c o m m u n i t y

HEALTH ASSESSMENT

A Process for Positive Change

A collaborative process for improving community health

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Acknowledgments

This document was originally conceptualized by a working group representing the Voluntary Hospitals of America Inc. (VHA), The Hospital Research and Educational Trust (HRET) of the American Hospital Association, the Catholic Health Association of the United States and the Centers for Disease Control. These organizations came together to consider a collaborative project, given the impetus of each of their community benefit initiatives. Members of this original working group included: Christina Bethell, senior policy analyst, VHA Inc.; Deborah Bohr, vice president, HRET; Carol Dietrich, chief operating officer, Butler Memorial Hospital, Butler, Pa.; Annette Fetchko, director, communications and marketing, VHA Pennsylvania; Barbara Giloth, then-director, Health Services Research, HRET; Karen Madura, research associate, HRET; Charles Nelson, chief, Community Health Promotion Branch, Division of Chronic Disease Control and Community Intervention, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control; Susannah Parker Sinard, then at Mercy Health Services, Farmington Hills, Mich.; and Julie Trocchio, government services, Catholic Health Association of the United States.

This project was subsequently coordinated by Christina Bethell, VHA Inc., who is also the primary author of the text. Barbara Giloth, now program planning consultant, provided ongoing consultation and editing and has had primary responsibility for developing Section V of the document. Julie Trocchio contributed valuable interviews with hospital staff who are or have been engaged in a community health assessment. The resource section is based in large part on documentation collected and organized by Karen Madura of the HRET staff. Judy Arnold, vice president of Lewin/VHI, contributed to the development of Section VI. Christine McFetridge, previously with VHA, provided research assistance.

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Contents

In the future, health care organizations and providers will be held increasingly responsible for a clear definition of service areas and will then be held accountable for the health status of people living in those areas. Accountability will require health care managers to pay attention not only to the financial status of their institution but also to the health status of the community they serve.

ARNOLD KALUZNY AND STEPHEN SHORTELL
HEALTH CARE MANAGEMENT, 1983

Perhaps as never before, America's health care organizations are being challenged to explicitly demonstrate accountability for maximizing patient and community health and minimizing costs. Popular notions for reform of the health care delivery system would require health care organizations to form integrated networks of care and assume financial risk and accountability for managing the health care of a defined population.

These developments in health care reform combine to facilitate many shifts in the way health care organizations think about, manage and deliver health care. The ultimate goal is to create healthier communities and a healthier America–still the most valid measure of success for our health care system.

The development of physician-hospital collaborative arrangements, health-care process and outcomes benchmarking initiatives, continuous quality improvement efforts and patient-focused care initiatives are examples of health care organizations' efforts to effectively manage under the expectations to demonstrate health outcomes, assume financial risk and operate within an integrated structure.

In addition, health care organizations increasingly are recommitting to work more extensively within the communities they serve to weave together a comprehensive set of health services to ensure coordinated, timely and appropriate access to care. Broad-based community partnerships are being developed to create healthier communities. These partnerships operate from an expanded definition of health that extends far beyond "absence of disease" to embrace a more comprehensive definition of health. Such partnerships allow health care organizations to extend their spheres of influence and share responsibility with other health care and community

organizations and individuals for addressing the physical, social, mental and environmental precursors to disease, and to enhance conditions for wellness.

Community health assessment can be a critical strategic planning and management tool for America's health care organizations that aspire to meet the tremendous challenges facing them. Community health assessment can play an important role within a broader agenda for change to achieve key objectives for reforming America's health care system, including:

- ensuring access to a seamless continuum of care for all;
- reducing and controlling the costs of medical care;
- maximizing the use of resources in the community to address health issues and objectives;
- focusing on prevention and a holistic notion of health and;
- explicitly demonstrating value and accountability for caring for the community's health

Community health assessment, as it is defined here, requires health care organizations to enter into community partnerships to collaboratively assess, address and share responsibility for health care issues. It is a process that can empower a community with knowledge, skills and opportunities for effectively coordinating services and initiatives to address community health problems. The process facilitates conscious management, coordination and use of health resources. In general, community health assessment may be seen as a tool to:

- understand the *patterns and pathways of health and disease*, including measures of health status, specific health problems, their related causes and socioeconomic context
- ascertain the *access to, availability, use and coordination* of community health resources
- assess the *potential for and willingness of the community* to address health problems
- determine *effective courses of action* that may improve and sustain health status over time and lead to productive and desired changes in the type, amount, mix or coordination of resources
- establish *benchmarks for determining effectiveness* in improving health status over time

This document addresses the challenge and imperative for health care organizations and practitioners to work together and partner with the broader community to assess community health issues, set goals and develop creative, efficient and integrative strategies for addressing those issues and goals. While each community will need to fashion their community health assessment according to their particular circumstances and objectives, this document presents some core concepts, a general process and challenges that are likely to be relevant to any assessment effort.

The first three sections of this document primarily focus on the strategic fit and conceptual and philosophical basis for such an effort. The next three sections focus on implementation of the six-phase community health assessment process outlined in the document. The final section lists many of the resources and references related to community health partnerships in general and community health assessment in particular. The information in this document was obtained through numerous interviews and reviews of hospital- and community-based efforts, an extensive literature review and the deliberations of a diverse working group of health professionals. A brief overview of the document is provided below.

Summary of Document

DEFINITION OF COMMUNITY HEALTH ASSESSMENT

Nine core concepts are introduced that comprise the operational definition of community health assessment. The document uses a broad definition of community health assessment most closely aligned with a collaborative and systemic vision of community health.

Operational definition of community health assessment

> A community health assessment is a 1) *dynamic process* undertaken to identify the 2) *health problems and goals* of the community, enable the communitywide establishment of 3) *health priorities*, and facilitate 4) *collaborative action planning* directed at improving 5) *community health status and quality of life*. Involving 6) *multiple sectors of the community*, the assessment draws upon both 7) *quantitative and qualitative population-based health status and health-services utilization data*. With a strong emphasis on 8) *community ownership* of the process, a community health assessment supports developing 9) *community competence* in the identification and response to community health problems and goals.

Dynamic Process: Rather than being a one-time event, a community health assessment is a dynamic and ongoing process that may be considered as continuous quality improvement applied to a community system rather than an individual institution.

Health Problems and Goals: It is common to determine health problems and goals based on an analysis of health "needs." However "need" is a relative term and there are numerous ways to determine a health need, based upon normative standards, community perceptions, comparisons with similar communities or the expressed demand for services.

Health Priorities: Determining priorities for action is a central task in the community health assessment process. Developing priority health goals and objectives requires the synthesis and organization of often-disparate and complex data and a careful balancing of viewpoints, values and realities regarding what issues should command priority attention. Many processes exist for developing priorities.

Collaborative Action Planning: Community health assessment, as defined in this document, suggests that a multisectoral community partnership engage in collaborative action planning to identify and address health objectives. To do so, the partnership must clearly address questions regarding who should be involved, how to conduct the planning process and what specific goals and objectives are for the action plans.

Community Health Status and Quality of Life: The overarching goal of most community health assessments is to improve health status and quality of life, but initially both must be defined and measured to establish baseline measures and assess improvements over time. Numerous lists of indicators and tools for measuring health status and quality of life exist.

Multiple Sectors of the Community: The involvement of multiple sectors of the community is necessary to achieve a systemic understanding and response to community health problems. Multiple sectors of the community are required to participate because health problems occur within a community system; and because identifying and establishing priorities and achieving support for efforts to address community health objectives and goals is largely a political process.

Quantitative and Qualitative Data: Capturing the dimensions of a community's health requires tapping and synthesizing information and data from various sources. Four broad, interconnecting profiles for initially collecting and organizing both quantitative and qualitative community data may be developed: 1) demographic profile of the number and types of people in the total population and its subgroups; 2) a health profile to assess the physical and mental well-being of a population; 3) a sociocultural profile of the many social conditions and cultural characteristics that influence and reflect the health and well-being of a community; and 4) a resource profile to understand the monetary, human, physical and social resources of a community.

Community Ownership: One of the fundamental goals of a community health assessment is to generate a genuine sense of community ownership, individual responsibility and shared accountability for creating a healthier community. The community health assessment process requires and provides an opportunity to create the meaningful community involvement that nurtures community ownership.

Community Competence: A community health assessment process assists with developing a community that is increasingly capable of identifying and responding to local health problems. Eight conditions of a competent community are presented.

THE COMMUNITY HEALTH ASSESSMENT PROCESS

Six phases constitute the community health assessment process outlined here. It is not a linear process, nor will all steps be relevant to all community health assessment efforts. Each phase requires several steps that are fully outlined in the document. The six phases are briefly described below.

PHASE I   Internal and external asssessment

This phase includes:

- Securing the willingness and readiness of each organization

- Reviewing current efforts underway in the community and specifying various parties for partnership

- Developing a strategy for affiliation with other organizations

PHASE II   Partnership building, and planning and tailoring the process

This phase includes:

- Beginning (or continuing) to build a partnership with other community organizations and individuals to conduct a community health assessment

- Convening potential partnership members and creating a partnership vision, strategy and structure for managing the collaboration

- Specifying the target community, goals, objectives, scope, timeline and resources for the assessment

- Surveying the preliminary data needs and options for methods of data collection

- Determining specific sources and modes of data collection for each data type

PHASE III   Data collection

This phase includes:

- Designing and implementing specific activities for collecting each data type

- Monitoring progress on effective collection and quality of data

PHASE IV   Synthesis and communication of information

This phase includes:

- Synthesizing information and data collected in various ways

- Presenting and communicating synthesized data to relevant audiences

PHASE V   Setting priorities and planning for collaborative action

This phase includes:

- Defining a process, criteria and alternatives for selecting priority health objectives

- Deciding on priorities, related health objectives and priority groupings for purposes of action planning

- Organizing action-planning teams and implementing a collaborative action-planning process around specific priority health objectives

PHASE VI   Action and evaluation

This phase includes:

- Securing the commitment, skills and resources to implement recommendations

- Continuously striving to improve implementation processes and maintain participation and commitment to goals

- Coordinating with other action-planning teams that have similar objectives

- Evaluating the community health assessment process against predetermined criteria

- Evaluating the success of action plans at appropriate intervals and feeding it back into implementation processes

Community Health Assessment Process

Phase I	INTERNAL AND EXTERNAL ASSESSMENT
Phase II	PARTNERSHIP BUILDING PLANNING AND TAILORING THE PROCESS
Phase III	DATA COLLECTION
Phase IV	SYNTHESIS AND COMMUNICATION
Phase V	PRIORITIZATION AND PLANNING FOR COLLABORATIVE ACTION
Phase VI	ACTION AND EVALUATION

ONGOING
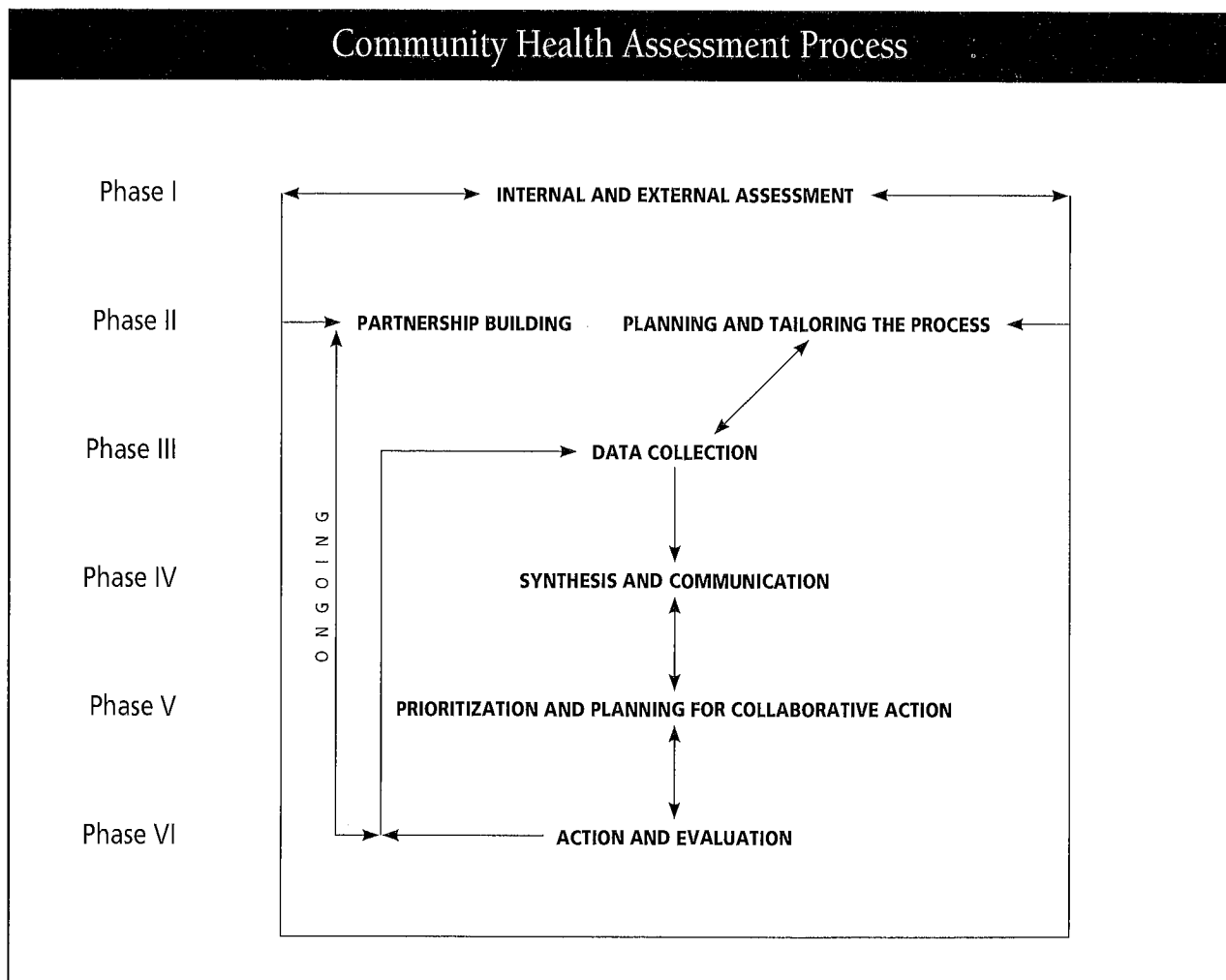
KEY MANAGEMENT CHALLENGES

Designing and implementing a community health assessment is a critically important, but sometimes difficult process. Health care organizations are especially challenged by the collaboration required among key health and community organizations and individuals, and the data collection issues and analysis required to implement such an initiative. Nine key management challenges are discussed.

Key Challenges Related to the Process of Partnership Building

Challenge #1: *Gaining and maintaining top leadership support.* Top leadership support is required to develop community consensus and implementation of action plans for community health priorities. Health care organizations are usually viewed as a community's major health resources, and if their leaders do not take a visible role in the assessment, community residents and leaders are less likely to take the process seriously. Many strategies may be used to spark the interest and commitment of top leaders.

Challenge #2: *Achieving ongoing community involvement.* A vision of community health must include shared decisionmaking around priorities and actions. Shared decisionmaking should be nurtured through the planning and implementation of a community health assessment. Health professionals who have traditionally taken charge of health-related decisions often need to step back and listen. Similarly, community leaders and residents looking for the magic bullet to solve health problems instead need to own their share of community responsibility for the solution. There are a number of strategies to consider for encouraging active community involvement.

Challenge #3: *Managing consensus-building.* To build consensus, process concerns must be monitored closely to ensure that each participant has a chance to speak, that brainstorming and other creative strategies are used to generate options and that group decisionmaking techniques are used to help the group make important decisions. Consensus-building may be most successfully managed if a neutral and well-respected individual(s) skilled in group process serves as a process champion and meeting facilitator.

Challenge #4: Maintaining realistic expectations. Ensuring that a community maintains realistic expectations about organizational roles and resources is a common concern of health-care-organization leadership. A focus on listening, the active involvement of key community leaders from all sectors and a willingness by the organization to support and be involved in inititatives of other organizations to achieve health objectives all can help in managing expectations.

Key Challenges Related to Data Collection and Analysis

Challenge #5: Selecting cost-effective approaches to data collection. Seven primary considerations can help a community health assessment partnership select the appropriate data and data-collection techniques: 1) the goals of the health assessment; 2) already-existing data; 3) political considerations; 4) heterogeneity of the population; 5) the mix of quantitative and qualitative data; 6) involvement of stakeholders; and 7) resources.

Challenge #6: Achieving adequate response to data collection. Achieving an adequate response to data collection is both a technical and communications challenge. Experts in survey research and focus-group techniques can assist with the technical aspects. Effective communication with the community is needed to faciliate a positive relationship and improve response to data collection inquiries. It is particularly important for the assessment to be representative of and involve the community.

Challenge #7: Digesting data for analysis and priority-setting. Digesting and summarizing data so that it can be used is a critically important and often difficult part of the health assessment process. The dilemma is how to summarize data for use without simplifying it so much that priorities are set without broad discussion. Strategies to ensure that data can be used successfully in setting priorities are suggested.

Challenge #8: Managing an equitable priority-setting process. Selecting priorities is one of the most delicate and potentially destabilizing aspects of the community health assessment process. Strategies for managing an equitable priority-setting process include: 1) using partnership members to identify criteria for communitywide priorities; 2) encouraging partnership members to take priorities back to their constituencies and get additional feedback before they become final; 3) encouraging individual agencies to identify criteria for selecting their own priorities; and 4) meshing the partnership and individual agency priorities to evolve a strong action plan.

Challenge #9: Moving from data collection to action. Partnerships organized to implement action plans from a community health assessment process may become bogged down in inaction after completing several previous phases. Some strategies may help including: 1) building shared decision-making and involvement from the beginning; 2) organizing a structure to facilitate planning and project development; 3) developing an operating code that guides the process and function of whatever structure has been chosen; and 4) developing a mechanism to maintain enthusiasm.

DATA NEEDS AND ISSUES

Collecting and analyzing data can be a challenging task for those not experienced in conducting a community health assessment. The partnership-building process offers many opportunities to tap data and research resources. This section discusses the various types of data likely to be sought for a health assessment, and some guidelines for tapping into local, state and national sources of data. The many types of data required for a community health assessment may be categorized into four data profiles of a community—demographic, health, sociocultural and resource profiles.

RESOURCES AND REFERENCES

A variety of resources related to the community health assessment process are profiled in the resource section, including information on other community health assessment manuals, publications regarding community benefit, and information and data sources for health promotion, health planning and program implementation. The reference list includes numerous articles and publications cited throughout the document and is useful for further exploration of community partnerships and community health assessment.

Introduction

This is an opportunity that doesn't come often; an opportunity to have a society that is once again a community.

<div align="right">

Hillary Rodham Clinton
AHA Convention, August 9, 1993

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System reform and community action

While policies to reform America's health care system are debated and legislated in the halls of Congress and our state capitals, the community level is where the true test for reform will occur. Throughout the nation, local health care organizations, practitioners, payers and consumers have been taking bold steps to transform the health care system–to control unsustainable increases in the cost of care, expand and coordinate access to care, and ensure accountability for quality and effectiveness of care. Perhaps more than anything, the success of these initiatives requires a renewed commitment and capacity among all involved to work in partnership and innovate to continuously improve health status, maximize value and minimize costs. Many of these efforts challenge traditional perspectives, policies and practices of health care providers, their patients, communities and payers.

Amid the seeming chaos of the many efforts underway is a discernable "zone of consensus" regarding the general direction of the health care system. Widespread agreement is increasingly evident that the health care system of the future is likely to be:

- increasingly composed of *integrated networks of care*

- increasingly required to assume *financial risk for the care of defined populations*

- *community-based and prevention- and wellness-oriented*

- *evaluated according to demonstrated patient and communitywide health outcomes*

These goals for transforming health care seek to establish a new infrastructure for financing and delivering health care in America and require unprecedented innovation and change in the

way that health care organizations and their communities think about, manage and deliver health care. Perhaps the most significant shift underway among health care providers has been the move to transcend a focus on competition and the delivery of acute-care to embrace a renewed commitment to collaboration and improving communitywide health status.[1]

A unique synergy between trends in both public- and private-sector health policies enlivens and sanctions this shift. For example, many private- and public-sector reform proposals advocate the purchase of health care through consumer purchasing alliances. Under these proposals, consumer and payer demand for integrated, comprehensive health services at a capitated rate is expected to be greatly enhanced and require the vigorous and continued development of collaborative community health care networks (also termed integrated services networks and accountable health plans).

The simultaneous trend to base assessments of health care quality and value on both patient and community health outcomes and satisfaction further encourages the development of community-based and preventive health-care strategies, structures and skills driven by the assessed health and perspectives of patients and the community.

In short, among many other trends, the trend toward capitation payments for the health care of a defined population, coupled with assessments of quality based on patient and community health outcomes and satisfaction, serve to reinforce a shift toward communitywide collaboration to integrate services, prevent illness, promote health and improve health status.

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[1] For purposes of this document, community will be defined as the organizations and population within the geographic area in which a health care network or organization is located rather than the enrolled or insured population associated with the network only. The majority of the information contained here is equally relevant under either definition. Community can be defined in numerous ways—each with different implications. See the brief discussion on defining community in "Section IV: The Community Health Assessment Process."

FIGURE 1

Vision of Success for Health Care Organizations

Narrow
Market
Orientation

Broader
Community
Orientation

ASSESS MARKET

Identify services
that expand market

ASSESS COMMUNITY

Identify services that improve health
status and address the health needs
and goals of the community

Success largely
defined by
proportion of
market share

Success largely defined by health of
community and successful management
of risk for the care of a defined population
(may lead to increased market share)

To date, many complex health care policy issues remain to be resolved both nationally and locally. These issues include specific mechanisms for financing and distributing the burden for costs of care, ensuring availability and access to health care, defining minimum health care benefits, and delineating specific payment methodologies and accountability standards for health care organizations and practitioners. Nevertheless, it is hoped that the move toward a broader community orientation will endure regardless of how these issues are resolved and readdressed over time (See Figure 1).

It is hoped that transformations sought in community health-care systems nationwide will go beyond the mere reformulation of current structures and procedures to generate new, innovative models reflecting a genuine commitment to rebuild and shape health care around a more expansive and inclusive vision—one that incorporates the essential values of community, resource conservation and sustainability, holism and basic equity in accessing and financing health care. Even as many proposed health-care reform policies seek to push the system in this direction through economic incentives and regulatory control strategies, these values must be embraced and

demonstrated to pull the health care system toward the vision of a coordinated, accessible, prevention-oriented and affordable health care system.

Partnering to set a community health agenda

Increasingly, health care organizations and practitioners must act on the knowledge that while medical care resources are important to achieve health goals, they are only one in a complex web of resources to be accessed and coordinated. Indeed, there is growing awareness that multiple sectors of a community must work together to set and act on an agenda that supports and improves health.

> *While medical care resources are important to achieve health goals, they are only one in a complex web of resources to be accessed and coordinated. Multiple sectors of a community must work together to set and act on an agenda that supports and improves health.*

Achieving greater balance and coordination in the use of resources to address a broad range of community issues are generally among the most significant challenges communities face today. Not only must they address issues related to the availability, cost and effectiveness of health care services, other related issues such as education, economic development, transportation and the environment must be addressed to improve and sustain overall community health and well-being. Effective community partnerships empowered by a comprehensive understanding of the community's health status and potential are key to not only setting and acting on an agenda for addressing specific health-care-related objectives, but also broader objectives related to overall community well-being.

Partnerships to support these efforts can be viewed as the enduring "social capital" that coordinates the human, physical and financial resources within the community to set and address health objectives and facilitate changes in system-level behavior (Coleman, 1988).[2] (See Figure 2) Such partnerships have tremendous synergistic potential, often leading to positive outcomes not envisioned when they are first formed. In addition, they constitute relationships that should endure and reconfigure to serve multiple purposes over time. In the case of health care, community health assessment is one important activity to bring together and empower a partnership to determine and meet community health objectives and goals.

[2] See VHA's "Community Partnerships: Taking Charge of Change Through Partnership" for a more complete discussion of community partnerships. Call (202) 822-9750 to order a copy.

