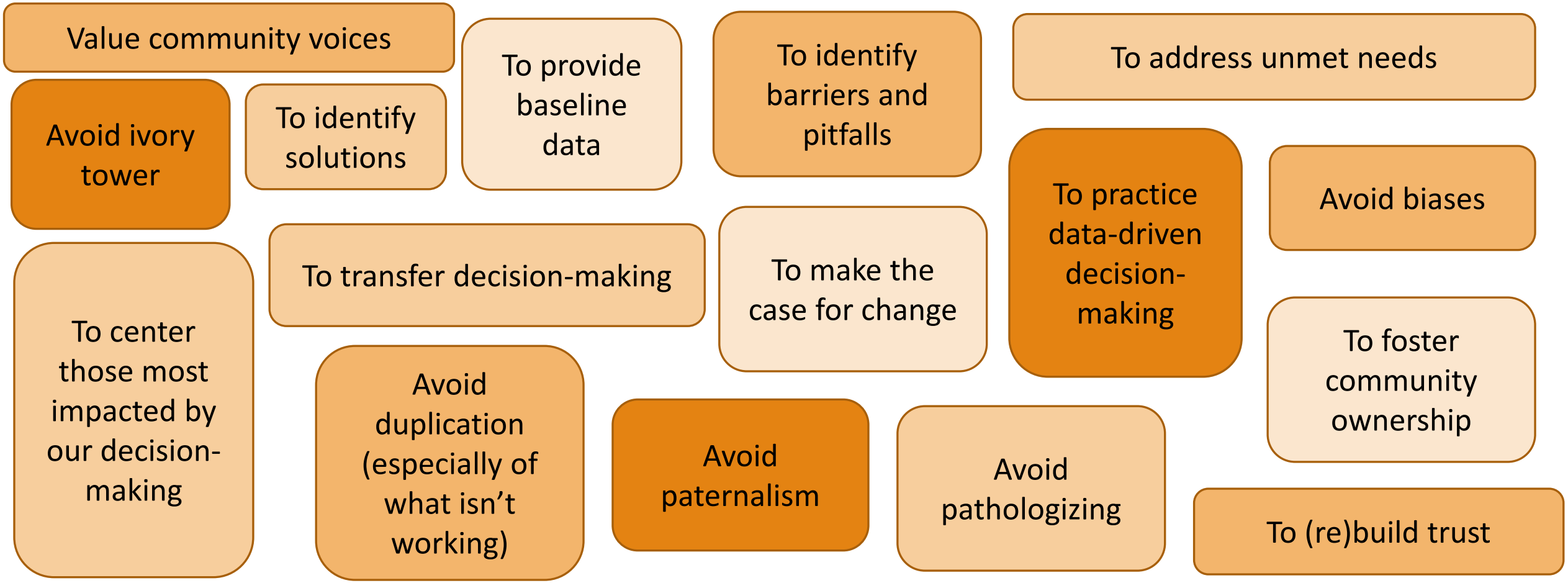
The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues. A variety of tools and processes may be used to conduct a community health assessment; ***the essential ingredients are community engagement and collaborative participation.***



Why conduct a CHNA?

- Government
- Funder
- Accreditation or reaccreditation
- To drive program planning (expansion, creation, revision)
- To identify community priorities
- To identify community assets

Why do we want and need community input?



