Assess the Community and Population

Population health assessments look at whole populations and groups within that whole. Collaborating partners look at indicators of health status, health equity, and factors and environments that influence health, often referred to as the social determinants of health (SDOH).

(Scroll down for more on health equity and SDOH)

Below are some recommended steps to help ensure your assessment provides quality information.

- **Engage communities and partners**
  - Maximize opportunities created by the way health care, public health and community partners are working together in new ways to improve health outcomes and lower costs.
  - Engage diverse organizations and individuals at the assessment stage, and keep them engaged throughout the entire process.

  Tools to help with community engagement are included in the **Resources** section. (Scroll to end of page)

- **Gather and analyze data, including**
  - **Quantitative data** - information that can be measured in numbers and may indicate prevalence and trends. This type of data lends credibility to your assessment.
  - **Qualitative data** - information that is non-numeric. It can help with understanding the “why and how” of a population’s health status. Qualitative data can be gathered from surveys, focus groups, key informant interviews, environmental scans, and asset mapping.

  Sources of quantitative data and tools for gathering qualitative data are included in the **Resources** section. (Scroll to end of page)

- **Review research**, including scientific literature, related to health issues that surface
- **Identify community strengths and resources** that can help address identified problems

**Health Equity and the Social Determinants of Health**

Attention to health equity and the social determinants of health makes for a stronger plan. Learn more by expanding the options below.
Assess the Community and Population

**Health Equity**

What is health equity and why is it important to population health? Health equity means equal access to health (not just health care) for all members of our population. Partners will need to be alert to the unique strengths and vulnerabilities of specific populations within a patient panel or geographic region.

The Guide offers data and resources on health equity concerns specific to several priority health issues. In addition, the resources below offer guidance on applying a health equity lens to population health:

- **Department of Health’s website provides health equity definitions, literature and a Tool for Policy Planning.**
- **Washington Health Alliance 2016 Disparities in Care Report** offers information on disparities in care among minority populations in Washington State.
- **American Indian Health Commission (AIHC).** A unique aspect to working with tribal partners is the sovereignty of American Indian and Alaska Native (AIAN) nations, and operating within the government-to-government relationship. Other important considerations include the overlap of tribal boundaries with health system regions, and the needs of the urban Indian population as contrasted with those living on reservations. New AIHC resource: Tribal Services Profile, providing geographic and demographic details along with information about health care and community services.
- **Foundation for Healthier Generations** provides information on some of the nuances of health equity, including how it intersects with social determinants of health such as housing and employment.

The Centers for Disease Control and Prevention offers health equity resources about chronic disease prevention and health promotion. The site includes links to health equity information on specific physical and behavioral health issues.

**Social Determinants of Health**

According to Healthy People 2020, social determinants of health are the conditions in which people live their lives that impact health and quality of life. These conditions can be physical and social.
Assess the Community and Population

How clean is the air? How safe are the streets? What about housing? Employment? These are all factors in population health and are important to consider when conducting an assessment. For example, if your community is focusing on a prevalence of obesity and diabetes, are you also tracking access to healthy food and physical activity?

The Washington State Health Assessment includes a section about Social and Economic Determinants of Health, and social determinants data is included in data gathered by the Washington Tracking Network.

Assessment Challenges

**Challenge: National or state data may not reflect your community, and local data may not be available.**

**Try:** Engage community partners in local surveys, key informant interviews, and focus groups. If you have a nearby community college or university, contact a health occupations or sociology instructor to see if gathering local data could be a class or individual student project. For tools on gathering good qualitative data, see the Assessment Tools at the bottom of this page.

**Challenge: Available data, even when local, may not provide enough data for a specific population.**

**Try:** Reach out to local schools and nonprofit organizations. They may have data available or be able to help gather it. Explore grant and philanthropic funding to support the data gathering. Also, let your local health jurisdictions and tribal governments know what your data needs are. Your input can help their data teams plan future state and local assessments.

Give us your feedback and we will share with appropriate local and state data stewards. Send comments to P4IPH@doh.wa.gov.

**Challenge: Data may not adequately reflect social determinants.**

**Try:** Resources such as the Washington Tracking Network can help. Also, local government and community partners may have qualitative data. Some communities have engaged partners and volunteers in Photovoice projects, to capture social determinant information in a way that can drive policy change.
Assess the Community and Population

Engagement Challenges

**Challenge: Potential participants may be wary of token engagement.**

**Try:** Be transparent as to whether (and how) input will actually affect decisions, and make a point of sharing progress and results with those who have been involved. See the Communications section for more information.

**Challenge: High level decision makers have many demands upon their time and energy.**

**Try:** Ask them to recommend a trusted staff or advisor who can devote more time. Make sure information is being shared up and down the chain of decision makers, from frontline individuals to high-level decision makers.

**Challenge: Consumers, especially from disparate populations, may face unique barriers to participation.**

**Try:** Find ways to compensate representatives from disparate groups for participating in collaborative work. Offer travel reimbursement, small stipends that cover child care and/or missed work. Look for opportunities to meet them where they are literally as well as figuratively. This usually provides insights that meeting attendance cannot.

**Challenge: Coalition may be heavily weighted with government and non-profit partners, limiting scope.**

**Try:** Identify non-traditional entities/individuals that could benefit as well. An example from tobacco prevention work: engaging property owners in supporting a smoke-free housing policy. The benefit to property owners was reduced fire hazard and lower cleaning and maintenance costs. The benefit to the community was reduced exposure to secondhand smoke.

**Resources**

**Data Sources**

Health-related data at the state and county level, primarily quantitative:

- [Washington State Health Assessment](#) identifies and prioritizes issues that affect the health of Washingtonians and includes data for health outcomes, health behaviors, access to care, the physical and built environment, and social determinants topics.
Assess the Community and Population

- **Health of Washington State Report** provides summary of information on health status, health risks and health care services in Washington, including health behaviors that influence outcomes.

- **Healthier Washington Data Dashboard** is an interactive tool for community assessments, with integrated data from multiple sources including Medicaid claims data. It is provided to all Accountable Communities of Health and local health jurisdictions.

- **Washington | County Health Rankings & Roadmaps** offers county-level information with county health rankings.

- **Health Behaviors of Washington State** provides data on behaviors and attitudes that affect health.

- **Washington Tracking Network** provides information about the social determinants of health, including interactive dashboards, map layers, and a new tool for environmental health topic

Assessment Tools
Tools to help you gather information, including qualitative data:

- Evidence-based tools to help get the most out of focus groups and key informant interviews: Guide to Effective Focus groups and Guide to Key Informant Interviews from UCLA Center for Health Policy Research.

- "Using Photovoice to Understand Barriers" from the Centers for Disease Control and Prevention (CDC). Often used with policymakers to gain a compelling picture of factors that impact health equity.

- **Community Health Assessment for Population Health Improvement (CDC)** may help with keeping a population health focus in your assessment.

- To assess resources along with needs, try Community Asset Mapping from the North Carolina Institute for Public Health.

Community Engagement Resources

- **Principles of Community Engagement Report**, Centers for Disease Control and Prevention (CDC)


- **Collective Impact**, Collaboration for Impact