FIGURE 2

Expanding the Definition of Health Resource

PHYSICAL CAPITAL
facilities, tools, technology

HUMAN CAPITAL
skills and capabilities of people

Community Health Resources

FNANCIAL CAPITAL
liquid assets, cash, wealth, access to capital

SOCIAL CAPITAL
relations among persons and organizations that facilitate and direct action
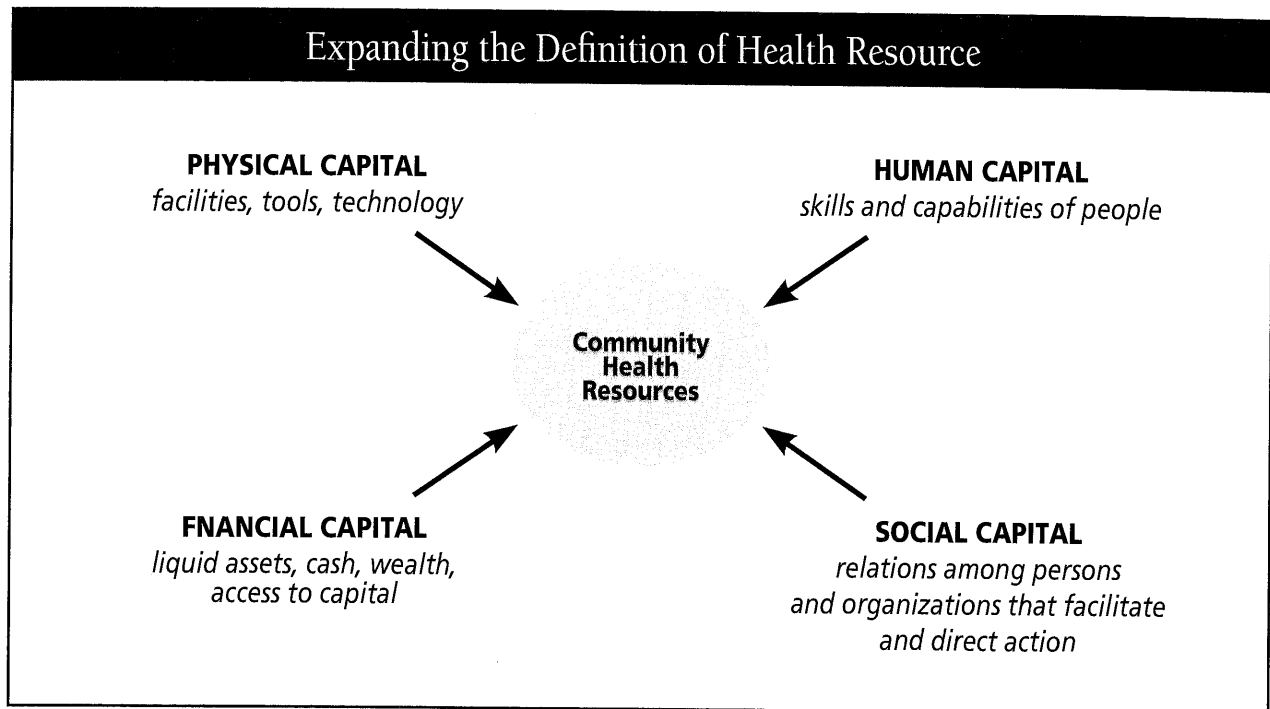
Community health assessment as a process for positive change

The process of community health assessment can empower community health partnerships with the knowledge to more effectively coordinate efforts to prevent and treat community health problems and conserve community health resources. They focus community attention on its health issues and serve as a continual reminder of what there is to learn and improve upon to support health. In general, community health assessment is a partnership, a process and a tool to:

- *understand patterns and pathways of health and disease*, including measures of health status, specific health problems, their related causes and socioeconomic context

- determine *access to, availability, use and coordination of community health resources*

- assess the *potential for and willingness of the community* to address health problems

- identify *effective courses of action* that can improve and sustain health status and lead to changes in the type, amount, mix or coordination of resources (including physical, financial, human and social resources)

- establish *benchmarks for determining effectiveness* in improving health status

The United Way of America, an organization involved in conducting community needs assessments for decades, suggests that an assessment may assist in the following (United Way of America, 1982):

- priorities ranking to assist in decisionmaking
- program planning
- service delivery structures and mechanisms
- information and referral services
- community education

- resource allocation
- fundraising
- legislation development
- data base development
- grant proposals

A community health assessment may serve many functions. However, numerous doubts are likely to exist, especially among those who were involved in the community-health planning movement of the 1970s when health assessments were commonplace and often unsuccessful in meeting their desired goals (Kimmel, 1977; Shapek, 1975). While skepticism may remain about the practical use of an assessment, past mistakes should serve to inform new efforts, not discourage them.

Past experiences teach us that a move to conduct a community health assessment begs many questions regarding basic issues such as:

- the definition of community
- the definition of health and health need
- the determination of appropriate processes and criteria for prioritizing health issues
- the role of community participation
- the collection, use and validity of various and often disparate data
- the shaping of organizational governance, strategic planning and management around assessed community health objectives and goals

This document addresses community health assessments conducted within the context of a community partnership and used as a tool and a process for positive change. The goal is to present a rationale for the strategic fit of community health assessment in today's health care envi-

ronment and provide a working definition and process for initiating, organizing, conducting and utilizing a community health assessment. Potential management challenges and examples of how health care organizations deal with these challenges will be provided, along with a discussion of data issues and needs for community health assessment. Finally, an extensive resource guide is included to support ongoing efforts by health care organizations and their communities.

When the world comes to us in pieces and fragments, lacking any overall pattern, it is hard to see how it might be transformed.

ROBERT BELLAH, ET AL.
HABITS OF THE HEART, 1985

Community Health Assessment and the Accountability Imperative

The hospital of the future will have to be capable of planning from a community-based needs perspective rather than from the hospital's perspective of its needs...if hospitals continue to go their own way, they can build a superhighway to a ghost town.

HOSPITALS AND PHYSICIANS IN THE YEAR 2000
AMERICAN HOSPITAL ASSOCIATION, 1991

Experts in the health care field have long been predicting a move back toward community. Although this move has been somewhat slow, it's now time to fully embrace a vision of a health care system focused on improving communitywide health status. Challenges facing health care organizations aspiring to this vision include redefining their products, services and customers, reassessing the design and location of services, the need for and use of practitioners and personnel, and the management of day-to-day operations and relationships with their various constituencies.

Numerous developments in health care are coalescing to encourage a focus on community health whereby communitywide partnerships and health assessments are essential enabling strategies for demonstrating effectiveness and managing financial risk for the health of a defined population. For example, the Pew Health Professions Commission report (Feb. 1993) creates a vision and recommendations for health care professions through the year 2005. It is based on the input of experts across the country and identifies seven core competencies for renewing the health care system. The first of these competencies, "Care for the Community's Health," calls upon health care organizations to:

Understand the determinants of health and work with others in the community to integrate a range of activities that promote, protect and improve the health of the community, appreciate the growing diversity of the population, and understand health status and health care needs in the context of different cultural values.

In addition, there is a renewed call from payers and consumers for health care providers to explicitly demonstrate accountability and value. For example, expectations for health care organizations to provide "report cards" on quality and value are being built into anticipated federal policy reforms and redefined payer protocols for assessing the quality of health care providers. These report cards are likely to include many measures of effectiveness in focusing on community health such as childhood and adult immunization rates, infant mortality and low birth-weight rates, the occurrence of preventable hospitalizations and delivery rates of various preventive health services (National Committee for Quality Assurance, 1993). Also, new approaches for measuring the quality of health-care provider organizations are being developed based on the expected impact on health care provided using both communitywide epidemiological and clinical indicators. Some of these approaches may even incorporate performance measures that would determine "missed opportunities" to improve health and reduce costs. (Rand Corp., Siu, et al., 1992).

Moreover, indicators to measure an integrated health system's performance are being jointly developed by prominent health-care systems. Included are measures of overall population health status, community benefit and community participation, preventable episodes of medical care and incidence of diseases (Center for Health System Studies, Henry Ford Health System, 1993). Given the overall trend toward integrated health network development, measures such as these could become quite influential if they are adopted by health networks and quality oversight bodies as expected.

Sixty-two percent of hospital CEOs surveyed in late 1992 agreed that by as early as 1995 their hospital will be a part of a regionally integrated health system with other hospitals, physician group practices and other providers (Hospitals, 1992). As these systems develop, various performance measures for health systems, such as those listed in Table 1, may be widely used to determine quality, consumer preference and reimbursement as their methodologies and validity are verified.

In short, current trends suggest that health care systems will be required to collect and synthesize community health data and work collaboratively within the community to address health problems and improve overall health status. Table 1 offers an abbreviated list of the primary performance indicators being developed by a group of more than 20 prominent health systems nationwide for vertically integrated health systems.

TABLE 1

Indicators of Performance for Vertically Integrated Health Systems

PERFORMANCE INDICATOR CATEGORY	SELECTED ELEMENTS OF PERFORMANCE INDICATOR
Population health	Measures of health status using conventional indices of physical and mental health, preventive health behaviors, incidence and prevalence of disease and disease-specific outcomes of care
Community benefit	Measures of community participation in health system decision making and system attention to overall community needs and caring for the needy
Quality of care	Measures include compliance with standard care patterns, hospital re-admissions, frequency of preventable acute episodes for chronic conditions, prescription drug interactions and death rates for surgical procedures
Episode prevention	Measures include avoidable hospital admissions, prevention visits per member per year, trends in marker conditions such as infant mortality and new, advanced cervical and breast cancer cases presenting for the first time, and meeting national prevention guidelines
Episode characteristics	Measures include redundancy of services provided within a care episode, continuity of care, number of sites visited per patient per episode, average lengths of stay, number of surgeries
Satisfaction	Measures of community, patient and employee satisfaction
Efficiency	Measures include cost per episode, percentage of administrative costs, fixed assets and salary costs per member, rate of increase in costs
Capacity	Measures include utilization rates, delays in admissions or care, outsourcing due to deficiencies in service capacity

Note: Additional performance categories were also developed for financial stability and the research and education activities of health systems. (Source: Nerenz, D., Zajac, B., AHA, HRET, 1991)

Finally, emerging industry norms for health system accountability are reinforced by the community benefit standards developed by Voluntary Hospitals of America, Inc., the Catholic Health Association of the United States and the community benefit initiatives of the American Hospital Association. The community benefit standards set forth by VHA, CHA and the previously New York University-based W.K. Kellogg Foundation-funded *Hospital Community Benefit Standards Program* were designed to encourage an explicit commitment to improving our health system's

> *Efforts to determine the value and ensure accountability of America's health care system challenge health care organizations to demonstrate increasing responsiveness to health problems as they occur within a community system.*

effectiveness in creating healthy communities. They provide guidance regarding the key values, policies and practices necessary to care for the community's health, prevent disease and contain health care costs. Appendix B provides a summary of each of the three sets of community benefit standards mentioned here.

In summary, recent efforts to determine the value and ensure accountability of America's health care system challenge health care organizations to demonstrate increasing responsiveness to health problems as they occur within a community system. Popular notions for reform of the health care delivery system would require health care organizations to form integrated networks of care and assume financial risk for managing the health care of a defined population. These developments in health care reform combine to make community health assessment a critical strategic planning and management tool for America's health care organizations. Figure 3 summarizes the role of community health assessment in achieving some of the primary objectives for reforming America's health care system.

FIGURE 3

Linking Health Reform Objectives to Community Health Assessment

REFORM OBJECTIVE: *Contain Health Care Costs*

As a resource allocation and strategic planning tool, a community health assessment can highlight opportunities and inform decisions that can lead to the more cost-effective targeting, organization and provision of community health services.

REFORM OBJECTIVE: *Ensure Access to and Coordination of Care*

A community health assessment can help communities understand current patterns of use and availability of services, thereby providing a basis for strategies to improve access and coordinate care.

REFORM OBJECTIVE: *Explicitly Demonstrate Value and Accountability*

A community health assessment can be used as a tool for benchmarking and assessing improvements in health status and meeting health objectives. In this way it may be seen as an application of continuous quality improvement methods at the community level. A community health assessment may also be a tool for health care organizations to use to ensure their responsiveness to the community by helping them enumerate and describe problems and goals from the perspective of the community.

REFORM OBJECTIVE: *Build Effective Community Health Partnerships*

A community health assessment process can aid in mobilizing the community on its own behalf–helping to overcome apathy and a sense of helplessness. It is a process for developing community collaboration, harnessing the unique strengths and creative potential of community organizations and citizens and gaining resolution of viewpoints regarding community health problems and goals.

REFORM OBJECTIVE: *Focus on Prevention and Holistic Notion of Health*

A community health assessment can provide population-based information to assess opportunities for disease prevention, health promotion and health protection. By capturing a broad snapshot of the community, a community health assessment supports a systems approach to improving health status and provides insights into the fundamental causes and pathways of disease and ill-health.

Note: Reform objectives delineated here are abstracted from review of all major private sector and governmental health care reform proposals available to date.

Definition and Core Concepts
of a Community Health Assessment

Nine core concepts comprise the operational definition of community health assessment (see Figure 4). This definition evolved based on interviews with experts, discussions with staff in health care organizations, the deliberations of the project's working group and an extensive literature review. Each concept is discussed briefly in this section and reinforced in Sections IV, V and VI.

This document uses a broad operational definition of community health assessment most closely aligned with a collaborative and systemic vision of community health. The breadth of the definition is designed to encourage discussion in communities where providers and community organizations are building partnerships to impact the community's health. It is not intended to discourage modest efforts at community health assessment that can grow and expand in the future as preliminary objectives are achieved.

Operational definition of community health assessment

A community health assessment is a: 1) *dynamic process* undertaken to identify the 2) *health problems and goals* of the community, enable the communitywide establishment of 3) *health priorities*, and facilitate 4) *collaborative action planning* directed at improving 5) *community health status* and quality of life. Involving 6) *multiple sectors* of the community, the assessment draws upon both 7) *quantitative and qualitative population-based health status and health-services utilization data*. With a strong emphasis on 8) *community ownership* of the process, a community health assessment supports developing 9) *community competence* in the identification and response to community health problems and goals.

FIGURE 4

Core Concepts of Community Health Assessment

- Dynamic process
- Health needs and goals
- Communitywide health priorities
- Community competence
- COMMUNITY HEALTH ASSESSMENT
- Collaborative action planning
- Community ownership
- Health status and quality of life
- Quantitative and qualitative data
- Multiple sectors of the community
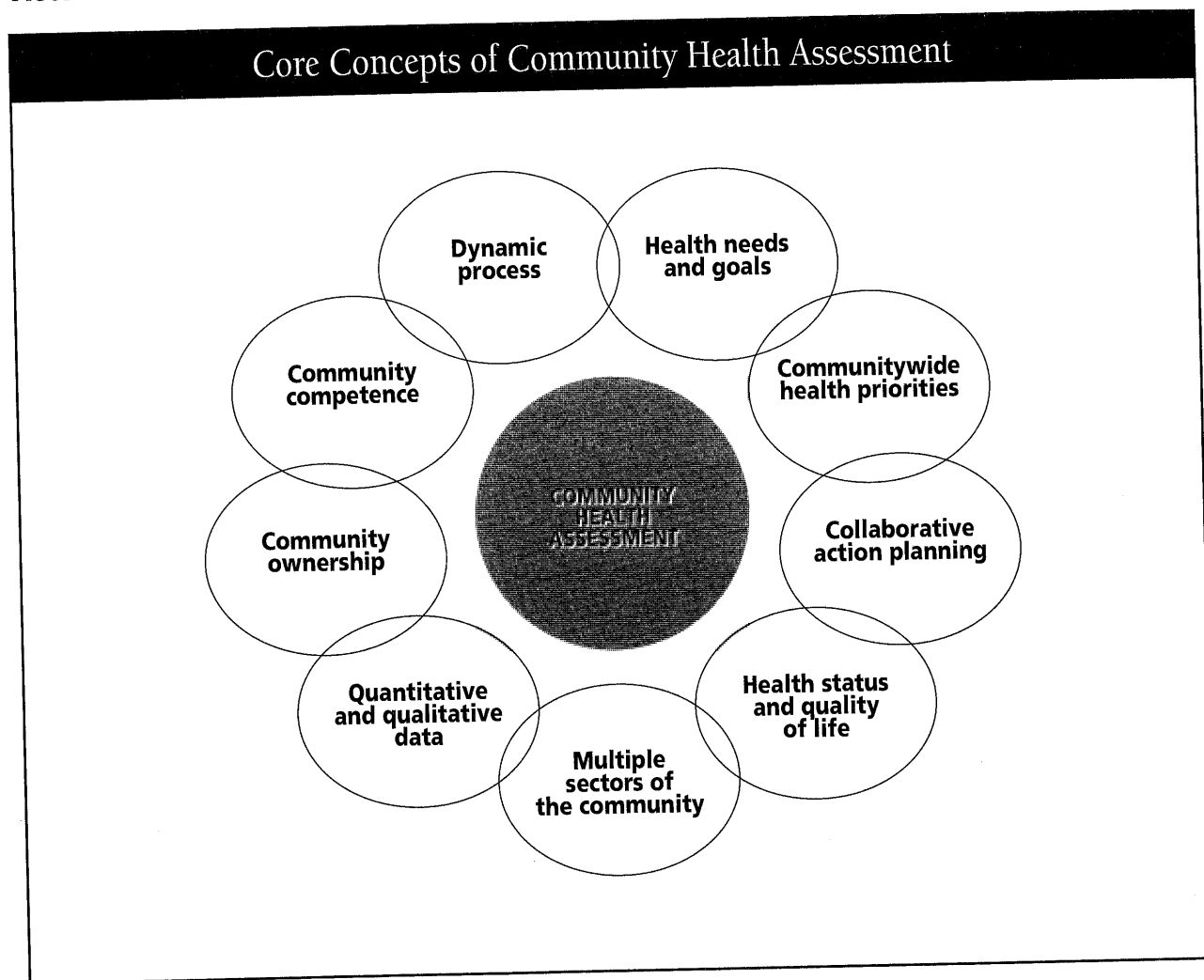
CONCEPT #1: *Dynamic Process*

> *It is anticipated that over time, baseline data and outcome measures will become more sophisticated and that as more citizens learn of this effort they will choose to be part of creating a healthier future.*

<div align="right">

HEALTHY LINN 2000
ST. LUKE'S HOSPITAL, CEDAR RAPIDS, IOWA

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A community health assessment is not a one-time event. Rather, it is a dynamic and ongoing process. For example, a community partnership formed to evaluate health issues and priorities and engage in collaborative action-planning should be developed and sustained as an enduring community resource. Similarly, selected community health data should be collected at ongoing and specified intervals to enable the continuous tracking of health improvements and illuminate subtleties of health issues not apparent during the initial assessment and action-planning. Indeed, many report that community health data are likely to be understood more clearly as the various data sets used for thorough health assessments are more meaningfully evaluated, interpreted or improved upon over time.

A community health assessment is likely to involve numerous cycles of learning and change. This process may require a profound restructuring of relationships among organizations and behavior changes from individuals and the entire community.

The idea of continuously learning and improving, illustrated by the continuous quality improvement (CQI) concept, also applies to the community health assessment process. In many ways the process may be thought of as CQI applied to a community system rather than an individual institution.

A community health assessment is likely to involve numerous cycles of learning and change. In the initial cycle of learning (see Figure 5), a community team may focus on a general assessment of current efforts and community health issues to improve upon those efforts and/or find straightforward solutions to specific problems. As the process continues, the team may better understand the underlying patterns and critical linkages among seemingly different community health problems and gain an appreciation of the overall community paradigm governing the issues.

As the cycle of planning, action and evaluation progresses, a community team can reach a transformational learning level. At this stage of the cycle, the team may gain a systemic view and understanding of community health problems and can work more consciously toward shifting the paradigm and community structures that may be preventing constructive efforts for change. This process may require a profound restructuring of relationships among organizations and behavior changes from individuals and the entire community.

Transformational learning requires many cycles of learning and change, but may occur more quickly if each member of the partnership is equipped with an advanced and systemic understanding of community health issues. Nevertheless, a successful community health assessment is a continuous and dynamic process.

FIGURE 5

Cycles of Learning and Cycles of Change

Initial Learning   Paradigm Learning   Transformational Learning
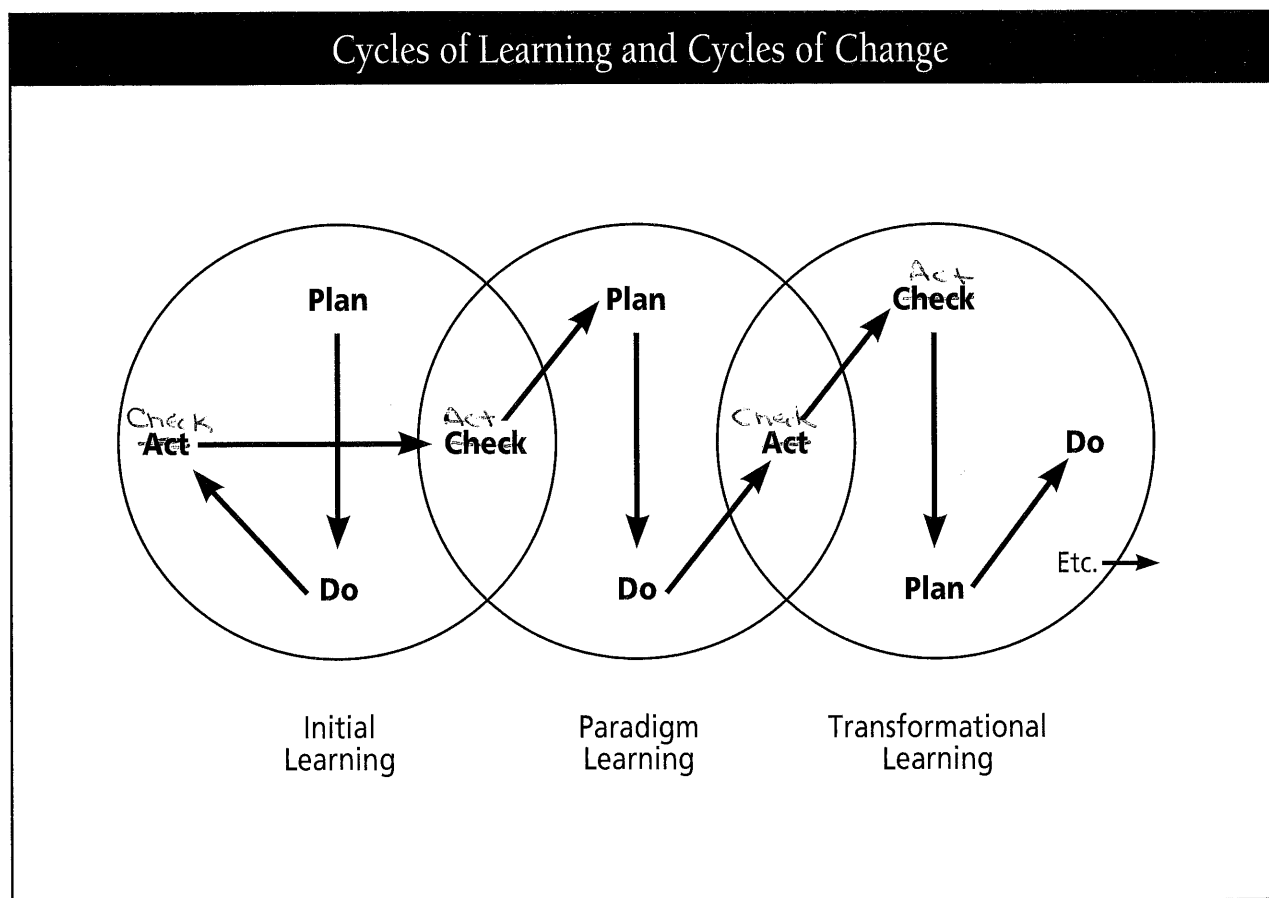
CONCEPT #2: *Health Problems and Goals*

The term "need" can be used to refer both to the identified problem and to the help which is required to alleviate it. Here, the former will be referred to as diagnostic need, and the latter as prescriptive need.

RICHARD THAYER, "MEASURING NEED IN THE SOCIAL SERVICES"
SOCIAL AND ECONOMIC ADMINISTRATION, VOL. 7 (MAY 1973)

It is common to determine health problems and goals according to an analysis of health "needs." However, the term "health need" is virtually meaningless when used on its own. Because there are at least eight ways to conceive of a "health need," continued use of the term may be questioned. Nevertheless, the term will likely continue to be used to describe the health problems and goals in a community. When different notions of "need" are unknowingly used in evaluating community health, confusion can occur in the community health assessment process. For example, imagine the confusion created when community members' self-reported perceptions of need are evaluated against the needs apparent from a review of the local health department's community health data. In this case, an apparent priority need based on community perceptions may not appear to be so according to community health data. Each group of data represents a different notion of need.

An understanding of the different concepts of need can help in collecting and analyzing community health information, and contribute to clearly specifying health problems and goals and determining courses of action to meet community health objectives.

Two broad categories can be outlined for defining a need, each with the same four sub-categories. The following material briefly describes the varying concepts of need (Bradshaw, 1972; Thayer, 1973).