Boston CHNA-CHIP
Collaborative

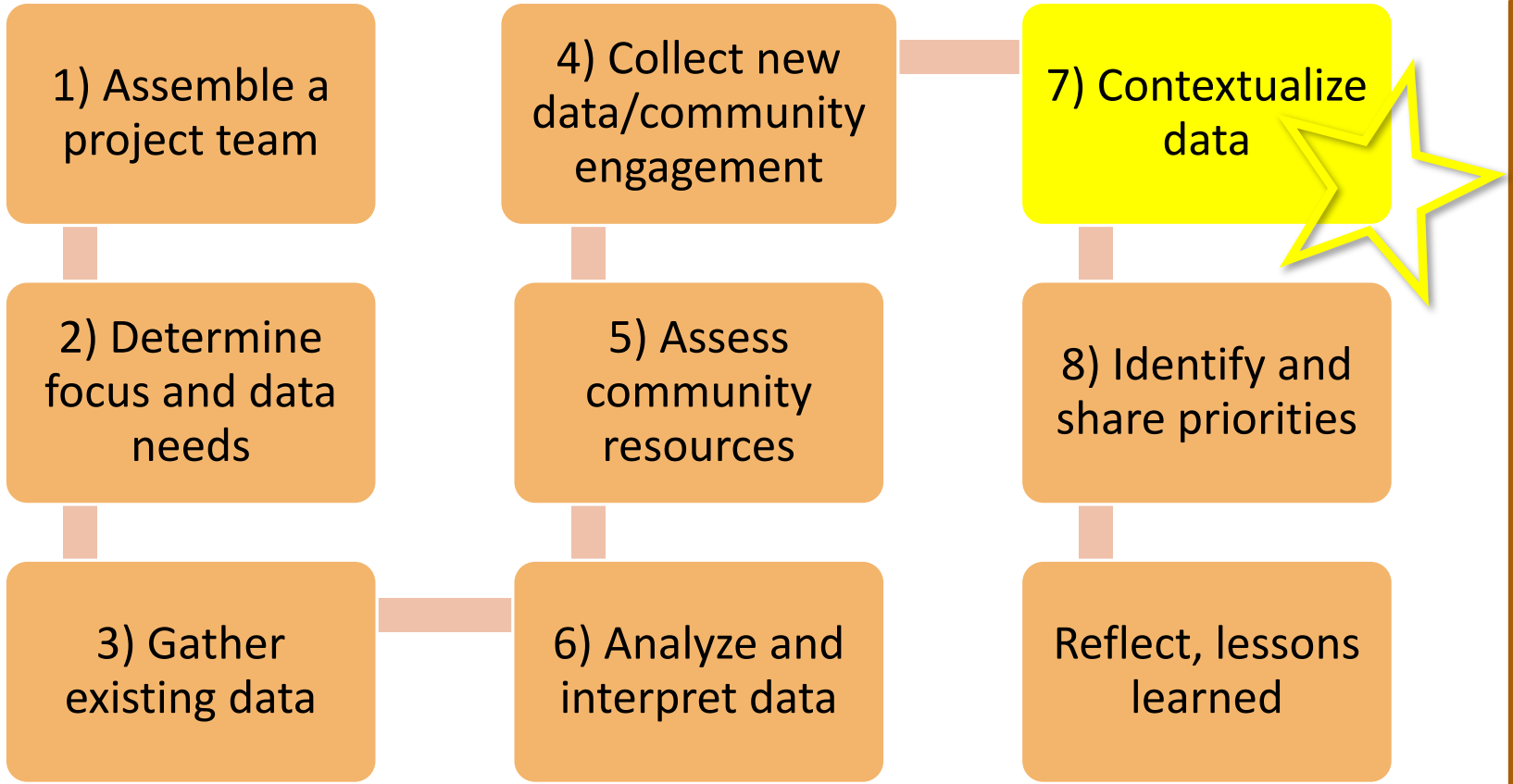
Boston CHNA-CHIP Collaborative

2022
Community Health
Needs Assessment

Example: Boston's CHNA & Community Health Improvement Plan

CHNA Process Steps

Overview of CHNA: steps 1-8



A CHNA can be most fruitful when relevant stakeholders can be engaged through the duration of the project period.

What are ways to engage stakeholders in steps 1-8?

1) Assembling a project team

Clarifying your scope:

- What are the parameters for your CHNA? Is it a population, health issue, geographic area, etc.?
- How can you reach your shared vision?
- Can you create a draft charter or scope document amongst the group with the population, objectives, timeline, methods, and reporting strategies clearly outlined?
- Who are the stakeholders? Who is missing from the table? Who are decision-makers?

Assembling Your Project Team or Workgroup

Who is on your team?

- Representation
- Anti-racism
- Staff who will hold different roles (lead, support, review)
- Thought partners

Skills for your team

Relationship building & collaboration

Effective communication & facilitation

Data comfortability & presentation skills

Racial justice & health equity lens

Project management

Considerations
Acknowledgement of power differentials
Create group agreements
Develop expectations from the lead & role clarity of all involved
Utilize strengths & support each other's growing areas
Involve an activity to assess the groups' hopes, wishes, visioning, what is needed from each other
Define success looks and feels like (at each meeting! Also, don't forget your project charter)
Develop talking points, your concise communication and messaging about your CHNA
There may be oops and ouch moments—how to address and move forward together

1) Assembling a project team

The Theory of Team Development

Forming—meets and learns about opportunities and challenges; little trust

Storming—conflict, power struggles, unclear purpose, clashing priorities

Norming—consensus, trust established, standards are set, collaboration, role clarity

Performing—successful performance, goal achievement, strategic progress

Adjourning—disband or new goal outlined

2) Determine your focus and data needs: What do you want to know?

