Glossary of Community Health Terms

Collaborators

Third-party, external community partners who are working with the hospital to complete the assessment. Collaborators might help shape the process, identify key informants, set the timeline, contribute funds, etc. [1]

Community Health [Needs] Assessment (CH[N]A)

An evaluation of a community's health needs and issues at the state, Tribal, local, or territorial level based on systematic, comprehensive data collection and analysis. Non-profit hospitals develop "community health needs assessments".[2]

Community Health Improvement Plan

A strategy that a community develops to describe how it will work together to address the public health problems highlighted in the community health [needs] assessment. It is typically updated every three to five years.[2]

Community Engagement

The involvement of people who will be affected by MAPP in the process to ensure their needs and desires drive the work. Strong community engagement involves interpersonal trust, communication, and collaboration. [2]

Community Meeting

The prioritization process or community meeting included one in-person or hybrid 90-minute facilitated session hosted in collaboration with the health council in each county. The goal of this session was to engage health council and local voices in a streamlined prioritization process and build out community recommendations for action around each priority need. [1]

Demographics

The population characteristics of your community. Sources of information may include population size, age structure, racial and ethnic composition, population growth, and density. [1]

Food Insecurity

Food insecurity is a household-level economic and social condition of limited or uncertain access to adequate food. [3]

Levels of Food Insecurity

- Low food security (old label=Food insecurity without hunger): reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake.
- Very low food security (old label=Food insecurity with hunger): reports of multiple indications of disrupted eating patterns and reduced food intake.

Food Security

Access by all people at all times to enough food for an active, healthy life. [3]

Levels of Food Security

- High food security (old label=Food security): no reported indications of food-access problems or limitations.
- Marginal food security (old label=Food security): one or two reported indications—typically of anxiety over food sufficiency or shortage of food in the house. Little or no indication of changes in diets or food intake.

Health Behavior

An action people take that affects their health positively (e.g., exercise) or increases their risk for disease (e.g., smoking). [1]

Health Council

In each county, there is a group of community members focused on improving the health of their county through a collaboration called a 'health council.' They are vital partners in the CHA process and focus on the CHA's priority health needs.[1]

Health Disparity

The difference in health outcomes or access to healthcare across populations, which results from socioeconomic, biological, and psychological factors and the behavior of individuals. This term does not account for the unequal structuring of life chances.[2]

Health Equity

When everyone has a fair and just opportunity to achieve optimal health (refer to optimal health).[2]

Health Outcome

The physical and mental well-being of residents in a community. It is measured by how long they live and their quality of life (feeling healthy, comfortable, and able to enjoy life events).[2]

Hunger

Hunger can refer to the discomfort, weakness, illness, or pain caused by a long-term lack of food. [3]

Identified Need

Health outcomes or related conditions (e.g., social determinants of health) impacting the health status of the community served.[1]

Indicator

A measure or data that describe community conditions currently and over time (e.g., poverty rate, homelessness rate, number of food stamp recipients, life expectancy at birth, heart disease mortality rate). It helps answer how we are doing regarding the community conditions we care about.[2]

List Serv

A List Serv is an electronic mailing list to communicate with a large group of people over email. [1]

Listening Session

The MPHD listening session consisted of the Health Department Director along with key staff from the Davidson County Health Department. The MPHD listening session was an interview with five open-ended questions gauged to learn about community assets, barriers, and how the prioritized needs have changed since 2021-2022 including recommendations for addressing the prioritized needs. 1

Local Public Health System (LPHS)

All the people and organizations who deliver the essential public health services in a community, including assessing the population's health, developing policies to support health, and ensuring people in the community can be healthy. It includes a wide variety of agencies (federal, state, and local), laboratories and hospitals, as well as non-governmental public and private agencies, voluntary organizations, and people. [2]

Medically Underserved Populations

Medically underserved populations include populations experiencing health disparities or that are at risk of not receiving adequate medical care because of being uninsured or underinsured or due to geographic, language, financial, or other barriers. Populations with language barriers include

those with limited English proficiency. Medically underserved populations also include those living within a hospital facility's service area but not receiving adequate medical care from the facility because of cost, transportation difficulties, stigma, or other barriers. [1]

Primary data

Data collected directly, for example through surveys, listening sessions, interviews, or observations. [2]

Prioritized Need/Community Prioritized Need

Significant needs which have been selected by the community that the hospital will address through the CHA implementation strategy. [1]

Qualitative Data

Information that is summarized without numbers and typically in textual or narrative format (e.g., focus group notes, open-ended interview or questionnaire responses, and observation notes). [2]

Quantitative Data

Data expressing a certain quantity, amount, or range. Usually there are measurements associated with the data. [2]

Secondary Data

Data that has already been collected by another group or for another purpose. [2]

Self-Assessment

Self-Assessment was given to NHWLC members and is a five-question questionnaire that addressed priority health needs, changes related to the needs, and recommendations for improvement. [1]

Significant Need

Identified needs which have been deemed most significant to address based on established criteria and/or prioritization methods. [1]

Social Determinants of Health (SDOH)

The conditions of the environments where people are born, live, learn, work, play, worship, and age that affect their health and well-being. [2]

Strategic Issue

Fundamental policy choices or critical challenges that must be addressed for a community to achieve its vision.

References:

[1] Catholic Health Association of the United States. (2015). Assessing & Addressing Community Health Needs, 2015 Edition II. https://www.chausa.org/focus-areas/community-benefit/resources/resource/assessing-and-addressing-community-health-needs.

[2] National Association of County and City Health Officials. (2023). Mobilizing for Action through Planning and Partnerships MAPP 2.0 User's Handbook. https://www.naccho.org/resource-hub-articles/mapp-2-0.

[3] Definitions of Food Security. USDA Economic Research Service. https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/definitions-of-food-security/ Accessed April 26, 2022.