Different Ways of Evaluating a Health Need

PRESCRIPTIVE NEED	Need Based Upon:	DESCRIPTIVE NEED
Solution Statement (e.g., "More physicians are needed in inner city areas.")	↓	*Problem Statement* (e.g., "Individuals in inner city areas do not have adequate access to physician services.")

COMMUNITY PERCEPTIONS

PROFESSIONALLY DETERMINED STANDARDS

COMPARISONS WITH SIMILAR GROUPS

PATTERNS OF DEMAND FOR SERVICES
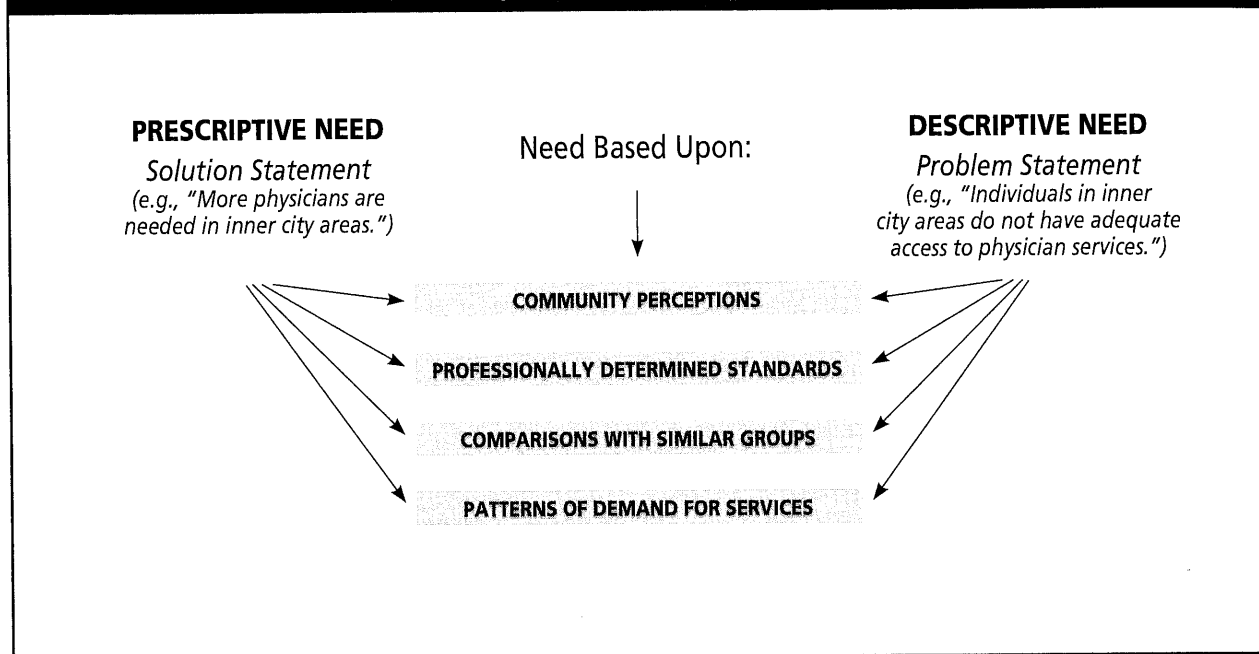
A community health issue is normally expressed two different ways in terms of the "need" accompanying that problem—as a prescriptive or a descriptive need. A prescriptive need is expressed according to what is thought to be the solution to the problem (i.e., "More physicians are needed in inner city areas"). A descriptive need is expressed as a problem (i.e., "Individuals living in inner city areas do not have adequate access to physician services"). When defining "needs" it is best to define them descriptively, as prescriptive statements presume a solution prior to thorough analysis.

Within each of the two broad categories discussed above are the following four ways to define need:

Defining need based on community members' perceptions: Perceived needs are determined using the expressed perceptions of community members. A survey of community members that indicates a need for more services to treat alcoholics and drug abusers is an example of a perceived need expressed prescriptively. Individual conception and interpretation of what constitutes health and health needs determine perceived needs.

Defining need based on professionally determined standards: Needs determined using professionally determined criteria or standards are known as normative needs. For example, if infant mortality rates are expected to be 7 per 1,000 live births but are 10 per 1,000 live

births in a particular community, a need may be defined based on the predetermined normative standard. An assertion that a community's infant mortality rate is above the national standard and therefore requires attention is an example of a normative need expressed descriptively. The nation's health objectives as set forth in the "Healthy People 2000" campaign are examples of normative standards and benchmarks used to determine need.

Defining need based on comparisons with similar communities or groups: Comparative needs are determined by comparing the health status or services available to a community or a particular group with that of other similar communities or groups. If obstetricians available per 1,000 population in one community differ dramatically from that of a similar community, then a comparative need may be identified.

Defining need based on patterns of demand for services: Needs determined by evaluating community members' demand for services are known as expressed needs. Some people view expressed need as perceived need turned into action through a request for services. If there are long waiting lists at a community health clinic, a need for more services may exist. The needs of those without access to services or who don't seek care are not normally captured by measures of expressed need.

Most health problems are very complex and needs related to these problems may be defined at any point within the continuum of factors contributing to the problem. For example, if a relatively large percentage of children in a community are shown to have elevated lead levels, the options for intervention could address any or all of the following needs:

- Lack of availability or access to treatment services for children with high lead levels
- Lack of parental knowledge about the dangers of lead poisoning
- Existence of homes with lead-based paint

Decisions about which need to address must be based on the partnership's process for setting priorities; an assessment of the feasibility of addressing each need; the likelihood that addressing a particular need will reduce the number of children with elevated lead levels; and the willingness of particular organizations to participate in strategies. For example, if a community development corporation is involved in the partnership, they might suggest organizing a project to strip and repaint homes with lead-based paint.

There is no magic path that can carry us to every goal. If we are wise, we will determine what we most deeply value and will realistically balance aspirations against resources. In short, we must choose and the choices we make will help determine how we live. The wisdom of those choices will determine how well we live.

VICTOR FUCHS
HOW WE LIVE, 1983

> *Developing priority health goals and objectives requires a careful balancing of viewpoints, values and realities regarding what issues can and should command the immediate attention of a community.*

Determining priorities for action is a central task in the community health assessment process. Developing priority health goals and objectives requires a careful balancing of viewpoints, values and realities regarding what issues can and should command the immediate attention of a community. The "most important" issues do not always become priorities, especially if addressing these issues would require conditions, resources and skills not feasible to secure in the nearer term. Here, "priorities" refers to those problems and goals that should be addressed first, not necessarily to a listing of the "most important" issues a community faces. There are four primary points to be made regarding the setting of health priorities.

Health priorities are defined within the context of prevailing values and goals and are constrained by the accepted definition of health. If health is defined narrowly in terms of physical health only, the priority-setting process for health goals and objectives will be limited to those clearly related to physical health. However, if health is defined as broadly as by the World Health Organization–"complete physical, mental and social well being"– priorities can cover an infinite array of health objectives. Similarly, if a community values an equitable availability of health services, for example, health issues involving inequities in access to care may take priority over issues such as reducing the occurrence of relatively rare diseases.

Health priorities may be defined at many different levels. Priorities are commonly defined in terms of both desired health outcomes and changes necessary in various

processes and factors affecting these outcomes. For example, "reducing infant mortality" may be a health priority defined as an outcome while "improving the nutrition of expectant mothers" or "ensuring access to prenatal care" may be considered a priority defined as a process related to the "reducing infant mortality" outcome.

Confusion can easily result when attempting to define outcome priorities versus process or factor priorities. Consider when "reducing infant mortality" is seen as one process/factor involved in reaching the broadly-based outcome "reducing health disparities among different racial groups," rather than the broad outcome goal itself. Any attempt to set priorities for health needs is likely to lead to a tiered list of outcomes, as well as processes and factors affecting the achievement of those outcomes. Clarity is required when setting priorities, and those involved must be aware of how they're defining a health outcome versus a health process or factor.

The process of defining health priorities may differ depending on whether the feasibility of attaining priority goals and objectives is initially considered. In the priority-setting process, some communities and individuals will tend to narrowly consider what is possible, while others are willing to set far-reaching goals for themselves even when it's not intially apparent the goals are feasible.

Goals such as "establishing world peace" are clearly not feasible for a community to address on their own; however, other seemingly unattainable goals, such as "making a job available to all who want to work" or "ensuring every pregnant woman receives prenatal care in the first trimester" may be considered as a viable goal for some communities and not others. Some communities may choose to advocate setting broad-based priorities regardless of their apparent feasibility to create a far-reaching vision for the health of the community.

Both a lofty vision and immediately feasible priorities for health should be determined. However, creating the vision before determining specific and realistic priorities for action is preferable and can serve to broaden the horizon of possibilities for those involved. After a preferred vision of community health is created, a careful assessment of community health data and available resources will further shape and specify priorities and action plans to achieve this vision.

Selecting clear criteria to determine priorities is essential. In addition to requiring careful analysis, determining health priorities is also a political process. Clear criteria are necessary to facilitate decision-making and negotiation among the varied interests represented throughout the process. Health issues enjoying a high degree of advocacy may have greater visibility than many others. Without clear criteria, advocacy pressures may inappropriately influence decisions before a thorough consideration of all health issues.

Tables 2 and 3 contain two lists of potential criteria for determining priorities. Table 2 is adapted from the Catholic Health Association's publication "Social Accountability Budget," while Table 3 represents a list used in the U.S. Department of Health and Human Services' "Healthy People 2000" initiative.

TABLE 2

Potential Criteria for Determining Health Priorities

Scope of the Problem
- How many people are affected? Are these numbers escalating?

Seriousness of the Problem
- What are the consequences of not addressing this issue?

Potential Community Effect by Addressing the Problem
- Will it improve quality of life?
- Will it improve the health status of the community?
- Will it improve access to needed services?
- Will it reduce health care costs?
- Will it open opportunities for collaboration?
- Will it help minorities, the poor or other underserved people?
- Will it address needs likely to increase in the future?
- Will addressing it now prevent future problems?

Feasibility for Addressing the Problem
- Can it be addressed by extending or improving existing services or efforts?
- Is there a true commitment to meet this need?
- Do the requisite skills and knowledge exist or can they be procured to meet this need?

TABLE 3

U.S. Department of Health and Human Services Criteria for Setting Healthy People 2000 Health Objectives for the Nation

Healthy People 2000 is a national partnership that employed the following criteria to define the nation's specific health objectives. These criteria may be adopted to help communities define both broad and specific priority health status, and quality of life objectives.

1. *Credibility*: Objectives should be realistic and address the issues of greatest priority.

2. *Public comprehension*: Objectives should be understandable and relevant to a broad audience, including those who plan, manage, deliver, use and pay for health services.

3. *Balance*: Objectives should be a mixture of outcome and process measures, recommending methods for achieving changes and setting standards for evaluating progress.

4. *Measurability*: Objectives should be quantified.

5. *Continuity*: Current objectives should be linked to previous objectives where possible, but reflect the lessons learned in implementing them.

6. *Compatibility*: Objectives should be compatible, where possible, with goals already adopted by the community as a whole and by major groups within the community, such as the public health department and/or major health care providers.

7. *Freedom from data constraints*: The availability or form of data should not be the principal determinant of the nature of the objectives. Alternate and proxy data should be used when necessary.

8. *Responsibility*: The objectives should reflect the concerns and engage the participation of professionals, advocates and consumers, as well as state and local health departments.

Need assessments are not done in a vacuum. They are conceived of and performed in a vortex of competing pushes and pulls from different groups with different values.

BELL, ET AL.

CONCEPT #4: *Collaborative Action Planning*

It is the flow among organizations that now matters more than anything else in the production of community health, and only leaders can redraw the boundaries of the system.

<div align="right">

DONALD BERWICK, M.D.
PRESIDENT, INSTITUTE FOR HEALTHCARE IMPROVEMENT
NEW ENGLAND MEDICAL CENTER, BOSTON, MASS.

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Community health assessment, as defined in this document, suggests that a multisectoral community partnership guide the assessment process through collaborative action planning to identify and address health objectives.[1] To perform effective collaborative action planning, the partnership must address questions regarding who should be involved, how to conduct the planning process and what the goals and objectives are that will require action plans. "Concept #6: Multiple Sectors of the Community" will discuss who to involve in the planning process.

How to conduct the collaborative planning process

The following success factors for community action planning may be considered when conducting processes that require multiple community actors be involved in planning and action (adapted from Bryson, "Strategic Planning for Public and Not-for-Profit Organizations," 1991).

1. **Start Where You Are**: Take advantage of current activities, structures and relationships to aid team-building and planning. Build from where you are.

2. **Establish a Compelling Purpose**: A compelling purpose can overcome the bias against planning. Players must see compelling benefits to begin a planning partnership.

3. **Have a Respected Sponsor**: At least one sponsor should be a recognized and respected leader. Multiple sponsorship allows those affected by the plan, or who must change the most to implement it, to be represented among the key decisionmakers.

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[1] See VHA's publication entitled "Community Partnerships: Taking Charge of Change Through Partnership" for a more thorough disccussion of community partnerships.

4. **Engage a Process Champion**: Engage at least one process champion who can work against the typical bureaucratic and political inertia of broad-scale collaborative efforts. The champion must believe in the process and be able to break through indifference and/or hostility to ensure movement in the process. Champions are both planning technicians and politicians. They should not have preconceived answers to important issues, but should facilitate a process to produce effective answers. One process champion may be a respected community member and should be distinguished from an individual who facilitates actual meetings of a collaborative group. At critical times, such a facilitator may need to be a third-party actor with no vested interest in or identification with the issues of the individual actors or process outcomes. In general, process champions may be required to be technical experts, even though this role is not typical for such persons.

5. **Tailor the Process**: A generic planning process should be tailored to each community. For example, the elements of the community health assessment process can be reordered to ensure a better fit with existing community actions. Several steps may be eliminated if they have been addressed in the past.

6. **Secure Participation of Key Decisionmakers**: A planning process cannot substitute for the participation, support and commitment of key decisionmakers to raise and resolve the critical issues. The time and attention of key decisionmakers is often the most-limited resource for community strategic planning. A clear definition of the time commitment of key players should be outlined and secured in advance.

7. **Be Open to Surprises**: Planning is a creative process and requires an openness to surprises. Such openness will allow a group to take advantage of opportunities as they become apparent during the process. Explicit, conscious planning is valuable. However, popular systems theories also suggest that a self-organizing capacity within complex systems, which cannot be isolated, should nonetheless be honored and trusted. Such theories confirm the limits of willful action and indicate a need for sensitivity about knowing when to trust rather than control the process.

8. **Use Third Parties When Needed**: Outside consultation can help educate and neutralize conflict among players in a planning process. Third-party players can be especially helpful

at key points in the process, such as the beginning phases of establishing a partnership and when making a transition between phases. Recognize the time to get help and ask for it.

9. *Remember the Benefits and Celebrate Small Successes*: Remember that small victories are big successes when diverse community groups convene to work together. Incorporate ways to recognize and celebrate small victories and regularly recall the potential benefits of collaborative action planning. For example, collaborative action planning can help communties:

- Think strategically and develop effective strategies

- Clarify future directions

- Establish priorities

- Make today's decisions in light of their future consequences

- Develop a coherent and defensible basis for decisionmaking

- Make decisions across levels and functions

- Solve major community problems

- Improve organizational and interorganizational performance

- Deal effectively with rapidly changing circumstances

- Build teamwork and expertise

The domain for collaborative community action planning

All the steps involved in health assessment, especially priority-setting and development of implementation plans to create a healthier community, may be considered the domain of collaborative action planning–or the "what" of the planning process. Specifying the domain of planning requires that health objectives and priorities be both broadly and specifically defined within the context of each health issue. Defining priorities was briefly discussed earlier and will be revisited throughout the document. However, three key points are useful to mention:

1. *During the action planning process, carefully analyze the origins and range of opportunities to address health problems*. Developing a rationale for why a particular health issue should be a health priority and clearly delineating options for addressing it guide the

development and implementation of action plans. A careful analysis should establish a common understanding among team members and facilitate the development, implementation and support of any plans.

2. **When identifying solutions for meeting a health goal, avoid rushing to create new services or programs.** There may be a tendency to assume that an increase in services is needed to address health issues. However, many issues exist due to insufficient demand for available services rather than inadequate levels of services and/or resources. Likewise, needs might arise because of poor access or insufficient coordination of services and not from absence of needed services.

3. **Be flexible and seek a balance between short- and long-term actions.** Action plans should address problems as close to their roots as possible. However, when health problems are acute or require immediate attention, immediate patch-up efforts may be necessary. Both short- and long-term responses should be considered simultaneously. Sustainable efforts take on a life of their own and introduce a self-correcting element into the system governing health issues. These efforts are difficult to develop and implement, but should be encouraged whenever possible.

CONCEPT #5: *Community Health Status and Quality of Life*

There seems to be general recognition of the existence of some kind of continuum between "health" and "well-being" at one extreme and death at the other extreme. However, there are various views as to the gradations that may exist between "perfect health" and "death."

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IWAO M. MORIYAMA
"PROBLEMS IN THE MEASUREMENT OF HEALTH STATUS"
IN *INDICATORS OF SOCIAL CHANGE*, 1968

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The overarching goal of most community health planning processes is to improve health status and quality of life, but initially both must be defined and measured to establish baseline measures and assess improvements over time. These tasks create important and difficult challenges for a community. One challenge is the lack of a single definition for "health" or "quality of life," while another is that a population's health and quality of life cannot be determined by a single set of health status and quality-of-life indicators.

The prevailing definition of health and quality of life is largely a function of community or societal norms and expectations. For example, by embracing a broad definition of health that includes an individual's physical, social, mental and even spiritual dimensions, even such indicators as "sense of purpose and meaning in life" and "amount of time for recreation and leisure" can be considered valid measures of health and quality of life. However, the same indicators may be less useful when considered under a narrower definition. Therefore, it is reasonable for communities to select indicators of health and quality of life that closely align with their own definitions. These decisions are necessary to logically delineate health priorities and action plans for improving community health.

> *Defining what constitutes health and well-being broadly determines what will and will not appear on the "radar screen" of any community health vision and assessment process.*

Defining what constitutes health and well-being guides what is and is not considered a health issue or goal. In effect, it broadly determines what will and will not appear on the "radar screen" of any community health vision and assessment

process. In addition, the indicators used to gauge health-status and quality-of-life improvement efforts are ultimately based on the operational definitions of these concepts.

Physical, mental and social indicators of health are commonly used now to assess the health and quality of life of the U.S. population, in addition to specific indicators of health by population group (such as male and female, children, adolescents, the elderly, minorities, etc.). Just a few of the health status and quality of life indicators are discussed below. While these lists represent measures of overall population health and focus broadly on illness and disease, indicators of individuals' health status and quality of life also exist and may be used to capture a more detailed picture of the community's health beyond these general measures.[2] The resources listed in Section VII provide a more thorough listing of health status and quality of life measurement references, and Section VI discusses the data categories often required for measuring health status and quality of life indicators.

"HEALTHY PEOPLE 2000" NATIONAL HEALTH OBJECTIVES AND HEALTH STATUS INDICATORS:

The U.S. Department of Health and Human Services, in conjunction with more than 300 public- and private-sector groups, has broadly defined five objectives for the nation's health status:

1. Infant mortality rate of no more than seven deaths per 1,000 live births

2. Life expectancy of at least 78 years

3. No more than 6 percent of individuals with disabilities caused by chronic conditions

4. At least 65 healthy years of life

5. No more than a four-year disparity in life expectancy between white and minority populations

More specific health measures have also been defined for the entire population and its sub-sectors. They can be found in the publication, "Healthy People 2000: Citizens Chart the Course," (National Academy Press, Washington, D.C., 1990). "Healthy People 2000" established a consensus set of 18 health-status indicators to assist communities in assessing their general

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[2]Measurement tools such as the well known SF-36 form, developed at the Rand Corp., for measuring an individual's functional status. Versions of the survey are available from The Institute for Healthcare Improvement in Boston, Mass., and Interstudy, Inc., in Jackson Hole, Wyo.) and the Wellness Appraisal for measuring the lifestyle and wellness skills and knowledge of individuals (developed by the Wellness Associates, Inc.) are examples of this.

health status and in "focusing local, state and national effort in tracking the year 2000 objectives." The indicators are:

1. Race/ethnicity-specific infant mortality, as measured by the death rate per 1,000 live births among infants under one year of age

Death rates per 100,000 population for:

2. Motor vehicle crashes

3. Work-related injuries

4. Suicide

5. Lung cancer

6. Breast cancer

7. Cardiovascular disease

8. Homicide

9. All causes

Reported incidence per 100,000 of:

10. Acquired immunodeficiency syndrome

11. Measles

12. Tuberculosis

13. Primary and secondary syphilis

Indicators of risk factors:

14. Incidence of low birth weight, as measured by percentage of total number of infants weighing under 2,500 grams at birth

15. Births to adolescents (females aged 10–17 years) as a percentage of total number of live births

16. Prenatal care, as measured by percentage of mothers delivering live infants who did not receive prenatal care during first trimester

17. Childhood poverty, as measured by the proportion of children under 15 years of age living in families at or below the federal poverty level

18. Proportion of persons living in counties exceeding U.S. Environmental Protection Agency standards for air quality during previous year

"KIDS COUNT" INDICATORS OF CHILD WELL-BEING:

The Center for Social Policy Studies, with support from the Annie E. Casey Foundation, has defined and tracked state-by-state measures of eight different indicators of child and adolescent health, education, social and economic well-being. Measures of these indicators are published annually in "Kids Count Data Book" (The Center for Social Policy Studies, (202) 371-1471). The indicators are:

1. Percentage of low-birth-weight babies
2. Infant mortality rate
3. Child death rate
4. Teen violent death rate
5. Percentage of teen out-of-wedlock births
6. Juvenile incarceration rate
7. Percentage of children in poverty
8. Percentage graduating high school

OBJECTIVE AND SUBJECTIVE SOCIAL INDICATORS OF QUALITY OF LIFE:

Researchers have suggested various indicators and measures of quality of life. One list of indicators is outlined below (Sneider, M. "The 'Quality of Life' and Social Indicators Research," Public Administration Review, May/June, 1975).

OBJECTIVE SOCIAL INDICATORS OF QUALITY OF LIFE MAY INCLUDE:

1. Income, wealth and employment (e.g., percentage of labor force employed, per capita income)
2. Environment (e.g., air quality, percentage of substandard housing units, cost of transportation)
3. Health (e.g., includes health measures considered to have primarily a social origin, such as infant mortality and suicide)
4. Education (e.g., median school years completed by adult population)

5. Participation and alienation (e.g., percentage of eligible voters who actually vote)

6. Social disorganization (e.g., crimes, drug addiction)

SUBJECTIVE SOCIAL INDICATORS OF QUALITY OF LIFE MAY INCLUDE:

1. Satisfaction with job

2. Satisfaction with housing

3. Satisfaction with money and income

4. Sense of self-efficacy to manage one's life

5. Satisfaction with community services

6. Citizen involvement and trust in government

CONCEPT #6: *Multiple Sectors of the Community*

The involvement of multiple sectors of the community is necessary to achieve a systemic understanding and response to community health problems–a primary goal of a community health assessment. The two primary reasons for this involvement are:

1. ***Health problems occur within a community system***. Efforts to prevent disease, promote and protect health, and comprehensively treat existing health problems require employing various bodies of knowledge, sets of skills and ranges of services and other resources of numerous individuals and organizations in any community. They often require simultaneous changes among numerous community participants.

2. ***Identifying and establishing priorities, and achieving support for efforts to address community health objectives and goals is largely a political process***. Without the involvement of multiple sectors of the community, the necessary widespread support is less likely to develop or endure even with significant public relations efforts.

The process of community health assessment leads to goals, objectives and action plans to create a healthier community. Implementing action plans to achieve goals and objectives is likely to require changes in the coordination, type, amount and/or mix of community resources. Securing broad-based input, commitment and support for such changes is necessary and should normally be preceded by a consensus that the health goals and objectives are legitimate and require a response. While players outside the community health assessment team may arrive at the same conclusions for health goals, priorities and action plans, if they are not involved in the process, they may not support required actions–especially if asked to change or otherwise contribute scarce resources to achieve success.

It is difficult to think of a prominent health problem that does not imply a role for multiple sectors of a community. A health problem can have various types of precursors and ameliorating factors that require a response by different individuals or organizations in the community. (Note that a "response" may imply "stop doing something" as well as "doing something.")

Figure 6 presents a simplified example of the indirect and direct contributors to the medically recognized "risk factors" (e.g., overweight, smoking or diabetes) of heart disease. An indirect con-

tributor can be "lack of marketable skills," which may contribute to an individual's unemployment and subsequent depression. Although a separate disease, depression can contribute to overeating, which may lead to being overweight—also a medically recognized risk factor for heart disease.