Define “the problem” you want to explore

Create a goal for the CHNA; SMARTIE

Draft a **SMARTIE** goal statement

S pecific

M easurable

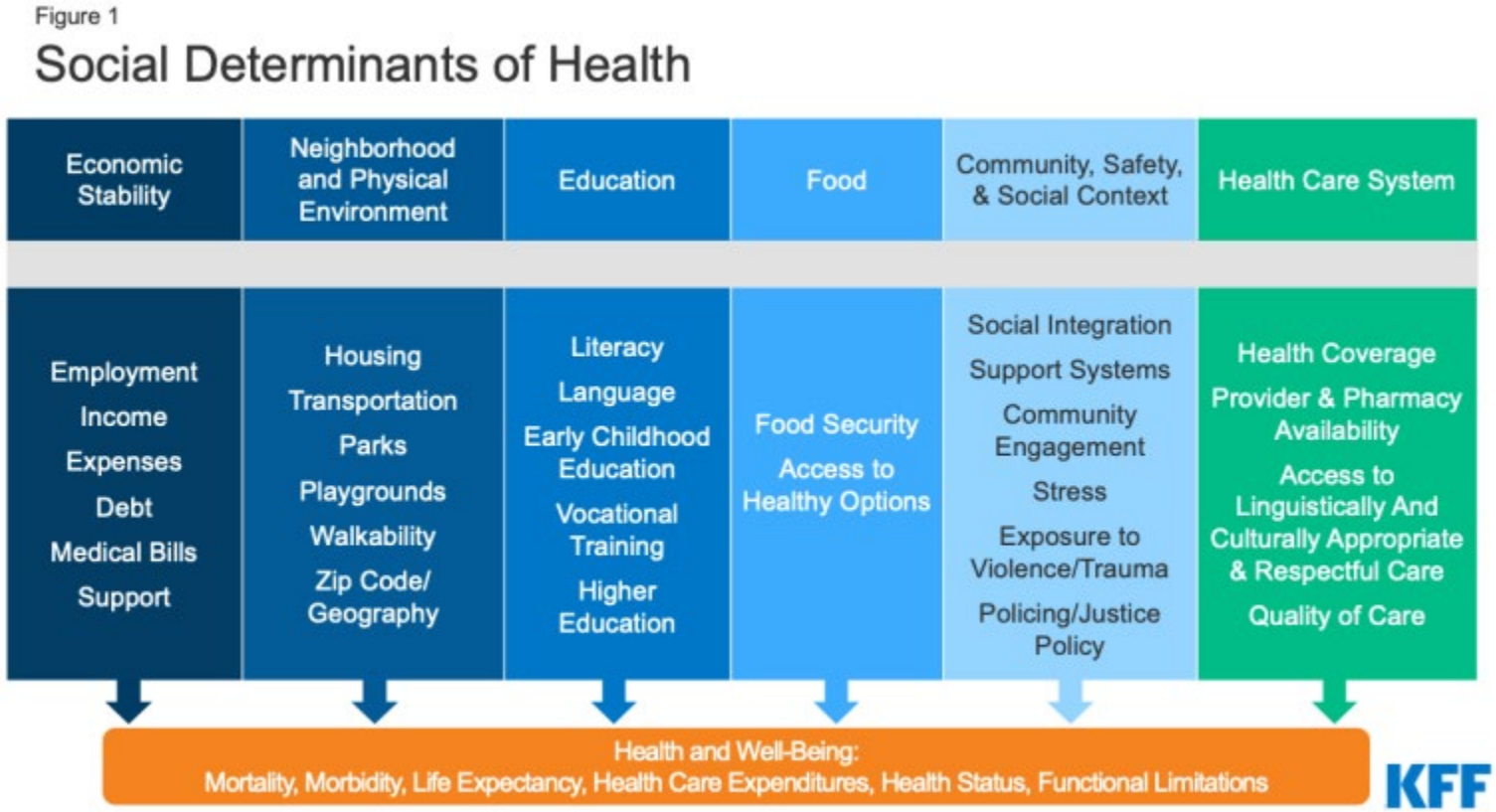
A ction-oriented

R ealistic

T imebound

I nclusive

E quitable



3) Gather existing data

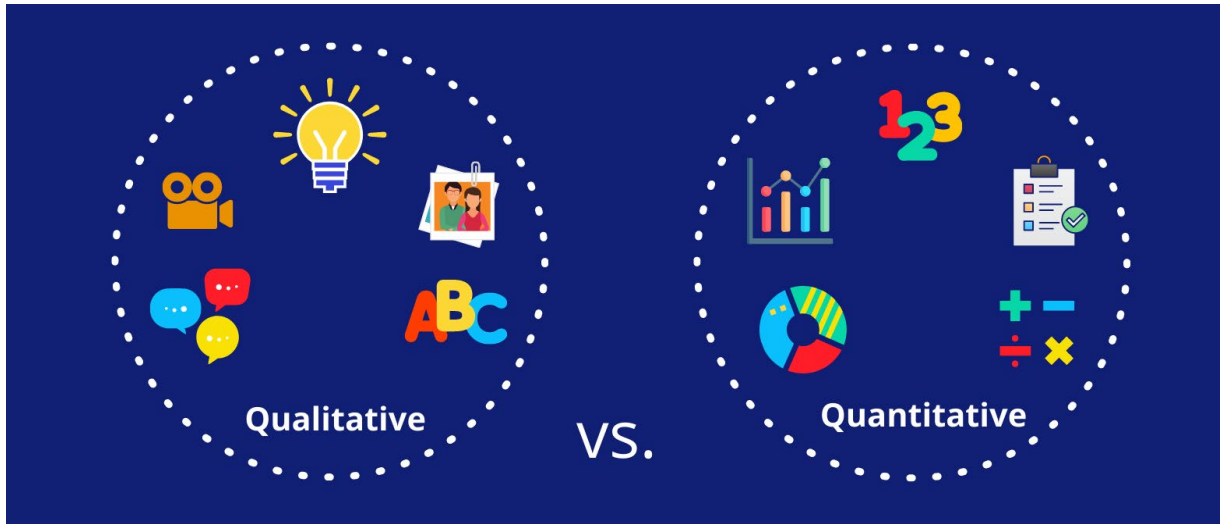
Examples include:

- program records

- published data like peer-reviewed journals

- national, state, or local data
  - YRBS
  - BRFSS
  - Boston CHNA/CHIP
  - BPHC Health of Boston reports (& Special Reports
  - Disease registries
  - 911 data

- community or practice knowledge, anecdotes



NOTE: When selecting data, ensure that it will be most useful to you. Does the data measure behaviors, health statuses, or health outcomes? Can it be broken out by demographics? Does it show trends over time?

4) Collect new data

What are some data collection methods you have used at BPHC?

