

Trustee Insights

COMMUNITY HEALTH



Applying a health equity lens to the CHNA process

Three crucial strategies for successful assessment

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When people are asked what makes a house a home, comfort is one of the most popular answers. Yet, we sometimes need to leave the comfort of our homes, to grow and add value to our lives and the lives of others. Similarly, there are two ways to conduct a Community Health Needs Assessment (CHNA): a comfortable way and the right way. For some, the CHNA process is only an IRS requirement that, once

completed, sits on a shelf until the next cycle. However, at CHRISTUS Health, the legacy of community service is evident in all projects and activities. Furthermore, the leadership is committed to ensuring that the CHNA is reflective of the community and its needs and used as a critical guide in informing the system's health equity goals.

"Difficult roads often lead to beautiful destinations," according to Zig Ziglar, a motivational speaker. The CHNA process is a journey that may have unexpected twists and turns, barriers, and roadblocks,

but in the end, the trip is worth it. Unlike regular journeys, we cannot simply make a U-turn whenever we face a challenging or uncomfortable situation. Instead, we must work together to address any issues. Applying a health equity lens to the CHNA process requires intention. Like a traveler carefully packing their essential items, we recommend three critical components as crucial strategies for a successful CHNA journey.

1. Aligning Data for Health Equity

Data doesn't lie, but sometimes it doesn't tell the whole story. If we rely on electronic medical records, we might miss the social factors influencing a person's health. And if we focus only on community data, we could underestimate the clinical needs of a population. This is why our approach to this CHNA — guided by a health equity focus — is about aligning and integrating data so that the entire organization can work toward eliminating disparities. No longer is this the purview of a single department.

So how are we striving toward that goal?

Data is empowering, but there are often hurdles to curating it so that every member of CHRISTUS Health — not just the data scientist or analytics leaders — can use it in their day-to-day work. CHRISTUS cleared those hurdles by sharing curated data and easy data visualiza-

tion tools from Metopio, its partner in the current CHNA process, so that everyone could consider equity, regardless of their role. The Metopio platform aggregates data from various sources and allows easy visualization and analysis of various health indicators, which helped us involve multiple departments throughout our system in the CHNA.

Health equity was a key component in the data collection strategy for the CHNA, and used when the community health indicators were developed to capture relevant community data. Collected community data was aligned with data captured clinically in the electronic health records. This data is stratified by race, ethnicity, age, preferred language, gender, payor and disability status (REaLG & PD), as well as sexual orientation and gender identity (SOGI) demographic information, which was also collected through the community survey. This demographic information allows for data stratification to identify the needs and specific challenges of some underrepresented and historically marginalized populations.

Once data capture was aligned with our clinical systems, we then applied the framework of the social determinants of health. The key variables included education level, income level, health insurance coverage, food security, unemployment rate, housing status, internet access, access to transportation and life expectancy. We also utilized the Social Vulnerability Index and the Hardship Index to identify communities of focus by zip codes within CHRISTUS Health service areas to ensure that we adequately assessed the needs of these areas.

This helped ensure we included data on populations that may not respond adequately to the typical survey dissemination and data collection strategies. These social indicators were integrated using secondary data readily available on Metopio.

2. Inclusive Language and Narrative

CHRISTUS Health serves a diverse population, many of whom have limited English proficiency. We are committed to fully understanding and addressing their needs, which means we need to consider language carefully. In addition to the equity data journey, we are also mindful of the language we use to create the narrative of the community to amplify their lived experiences (positive and negative). The data collection period used equity-centered and Person First Language (PFL), including the community survey, focus group discussions, key informant interviews, emails, and other promotional materials. For instance, answers in the survey were often accompanied by several examples so that community members unfamiliar with medical terminology would not be alienated. We also used the term “communities of focus” vs. “target population” to identify specific needs.

The surveys were available in English and Spanish, the most common languages spoken in the service area, but community partners were also engaged throughout the survey development process to inquire about other common languages within the communities. The survey was made available in these

languages as needed. And special attention was given to the wording choice. We strove to provide a survey in very simple language to ensure that people with low literacy could easily understand it and provide appropriate responses. We are also fortunate to have community partners such as food banks, Federally Qualified Health Centers, and Homeless Coalitions, who assisted residents who had poor literacy or language barriers to complete the survey to ensure that the captured data was representative of the communities.

3. Community Partnership and Governance

Trust is achieved by honest dialogue and ongoing community engagement and partnership. Without trust, community participation will be difficult, and it can bias the data. The CHNA should not be a unilateral flow of data from the community to researchers; instead, this process should involve co-learning where community feedback is sought at every step. This information feedback loop improves the needs assessment process.

Each CHRISTUS Health ministry has a Community Advisory Council (CAC), which plays an important leadership role in the CHNA process. To ensure community partnership, diverse community residents and partners with lived experience from the service area were invited to the committee. Furthermore, community integration was conducted through data collection and our CHRISTUS Fund Community Learning Collaborative. A system-wide community survey

was implemented as a data collection strategy for the first time. The surveys were distributed in three phases involving CHRISTUS Fund grantees, CHRISTUS associates, and the community.

Additionally, community partners were involved in recruiting focus group participants and key informants as they recommended important “ambassadors” and community residents. Diversity in residence, race, ethnicity, gender, and other demographic factors were considered during recruitment. This qualitative data provided a different perspective on community needs and strengths; it elicited thoughtful, personalized insights into the lived experiences of community members. Because one of our first steps in the CHNA was data integration, we had a system in place to align the quantitative data with the qualitative data. This has given us a more accurate understanding of needs.

Data collection should not be a burden. It is essential to understand the lived realities of who we serve and integrate their experiences, knowledge, and talent to improve the vital conditions of our communities and work with cross-sector partnerships and stakeholders to ensure their comfort and participation. To improve participation, meetings with community residents, including focus group discussions and key informant interviews were held in person, virtually, or in a hybrid format, with the respon-

dents choosing the most convenient platform for themselves. Finally, after the data collection phase of the needs assessment, the key stakeholders, including community residents and other important community partners, helped prioritize the identified needs and goals unique to their communities that will be addressed by the Community Health Implementation Plan (CHIP).

Increasing the Impact of Community Benefit Investments

The data collected from a CHNA should be an essential piece of any health equity strategy. At the same time, a health equity strategy should guide how data is sought from the community. If it doesn't, the data collected will not give an accurate picture of the community and as a result, programs and interventions will be developed on a foundation of faulty data. With new data sharing and analytics technology, CHNAs can now be a fully integrated part of any health system's strategy. There's no excuse for them to be “one and done.”

To ensure that community benefit investments are impactful, as an anchor organization, we must engage our associates and integrate our community partners. This means making a point of partnering with diverse stakeholders, including the community, when making important decisions related to community benefits. This culture of

community partnership needs to be promoted internally within the organization and externally through appropriate communication channels. This is not simply to receive recognition but to nurture a culture of health that demonstrates tangibly how the contributions of our associates will lead us towards a just world in which we all live our mission and model our values.

In conclusion, the benefits of this journey are committing to inclusive practices that integrate the people affected by the decisions, while creating a reciprocal process of sharing power and resources. We will continue to build a culture that ensures that we all experience and extend God's healing presence and love to improve the health outcomes of historically marginalized communities. We are still on the journey toward working together to eliminate health inequities.

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