In this simplified example, one can imagine that a community's education, job training and placement services may need to target individuals at risk of unemployment. Likewise, the community self-help and mental health services may need to address depression and overeating early in an individual's development. Finally, the medical care system is then implicated once risk factors are developed and the disease process is well underway. While this example is simplified, researchers have identified pathways of poor adult health outcomes, for example, originating as far back as childhood (Rutter, M., 1989 and Brown, et al., 1986). Studies confirm the common-sense notion that *health problems are multi-faceted, often evolve over long periods of time and that opportunities for multisectoral responses are abundant.*

FIGURE 6

Pathways, Contributors and Response to Health Problems

Type of Contributor	Hypothetical Disease Pathway (simplified for illustration)	Sector of Community Needed
Indirect contributor	**Lack of marketable skills** ↘↖ **Unemployment**	Educational and employment sector
Direct contributor to medical risk factor	**Low self-esteem/depression** ↘↖ **Inactivity and overeating**	Mental health and self-help sector
Medical risk factor	**Overweight**	Medical preventive, diagnostic and therapeutic sector
Disease established	**Heart disease**	

Successful work within a diverse group requires exceptional group-process skills and sensitivity to cultural, socioeconomic and political diversity. It also requires defining the "community" that the partnership wishes to impact. VHA's document, "Community Partnerships: Taking Charge of Change Through Partnership," and many other references listed in Section VII contain a more lengthy discussion on cultural sensitivity, defining community, and organizing and managing within a multisectoral community health partnership.

Obvious types of organizations and individuals to involve in a community health assessment partnership include:

- Businesses, chambers of commerce and economic and community development organizations
- Churches, self-help and other social support organizations
- Civic organizations
- Elected officials
- Environmental organizations
- Foundations
- Health and human services provider organizations, including mental, social and physical health providers
- Housing and transportation organizations
- Local, state and federal public-sector agencies and health care providers
- Media
- Schools
- Service recipients
- Universities, researchers and technical experts

Typically, any group seeking to implement action plans should involve key stakeholders. A stakeholder is defined as "any individual, group or other organization that can place a claim on the (community's) attention, resources or output, or is affected by that output" (Bryson and Roering, 1989). In most cases, players will wear many hats. One participant may be a business owner, health care consumer and taxpayer, challenged to take a stance when his/her various

interests conflict. To avoid misunderstanding, each participant should try to explicitly define the interests that she or he represents.

Clearly, an organization, individual or group is needed as a catalyst to convene a community partnership. (Many players who eventually constitute a broad-based community partnership may already be participants in other more narrowly focused partnership efforts.) Rather than being overridden by a broader partnership for community health assessment, in most cases, these groups should be included as leaders and sources of expertise and support.

CONCEPT #7: *Quantitative and Qualitative Data*

Life is the art of drawing sufficient conclusions from insufficient premises.

SAMUEL BUTLER

Capturing the dimensions of a community's health requires tapping and synthesizing information and data from various sources, including:

- Both quantitative data (information expressed numerically) and qualitative data (information expressed by words, deeds or concepts) are needed for framing and understanding a community's health.

- Both population-based health status data (data on the various health dimensions of an entire population or its subgroups) and health services utilization data (data on the patterns and frequency of health-service use for various health conditions by different groups of individuals in the population) are required.

> *Data from various points in time allow trends in the health and well-being of a community to be identified. The information and knowledge gained from data are only as good as the data itself.*

Data may be gathered from secondary sources (data compiled by another group), although at least some primary data (new information collected for purposes of a health assessment) is usually required. Primary data can be gathered by surveying health and health behaviors of individuals and households using, for example, the SF-36 Functional Status Survey or the Centers for Disease Control and Prevention's Behavioral Risk Factor Questionnaire (see reference section). Important information from various community members may also be collected through community perception surveys, focus groups and/or one-on-one interviews. Data from various points in time allow trends in the health and well-being of a community to be identified.

The information and knowledge gained from data are only as good as the data itself. An awareness of the weaknesses in collected health-related data will guard against naive or inaccurate interpretations as it is translated. The data must be:

- valid (measuring what it says it measures)

- unbiased in representing a population or phenomenon

- comparable if different sources are used. (i.e., Identical units of analysis must be used for each data set to be compared. An example is a rate of disease calculated as numbers of cases per 100 individuals. It cannot be compared to another rate calculated as numbers of cases per 1,000 individuals without first being transformed into similar units of measurement.)

Section VI, "Data Needs and Issues," lists the types and sources of data used when developing various profiles of a community's health. It also includes a glossary of terms commonly encountered when working with data.

Below is a brief description of four broad profiles that can provide a framework for organizing community data. Although each profile requires different types of data, there is some overlap and many of the data elements are interrelated.

1. Demographic Profile

A demographic profile includes data on the number of people in the total population and its subgroups. Demographic data is commonly segregated into categories such as income, race, sex, age, marital status, education level and political-party and religious affiliation. Other categories are also common. When such data are available by zip code areas, a community's character becomes more apparent. When matched with data from other profiles, demographic data allow a rich picture of a community to be created.

2. Health Profile

A community health profile includes all types of data normally considered to represent the physical and mental well-being of a population. When combined with demographic data, different health and disease experiences of the population's various sectors are readily apparent. Information collected through household surveys on health and health-related behavior can enhance analysis of the driving forces for the discrepancies discovered. As discussed previously, a health profile includes both health services utilization and population-based health and disease information.

3. Sociocultural Profile

A sociocultural profile can highlight the social conditions and cultural characteristics that influence and reflect the health and well-being of a community. Indicators such as crime rates; perceived safety of neighborhoods; traffic patterns and noise; availability of basic services, such as food stores, phones and open areas for recreation; unemployment rates, education levels; work habits and languages spoken influence the likelihood that individuals will engage in healthy behaviors (i.e., exercise, good nutrition, stress management) and access needed services. These factors should be considered when profiling a community's health.

Likewise, a community's culture should be understood for how it may shape the general disposition, attitude and will of a community to act on its own behalf and respond to assistance made available. Community pride, trust and hope are important factors in securing the willingness of a community to invest in improving the residents' quality of life. In addition, a sociocultural profile reveals information about various community subcultures within a community and assists in identifying specific actions that the community may be most interested in and responsive to when addressing health problems. Without input and active involvement from various cultural groups in the community, and an understanding of the social conditions and cultural factors influencing health problems, an analysis and plan for improving community health will be incomplete and less effective.

4. Resource Profile

Understanding the monetary, human, physical and social resources of a community is critical to both identifying the sources of health problems and devising feasible action plans to address these problems. A health assessment team can collect information to visualize the flow of money into a community, the types and numbers of community health services, businesses, schools, churches and civic groups, and other less-tangible resources. Community qualities such as "strong community pride" and "willingness to improve" should be considered as valuable resources to access and nurture, in addition to financial, physical and human resources. Brainstorming opportunities for addressing community health issues identified in the health assessment process will be facilitated by understanding the scope of resources available to a community.

Citizen participation in decisionmaking is the essence of needs assessment.

GENE SUMMERS

One of the fundamental goals of a community health assessment is to generate a genuine sense of community ownership, individual responsibility and shared accountability for creating a healthier community. Meaningful, ongoing participation from various health care providers and numerous sectors of a community is required to nurture this community ownership and shared accountability. To secure meaningful community involvement, community organizations and members must have a clear mechanism to be involved in creating change. The community health assessment process requires and provides an opportunity for meaningful community participation that furnishes such a mechnism for change.

The notion of community ownership reflects a philosophy for creating change that supports community mobilization to achieve desired outcomes and improvements in conditions. This philosophy can be contrasted with one that primarily supports the actions of official institutions in creating change and dilutes the importance of widespread involvement and input–especially from those who supposedly will benefit from that change.

> *Community ownership represents a particular management philosophy– one that recognizes an organization cannot be effectively accountable for outcomes it can only partially influence without extending its sphere of influence through communitywide linkages.*

While community ownership may reflect a particular social philosophy, it also represents a particular management philosophy–one that recognizes an organization cannot be effectively accountable for outcomes it can only partially influence without extending its sphere of influence through com- munitywide linkages. Traditionally, health care organizations have consulted, informed or interacted with their patients and communities in a paternalistic and in some cases a patronizing manner. In return, they increasingly have been held solely accountable for addressing health problems. Many have been left largely without the critical community linkages and patient-practitioner relationships needed to prevent disease and address health problems before they reach the point of requiring

medical attention. The paradigm supporting this phenomenon is changing. If nothing else, the emerging requirement for health care organizations to manage the care of a defined population under fixed resources makes such changes a necessity.

Today, there is increasing awareness among health care providers and other organizations that they comprise only a few of the groups that must have a sense of ownership and responsibility for health. If they are the only groups with such beliefs, accountability rests too heavily on the shoulders of too few. Still, it is reasonable to expect recognized leaders in these organizations to be catalysts for generating the necessary community ownership, individual responsibility and involvement.

Your chance of awakening the possibilities in others depends heavily upon you yourself having faith in them.

JOHN GARDNER
THE TASKS OF LEADERSHIP, 1986

> *Traditionally, health care organizations have consulted, informed or interacted with their patients and communities in a paternalistic and in some cases a patronizing manner. The paradigm supporting this phenomenon is changing. If nothing else, the emerging requirement for health care organizations to manage the care of a defined population under fixed resources makes such changes a necessity.*

CONCEPT #9: *Community Competence*

A community health assessment process helps develop a community that is increasingly capable of identifying and responding to local health problems. Just as there are various ways to describe the qualities of a well-functioning hospital or organization, the qualities of a competent community also can be characterized in many ways. One definition of a competent community includes the following eight characteristics (Goeppinger, J., and Baglioni, A.F., American Journal of Community Psychology, 1985):

Commitment: Residents value the community and are willing to expend time and energy for its maintenance.

Self-Other Awareness: Community members perceive clearly their own identity and their positions on issues of concern to the whole community. They also accurately perceive the identities and positions of other community members.

Articulateness: Members of the community clearly verbalize their needs, views, attitudes and intentions. They express perceptions of their positions as they relate to positions of other community members.

Effective communication: Information is sent and received accurately. The community strives to develop a shared vision and language for discussing community problems.

Conflict containment and accommodation: The community shows inventiveness in managing conflicts. Conflict is faced openly and managed effectively rather than denied or suppressed.

Participation: Residents actively contribute to defining and achieving community goals.

Management of relations with the larger society: The community recognizes, obtains and effectively utilizes the resources and support available from the larger social system.

Machinery for facilitating participant interaction and decisionmaking: The community creates formal yet flexible mechanisms to facilitate interaction and decisionmaking.

Sectors of a competent community have learned to work together to:

- Identify the community's problems and goals

- Achieve a working consensus on goals, priorities and action plans

- Implement the required actions

Because a community health assessment involves each of these activities, a community engaging in the process may improve its overall ability to manage local affairs and achieve a preferred future.

A community filled with competent individuals is not necessarily a competent community.

ANONYMOUS

The Community Health Assessment Process

As discussed in Section III, a community health assessment can help coordinate, inform and enable actions that impact health in ways desired by the community. It is not institution-focused or a one-time data collection activity. The complex nature of the task, changing health issues and political considerations require that the process be ongoing and interactive. The success of the assessment process depends on commitment to a common set of outcomes, careful coordination, clear communication, and skillful data collection and interpretation. Individuals and organizations who do not usually speak or work with each other for a variety of reasons often are required to form a partnership–highlighting the need for mutual tolerance of differences and skill in managing consensus-building in a group process.

While the community health assessment process appears to be linear, in fact it is circular and may require several steps to occur simultaneously, be repeated, deleted or implemented out of sequence.
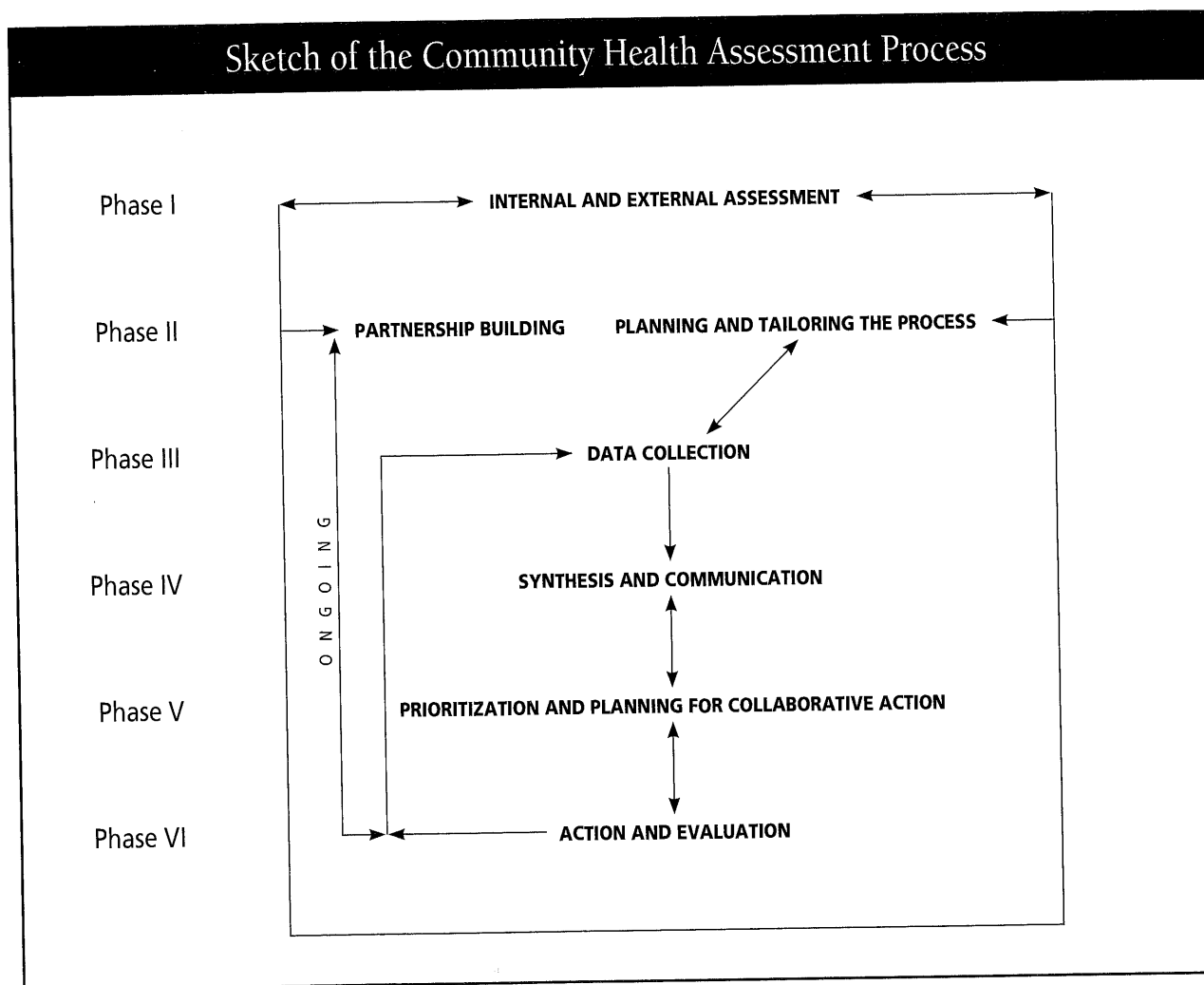
While the community health assessment process appears to be linear, in fact it is circular and may require several steps to occur simultaneously, be repeated, deleted or implemented out of sequence. An example is the question of defining community. While it appears as a first step in the process, defining community is in practice refined as the populations targeted for action are clarified. Another example is the importance of responding immediately to certain needs before completing the collaborative action planning phase, because a "window of opportunity" appears that would otherwise not be available if the group delayed their response.

Figure 7 presents a schematic sketch of the six phases of the community health assessment process defined in this document. These phases are as follows:

PHASE I Internal and external assessment

PHASE II Partnership building, and planning and tailoring the process

PHASE III Data collection

PHASE IV Synthesis and communication of information

PHASE V Prioritization and planning for collaborative action

PHASE VI Action and evaluation

FIGURE 7

Sketch of the Community Health Assessment Process

Phase I   INTERNAL AND EXTERNAL ASSESSMENT

Phase II   PARTNERSHIP BUILDING   PLANNING AND TAILORING THE PROCESS

Phase III   DATA COLLECTION

ONGOING

Phase IV   SYNTHESIS AND COMMUNICATION

Phase V   PRIORITIZATION AND PLANNING FOR COLLABORATIVE ACTION

Phase VI   ACTION AND EVALUATION

This section provides a more thorough sketch of the six phases and related steps involved in a community health assessment. Further insights about the principal critical success factors listed at the end of each phase, and the management of the various phases and steps are found in "Section III: Definition of Community Health Assessment," "Section V: Key Management Challenges" and "Section VI: Data Needs and Issues." The process draws from a variety of sources, including the experiences of organizations that have engaged in an assessment process, a review of the literature and the deliberations of a diverse group of health professionals.

Internal assessment

The internal assessment portion of Phase I involves getting an organization to commit and become ready to engage in a community health assessment process. The primary goal is to gain top leadership support, create an internal team to manage the organization's role in the process and delineate the organization's resource commitment. Any constraints governing the organization's participation should be identified prior to beginning an assessment process with other community organizations. Similarly, clarifying the specific objectives for involvement in the assessment will guide the organization's participation in a broader communitywide effort. The primary steps of an internal assessment are:

PRIMARY TASK:

Securing willingness and readiness of each organization

> STEP 1 Educate and gain formal support of organization leaders
>
> STEP 2 Identify, educate and organize an internal team
>
> STEP 3 Identify a process champion to coordinate the organization's involvement

Responsibilities may include:

- a. coordinating internal planning efforts for the community health assessment
- b. building relationships with other organizations
- c. soliciting and coordinating organizational resources required throughout the process (includes data, staff time, meeting space, etc.)
- d. educating and updating the internal team and leadership about the community health assessment
- e. communicating findings
- f. engendering further action required by the organization to address the community health issues identified

> STEP 4 Specify the nature and extent of organizational involvement in a community health assessment, which includes:

a. defining the scope envisioned for the community health assessment

b. identifying specific organizational goals for the activity

c. specifying a strategy for working with other community groups

d. defining the types and amount of resources that may be required, and any minimum and maximum resource commitments

e. determining a preferred time line

f. identifying an initial definition of "community" for purposes of an assessment

A Note on Defining Community

Community is defined as a group of organizations and/or people who share a common characteristic, interest, commitment or living condition within a larger group. Some specific ways of considering what defines a community include:

Geographic– a community defined by proximity or physical boundaries (e.g., neighborhood/district/county/state/people in areas between clear geographic lines such as rivers, mountains, etc.).

Enrolled population– the community within a given program or project as defined as: 1) client as an individual, not a family; 2) client has given consent to keep records (including demographic and clinical information); and 3) client receives ongoing services from program.

Social interaction– a community defined by people who congregate in a particular setting (e.g., school, work, place of worship).

Mind-set/belief– a community defined by people who share a distinctive mind-set and set of beliefs.

Political district– a community defined by the area comprising a defined political/congressional district (i.e., cultural groups, political parties, religious sects, people with a particular philosophy of health such as the community of people who use alternative therapies).

Shared experience– a community defined by the shared experiences of individuals (i.e., those with AIDS, those in poverty, war, veterans, etc.).

For a health care organization, community might be thought of as a "sphere of accountability" (those for whom the organization assumes accountability) or "sphere of influence" (those whose health the organization is able to positively influence). Ideally, the sphere of accountability and sphere of influence for any health care network, for example, will be the same. However, if community is defined as the enrolled population of any one health "network," that network will be limited in its ability to impact many community health status indicators unless it interacts with the communities of other networks' enrolled populations. Changing community structures to support community health ultimately requires that a community be defined geographically, such that all health providers work together to affect those community factors that influence the enrolled populations of all health systems in the area. In short, even if the health care system is reconfigured to comprise various health networks, collaborations among these networks and their geographic community will still be necessary.

External Assessment

The external assessment portion of Phase I involves specifying the organization's partners for conducting a community health assessment and understanding current and previous community health assessment efforts. It also involves developing a strategy for affiliation with other organizations. Information collected in an external assessment can be assimilated into the internal assessment process and used to shape the activities listed above for the internal assessment step. The major components of an external assessment are:

PRIMARY TASK:

Review current efforts underway in the community and specify various parties for partnership

STEP 1   Identify current or previous activities by community members and organizations that involve community health assessment. Determine how these efforts differ from the process envisioned. List these efforts by each stakeholder group

STEP 2   Identify possible "stakeholders" to involve in the process. Create a visual diagram of the organization's current relationships in the community to identify current and potential partners. List efforts underway in the community according to each stakeholder group

STEP 3   Confirm an initial list of desired partners to initiate a community health assessment

PRIMARY TASK:

Develop a strategy for affiliation with other organizations

STEP 1   Decide a mode and point of entry (if not already involved in a community partnership) into any community efforts currently under way

STEP 2   Develop a strategy as a catalyst for organizing a broad-based community partnership to conduct a community health assessment if a local partnership does not currently exist to do so

PRINCIPAL CRITICAL SUCCESS FACTOR FOR PHASE I:
Gaining Top Leadership Support

A Note on Organizational Options for Involvement

Many health care organizations may want to be the primary leader in any community health assessment effort. However, this option should not be the only one considered. In some instances, other community organizations initially will approach the institution or significant efforts will already be underway in the community, precluding the organization from serving as the initial catalyst for community action. Below is a list of roles an organization may play in any community health assessment partnership:

1. Catalyst for community action

2. Resource broker for partnership efforts

3. Technical support

4. Process facilitator

5. Educator

6. Conflict negotiator

7. Health planner

8. Impartial consultant

As a natural leader for community health, the health care organization will ultimately be needed to play an active leadership role in a process to identify and respond to goals to create a healthier community.

Partnership Building

A principal goal of Phase II is to begin (or continue) a partnership with other community organizations and individuals necessary for involvement in a community health assessment, convene potential partners, and create a partnership vision, a strategy and structure for managing the collaboration. Partnership-building is ongoing and must be given special attention throughout the entire community health assessment process. Some of the major steps involved in building the partnership include:[1]

PRIMARY TASK:

Begin (or continue) to build a partnership with other community organizations and individuals to conduct a community health assessment

STEP 1   Generate awareness and provide education to inspire and inform, which involves:

A. Identifying benefits of participation for players

B. Specifying activities or materials to excite individuals and organizations about collaboration

C. Engaging potential partners in an assessment of how individuals/organizations can contribute and benefit from the process

STEP 2   Prepare to formally convene potential participants/stakeholders

A. Determine and develop an appropriate manner to seek involvement of various players. Pay special attention to the nature of past relationships with each player when determining style and mode of communication. Communications with desired partners should convey the following:

1. An understanding of issues most important to the organization being approached

2. Ways the organization might contribute and the overall benefits of a community health assessment for their organization and the community

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[1]See VHA's publication "Community Partnerships: Taking Charge of Change Through Partnership" and Section VII for more information on developing and managing community partnerships.

3. The seriousness of the catalyst organization's commitment

4. An assurance of the collaborative nature of the activity and of the open sharing among all participants of all information gained

STEP 3 Invite respected representatives of organizations to convene in a neutral setting

PRIMARY TASK:

Convene potential partnership members, and create a partnership vision, strategy and structure for managing the collaboration

STEP 1 Convene potential partners in a neutral setting to discuss community health, secure preliminary commitments for an assessment and define potential roles of players

STEP 2 Develop a partnership-coordinating mechanism and subcommittee structure

A. Group identifies and secures commitment from individuals to serve as the partnership coordinating committee of a community health assessment process

B. Identify other working committees needed and gain commitments to serve on committees (see "A Note on Partnership Structure" on page 66 of the document)

C. Identify necessary process champions who will serve to a) facilitate the group process during meetings and b) manage the political turf issues and inertia likely to exist and emerge in between group meetings. In many instances, this may need to be two different individuals. Most likely the meeting facilitator will need to be a true third party–especially in the initial phases of the effort and during key transition points

D. Work with a group process facilitator to determine the current level of trust and compatibility of styles, values and goals, and develop a plan for nurturing and/or maintaining an effective group process

STEP 3 Create a plan to bring consumers into the decisionmaking process, and encourage participation of key health and community decisionmakers not yet a part of the partnership

STEP 4 Create a broad-based vision for community health and a common set of values to guide the team's efforts over time. Brainstorming answers to the questions, "What is community?"; "What is a healthy community?"; "What is necessary to

create and maintain a healthy community?" may help develop a conceptual and philosophical foundation for a vision.