Focus groups

Surveys

1:1 interviews

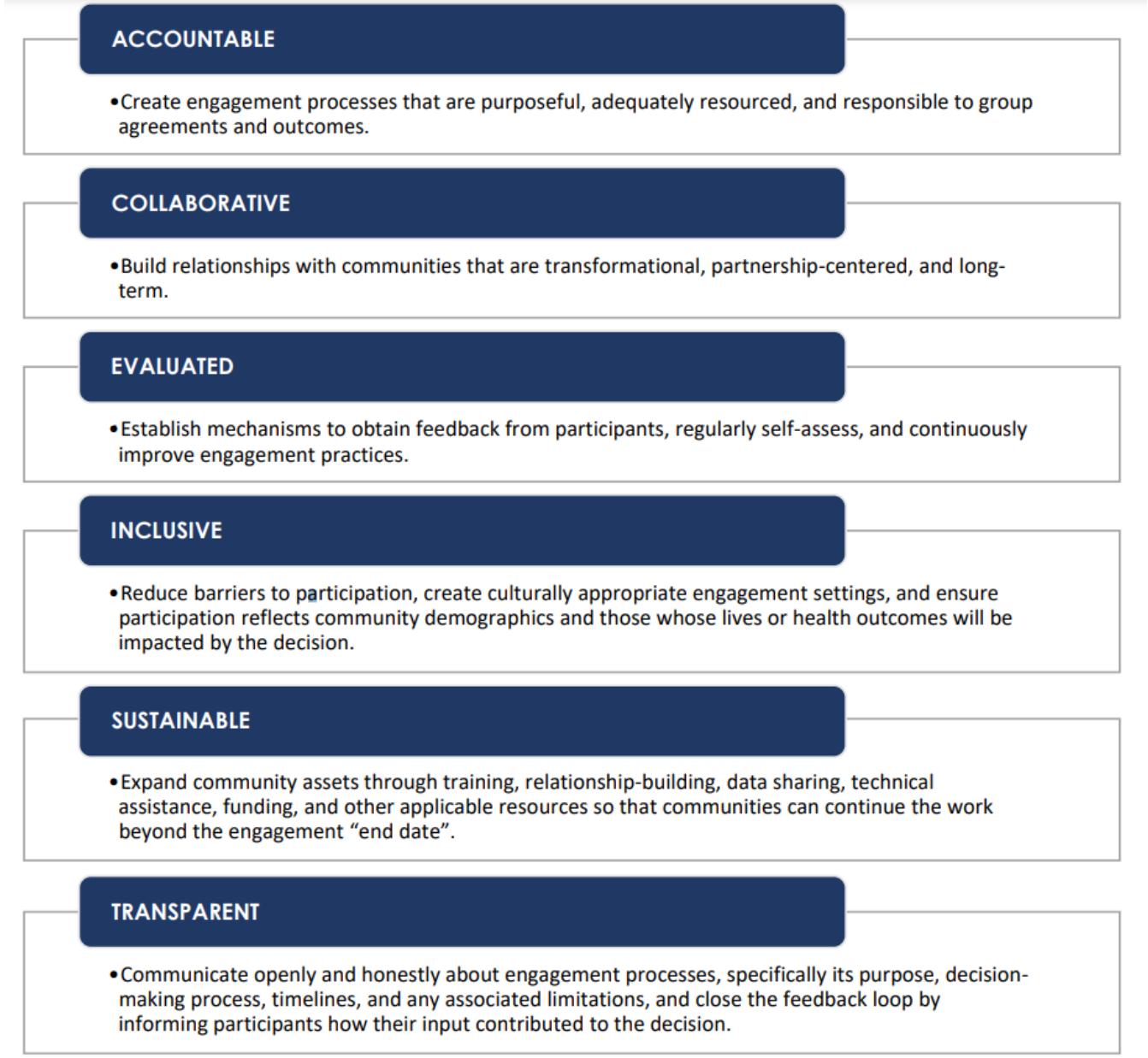
Asset mapping

Community forums

Quantitative data can't answer the questions of why, how, and what should be done.

The qualitative data collection you embark on can help to **contextualize** and **interpret** quantitative data, **focus your inquiry**, **involve community,** and **identify solutions**.

While data can be intimidating, it can be important to grasp how to utilize data to inform decision-making. Please reach out to your resources for support.