A Note on the Role of Values

Explicitly-stated values are especially important when a group addresses problems with no clear solution, when the solution involves multiple parties and when the consequences of a discussion are important—precisely the circumstances of a community health assessment.

Explicitly-stated values can help a group:

1. Guide information collection

2. Shape the definition and evaluation of alternatives for action

3. Interconnect numerous decisions

4. Improve communication

5. Become involved in multiple stakeholder decisions

6. Guide strategic thinking

(For a thorough discussion of the role of values in decisionmaking, see "Value-Focused Thinking: A Path to Creative Decisionmaking" by Ralph L. Keeney, published by Harvard University Press, 1992)

Planning and Tailoring the Process

Although each health assessment includes similar elements, the community partnership must tailor the process to local needs and resources. Each community has different strengths and weaknesses regarding available research and data collection skills. Similarly, each community has a different history regarding community health assessment efforts. In communities where more narrow assessments have already occurred on various health issues, the scope of new efforts may be directed to prevent duplication and enhance already-completed data collection efforts. Planning and tailoring the process involves setting clear goals and objectives and specifying the target community and scope for the community health assessment. It also involves surveying available resources and specifying preliminary data needs and the likely modes of data collection.

A Note on Partnership Structure

Achieving partnership goals requires an enabling structure to oversee the entire partnership strategy and success, and to organize and accomplish tasks. While significant decisions such as the partnership vision, goals and objectives; the definition of community; decisions regarding communications with and involvement of the broader community; a delineation of how health will be defined and measured; and selecting priorities for action are best made by the whole partnership team, refining and acting on these decisions may be best accomplished by smaller work groups able to dedicate more time and attention to the execution of partnership objectives. Three working subgroups that most partnerships are likely to require include:

1. Partnership Coordinating Subgroup

2. Data and Research Subgroup

3. Community Interface/communications Subgroup

While each subgroup will need to delineate specific areas of responsibility that are distinct from the other subgroups, in reality, because the activities of each subgroup are interrelated, activities must be carefully coordinated through joint planning and communication among all subgroups.

Partnership Coordinating Subgroup

This group may function as the coach and manager of the partnership itself. The responsibilities of the Partnership Coordinating Subgroup may include refining the partnership vision, goals and objectives, the coordination of regular meetings and dissemination of meeting minutes, development of proposed meeting agendas, mapping the overall partnership strategy over time, supporting and coordinating the efforts of the other subgroups, managing political issues, managing partnership finances and ensuring continued partnership momentum and enthusiasm.

(continued)

A Note on Partnership Structure

Data and Research Subgroup

This group may function as the data development and intelligence arm of the partnership. The responsibilities of this group may include refining a definition of health and a healthy community for purposes of a health assessment, assessing community health-related data already available, analyzing the quality and usefulness of available data and developing recommendations and a strategy for collecting new data or improving already-available data. This group may also facilitate the coordination of data collection, data synthesis and recommendations for choosing criteria and establishing a process for setting health priorities.

Community Interface/Communications Subgroup

This group may function as the community outreach and communications arm of the partnership. The responsibilities of this group may include refining a definition of community for purposes of a health assessment, delineating all groups/individuals to inform about and be involved in the efforts of the partnership, coordinating events and materials for involving and communicating with these groups, listing and qualitatively assessing current efforts underway to address health issues, and developing recommendations for involving the broader community in the development of health priorities and action plans.

This group may also be responsible for media relations to ensure a consistent message regarding the partnership vision, goals, objectives and activities. They may also coordinate the involvement of community members in data collection activities such as focus groups and community surveys.

PRIMARY TASK:

Specify the target community, goals, objectives, scope and timeline and resources for the assessment

STEP 1   Define "community" for health assessment purposes

A. Scan various ways to define the community and select most appropriate definition for the overall assessment. Remember the iterative nature of defining community such that an initial definition may be refined over time or modified for particular action plans

B. Double-check for community representation within the partnership. Ask, "Is the initiating partnership complete?," and "Who should become involved in the process over time who is not involved now?"

STEP 2   Decide upon the scope of the assessment, specifying how broad or narrow in scope it should be in terms of the community assessed and the dimensions of health measured (i.e., physical, mental, social, spiritual, etc.). The process includes:

A. Deciding between a global or targeted assessment of a specific group, which may lead to a redefinition of community

B. Delineating the aspects of health to be measured

C. Balancing feasibility and relevance (If it's too narrow, it may miss major connections. If it's too broad, it may never be finished)

STEP 3   Discuss and identify the core goals and objectives for the community health assessment process. Struggle through goal conflicts until agreement is reached on a common set of goals, which will greatly facilitate the partnership's ongoing efforts

STEP 4   Indicate how success of efforts will be evaluated and incorporate the capacity to evaluate progress and success into subsequent plans

STEP 5   List each major activity involved, create a timeline and clearly delineate any critical deadlines

STEP 6   Brainstorm and broadly define financing options and resources required and available for the health assessment process

STEP 7   Develop a financing plan for the health assessment. Strive for a sense of fairness in the contribution of various players remembering to value financial and nonfinancial contributions alike

PRIMARY TASK:

Survey preliminary data needs and options for methods of data collection

STEP 1   Brainstorm types of data likely to be needed according to an agreed-upon definition of health and measures for the indicators of health selected to develop a community health profile

STEP 2   Determine readily-available data and its specific uses. Ask if national or regional

availability of data to develop each of the four broad profiles of the community–demographic, health, sociocultural and resource profiles

STEP 3 Determine priorities for additional data. Address issues such as the age of the available data, its likely validity for what is being measured, and applicability to the specific popu-lations of concern. Specify how the additional data may improve decisionmaking and outcomes. See the data section of this document for a list of data types likely to be sought.

STEP 4 Agree on a list of data to collect and decide who will guide data collection. Involve data collection and analysis experts if necessary

PRIMARY TASK:

Determine specific sources and modes of data collection for each data type

STEP 1 Consider various sources, opportunities and methods for further data collection and associated costs (i.e., time, money, etc.)

A. Consider a wide range of opportunities to gather information. Don't rush to do a survey. See "Section VI: Data Needs and Issues" for a discussion on using surveys and focus groups to collect primary data

B. Avoid implementing activities just because resources are available

STEP 2 Specifically define and delegate responsibilities

A. Use task forces and subcommittees to engage leadership talent and encourage simultaneous activities

B. Involve a wide range of individuals in data collection activities

STEP 3 Discuss how the data might be synthesized and communicated once it's collected. Note the effect on the nature and method of data collected

STEP 4 Discuss how synthesized data may be used for setting priorities for health objec-tives, and how the collaborative action planning process can be structured and managed. Note if it will affect the nature and method of data collected.

PRINCIPAL CRITICAL SUCCESS FACTORS FOR PHASE II:

Achieving Community Involvement
Managing Consensus-Building

PHASE III: *Data Collection*

Different sets of knowledge and skills are needed to effectively collect information and data for a community health assessment. They include interviewing and communication skills, epidemiological knowledge, data compilation and statistical analysis capabilities, survey design expertise and political acumen. The individuals and organizations in your partnership may have many of these skills. Others can be obtained from sources such as a local educational institution or a consulting firm specializing in collecting and providing the required data.

Phase III's primary activities include designing and implementing specific collection activities for each data type, and monitoring progress to enhance effective collection and quality of data.

PRIMARY TASK:

Design and implement specific activities for collecting each data type

STEP 1   Develop specific plans for information and data collection

A. Begin with a clear listing of each type of data to be collected, specific objectives for each type and matching with likely sources

B. Assess the likely precision and validity of the data and devise ways to maximize the quality of information and data collected

C. Address any cultural issues involved in collecting data (i.e., Language barriers may exist between collectors and sources of data)

D. Address any political issues involved in collecting data (i.e., In some communities collecting data about teen-age pregnancy, abortion or AIDS may pose political challenges. In addition, some potential sources may not want their reputation harmed by revealing information from sources such as local hospital emergency room utilization data or a community's specific uninsured rate.)

STEP 2   Create a time line for data collection and compilation

STEP 3   Plan for the development of necessary survey instruments and focus group formats, and train and/or obtain skilled interviewers and survey administrators if primary data collection is a part of the process

STEP 4   Delegate specific tasks within data collection team(s)

STEP 5   Expect and actively address frustration over collecting and understanding quantitative data

PRIMARY TASK:

Monitor progress on effective collection and quality of data

STEP 1   The assessment team coordinator should determine if data collection is on schedule and monitor any accompanying quality or resource problems. Gain feedback from information collectors to obtain suggestions for immediate or eventual improvements

STEP 2   Continue to assess data validity, checking for possible biases and other faults

STEP 3   Review early results for usefulness and determine the need for further revisions of data collection tools and/or methods

STEP 4   Seek and respond to any data collection feedback from community or health assessment partnership members

PRINCIPAL CRITICAL SUCCESS FACTORS FOR PHASE III:
Selecting Cost-Effective Approaches to Data Collection
Achieving Adequate Response to Data Collection

PHASE IV: *Synthesis and Communication of Information*

Phase IV involves the synthesis and communication of collected information and data to affected constituencies prior to establishing priorities and beginning collaborative action planning. It is important to remember that synthesizing and communicating data is not a value-free endeavor.

> *Synthesizing and communicating data is not a value-free endeavor. How information is synthesized and presented and when and where it is communicated is easily affected by the values, goals and beliefs of those performing these tasks.*

How information is synthesized and presented and when and where it is communicated is easily affected by the values, goals and beliefs of those performing these tasks.

The values and goals identified in the community health assessment process should be explicitly used to guide the synthesis and communication of information and data. This process should be a group rather than an individual endeavor. Discrepancies and weaknesses in collected data should be noted and interpreted. Also, major assumptions used to synthesize the collected data should be included to explain and defend the process and logic used, if necessary. Some of the major steps involved in Phase IV are:

PRIMARY TASK:

Synthesize information and data collected in various ways

STEP 1 Summarize the data at several levels for presentations to various audiences (e.g., community forums, medical staff meetings, hospital executive staff meetings, etc.)

STEP 2 Summarize the data according to many cross-sections of the population (i.e., children, elderly, males, females, blacks, Hispanics, whites, etc.)

STEP 3 Connect demographic, health, sociocultural and resource data in useful ways, such as viewing data synthesis as an attempt to tell a story or paint a picture. It can be helpful to draw a schematic of collected data and identify various options for combining and presenting it to tell different stories

STEP 4 Create a comprehensive list of potential community health issues to be considered when setting priorities. Categorize problems in a useful way; one may be problems related to: 1) health protection; 2) health promotion; and 3) disease prevention as done in the "Healthy People 2000" initiative

PRIMARY TASK:

Present and communicate synthesized data to relevant audiences

STEP 1 Develop a plan and materials to communicate findings

STEP 2 Present findings at key meetings of constituency groups, such as open community meetings

STEP 3 Carefully use public media and closely monitor the portrayal of information. Actively look for and attempt to correct misinterpretations

STEP 4 Seek feedback on the perceived validity of the information and data and get the partnership to "buy in" before setting priorities and planning action

STEP 5 Expand the partnership if necessary to include a particular group not involved in the process whose interests, expertise and insights are relevant to the health issues revealed by data collection

PRINCIPAL CRITICAL SUCCESS FACTOR FOR PHASE IV:
Digesting and analyzing data to set priorities

Establishing Priorities

Defining community health priorities for future action is one of the most critical activities of a community health assessment. "Section III: Definition of Community Health Assessment" and "Section V: Key Management Challenges" contain a more complete discussion about establishing priorities. The major steps in setting priorities are:

PRIMARY TASK:

Define a process, criteria and alternatives for selecting priority health objectives

STEP 1   Agree that the list of alternatives for selecting priority areas is both valid and complete (list generated in previous phase)

STEP 2   Clarify criteria for selecting action priorities. These criteria should be selected from the vision, values and goals specified by the partnership earlier in the process. Section III and this section contain suggested criteria for defining priorities

STEP 3   Verify the relevant scope for defining priorities in terms of the populations targeted and dimensions of health to be addressed. If the group has agreed to focus on a special population, on non-medically related health needs or on another population or issue subgroup, reconsider and verify this decision when more information is available

STEP 4   Agree on a process for deciding priorities. Section V contains examples of existing group processes. Strive for consensus and resist the temptation to vote on priorities. Clearly link decisions or priorities to criteria established for such decision-making

PRIMARY TASK:

Decide on priorities and related health objectives

STEP 1   Define priorities and generate broad health objectives with specific health objectives related to each broad area. Look for overlapping priority areas and synthesize where possible. If all players agree on a concise, thoughtful list, the collaborative-action-planning process and later action plans in the community health assessment process are likely to be more successful

STEP 2   Review list(s) to ensure that important minority opinions have not been ignored or dismissed. While choices about the relative importance of issues must be made, if minority opinons are suppressed the list of chosen priorities can be viewed as invalid and diluted

STEP 3   Group priorities into meaningful subcategories to help name collaborative-action-planning teams. Strive for simplicity. Several health issues may be addressed through one action plan. Look for these opportunities and don't unnecessarily narrow the sphere you want to influence

Planning for Collaborative Action

The major steps involved in collaborative-action planning are:

PRIMARY TASK:

Organize action-planning teams and implement a collaborative-action-planning process around specific priority health objectives

STEP 1   Specify and secure commitment from those who should be involved in action planning for each priority area

STEP 2   Review and recommit to the health assessment's overall criteria, values and goals and apply to the action-planning process

STEP 3   Review the issue at hand. Each team carefully examines the indirect and direct contributing factors and risk factors of the specific health problem and analyzes linkages between the problem and other priority issues under review

STEP 4 Generate options for responding to the health problem by surveying the current efforts in the community and in other communities, looking for role models and reviewing the professional literature. Avoid quick recommendations to create a new service and instead consider improving the coordination and/or focus of existing resources and services. Techniques for fostering creativity should be encouraged and used

STEP 5 Analyze recommendations for their technical feasibility, political acceptability and moral defensibility

STEP 6 Recommend actions for responding to priority health objectives to a larger work group and seek their feedback. Coordinate when recommendations from separate groups overlap or interrelate

STEP 7 Develop plans to implement specific activities and programs, including objectives, interventions, resource specifications, work plans and evaluation mechanisms

In addition to the steps outlined above, Section III discusses several success factors for collaborative action planning. Also, Section V provides additional tips about managing potential challenges involved in collaborative action planning. In addition, the resource section of this document contains several references to assist collaborative action planning.

PRINCIPAL CRITICAL SUCCESS FACTORS FOR PHASE V:
Managing an Equitable Priority-Setting Process
Moving from Data Collection to Action

PHASE VI: *Action and Evaluation*

Action

Many of the skills and processes used to conduct the health assessment process to this point will be needed to implement action plans.

In general, community teams should:

1. Be reminded to avoid the tendency to expect substantial change in a short period of time. Instead, patience and tolerance concerning expectations for the implementation of action plans should be nurtured

2. Remember that the strong commitment of those involved is the most valuable and yet difficult-to-maintain resource for implementing action plans. It is necessary to find ways to maintain participation and commitment while actions are implemented

3. Be sure to communicate progress to the larger health assessment partnership

4. Expect a need for extensive problem-solving skills

Evaluation

An assessment of success and feedback from those involved in and affected by a health assessment should be sought. While evaluation should occur throughout the assessment process, a more-focused evaluation at specified points provides insights on how to improve over time. Information gained through evaluation can guide how goals are reassessed and processes redesigned.

PRIMARY TASK:

Evaluating the community health assessment process

STEP 1   Select criteria for evaluating the process. Consider:

A. If the process was successful in focusing the attention of key decisionmakers on matters important to the community

B. If the process was successful in setting action priorities

C. If the process generated desired actions

D. If community organizations worked together in a productive partnership

STEP 2   Decide on the time and process for evaluation. Consider that:

A. Premature evaluation may yield incomplete responses just as late evaluations can yield diluted and vague responses

B. Third-party management of a formal evaluation process can improve objectivity

C. Not every aspect of the process may be evaluated. Decide which dimensions of the process require a more thorough evaluation versus those that can be monitored over time.

PRIMARY TASK:

Evaluating success of action plans

STEP 1   Establish dimensions of the actions to be evaluated

STEP 2   Decide on criteria to evaluate those dimensions and the data required to assess against these criteria

STEP 3   Identify intermediate milestones as indicators of success

STEP 3   Consider the appropriate timing for evaluation

STEP 4   Decide who should be involved in the evaluation. Choices include: partnership members, recipients of actions taken, a third-party evaluator, etc. Sources for information include: interviews with "customers," records of services provided, administrative documentation, interviews with "personnel" managing the activity or program, media attention to the program

STEP 5 Synthesize findings and outline the lessons learned and possible actions related to:

A. Continuing the program or activity as is

B. Modifying the scope of programs or activities (i.e., limiting, expanding, or terminating activities)

C. Changing goals and tactics for the program or activity

STEP 6 Prepare a feedback report and communicate widely. Include in report:

A. Background and assumptions underlying the evaluation

B. Purpose of the evaluation (what it will and won't do)

C. Mechanism for evaluation and methods used

D. Synthesized findings, lessons learned and recommendations

PRINCIPAL CRITICAL SUCCESS FACTOR FOR PHASE VI:
Managing Realistic Expectations

Key Management Challenges

As emphasized previously in this document, designing and implementing a community health assessment is a critically important, but sometimes difficult process. Health care organizations are especially challenged by the collaboration required among key health and community organizations and individuals, and the data collection issues and analysis required to implement such an initiative.

A community health assessment is a complex process requiring simultaneous management on many different levels, and it can be a daunting proposition for those not confident of their ability to successfully manage the process and outcomes. This monograph's initial sections have provided a conceptual base for an assessment and realistic steps to organize and implement the process. This section offers practical advice from health care organizations that have addressed the management challenges associated with a community health assessment.

Although not meant to be all-inclusive, this section focuses on two major categories of challenges: those relating to the process of partnership-building and those addressing steps in the process of data collection and analysis.

KEY CHALLENGES FOR THE PROCESS OF PARTNERSHIP-BUILDING

- Gaining and maintaining top leadership support
- Achieving ongoing community involvement
- Managing consensus-building
- Maintaining realistic expectations

KEY CHALLENGES FOR THE PROCESS OF DATA COLLECTION AND ANALYSIS

- Selecting cost-effective approaches to data collection
- Achieving adequate response to data collection
- Digesting data for analysis and priority-setting
- Managing an equitable priority-setting process
- Moving from data collection to action

CHALLENGE #1: *Gaining and Maintaining Top Leadership Support*

The importance of top leadership support is a clear message gained from health care organizations assuming a leadership role in community health assessment After all, a primary purpose of an assessment is to develop community consensus around priorities for action–something which cannot be done without the commitment and involvement of top community leadership. Every organization involved in the assessment and priority-setting must have its leadership support if their commitments are to be made and honored. Without top leadership commitment to the process, resources, especially staff time, are less likely to be provided as new roles and responsibilities are defined for the organization's contribution to creating a healthier community. Finally, health care organizations are usually viewed as a community's major health resources, and if their leaders do not take a visible role in the assessment, community residents and leaders are less likely to take the process seriously.

Is strong hospital leadership support necessary to consider a leadership role in a community health assessment? The answer appears to be a qualified "yes." For nearly every health care organization interviewed for this document, the CEO played a critically important role in spearheading the assessment process. For many religious systems, their corporate offices recommended or mandated community health assessments. In some organizations, their boards of trustees played an active role in the process. Medical staff, often through local medical societies, were also active participants. While not necessarily sufficient to assure the ongoing support of a community health assessment from executive staff, trustees and physicians, the following strategies can spark initial interest among leaders:

- Engage leaders is a discussion to emphasize the strategic and health-care reform benefits of the hospital's leadership role in community health assessment

- Encourage communication from CEOs of competing hospitals or other hospitals in the same system about the value of a community health assessment

- Seek communication from key community and business leaders regarding the significance of community health problems and the need for collaboration to address them successfully

- Seek to involve administrative staff, trustees and medical staff in any existing community health efforts to increase the salience of local health issues

From day one, the community health assessment was a major initiative of the board and senior management. It wasn't just an activity delegated down. I think our reception in the community was improved by the fact that they understood that this had a major organizational commitment behind it.

JOHN MCMEEKIN, PRESIDENT
CROZER-KEYSTONE HEALTH SYSTEM

According to the Crozer-Keystone Health System, the most comprehensive health care provider in Delaware County, Penn., leadership support for a community health assessment is something that you can't "gain and maintain." "If you don't have it at the beginning, your health assessment will probably not get off the ground," says John McMeekin, president and chief executive officer of the three year-old system. McMeekin comes to his leadership position with a goal to implement a broad-based community health assessment. Given that the mission and vision of the system is to improve the health status of the entire community, he firmly believes the goal can't be achieved without an initial in-depth health assessment. The Delaware County Healthy Priorities 2000 project is the system's first major initiative and represents a $300,000 investment whole-heartedly supported by the system's board in 1991.

The first four phases of the health assessment process were completed in 14 months. A local advisory group included the president of Crozer-Keystone, the provost of Swarthmore College, the dean of Bryn Mawr's School of Social Work and Social Research, the director of the Delaware County Planning Department, and key personnel from the county medical society and county government. The data collection and analysis phase was directed by a professor of health administration at Temple University. Thus far, the project has involved the compilation and analysis of census, vital statistic, hospital discharge and household survey data for subareas within Delaware County. It also has incorporated more than 2,000 interviews with many health-care and human-service professionals in the county and with focus group participants from professional and consumer groups. The effort has entered the collaborative action planning phase where the top 12 health priority areas are being developed and implemented. An extensive report on this project concludes that the problem concerning insurance and reimbursement stems from a failure to ask the correct first question. Instead of asking, "How will individual services be paid for?" the correct question is, "What can we do to best improve the health of people in our community?"

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Board members need to become involved in assessing the needs of the community to identify health care priorities. In turn, they need to assist health care systems in the design, development and implementation of community-based prevention-oriented programs that will improve and advance the health status of the community.

MARK D. PILLA, PRESIDENT AND CEO
COMMUNITY MEDICAL CENTER

At Community Medical Center, a 596-bed hospital in Toms River, N.J., trustees are taking an active role in key health-assessment activities. In 1992, each member of the Community Benefit Board (composed of hospital trustees, hospital administrative staff, medical staff and heads of key community health agencies and local businesses) interviewed five members of an at-risk group in the community using a common interviewing guide. Members interviewed homeless people, AIDS patients and their families, and victims of family violence to explore the groups' perceptions of their health problems, and their perceptions of available prevention and treatment services. Participation in this data collection process dramatically increased board members' appreciation for the health problems experienced in their community.

In 1993, the hospital's strategic planning committee is coordinating implementation of the broader APEXPH (Assessment Protocol for Excellence in Public Health) community health assessment. Community leaders (including all hospital trustees, businessmen and women, and other opinion leaders) have each completed a community survey designed to assess their perceptions of the importance of a wide range of health concerns and the adequacy of available prevention and treatment services. As with health interviews, participation in a survey process increases the salience of community health problems among trustees and other decisionmakers and provides impetus for their support of appropriate action programs.

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CHALLENGE #2: *Achieving Ongoing Community Involvement*

Achieving ongoing community involvement is one of the most critical challenges facing hospitals interested in the design and implementation of a community health assessment. The experience of a variety of institutions shows that waiting until the data has been collected to involve community leaders makes it more difficult to achieve a meaningful participation level in the action-planning phase. A vision of community health must include shared decisionmaking around priorities and actions. Because of the inherent difficulties in achieving such a partnership–cultural, communication and goal differences–the shared decision-making should begin as early in the process as possible.

> *Waiting until the data has been collected to involve community leaders makes it more difficult to achieve a meaningful participation level in the action-planning phase.*

Behavior changes must be nurtured through the planning and implementation. Health professionals who have traditionally taken charge of health-related decisions often need to remember to step back and listen. Likewise, community leaders and residents looking for the magic bullet to solve health problems instead need to own their share of community responsibility for the solution.

STRATEGIES TO ENCOURAGE ACTIVE COMMUNITY INVOLVEMENT INCLUDE THE FOLLOWING:

- Tap a broad range of community leaders for input before plans for the health assessment are developed

- Form a steering committee or coalition of effective community leaders, especially from minority or underserved communities, to guide the assessment and planning process

- Use a process consultant to observe who attends, participates, asks questions and abstains from decisions in meetings. If the balance appears to be shifting to hospital control, the group can consider changing the meeting time or place, or using a facilitator to ensure that everyone has a chance to participate in discussions

- Set clear agendas so that people believe their time is being used well

- Use subcommittees to address specific topics of interest to different members of the overall committee

- Consider action steps before the assessment is completed to encourage participation and emphasize that the data won't sit on a shelf

- Work with community leaders to identify others in their organizations and groups who might be encouraged to assume leadership roles in the health assessment and planning phases

- Avoid majority votes that may alienate an important subgroup of the coordinating committee or coalition

- Accept and recognize participation in various ways; everyone is not comfortable with the formal meetings used by business and health professionals

In the context of a reformed health care system with increasing public financing, it is likely that community hospitals will be more accountable to the public for the appropriateness of their services. The public will not legitimize hospital services unless they have participated in the identification and prioritization of health care needs.

NORMAND E. GIRARD, PRESIDENT
SOMERVILLE HOSPITAL

The Somerville Hospital and the Somerville Health Department have adapted the APEXPH (Assessment Protocol for Excellence in Public Health—see Resource Section) to guide the health assessment process and development of a community health agenda. Throughout this initiative, both partners have emphasized the following strategies to keep the community informed and involved:

- A health assessment survey was distributed to 300 community leaders including members of the hospital's board of trustees, business leaders, PTA presidents, school principals, politicians and heads of city departments. Although not an official part of the APEXPH process, the survey helped explain the project to key community members and elicit general perceptions about health needs and resources. It also helped to identify persons interested in serving on work groups and the coordinating committee

- Several community meetings were held to further involve community members in reviewing initial data and in setting priorities

- Community coordinators were asked to co-lead each work group with the project coordinators. For example, for the work group on Uninsured and Immigrant Access to Care, the executive director of the Portuguese Language League was invited to serve as the co-leader

- Key community leaders have been invited to participate as members of the ongoing Community Health Agenda Coordinating Committee that will monitor implementation of the objectives by participating organizations

- Project coordinators are sensitive to the barriers to ongoing community involvement. For example, since key leaders representing important population subgroups are often overcommitted to participation in community projects, it has been important where appropriate to encourage additional leadership development from those organizations and groups

- A periodic newsletter about the project is mailed to more than 400 community leaders and health providers. This publication informs all work groups about the efforts of the others, and is a vehicle for soliciting input and help for specified projects from others in the community.

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CHALLENGE #3: *Managing Consensus-Building*

Managing consensus-building is a critically important challenge throughout the community health assessment process. Without agreement on goals and a process to reach those goals, desired outcomes are not likely to be achieved. An important distinction should be made between consensus and majority rule. A consensus implies that a general agreement has been reached, not necessarily by a vote; majority rule means that at least one more than half of a group supports a particular direction. As Ralph Hergert, director of the Mayor's Office of Human Services and a member of the Somerville, Mass., Community Health Agenda Coordinating Committee explains, "It's worth taking the time to get 50 people to work through things. Once you've done all that, you have 50 people on the same wavelength; majority rule doesn't address the major issues."

To build consensus, process concerns must be monitored closely to ensure that each participant has a chance to speak, that brainstorming and other creative strategies are used to generate options, and that group decisionmaking techniques are used to help the group make important decisions.

Each coalition or partnership must make an important choice regarding the extent of agreement required for every decision. For example, a large and diverse coalition may have difficulty achieving consensus on specific priority objectives even though consensus has been reached regarding the broad, overarching priorities for action. The group may decide to defer to the recommendations of subgroups assigned to work through an in-depth planning and priority-setting process for a more targeted area of responsibility. Other groups may only feel comfortable proceeding when consensus is reached for all decisions–both broad and specific.

> *Depending on the political context of the partnership, consensus-building may be most successfully managed if a neutral and well-respected individual or individuals skilled in group process serve as process champion and meeting facilitator.*

Depending on the political context of the partnership, consensus-building may be most successfully managed if a neutral and well-respected individual or individuals skilled in group process serve as process champion and meeting facilitator. Another option is to use external facilitators for meetings when critical decisions are made. Human resource departments, universities, training organizations or consulting companies are often good sources for facilitators.

Success in collaborative relationships demands that you be inclusive in bringing everyone to the table, and that you leave your ego aside and be willing to play a variety of roles–leader, partner, support–as the need dictates. What is important is for hospitals to use their resources wisely to advance the health status of a given service area.

SAMUEL T. WALLACE, PRESIDENT
ST. LUKE'S HOSPITAL

St. Luke's Hospital in Cedar Rapids, Iowa, is a leader in fostering community partnerships. Over the last decade, the hospital has been involved in community health projects ranging from the development of a child protection center and joint management of Iowa's largest not-for-profit day-care center to participation in a multi-county partnership providing health services to rural areas with limited access to care. The hospital has a long history of collaborating with diverse community organizations. "This fact," notes Linda DeWolf, formerly associate vice-president, community services, "gave the hospital great credibility as we approached other key organizations with an idea to create a broad-based health agenda for the county. It also made a difference that the community sees us participating in projects where there is not always clear gain for the hospital."

Healthy Linn 2000 represents a year and a half of work of nearly 200 volunteers to review the national Healthy People 2000 objectives, collect and examine health data specific to the county, and create specific strategies for Linn County to meet agreed-upon health objectives by the turn of the century. This process has been marked by enthusiasm, widespread participation and little disagreement or conflict–likely results when partners emphasize inclusiveness, openness and the following strategies to encourage consensus-building:

- *Inclusion of key partners*: Although the hospital had the original idea for this initiative, when considering who had the most investment in this public-health-oriented process, staff collaborated with the local health department to sponsor the kick-off town meeting.

- *Developing a structure*: Although much enthusiasm was generated by the town meeting, people were overwhelmed by the immensity of the task. A structure was needed to provide ways for people to work productively on pieces of the overall project

within previously set parameters. A nine-member steering committee was organized, co-chaired by St. Luke's, Mercy Medical Center and the health department. Two members of this committee chaired each of five major task forces and brought in other participants as their tasks demanded.

- *Community-based meetings*: All Healthy Linn meetings were held at the health department, which was viewed as a neutral place by all participants.

- *Combination of flexibility, open communication and consensus*: The steering committee ensured that there was agreement on a vision, purpose, basic time line, parameters of data collection and the overall process. However, individual task forces had substantial flexibility to shape their tasks in different ways. The steering committee was unable to reach consensus on only one major issue—whether or not to set priorities for the needs identified during the data collection phase. Some members believe setting priorities is important to focus the efforts of the committee, while others maintain that it will limit the enthusiasm of some work groups whose objectives may fall lower on the priority list.

- *Avoidance of forced votes*: The steering committee has emphasized advance preparation, dissemination and information discussion as precursors to consensus development. Most issues were not "taken to the vote."

- *Facilitation of process*: Active and positive participation by nearly 200 volunteers has been substantially aided by good meeting and process facilitation. Participants agree that Healthy Linn meetings are productive. Given that the steering committee met every other week for nearly 18 months, this is a substantial achievement. Ms. DeWolf credits this success to the members' commitment to a vision, effective facilitation and a combination of long- and short-term goals that enabled everyone to see the progress being made.

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FOCUS: Our Lady of Lourdes Medical Center, Camden, New Jersey

Initiating an ongoing dialogue with our neighbors was an important first step in our hospital's evolution toward becoming truly proactive and responsive to community health care needs.

SR. ELIZABETH CORRY, PRESIDENT
OUR LADY OF LOURDES MEDICAL CENTER

Two and a half years ago, when Our Lady of Lourdes Medical Center, Camden, N.J., asked the local zoning board for a variance for a new hospital sign, nearly 60 residents fought the request. Since that time, hospital participation in the newly formed Parkside Residents Association has turned this negative relationship into a partnership. Joining the organization as a neighbor, without making a large financial contribution that might have unduly influenced decision-making, the hospital has now appointed the director of marketing and the director of pastoral care to be the two principal liaisons to the association. At the same time, Parkside has been asked to appoint three members—the association chair and two others—to the hospital's newly reformulated community advisory committee.

To change the often-adversarial attitude that residents held toward the hospital, senior executive staff developed a partnership with the residents' organization through ongoing participation in meetings, lack of defensiveness and a willingness to openly discuss disagreements. Additionally, the hospital's interest in problems that go beyond narrow health issues—such as organizing food banks, building a youth center and opening the Medical Center's facilities and meeting rooms for community use—have contributed to reversing negative attitudes.

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CHALLENGE #4: *Maintaining Realistic Expectations*

Ensuring that a community maintains realistic expectations about organizational roles and resources is one of the most common concerns of health-care organization leadership about their involvement in a broad-based community health assessment and planning process. Many CEOs worry that the process of soliciting community involvement in a community health assessment will imply that their organization is willing to act on or solve any problem identified in this assessment. At the same time, community leaders wonder why the organization wants to "ask them more questions." Will it result in another report that sits on the shelf? Will it collect information so that the hospital can develop a new service and make more money?

From the health care organization's perspective at least three key strategies can prevent many of these problems:

- A focus on listening by meeting with a wide variety of community groups to hear concerns, especially those who have a history of difficulty in dealing with the hospital

- A focus on involvement by inviting key community leaders from all sectors to the table as the planning begins and encouraging them to communicate their expectations directly

- A willingness by the health care organization to support and be involved in achieving objectives that contribute to a healthy community, but may not represent their particular organizational priorities

By bringing together people who are involved and concerned with the health of this community, we are fine-tuning the services that each organization provides. The measurable benefit from our community partnership efforts is evident: a new service for the community. The less-tangible benefits from this alliance are improved communication, accurate information and a spirit of cooperation that is remarkable in today's competitive society.

THOMAS A. NORD, CEO
IVINSON MEMORIAL HOSPITAL

Hospital staff and community members' expectations have an important influence on the perceived success of a community health assessment. The 110-bed Ivinson Memorial Hospital in Laramie, Wyoming, discovered that because of the hospital's increasing community focus, many community members expected the hospital to foot the bill for addressing identified needs. Tom Nord, hospital CEO, emphasized throughout the early planning process that although the hospital did not have cash resources for the program, it was ready and willing to invest the talent of its employees and in-kind resources. Initial assessment activities identified duplications in services that enabled many organizations to better use existing resources. Since no single organization provided a large sum of money, everyone could come to the table with an appropriate contribution.

While the lack of grant funds limited the breadth of programming, it also allowed the Albany County Community Health Awareness Committee to work uninhibited by regulations or rules from funders. Finally, the lack of a major funding source enabled volunteers to be the life force for the program, which fostered community ownership of the projects undertaken.

Early in 1992, the Albany County Committee and the hospital began planning a health assessment survey that would be mailed to a sample of county residents. A major concern was that this survey would be "just another study," and a waste of residents' time. Another concern was that the results would sit on the shelf until another "study" of the community. Nord believes that the formation and activation of the broad-based community committee before beginning assessment

activities helped counter this concern. This committee was action-oriented, and based on previously collected information, was already working on developing a Community Helpline when the health assessment survey was distributed. Substantial volunteer involvement in preparing the assessment mailings was also a likely contributor to the widespread willingness to participate in the survey process.

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CHALLENGE #5: *Selecting Cost-Effective Approaches to Data Collection*

Seven considerations can help a community health assessment partnership select the appropriate data and data collection techniques.

Goals: The partnership's goals, and more specifically those of the community health assessment, will strongly influence choices for data collection activities. For example, Crozer-Keystone Health System in Media, Pa. was interested in benchmarking progress in Delaware County with national data. By using Healthy People 2000 key health-status indicators as benchmarks, they identified health behavior data required to be collected locally.

Already-existing data: Although the specifics vary for each city, county and state, a large amount of health data usually exists in a given community. State data commissions, bureaus of vital statistics and health departments have collected substantial mortality, morbidity and SES data. Local organizations and coalitions such as the United Way, Area Council on Aging or AIDS council may have implemented needs assessments. An initial review of this information is critical to determine existing information gaps. For example, a review of prenatal care, infant mortality and availability of maternity service data may lead to the unanswered question, "Why are high-risk mothers not using available services?" This can then be explored through new data-collection efforts using focus groups with women of color, residents of housing projects or other high-risk populations.

Political considerations: Many politically sensitive issues drive decisions on collecting new data. Considerations must include competition between two or more members of the coalition or partnership, questions about the validity of previous data-collection activities and minority groups' beliefs that they have been excluded from previous data-collection activities.

Heterogeneity of the population: If the population being assessed is relatively homogeneous, then the need for varied data collection strategies may be decreased. However, if your county has varied ethnic and cultural groups, populations such as migrant workers or a high prevalence of illiteracy, mental illness or homelessness, then your data collection strategy can be adjusted to tap specifically into the needs and perceptions of these groups. Differences even within an appar-

ently homogeneous population should be identified, as the perceptions of different age groups may vary widely even within an ethnic or socioeconomic group.

Mix of quantitative and qualitative data: A useful health assessment will contain both kinds of data. Quantitative data provides the overview–the benchmark, the objective measure-ment of health status, health behavior and health perception variables. Qualitative data allows you to explore the questions raised by the quantitative data and uncover the reasons people feel and behave the way they do. This type of data will be particularly important during the action-planning phase.

Involvement of stakeholders: One of the reasons for organizing the partnership or coalition *before the data collection* is to encourage members to buy into the overall assessment and planning process. Having volunteers distribute questionnaires, using interviews that alert a variety of community agencies to the process and using focus groups to talk with those who often feel isolated from the community not only result in data, but also create potential program advocates.

Resources: It is difficult to specify the amount of resources needed to implement a community health assessment. Examples of new dollars spent (not in-kind) range from a few thousand to several hundred thousand. The amount of resources needed is determined by factors such as goals, availability of data and the willingness of organizations to make in-kind contributions. Experience with hospitals nationwide suggests that a community health assessment should never be cancelled because of lack of resources. The data-collection portion of the assessment process can be done with initial steps focused on reviewing existing data while later steps can include surveys and focus groups as resources become available.

Responsibilities for agency interviews and focus groups can be divided among coalition members, with training programs and common interview tools used to maintain consistency. All of these strategies bring associated problems. The telephone survey, for example, is likely to under-represent low income populations, but these problems can be considered in the planning and priority-setting phases. Most importantly, each partnership should look broadly within its community for resources to tap from universities, community agencies, schools, churches and governmental offices that can contribute to the data-collection process.

FOCUS: Miami Valley Hospital, Dayton, Ohio

It is important for the hospital to integrate its assessment process with ongoing community assessments. Otherwise we risk reinventing the wheel. If we only use our assessment criteria, we also may be imposing our values on the community; if we use their criteria we can be certain to get a more pluralistic approach.

THOMAS G. BREITENBACH, PRESIDENT AND CEO
MIAMI VALLEY HOSPITAL

When Miami Valley Hospital in Dayton, Ohio, began an inventory of their community benefit efforts, a needs assessment subcommittee was charged with identifying where the hospital should focus its priorities in coming years. While the committee considered collecting new data to address this charge, members soon discovered that much had already been collected by other community agencies. Although several needs assessments were very broad and addressed more than health needs, the committee was able to review the data, identify common elements across assessments and pinpoint the information on community needs most relevant to the hospital's health care mission. A series of interviews with physicians already involved in community service activities complemented the community agency assessments.

Data from four key sources were examined:

- The Montgomery County Human Service Levy Council distributes local tax money to key agencies such as the health department, reserving 10 percent of funds to address other needs. Based on surveys, agency comment and consumer input, the Council annually identifies priority needs

- Every February, local funders including the United Way and local foundations hear agency and consumer testimony about community needs during a two-day "joint hearing" at the convention center. The Joint Hearing Project Report summarizes this testimony

- Senior Information Services (the information and referral component of the Greater Dayton Senior Citizens Center) tracks unmet needs of callers who are seeking community referrals for a variety of problems

- The local United Way also annually surveys its contributor and recipient agencies to identify unmet needs

The use of existing data has the advantage of reducing the need for additional data collection. Additionally, a review of broad-based assessments provides the benefit of seeing how health needs stack up against other human service and community problems. After reviewing various data sources, Miami Valley Hospital identified seven priority areas for 1993:

- Adolescent pregnancy prevention and supportive services

- Adult day-care services

- Mental health services

- Prescription assistance

- services to low-income individuals/families

- substance abuse/chemical-dependency services

- transportation services for medical care

To develop cost-effective community service programs, internal staff are being asked to submit applications for funding projects that address one of the identified priorities. To be considered, a project must be planned in collaboration with a community agency, show impact and represent at least $50,000 in effort. The required 10-page narrative application must include a discussion of the problem, proposed project activities, projected impact, at least three objectives and an evaluation plan.

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1 Wyoming St.
Dayton, Ohio 45409
(513) 220-2371

FOCUS: Our Lady of Lourdes Medical Center, Camden, New Jersey

As chief of obstetrics and gynecology for the past 12 years, I have seen first-hand the results of poverty in peoples' lives. This program is an example of using creativity and caring in balancing the bottom line.

BRUCE MAYBINE, M.D.
CHIEF OF OBSTETRICS AND GYNECOLOGY, OSBORN FAMILY HEALTH CENTER
OUR LADY OF LOURDES MEDICAL CENTER

Staff at the Osborn Family Health Center, a primary care clinic sponsored by Our Lady of Lourdes Medical Center in Camden, N.J., are interested in discovering why a substantial percentage of women are not beginning prenatal care until late in their pregnancies. Responses from women during interviews at the hospital emphasize lack of transportation and child care. Yet an analysis of their family residences showed them to be generally clustered around health-care providers.

To collect more valid information, the hospital, as a member of the Healthy Mothers/Healthy Babies coalition, encouraged the coalition's outreach workers to personally interview clients at home and conduct focus groups in community locations. The information from this data collection process substantially helped clinic staff to make program changes resulting in a decrease in missed appointments among prenatal patients and an average 100-gram increase in birth weight. Key results of this needs assessment included the following:

- Most women who fail to obtain prenatal care must deal with issues as basic as where they get food for dinner. Their focus on having a healthy baby is not uppermost in their minds because they have other mouths to feed. Clinic staff used this information to change their incentive program from one featuring car seats and other baby-related items to one offering food certificates. They also made food available in the clinic during prenatal visits.

- Although the Osborn Clinic has been targeting the most difficult population—pregnant women who are/were substance abusers—the needs assessment showed that this group would be unlikely to respond to any elements of the incentive or education program.

Clinic staff are now targeting women with prior pregnancies who have shown some willingness to keep appointments.

- Because many women did not want to wait an entire morning or afternoon for their appointments, the clinic set a new objective to hold waiting time to no more than 30 minutes

- Many women also said that they feared being treated indifferently or without respect. Enlarging the clinic, painting the walls and redoing the bathrooms have communicated caring and respect to the patients. Ongoing use of patient satisfaction surveys identifies other problems to be addressed.

For more information contact:

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Director

Osborn Family Health Center

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CHALLENGE #6: *Achieving Adequate Response to Data Collection*

Gaining adequate response to data collection is both a technical and communications challenge. Survey research and focus group guides clearly identify the steps needed to assure response within the context of a research project. University faculty, graduate students and consultants can provide a community health assessment partnership with the technical aspects of assuring adequate response rates.

> *Gaining adequate response to data collection is both a technical and communications challenge.*

However, a community health assessment is not just a research project, but a collaborative initiative empowering the community to address its priority health problems. This challenge covers the broader issue of communicating with the community about the overall project. Using town meetings to discuss the scope of the project, collaborating with local media to encourage participation in various aspects of data collection, and using volunteers who include informal community leaders are ways to meet this communication challenge.

The partnership's internal processes can be used to ensure adequate response to data collection. A coordinator should be selected and a time line and responsibility chart established for each data collection activity. In some cases, it is important to have an in-service program for data collectors, which can be a formal training program on running focus groups or an informal discussion of agency interview protocol. Depending on the nature of the data collection, it can be helpful to have intermittent meetings of these data collectors to discuss progress and problems.

FOCUS: Henry County Memorial Hospital, New Castle, Indiana

Through the hospital's involvement with the Healthy Cities survey, we were able to include questions regarding access to services and insurance coverage that will assist in our planning. In addition, the data on health behaviors will help us focus our community health education programs.

JACK BASLER, PRESIDENT
HENRY COUNTY MEMORIAL HOSPITAL

In 1991, the New Castle, Indiana Healthy Cities Committee, co-chaired by Ceil Martin, vice president of patient management services at Henry County Memorial Hospital, declared Saturday, June 1 as kickoff day for distribution of the committee's health survey. The survey was designed to identify why the town's death rates for heart disease, diabetes, cancer, stroke and arterial diseases were higher than state and national norms, and what could be done to improve these rates. A press release and articles in local papers prepared the community for the kickoff day.

Volunteer teams and a comprehensive distribution plan were used to maximize response rate and assure responses from all areas of the city. New Castle was divided into 14 fairly equal sections with approximately 72 surveys distributed in each section. Fourteen teams of seven workers each were recruited by committee members who also became team captains.

On the morning of June 1, teams met at the hospital for a brief orientation session before going to their sections. Each team member wore Healthy Cities identification and was responsible for distributing 10 surveys, stopping at every third house to request participation. If the occupant refused, the team member continued to the next appropriate residence. If the person agreed to participate, the volunteer spent a few minutes explaining the purpose of the survey and how to complete it. Surveys could then be completed at the participants' convenience. Postage was prepaid so there was no cost to survey respondents.

Henry County Memorial Hospital sponsored a "thank you" luncheon for all volunteers at the end of the day. The Healthy Cities Committee hoped for 200 responses given the distribution of 1,000 surveys; 496 community members mailed completed surveys, for a response rate of nearly 50 percent.

For more information contact the Healthy Cities co-chairs:

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Vice President, Patient Services
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Joanne Rains, Assistant Professor
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Strategically, hospitals need to become even more aware of the needs of the population. We have tended to manage and grow within our own walls. We need to move beyond those walls, collaborating with community leaders and our competitors. This type of innovative teamwork will be the pivotal point in addressing access to health care in the years ahead.

JACK BARTO, CEO
ST. MARY HOSPITAL

St. Mary Hospital of Port Arthur, Texas, a member of the Sisters of Charity of the Incarnate Word Health System, used four important process techniques to ensure maximum participation in the data collection phase of their community health assessment. The hospital's director of mission services headed a five-person team (three other hospital staff members and a civic leader) to implement a six-month assessment that encompassed more than 80 interviews and nine focus groups.

- To identify who should be interviewed, the team brainstormed on index cards nearly 300 potential interviewees. Using the storyboard technique, the cards were mounted on an 8- by 4-foot board and eventually organized under three headers–executive level (mayor, chief of police, executive director of the housing authority); mid-level (e.g., director of social services for the housing authority); and users (e.g., residents of housing project). Once the team reached consensus about this dimension of the process, the headers and groupings were recorded, and the cards reshuffled. The team then organized the cards under a different set of headers, in this case by interview type–single-person interview, two-person interview or focus group.

- Once the interview process began, a briefing board was set up in a central location so that not only team members but other key administrative staff could visualize the assessment progress. The board had five divisions– "to be done," "in process," "completed," "problem" and "input." Index cards moved across the board as appointments were made and interviews completed. If a team member had difficulty setting an appointment, for example, they could note the problem on an index card and post it in the problem column.

Often, the CEO or another hospital staff member who stopped by the board was able to resolve the problem.

- Two-person interviews were often used to ensure maximum effectiveness of the data collection. Each team met prior to an interview to review the questions to be asked. The observer team member held this list and monitored progress of the interview so that all pertinent issues were covered.

- Focus groups were used primarily with user populations–mothers on AFDC, pregnant teens, young African-American men, Vietnamese immigrants, Spanish-speaking residents, and junior and senior high-school students. Health care providers for homebound patients were also included as a focus group. To communicate the importance of their input to group members, all groups met on their own turf, away from the hospital.

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CHALLENGE #7: *Digesting Data for Analysis and Priority-Setting*

The amount of computer reports sitting unopened on health care managers' desks is often over-whelming. Digesting and summarizing data so that it can be used is a critically important and often-difficult part of the health assessment process. At the same time, many community leaders and residents can be even less comfortable than health care providers about making sense of large amounts of perhaps confusing, contradictory data. The dilemma is how to summarize data for use without simplifying it so much that priorities are set without broad discussion. Here are suggested strategies to ensure that data can be used successfully in setting priorities.

- Present results from different data collection activities at different points in time so that partici-pants have a chance to digest it in smaller chunks.

- Summarize qualitative data so that it can be presented simply. For example, Providence Medical Center in Seattle, Washington, has been involved in a community health assessment that includ-ed interviews with more than 40 city agencies. To present the results of these interviews, a matrix of the issues identified by each interviewee was developed, along with a summary list of issues and the number of times each was identified. A bar chart showing the top five issues (see below) or the frequencies for 29 issues/barriers can be presented:

ISSUE	NUMBER OF TIMES IDENTIFIED
1. Lack of sufficient mental health services	21
2. Insufficient funding of services	15
3. Transportation difficulties	14
4. Lack of knowledge of available services	13
5. Language/ethnic barriers	12

- Prepare written summaries of data to be used during the presentation and taken home for further discussion. These summaries can be used by community leaders as a basis for discussion within their own organizations.