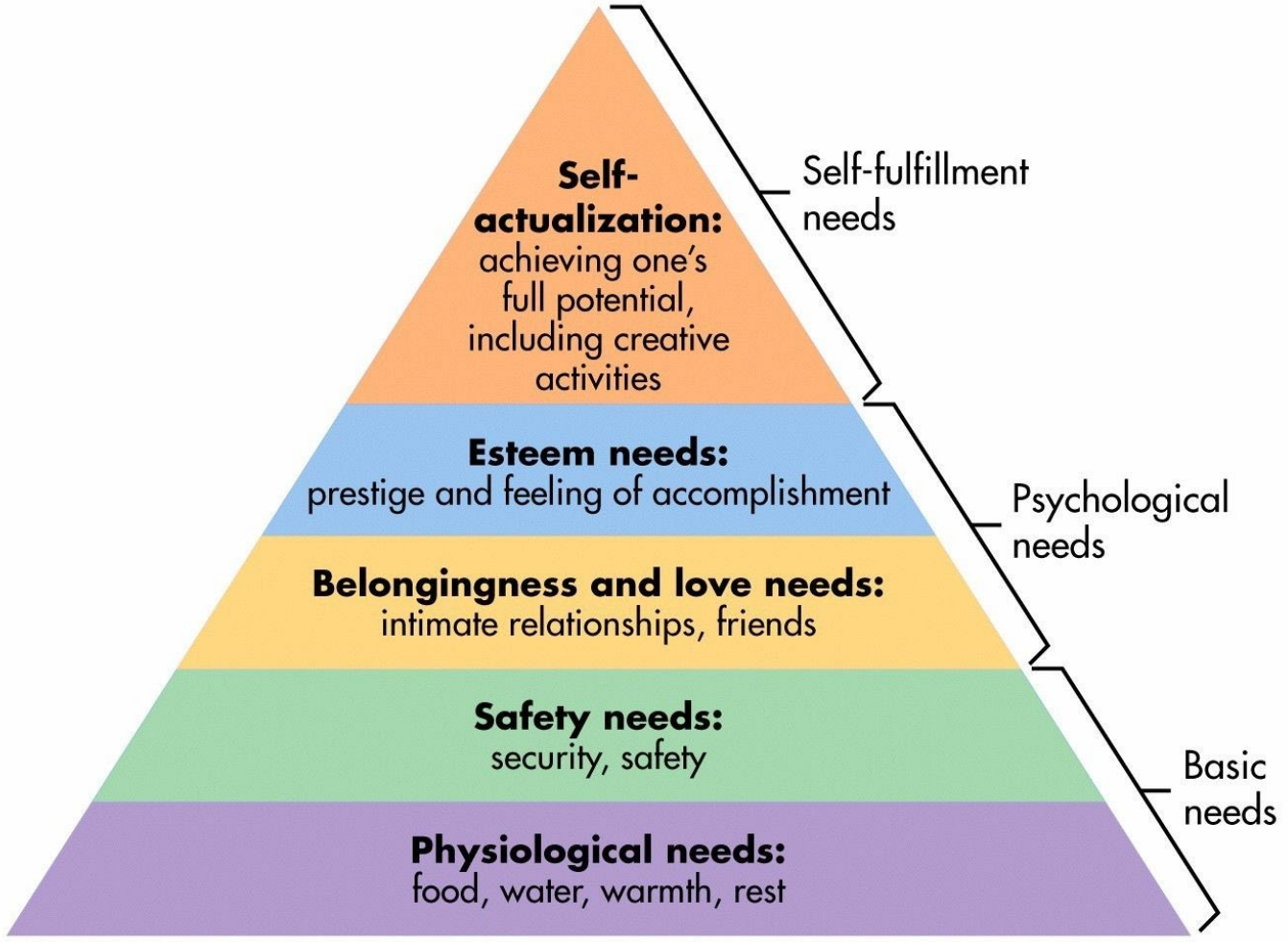


Resource spotlight!

BPHC'S EQUITABLE COMMUNITY ENGAGEMENT FRAMEWORK – AVOIDING HARM

Engagement considerations

- Role within an organization
- Perception
- Generalization
- Relative privilege & bias
- Humility
- Relationship building, not a one off



5) Assess community resources

Public health practitioners or localities often look to perform a CHNA or other forms of community engagement to identify gaps in services, care, resources, etc.

As we do, it is important that we use a strengths-based approach and identify community assets. What happens if we, as a health department, only identify gaps?

THINK about your neighborhood: What are some assets in your community?

As public health practitioners, we must

- consider all determinants of health, not just the negative

- acknowledge the interplay of the socio ecological model—the individual-, interpersonal-, community-, institutional-, and structural-level factors and the impact of racism that contributes to health outcomes

6) Analyze and interpret data: What did you learn?

ANALYZE & INTERPRET

- check the quality of data (missing, completeness, relevance, readability, etc.)

- for your qualitative responses, refer to your original data collection questions and scope—then **identify themes** of the responses

- for data out of scope, put in the parking lot for a later review

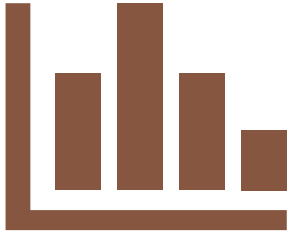
- for quantitative responses, you can create a numeric spreadsheet that codes responses (e.g. true = 1, false = 2)

- **identify patterns**, averages, trends, frequencies, rates (e.g. X number of cases per X number of residents), etc.

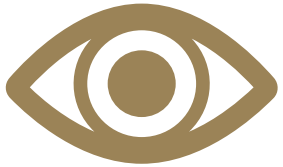
7) Contextualize your data

7) Report out—Know your audience!

Create a data summary or report



Data as storytelling



Visualization and infographics

Identify a platform (i.e., community meetings, town hall, etc.)

Questions?

Thank you for watching!

Contact info

- Alyssa Benalfew-Ramos
- ORECE, Associate Director
- abenalfew@bphc.org
- 617-534-7841
- www.linkedin.com/in/alyssabenalfew-ramos

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Breakout activity

In pairs, please identify one of the eight CHNA process steps and identify how the step can be applied to the work of your program.

For example, Step 3) Gather Existing Data—where would you look for data relevant to the population your program serves?