- Work with key community leaders to co-present data. This strategy allows leaders to utilize years of experience in communicating with their constituencies to make health-assessment data more understandable.

- Identify areas of disagreement so that meeting time can be used to discuss the importance of the differences and whether these differences suggest the need to collect additional information.

Selecting priorities is one of the most delicate and potentially destabilizing aspects of the community health assessment process. At this point decisions are made about where action will or will not be taken. Participants whose top priorities are not selected by the group may or may not want to continue participation in the overall initiative. While a variety of strategies to promote consensus-building have been previously discussed, it is clear that some priority-setting must occur if action plans are to be developed. Suggested steps to assure an equitable priority-setting process include:

- *Use partnership members to identify criteria for communitywide priorities*. A brainstorming process may be needed to identify and then consolidate key criteria for selecting priorities. Pay particular attention to the feasibility criteria. While a fledgling coalition should choose some short-term manageable objectives, an unwillingness to grapple with thornier community health problems such as violence, drug abuse, lack of access to health care and poverty can make the coalition's activities appear not to be meaningful.

- *Encourage partnership members to take priorities back to their constituencies and get additional feedback before they become final*. This point could be the time to have an open community meeting to discuss priorities.

- *Encourage individual agencies to identify criteria for selecting their own priorities*. Catholic Healthcare West in San Francisco, Calif. has developed the priority-setting process outlined in the table below. This process allows hospitals to determine priorities from their perspective. The process could be modified for use by any agency or coalition simply by changing the criteria and/or weights.

- *Mesh the partnership and individual agency priorities to evolve a strong action plan*. If addressing the needs of the homeless is one of the broad-based priorities that evolves at the coalition level, the local community development corporation and local churches may take a leadership role in building a new shelter.

A health care organization may not believe that housing and support needs are its priority. However, the hospital may contribute extra food from its food service to the new shelter, encourage its employees to volunteer at the shelter, participate in a communitywide fundraiser for monies to build a shelter and evaluate how it can extend its primary care and emergency services to the shelter.

TABLE 4

Priority-Setting Process Used by Catholic Healthcare West, San Francisco, Calif.

A. Steps in the priority-setting process:

1. Identify desired criteria and categorize under appropriate headings. Group processes such as an affinity process can be used for this function.

2. Weight the criteria: 1 = overriding importance; 2 = important; and 3 = worthy of consideration, but not a major factor. This function can also be performed using group processes.

3. Rate needs identified during the health assessment by using the 1 (low)–5 (high) rating and without considering weights. This process can be accomplished through individual or group discussion.

4. Total scores for each need are calculated by multiplying weights by rating (multiply times 3 for #1 rating and times 2 for #2 rating) and adding all criteria scores. These scores can range from 0 to 180 if 12 criteria are used. More or less criteria would expand or constrict the scoring range. If scoring is done by individuals, the resulting scores can be averaged.

B. Sample criteria used for setting priority needs with weights for each criterion indicated in parentheses. Each health need should be rated from 1 (low) to 5 (high) on each criterion.

1. Relative number of persons in need

   _____ (2) How does the size of the affected group compare to other special needs groups?

   _____ (2) Is the group growing? How fast?

2. Relative acuity of need

   _____ (1) What are the consequences of no services?

   _____ (1) How deep is the suffering?

3. Potential effect of services in the community

_____ (1) To what extent will services improve the quality of life for the affected group and the community as a whole?

_____ (2) To what extent will duplication of services be avoided?

_____ (2) Are there opportunities to work with other agencies or providers to achieve economies and synergies?

4. Historical tradition and expertise in serving the group

_____ (3) What has been the hospital's commitment to this group in the past?

_____ (3) What traditions of serving people in similar circumstances have been established?

_____ (1) Is the necessary expertise available or easily accessible?

5. Density of affected persons in the primary service area (PSA)

_____ (1) How heavily is this group concentrated in the hospital's PSA?

_____ (2) To what extent does the community look to the hospital for help?

CHALLENGE #9: *Moving from Data Collection to Action*

The Cuban writer Lisandro Otero, commenting on the current status of Cuba's paralyzed economy said, "This is the only country where every solution has a problem." Unfortunately, partnerships organized to implement action plans from a community health assessment process may be similarly bogged down in inaction after completing several previous phases. This inaction can result for many reasons: the needs are too overwhelming; the data is too complex; there is not really agreement on an action process; there are turf battles; there is the inertia that comes from finishing a major activity.

There is no easy response to this challenge, and many community health assessment partnerships have not had time to move through the action phase. However, the following strategies appear promising:

1. **Build shared decison-making and involvement from the beginning**. This point is critical. Having key hospital and community leaders buy in on the process before beginning a health assessment makes the move to action-planning an easier transition.

2. **Organize a structure to facilitate planning and project development**. A loose-knit and unstructured committee will probably not be able to move forward with an action-planning process; however, communities can choose their own organizational structures. Many communities have found a coordinating committee structure with subcommittees to be the appropriate vehicle. The New Castle, Indiana, Healthy Cities Committee has determined that it must incorporate as a 501c(3) organization to attract needed funds from corporations and foundations. Another citywide partnership plans to move under the umbrella of a community development corporation.

3. **Develop an operating code that guides the process and function of whatever structure has been chosen**. Decisions must be made about meeting organization, leadership, decisionmaking processes and communication guidelines. While different partnerships will opt for different processes, they should emphasize maintenance of diverse input, open communication and shared or rotating leadership.

4. **Pick a winnable issue**. In its early efforts the partnership should identify an objective that can be accomplished relatively easily. This choice will tell the community that the group will actually do something and reinforce to the members that the group will make a difference.

5. **Develop a mechanism to maintain excitement**. Given the competing demands faced by every hospital and community leader, important challenges to maintaining the action process are the questions, "How do we keep everyone excited?" and "How do we make sure that the follow-up to the community health assessment continues to be a high priority within the community?" Whether this happens has much to do with the level of community involvement in the preceding steps, and the extent that the agreed-upon priorities represent important expressed needs.

STRATEGIES THAT HELP MAINTAIN BROAD INTEREST INCLUDE:

1. Ongoing media coverage of accomplishments

2. A yearly report card showing progress toward objectives

3. Honoring one community leader annually for his or her contribution to the action plan

4. Selectively continuing certain types of data-collection activities

5. Participation by coalition members in regular meetings of key community organizations to answer questions and update them on progress

Data Needs and Issues

Data collection and analysis are critical components of a community health assessment. Data–quantitative and qualitative, primary and secondary, empirical and perception, baseline and trend–all serve as crucial sources of information for an ongoing health assessment. Together they enable the development of a comprehensive community profile to:

- Understand the nature and composition of the community

- Identify community health problems and goals

- Consider underlying causes of health problems

- Assess available resources

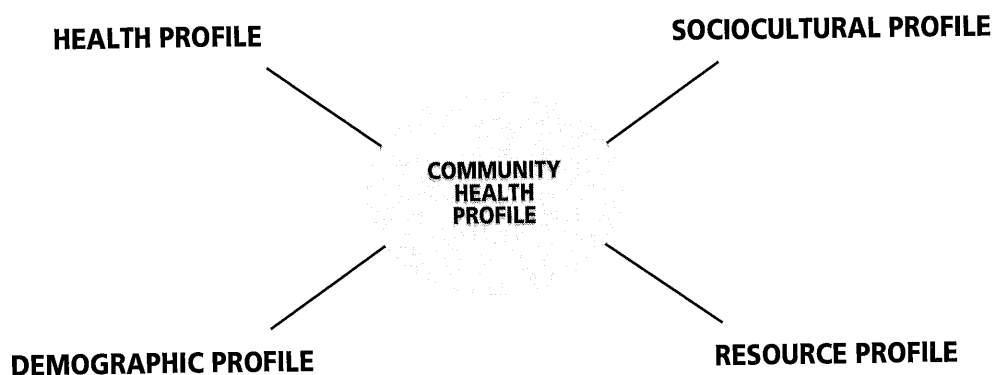- Develop criteria for determining priorities

> *Data–quantitative and qualitative, primary and secondary, empirical and perception, baseline and trend–all serve as crucial sources of information for an ongoing health assessment.*

Collecting and analyzing data can be a challenging task for those not experienced in conducting a community health assessment. One of the first priorities of the planning process is locating potential resource people and organizations and negotiating how these resources can contribute to the overall assessment. Some partnerships have hired consultants with experience in community health assessment. Others have worked with research and survey experts in nursing, public health and health services research from local universities. In some instances, university faculty may contribute a defined amount of consulting time to the partnership to assist with data collection and analysis.

The partnership-building process offers many opportunities to tap data and research resources. For example, hospitals that have teamed up with health departments know that local or county health departments have access to data collected by state agencies. Similarly, each partner is likely to have its own data connection that can expand data sources without expending funds. Several needs assessment resources listed in "Section VII: Resources and References," such as the APEXPH process, provide detailed guidelines for tapping into local sources of data.

Creating a Community Profile

As suggested in "Section III: Definition of a Community Health Assessment," data types may be categorized according to their contribution toward creating various community profiles such as health, demographic, sociocultural and resource profiles. These profiles can be interwoven to create a total community profile. Below is an overview of the major data types that can be used to develop each profile. A more detailed discussion of commonly-sought secondary data and several key options for primary data collection follows this overview. While suggested data categories are provided here, they are merely illustrative. The specific data for an assessment depend on the particular focus of each community's process, as well as the nature and composition of the community. For example, some may choose to begin with attitudinal data by assessing community perceptions, while others may begin with organizing data from health organizations and agencies.

HEALTH PROFILE **SOCIOCULTURAL PROFILE**

COMMUNITY HEALTH PROFILE

DEMOGRAPHIC PROFILE **RESOURCE PROFILE**

While certain data are useful for more than one profile area, examining data needs in terms of various profiles can help organize the massive amount of data likely to be collected—especially in the initial phases of the process. Profile categories other than those listed can be created as the community health assessment team chooses.

Table 5 lists the types of data and likely sources that may be relevant for each profile category. The list includes initial sources only. More detailed information may require alternative sources or more extensive primary data collection. Following this table is a more thorough discussion of commonly-sought data. Appendix C contains a list of selected sources of national data that are available from surveys and surveillance systems sponsored by the federal government and national organizations. These data are particularly useful for normative measures. However, in many cases, the information can be broken down to state and county levels.

TABLE 5

Range and Sources of Data for Creating Community Profiles

TYPE OF DATA FOR PROFILE	LIKELY/POTENTIAL SOURCES
Demographic Profile:	*Demographic Profile:*
Population categorized by:	• U.S. Bureau of the Census
• Income	
• Age	
• Sex	
• Race	
• Type of household (i.e., female-head, two-parent family, etc.)	
• Education level	
• Marital status	
• Occupation	
• Geographic setting (i.e., urban versus rural)	
Health Profile:	
• Morbidity and mortality data (reportable disease occurrence and causes of deaths)	• State Department of Health • Area Resource File, Bureau of Health Professions, U.S. Department of Health and Human Services
• Birth and death rates	• State Department of Health, Vital Statistics
• Behavioral risk factors (i.e., smoking, alcohol use, excess weight, seat belt use, physical inactivity, unprotected sexual activity)	• Local application of the Centers for Disease Control and Prevention survey, "Behavioral Risk Factor Surveillance Survey"
• Disabilities (i.e., prevalence of hearing and vision impairment and limitations in daily-living activities)	• Area Council on Aging • National Health Interview Survey • National Center for Health Statistics • Disabilities Advocacy Groups
• Pregnancy rates and prevalence of low birth weight	• State Department of Health
• Mental health	• National Center for Health Statistics • Mental Health Association • Health services utilization data
• Chronic diseases	• Voluntary organizations with a chronic disease focus (e.g., the American Heart Association) • Health Services Utilization Data

Range and Sources of Data for Creating Community Profiles

TYPE OF DATA FOR PROFILE	LIKELY/POTENTIAL SOURCE
Health Profile: (cont.)	*Health Profile:* (cont.)
• Prevention services delivery (i.e., immunizations, mammograms, prenatal care)	• National Centers for Disease Control and Prevention • National Center for Health Statistics
• Dental health	• National Institute of Dental Research • Center for Health Statistics, National Health Interview Survey • State Department of Health, Division of Dental Health
• Hospital utilization rates	• National Center for Health Statistics • National Hospital Discharge Survey and National Health Interview Survey • Local hospital associations • State data organizations • Hospital utilization data
• Emergency department utilization	• Same as above • Trauma network data
• Outpatient physician and hospital visits	• Same as above, plus local medical associations and survey of physician clinics
• Levels of air, noise and water pollution	• Environmental Protection Agency • Private environmental-concern organizations • State Department of Environmental Resources
• Percentage of population with a work-related disability	• U.S. Department of Labor, Annual Survey of Occupational Illness and Injuries • Community survey
• Health insurance coverage by type of health insurance carrier	• Community survey • State Department of Health data from the Current Population Survey for state level insurance status data • Third-party payers, employers, hospital data
• Access to primary care	• Administrative records of waiting times for appointments • Evaluation of hospitalizations and medical care provided for conditions that are clearly preventable if primary care were provided (called Ambulatory Sensitive Conditions)

TYPE OF DATA FOR PROFILE	LIKELY/POTENTIAL SOURCE
Sociocultural Profile:	*Sociocultural Profile:*
• Community affairs	• Content analysis of sample of local newspaper editions • Interviews with community leaders
• Social history and traditions	• Same as above
• Sense of community cohesion	• Community perception survey
• Degree of isolation	• Same as above
• Suicide rates	• State Department of Health
• Percentage of eligible voters who vote	• Secretary of State
• Political party affiliation	• Secretary of State
• Unemployment	• State Department of Labor
• Work Absenteeism	• Business Coalitions and Chamber of Commerce
• Business and development failures	• Same as above • State and local Departments of Economic Development, U.S. Small Business Administration
• Population near or below the federal poverty level	• U.S. Bureau of the Census and local surveys • State Office of Medical Assistance
• Low-income housing units	• Local housing agency
• Substandard housing units	• Same as above
• Homelessness	• Local surveys by housing agencies or social support organizations • Homeless shelter census information
• Population density	• U.S. Bureau of the Census
• Literacy rate	• U.S Bureau of the Census indicators • State Department of Education, Office of Adult Education
• High-school dropout rate	• School system
• Percentage of the population with a high-school diploma	• U.S. Bureau of the Census
• Elementary school absenteeism	• Local school system

Range and Sources of Data for Creating Community Profiles

TYPE OF DATA FOR PROFILE	LIKELY/POTENTIAL SOURCE
Sociocultural Profile: (cont.)	*Sociocultural Profile:* (cont.)
• Juvenile incarceration rate	• Local and state police department • State Department of Corrections
• Crime statistics	• Same as above
• Level of fear reported by those living in various neighborhoods in the community	• Community survey
• Estimated domestic violence rates	• Local and state police department • Hospital emergency rooms • State Department of Social Service
• Amount of gang crime activities	• Interviews with community leaders, school officials, police and citizens • Local police department • Local school system
• Weapons and drug activity near schools	• Same as above, plus student surveys
• Percentage who are non-English speaking	• U.S. Bureau of the Census • Community survey
• Legal and illegal immigrants	• U.S. Immigration and Naturalization Service • Community survey • U.S. Bureau of the Census

• Racism
    Segregation
    Redlining
    Discrimination
	• Survey of businesses for diversity of workplace (by race, by industry, by salary)
	• Home Mortgage Disclosure Data, Federal Reserve
	• Community survey
	• Equal Opportunity Commission

• Individual's perception of their ability to influence government and their satisfaction with government (especially local)	• Community survey
• Percentage of the population who say they are happy/satisfied	• Community survey

Resource Profile:

HEALTH AND HUMAN SERVICES
FACILITIES AND MANPOWER:

Private and public sector hospital beds, physicians,
primary-care clinic capacity, long-term care facilities
and home care services; dental services; mental
health services, etc. (may calculate per 1,000
population to compare with national norms)

Resource Profile:

- Area Resource File,
  Bureau of Health Professions, DHHS
- Local hospital council/medical society
- State Department of Health
- Provider interviews
- County Medical Society
- Hospital and other health care
  provider associations
- Provider survey
- Yellow pages

KEY ORGANIZATIONS:

Foundations

- The Foundation Center, New York, N.Y.

Businesses by industry, numbers employed,
employee services provided, etc.

- Chamber of Commerce

Community coalitions for political
and social causes;

- Interviews with hospital trustees,
  other community leaders

Churches and Interdenominational organizations;

- Yellow Pages community directories, hotlines

Universities and Community Colleges
(note their special programs and full range
of educational opportunities);

- Community survey
- City government and social service agencies

Preschool and daycare facilities;

Primary and Secondary School Libraries;

Community development corporations;

Civic organizations;

Voluntary organizations;

Self-help mutual aid groups;

Charities;

Homeless shelters and other shelters;

Specialty service organizations;

Fitness and recreational organizations and facilities

Range and Sources of Data for Creating Community Profiles

TYPE OF DATA FOR PROFILE	LIKELY/POTENTIAL SOURCE
Resource Profile: (cont.)	*Resource Profile:* (cont.)
PROGRAMS:	
Hospital community-benefit programs	• Hospitals and local, state and/or national health associations and alliances
School health programs (i.e., fitness education, sex education, etc.)	• Schools
Child-care availability and accessibility	• Child welfare organizations (survey, yellow pages)
Work site health-promotion programs	• Chamber of commerce, business and health coalitions
Community recreation opportunities	• Recreation and Parks District Office
Other community health initiatives	• Interviews with community leaders
POLICY ENVIRONMENT:	
Restaurants with low-fat options	• Restaurant associations
Seat belt, gun-control, anti-smoking, bicycle helmet, smoke-detector, fluoride, noise-reduction laws or regulations	• City government

Secondary Data Sources

A range of secondary data sources are available for a community health assessment. This section discusses the issues in collecting and analyzing population health, health insurance, provider and other data that might provide information about a community's current and potential health.

TABLE 6

Secondary Data Sources for Community Health Assessment
A. Population data
B. Health statistics
1. Mortality data
a. Infant mortality
b. Childhood and adult mortality
2. Hospital discharge data
3. Cancer registry
4. Reportable diseases
5. Low birth-weight data
C. Health insurance status
D. Other providers/services
E. Other data

A. Population Data

Population data provide information on a community's size and demographic composition. Information is available on demographic characteristics such as age, gender, race/ethnicity and income. Population data are used, for example, to develop a profile of a community in terms of economic status and ethnicity and to identify vulnerable populations (e.g., children, women of childbearing age, and the elderly).

While such population data are readily available at the state, county and city levels, it can be important to obtain zip-code or census-tract data. This step is necessary when a community is defined as some portion of a city, for example. It also permits the identification of specific sub-populations or geographic areas with specific characteristics (e.g., race/ethnicity, income).

Population data can be obtained at the zip-code and census-tract levels, although it may be difficult (and expensive) to access. It may be useful to obtain a zip code or census tract map to identify the locations of specific demographic groups within the community for which disaggregated data are desired. Many health care organizations have already obtained much of this information to support their marketing and strategic planning efforts. Population data are drawn from the dicennial census conducted by the U.S. Bureau of the Census and may be obtained from several sources:

- Data files are obtained directly from the U.S. Bureau of the Census. These data may be purchased at the census-tract or zip-code level for specific demographic groups

- Some state governments also produce and disseminate population projections based on census data

- Data may be purchased from private, for-profit marketing firms that compile and distribute such information to the public

If the proper computer equipment and programming capabilities are available, population data can be obtained directly from the Bureau of the Census on computer tape. The institution must carefully consider its computer and programming capabilities to assess whether this option is feasible. Although the cost associated with purchasing census data in this way will be less than utilizing a private data service, staff resources required to analyze the data internally must be carefully assessed. If there are plans to make extensive use of population data, it may be worth the investment to develop the internal capacity to manipulate the data. Alternatively, if the organization needs only a few items from the data, purchasing special analyses may be the most cost-effective approach.

As mentioned previously, a health care organization may already obtain population data from a marketing firm for other purposes. Hospital marketing or planning departments often subscribe to such data services, and it may be less expensive and more efficient to obtain the additional population data required for the needs assessment from these services. Given that most organizations

do not have the staff or computer capabilities to manipulate data of this magnitude and complexity, using outside sources may be the most practical and efficient method. Census data pose several challenges for conducting community health assessments. Since the data are collected only every 10 years, some states and private marketing firms conduct mid-decade updates to the census data. The census data are also limited in how specific minority groups are identified, which may be a problem for some geographic areas where health needs are concentrated in specific subpopulation groups.

B. Health Statistics

Health statistics data (such as mortality , hospital discharge, cancer registry, reportable disease and low birth weight data) can provide important information on the community's health. Again, accessing such data at the zip-code or census-tract level is desirable to obtain the best indication of the health status of a community (or specific segments of its community). It will also be useful to obtain state- or county-level data to determine how the target community's health statistics compare to the broader population. If available, health statistics data should be disaggregated by demographic characteristics. Although overall disease rates for a zip code or census tract may not be abnormally high, the disease rates of minority or low-income residents may be significantly greater.

If available, health statistics data should be disaggregated by demographic characteristics. Although overall disease rates for a zip code or census tract may not be abnormally high, the disease rates of minority or low-income residents may be significantly greater.

State health departments are the primary source for health statistics data. It is important to note that each type of data may be handled by different divisions or offices within the health department. The organizational location of these offices will vary by state.

A health care organization should anticipate multiple phone calls to the state health department to locate appropriate sources for the data it wishes to access. Typically the data will be available from either general health statistics bureaus or from disease- or population-specific offices (i.e., bureaus of communicable diseases, bureaus of maternal and child health, etc.).

1. Mortality Data

a. Infant Mortality

Infant mortality data serve as a popular indicator for a community's overall health status, and is often an indicator of access and use of prenatal and postnatal care by different groups of women. Such data identify specific geographic areas within the community with particularly severe infant mortality rates.

Infant mortality can also be analyzed by race and age of the mother to determine if specific age groups or ethnic minorities experience higher rates of infant death. When viewed in conjunction with other types of information (i.e., demographic data and teen pregnancy rates) such an analysis can provide valuable insight into which segments of the community are most at risk for infant mortality.

While these infant mortality rates are frequently used to assess a community's access to prenatal and postnatal care, high infant death rates may be caused by complex, interacting factors such as poverty, substance abuse and poor nutrition. Caution must be used before a community's infant mortality rate is attributed to any single cause or set of causes. Infant mortality data are readily available by zip code or census tract from state health departments in computerized format for a nominal charge.

b. Childhood and Adult Mortality

Other mortality data can provide information on the major causes of death in certain communities or among certain age groups. They can be used to identify whether some areas have higher-than-average rates of death from heart disease, cancer or other causes.

Mortality data are drawn from death certificates that may not accurately identify the true cause of death. For example, the reported cause of death (e.g., pneumonia) may not represent the underlying cause of death (e.g., AIDS). Despite these deficiencies, the data do provide an overview of the community's health problems. Of particular interest for a health assessment is examining the mortality rates for potentially avoidable deaths such as breast and cervical cancers.

Mortality data are collected by the state health department and are readily available by county. Obtaining data below the county level can be problematic for several reasons. In small states, confidentiality concerns can prevent the release of data at local levels. In other states, resource constraints may hinder an institution's ability to obtain the data. Programming and staff costs associated with producing data at local levels may discourage states with constrained resources from producing local data for the public.

To increase the likelihood of obtaining needed data, it may be helpful to narrow data requests to a group of zip codes and several conditions (causes of death) for which enough cases exist so as not to trigger confidentiality concerns.

2. Hospital Discharge Data

Hospital discharge data can be used to assess hospital utilization, analyze patient origin and identify how many people in the community are being admitted to the hospital with potentially avoidable conditions (e.g., hospitalizations for asthma). Hospital discharge data provide a record for each discharge by zip code of the patient's origin. These data have been used to identify ambulatory care-sensitive conditions that are defined as hospitalizations which could have been prevented (or reduced) with access to appropriate primary care. Examples include:

- Hospitalizations for diseases for which immunizations are available (i.e., rheumatic fever, polio, measles and pneumonia)

- Hospitalizations for normally minor problems such as ear infections, upper respiratory infections, urinary tract infections and certain dental problems

- Hospitalizations for chronic conditions that may normally be managed in ambulatory settings, such as asthma, hypertension, diabetes, angina, anemia and epileptic convulsions

Hospitalizations for these and other ambulatory care-sensitive conditions can provide useful indicators that help assess the community's access to primary care and its efficiency in the management of chronic disease. These hospital discharge data can be disaggregated by demographic characteristics to ascertain if certain subpopulations (i.e., minorities, low-income residents) experience higher rates of ambulatory care-sensitive admissions. Hospital discharge data may be obtained from individual hospitals in the community. In many states, the hospital association or

state agency may maintain these data for all hospitals and can provide data extracts or special analyses on request. It should not be assumed that the number of admissions for a health problem represents all cases of that problem in a community. Those without access to care may suffer a condition for which care is needed but not obtained.

3. Cancer Registry

Cancer registry data provide information on the number and types of cancers experienced in a population. They may also provide information on the stage at which the cancer was diagnosed. These data are useful in a health assessment to identify areas with particularly high rates of cancer and determine differences in the stage of diagnosis among different demographic groups. Diagnosis in the later stages of the disease process may indicate health-care access problems in the community, particularly in the cases of cancer types for which early screening and diagnostic technologies have been developed (i.e., breast cancer and colon cancer).

Cancer registry data may be available from either state-health-department sources or private registries. The American Cancer Society may also identify appropriate sources of cancer data. Such data may not be available in all states at the zip code level and in some states may require a special data request.

4. Reportable Diseases

Reportable disease data are useful for identifying areas or populations with high rates of tuberculosis or sexually transmitted diseases. These data can also be used to identify areas that have experienced outbreaks in vaccine-preventable diseases such as measles. Reportable disease data can serve as indicators for the need for increased vaccination rates or educational efforts (i.e., AIDS prevention).

All states collect reportable disease information, although the data may be difficult to obtain because in many states they are not available in a computerized format. In addition, states may be reluctant to release some information (particularly related to sexually transmitted diseases) due to confidentiality concerns. For this reason, many states only release their data at the state or county level.

5. Low-Birth-Weight Data

Low-birth-weight data can provide important information on the incidence of low-birth-weight babies in the community or in specific areas or subpopulations. Like infant mortality data, low-birth-weight data can serve as a useful indicator of access to prenatal care in the community. These data are readily available by county from state health departments and are typically available by zip code.

C. Health Insurance Status

The source and type of insurance coverage is an important data element for a community health assessment. Data on the number and characteristics of persons covered by Medicaid can be obtained from the state health department. Data on how many are covered by Medicare may be obtained from the regional Health Care Financing Administration office or the U.S. Department of Health and Human Services, Health Care Financing Administration. Data on other sources of coverage are only available at the state level from the Current Population Survey.

There is no centralized source of data on coverage at the local level. Some states and local areas have conducted surveys of insurance status that can provide estimates of the uninsured by zip code. The local governments and chambers of commerce are good sources to determine if such surveys have been conducted with the institution's target community. Local or state health insurance associations or business and health coalitions may have data on types of coverage for a large portion of the population. Hospitals and other health care providers can provide data on their payer mixes.

D. Other Providers/Services

A community health assessment must be able to identify other providers and services available to the community. This information will assist in identifying gaps in services and in forging linkages with other service providers.

There is no centralized source of information on other health-related providers and services. Some of these providers will already be known by the institution (i.e., competing institutions, members of the medical staff). Other sources of information include the Yellow Pages, city/county resource guides, community hotlines and social service agencies such as the United Way and

Catholic Charities. Regional chapters of professional associations (i.e., medical societies, American Nurses Association, etc.) can also provide valuable information on the community's health care resources. The state Medicaid department can determine how many local health-care providers participate in the Medicaid program.

E. Other Data

Data on other non-medical, but health-related community needs will also be required. Health problems often result from other underlying problems such as lack of adequate housing or unemployment. Some possible sources of other data on community needs are:

> *Data on other non-medical, but health-related community needs will also be required. Health problems often result from other underlying problems such as lack of adequate housing or unemployment.*

- Schools can be an important source of data on teen-age pregnancy, absenteeism, nutrition issues and high school dropout rates. They can also provide qualitative information on the prevalence of substance abuse among young adults, the extent of gang participation and the availability and use of weapons in schools

- Housing agencies can provide information on problems in low-income housing, homelessness and sanitation issues

- Community and religious leaders can provide information on the economic, social and spiritual needs of their members

- Chambers of commerce and employment-related services may provide information on economic development, business growth and employment trends

- Social service agencies can provide information about a wide variety of problems, including mental illness, family violence, homelessness, low literacy, lack of recreational and day-care facilities, etc.

Primary Data Collection

In conducting the health assessment, it may also be necessary to collect primary data to obtain information that is unavailable from secondary sources, or confirm the information from secondary sources. Three types of primary data collection are: 1) surveys, 2) focus groups and 3) one-on-one interviews.

A. Surveys

The organizations responsible for the health assessment may choose to conduct a community-wide survey to obtain information about the community's health. Surveys may provide information that is not available from secondary data. Some of the information that may be obtained through surveys are:

- Insurance status

- Self-reported health status and health behaviors

- Self-perceptions about access to care

- Perceptions about other factors affecting the health of the community
  (e.g., violence, environmental factors)

- Services available through other providers and perceived gaps in services

- Willingness and ideas of the community to address health needs

- Suggestions for specific strategies to address health needs

Surveys can be conducted by mail, telephone or in-person. A mail survey is the least expensive approach but also produces the lowest response rate. A mail survey may be appropriate if the questionnaire is short and focused.

An in-person survey is the most costly but research has shown that it produces the best results. The telephone survey is the most common type of survey. If the survey is being conducted in a particularly low-income area, the telephone survey excludes households without telephones and may bias the results. Regardless of the approach taken, surveys are usually expensive, either financially and/or from a human resources perspective. They require expertise that may not be available within the organizations sponsoring the assessment.

If the organization chooses to conduct a survey, the project director can hire a survey researcher to design, administer and analyze the survey, unless individuals/organizations capable of doing it are represented within the health assessment partnership and are willing to donate their services. Surveys can be conducted in-house, and many prototype surveys are available (See Section VII for references to various prototype surveys). Many complex issues regarding

designing a questionnaire, selecting a sample of the population to be surveyed and analyzing results warrant the help of a survey research specialist.

Conducting surveys requires a number of steps to be considered:

- *Selecting the sample*. Who will be surveyed and how they are selected is the first and perhaps most important step in the process. The sample or subsector of the community must be large enough to produce reliable results and must be representative of the subjects of interest so that results are not biased.

- *Designing the questionnaire*. The organizations may want to work with a survey firm or trained survey researcher to design the questionnaire. How the questions are asked, in what order and context, and by whom, when and where all influence the results. Survey researchers ensure that questions are as neutral as possible and do not bias the responses. They will also counsel you on survey length to enhance the probability of obtaining complete surveys.

- *Administering the survey*. The survey should be administered by trained interviewers (if a telephone or in-person survey). If a mail survey is conducted, a process for following-up on non-respondents should be established.

- *Analyzing the results*. The final step in the survey process is to analyze the results and summarize the findings. Selecting how the data are analyzed is important. Think carefully about what is really needed. It is expensive to create cross-tabulations of responses to various questions.

B. Focus Groups

A focus group is a targeted group interview that is a particularly useful data collection strategy when exploratory or explanatory information is needed. Such groups can be used to explore why a particular health service is not being utilized, gain insight into the opinions of a particular population subgroup about available health-care resources, discuss how to interpret the results of a household survey and brainstorm ways to address an identified community health problem. Focus groups allow for group interaction and greater insight into why certain opinions are held and certain problems exist.

Focus groups can be defined as carefully planned discussions designed to obtain perceptions on a defined subject area in an interactive and non-threatening environment. Once a research goal is identified, a detailed discussion guide is planned. A skilled facilitator conducts the 7- to 10-member group for a 90-minute to two-hour time period, with observers in the room or behind two-way mirrors if a formal focus group facility is used. An incentive is often used to encourage participation by a small payment ($25), a gift or a donation to the sponsoring organization. Within the context of a community health assessment, the availabilities of food and babysitting service are likely to be effective incentives.

Focus groups can be a lower-cost substitute for surveys if the information desired is qualitative rather than quantitative. Such groups have a number of limitations that must be recognized. First, the small numbers that participate even in several different groups significantly limit generalization to a larger population.

Second, by their design, focus groups allow participants to influence and interact with each other. While some creative results can be produced, group members are able to influence the course of the discussion. Thus a dominant group member may persuade other group members to share his/her opinions or suppress the expression of others' views. Third, because of the interactive nature of a focus group, it is more difficult to analyze data and produce results than from a survey. However, the information obtained is often richer and more reflective of the complexity of the issues discussed.

If conducting focus groups is a part of a community health assessment, good preparation is essential. Much of the success of the focus group depends on the clarity of purpose, the focus of the questions and the skill of the facilitator. The questions should proceed from the general to the specific and be open-ended. Utilizing professional facilitators can be cost-effective because of their experience in group process and focus-group report preparation.

At a minimum, facilitators should receive orientation and basic training. Substantial thought also should be given to participant selection. The homogeneity of participants is recommended for individual groups. Individual interviews are recommended for people who could be disruptive to the group process including those who are not cognitively capable of participation in a group process such as patients with advanced Alzheimer's or those who are acutely ill.

C. One-on-one Interviews

The input of many individuals may not be easily obtained through either surveys or focus groups. Rather, individuals such as business executives and leaders of other community organizations may require direct interviews, if they are to be tapped at all. As mentioned previously, there are also individuals who may be disruptive or cannot participate in groups (such as the homebound elderly). If many interviews are conducted, a common set of questions for each interviewee should be created and the various responses compared. In addition, open-ended questions particular to each interviewee will be needed.

The context in which the interview is conducted, the way questions are asked and the interviewer all can bias responses. Precautions can be taken to minimize such biases, but it is not possible to eliminate them entirely. Section VII contains a list of references on survey research where suggestions for obtaining information through one-on-one interviews may be found.

Appendix A contains a glossary of data-related terms.

Resources and References

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A. Community Health Needs Assessment Programs

PATCH–Planned Assessment to Community Health

Contact: Chuck Nelson

Organization: Centers for Disease Control
Community Health Promotion Branch
1600 Clifton Road, N.E.
Mail Stop K-46
Atlanta, GA 30333
(404) 488-5438

Cost: Materials free of charge

Publication Date: 1993

Program Components: The PATCH (Planned Approach to Community Health) manual consists of background and program introductory material, training information, PATCH program components, tip sheets, overheads, examples and directions for data collection, development of tools and finished data analyses.

Summary: The mission of PATCH is to reduce the prevalence of modifiable risk factors for the leading causes of preventable illness, death, disability and injury. The goal is to establish methods for planning, implementing and evaluating community health promotion programs.

The PATCH process consists of:

1. Diagnosing priority health problems
2. Assessing community health problems
3. Assessing the risk factors that contribute to those problems
4. Determining causes of risk factors
5. Intervening on the problems
6. Planning, implementing and evaluating the intervention

PATCH is a comprehensive health-planning program. The process is designed to be ongoing and adaptable to the changing needs of the community. Emphasis is placed on the collection and reporting of community-based data. The manual provides information on the collection, analysis and presentation of data. The CDC provides support through its PATCH coordinators training program and ongoing technical assistance documents.

APEX-PH Assessment Protocol for Excellence in Public Health

Contact: Beth Flax, research associate

Organization: National Association of County Health Officials
                        APEX-PH Project
                        440 First Street, N.W.
                        Suite 500
                        Washington, D.C. 20001
                        (202) 783-5550

Cost: $20 nonmembers, $15 members of NACHO, USCLHO

Publication Date: March 1991

Program Components: APEX-PH is a manual comprised of activities, worksheets and assessment tools. The program is divided into two separate activities.

Summary: APEX-PH is a voluntary process for organizational and community self-assessment. The process includes implementing planned improvements and continuing evaluation of the organization and it's activities. It is not intended to be used by an outside agency to evaluate a local health department. APEX-PH is designed to be flexible and adaptable to meet the needs of individual institutions. APEX-PH is comprised of a three-part process: Part one is an organizational-capacity assessment designed for a health department to determine the resources it has available and the strengths and weaknesses that need to be addressed before moving on to the second part. Part two is a community needs assessment, designed to enable the health department or community organization to determine the health problems and needs within a designated community. Part three discusses how to incorporate the information from the needs assesment into ongoing activities and move toward policy development.

Community Health Assessment: A Process for Positive Change

Organization: Voluntary Hospitals of America Inc.
Community Health Improvement
1150 17th Street, N.W.
Suite 300
Washington, D.C. 20036
(202) 429-0508

Cost: Members: One copy free, additional $25; Nonmembers, $45

Publication Date: 1993

Program Components: This manual provides an operational definition and six-phase process for community health assessment. A broad conceptual framework linking community health assessment to delivery-system reform is provided along with a discussion of key management challenges, data issues and needs, and additional resources and references.

Summary: This document addresses the challenge for health-care organizations to partner with the community to assess community health issues, set goals and develop creative, efficient and integrative strategies for addressing those issues and goals. The first three sections focus on the strategic fit and conceptual and philosophical basis for such efforts. The following three sections focus on implementation of the six-phase community health assessment process outlined in the document. The final section lists many of the resources and references related to community health partnerships in general and community health assessment in particular. The information contained in this document was derived through numerous interviews and reviews of hospital and community-based efforts, an extensive literature review and the deliberations of a diverse working group of health professionals.

The operational definition of community health assessment is presented as comprising nine core concepts as follows: A community health assessment is a 1) *dynamic process* undertaken to identify the 2) *health needs and goals* of the community, enable the communitywide establishment of 3) *health priorities* and facilitate 4) *collaborative action planning* directed at improving 5) *community health status and quality of life*. Involving 6) *multiple sectors of the community*, the assessment draws upon both 7) *quantitative and qualitative population-based health status and health services utilization data*. With a strong emphasis on 8) *community ownership* of the process, a community health assessment supports developing 9) *community competence* in the identification and response to community health needs and goals.

The six-phase process is not presented as a linear process. The six phases identified as a framework for community health assessment are further detailed by a set of steps. The phases are:

PHASE I	Internal and external assessment
PHASE II	Partnership building, and planning and tailoring the process
PHASE III	Data collection
PHASE IV	Synthesis and communication of information
PHASE V	Prioritization and planning for collaborative action
PHASE VI	Action and evaluation

Community Assessment of Human Needs

Contact: Public Relations Department

Organization: Mercy Health Services
34605 Twelve Mile Road
Farmington Hills, MI 48331
(313) 489-6000

Cost: To be determined

Publication Date: March 1988

Program Components: Background and reference material, community opinion survey, tools for internal assessment and completed statistical profiles of sample communities.

Summary: The Community Assessment of Human Needs (CAHN) is a systematic approach to identifying and understanding the unmet human needs of populations at risk within the defined community of health-care providers. The guide is a comprehensive source of information which has been designed to be a flexible tool to provide guidelines and technical assistance. The assessment contains four phases: 1) Community characteristics, 2) Human service providers, 3) Community leaders, 4) Populations at risk. Phase I is designed as a quantitative methodology for identifying the populations at risk and where in the community of health care providers these populations are most likely located. Phases II through IV are interactive phases designed with a threefold purpose: They provide an opportunity to validate the data in phase I by speaking with people directly informed; they provide vehicles for gathering information and interviewing providers, community leaders and persons at risk; and they create an opportunity to network by identifying needs and discovering new and creative ways to address those needs.

Healthy Futures: A Development Kit for Rural Hospitals

Contact: Paul McGinnis

Organization: Mountain States Health Corporation
P.O. Box 6756
Boise, ID 83707
(208) 342-4666

Cost: $395, plus shipping

Publication Date: 1991

Program Components: The program consists of a comprehensive manual which contains a variety of planning worksheets, overhead templates, floor plans for meetings, examples of press releases, two instructive, demonstrative videos and other tools necessary for the implementation of the community decisionmaking process.

Summary: Community Decision-Making in rural hospital communities (CDM) is a process which seeks to involve residents of rural communities in developing solutions to problems with local health care systems. The project generates citizen participation in rural health public policy decisions. The hospital board of directors endorses the CDM project and hires a community encourager (a local resident) to organize and coordinate the program. The community encourager helps organize and guide the community by identification and use of available local resources to solve common problems.

The process involves establishing citizen involvement through several mechanisms: development of a community council which contains representatives from key areas (education, health, government, agriculture, business, retail etc.), establishing and conducting town meetings, conducting a needs assessment and establishing mechanisms to coordinate care. The needs-assessment components provide original ideas on how to obtain community-level data, while also providing guidance on how to obtain access to traditional data-collection methods (e.g., vital statistics and census information). Analysis of the data and community discussion results in the development of a health care plan or recommendations which are submitted to the hospital board of directors. The CDM process is designed to focus primarily on developing a plan and recommendations not necessarily on implementation of the plan.

A Guide for Assessing and Improving Health Status

Organization: Hospital Association of Pennsylvania (HAP)
Policy Research Department
4750 Lindle Road, P.O. Box 3344
Harrisburg, PA 17105-3344
(717) 564-9200

Cost: Manual: $20 members, $50 nonmembers
Community Profile: $5 members, $10 nonmembers

Publication Date: 1993

Program Components: The health assessment guide is a manual designed to guide an organization through a community health assessment.

Summary: HAP has done an excellent job in developing a low-cost method for assessing and improving community health status. In addition to developing the workbook, HAP has developed workshops to introduce the process to its members. The guide primarily focuses on data collection and interpretation, with some emphasis on providing assistance and tools for involving the community in the process. Key components include:

- County Health Profile–HAP's data center is set up to provide data on a county by county basis to its members. Data includes demographic data, community characteristics, morbidity and mortality information.

- Personal Health Behavior Assessment and Economic Impact–Provides information on the types of questions and methods used for getting community-level data on personal health perceptions. Economic Impact provides techniques to calculate financial effects of health-care services on the community.

- Prioritization of Community Health Needs and Development of Community Action Plan–This plan addresses how to get community leaders and community involvement in prioritization of health issues and action planning.

- Implementation and Evaluation–Provides guidelines and techniques for evaluating and measuring improvements in health over time.

B. Community Benefit Publications

Voluntary Standards: A Framework for Meeting Community Needs
An Introductory Guide to VHA's Voluntary Community Benefit Standards

Organization: Voluntary Hospitals of America Inc.
       Community Health Improvement
       1150 17th Street, N.W., Suite 300
       Washington, D.C. 20036
       (202) 429-0508

Cost: Free for VHA organizations; $15 for non-VHA organizations

Publication Date: April 1992

Program Components: The guide provides details about VHA's community benefits standards and explores how the standards relate to current efforts in health-care reform and to the underlying concepts and process orientation of total quality management. It also provides examples of how VHA institutions are reshaping and strengthening their community benefit efforts.

Summary: This document can be characterized as a motivational and informative piece. It provides ideas and new concepts to consider and address when developing a community benefit plan. The resources provided in the bibliography provide some additional information on defining community benefit, collaboration and coalitions. This document provides insight into the types of community benefit activities and programs a hospital should be focusing on.

Key concepts include: 1) Challenge to hospitals to assume responsibility for health status, 2) Assess the needs of the community 3) Develop effective community partnerships and collaborative relation- ships 4) Tax-exempt status 5) Competition versus collaboration 6) Relationship between community benefit standards, community benefit orientation and total quality management.

Standards include:

  1.Demonstrate leadership as a charitable institution
  2. Provide essential health-care services
  3. Be accountable to the community
  4. Evidence of commitment to community benefit
  5. Operate free from private profit

Social Accountability Budget for Not-for-Profit Health Care Organizations

Organization: Catholic Health Association
                     4455 Woodson Road
                     St. Louis, MO 63134-3797
                     (314) 427-2500

Cost: $27.50

Publication Date: 1989

Program Components: The manual is comprised as narrative text and is supplemented with worksheets, exercises and activities that include data-collection exercises for use by hospital administrators for an internal assessment.

Summary: The social accountability budget is a set of tools designed as a self assessment to health-care executives to gauge and determine the amount of resources being allocated to community benefits. The manual is organized in a methodological fashion, to enable the user to complete the individual steps of the internal assessment in a logical manner. The main objective is to inventory the community benefit activities provided by the individual hospital or system to determine a basic understanding of community need through data collection and interviews to develop a community benefit plan for the future.

The Steps to Building a Community Service Plan

Contact: Mary Ann Roche

Organization: Hospital Trustees of New York
                     74 North Pearl Street
                     Albany, NY 12207
                     (518) 434-7999

Cost: To be determined

Publication Date: July 1991

Summary: In 1990, the Legislature of the State of New York initiated a mandate requiring the governing body of each voluntary not-for-profit general hospital to develop a community service plan. Each hospital is required to conduct an assessment and develop a plan for meeting the needs of its community. In response to this legislative requirement the Hospital Association of New York and the Hospital Trustees of New York State developed a guide that outlines the various steps hospitals can take to comply with current requirements.

Topics include: Defining the hospital's mission, gathering community views on hospital performance and service priorities, meeting community health-care needs, preparing a statement of financial resources and documentation and reporting. Also included are sources and organizations for community need data.

This publication is written in an organized and concise manner. It focuses on the main issues and concerns of developing a community service plan. Although it has been developed as a resource for New York hospitals to use in developing a community needs plan, it discusses and organizes topics that coincide with other community benefit and community health-needs assessment programs or tools.

Community Benefit and Tax-Exempt Status:

A Self-Assessment Guide for Hospitals

Organization: American Hospital Association
840 North Lake Shore Drive
Chicago, IL 60611
(800) AHA-2626

Cost: $25 members

$40 nonmembers

Publication Date: 1988

Summary: AHA developed a guide for hospitals to use as a way to quantify the amount of resources being allocated on community benefit activities and to document the services and activities a hospital provides to promote health and benefit the community. The self-assessment guide has been designed to be used as a workbook. It is organized into three major sections, which cover a number of topics that play a role in establishing the basis for hospital tax exemption. Within the first part of each section, background material is presented on content and relevance of the topic to a hospital's tax-exempt status. The second part consists of a series of questions and exercises related to the topic. The questions provide a framework for examining the characteristics and aspects of a hospital relative to its tax-exempt status.

C. Community Health Assessment Examples and Other Resources

Healthy Cities Indiana – The CITYNET Model for Healthy Cities

Contact: Beverly Flynn, Ph.D.

Organization: Healthy Cities Indiana
                         Indiana School of Nursing, Department of Community Health Nursing

                         Institute of Action Research for Community Health
                         1111 Middle Drive, NU 237
                         Indianapolis, IN 46202
                         (317) 274-3319

Cost: Varies depending on type of assistance and materials required

Publication Date: 1993

Summary: Healthy Cities Indiana is a joint venture between the Indiana University School of Nursing, Department of Community Health Nursing and the Indiana Public Health Association. The W.K. Kellogg Foundation provided funding for Healthy Cities Indiana for three years to work with six Indiana cities in workshops and technical support in developing broad-based city health and action plans. The CITYNET project is the continuation of Healthy Cities Indiana. The CITYNET model is one of the first attempts to develop a Healthy Cities program in the United States. The main strategy of CITYNET is to link health and community through the Healthy Cities program. Recently, the Institute for Action Research received additional funding for a Healthy Cities Dissem-ination grant. The first year will provide funding for further development of materials and the second year will be dissemination of the materials. A subcontract with the National League of Cities provides Healthy Cities information to its 17,000 city members.

The CITYNET manual, which describes the Healthy Cities process, will include a chapter devoted to gathering community level data. This includes using existing data, development and implemen-tation of surveys and data analysis. The WHO (World Health Organization) Resource Center also has many resources available related to Healthy Cities. Nonmembers receive a resource list and purchase books, pamphlets and videotapes.

National Civic League

Contact: Jill Steckle

Organization: National Civic League
1445 Market Street, Suite 300
Denver, CO 80202-1728
(303) 572-4343

Cost: Membership cost is $4,000 and includes project materials, workshops, conference registration and consulting fees.

Cost of individual documents anticipated is $25 to $35

Publication Date: 1993

Summary: The national healthy communities project is a program of the Denver-based National Civic League and the United States Public Health Service. The healthy communities program will develop a link between the business community, government agencies, citizen groups, and nonprofit organizations to improve the way local communities assess their health needs and make health improvements. The National Healthy Cities Project will serve as a clearinghouse for information; provide advice and support on how to get a project started and see it through to completion; organize regional and national conferences and workshops on the healthy community concept; and provide information in the form of newsletters and source material in support of healthy community projects.

The Healthy Communities Handbook outlines a collaborative citizen process, offers several methods of community health assessment, documents exemplary cases and provides a directory of resources for building a healthy community. Another document under development is the Civic Index. The index is designed to assess how well the community functions in areas of citizen participation, community leadership, government performance, volunteerism and other areas of citizen involvement. This will help a community determine its readiness prior to initiating a Healthy Communities project.

National Safe Kids Campaign

Contact: Amy Miller

Organization: National Safe Kids Coalition
111 Michigan Avenue, NW
Washington, D.C. 20010-2970
(202) 939-4993

Cost: Resource packet at no charge. Prices vary for additional materials.

Components: Information kit contains background information, pamphlets, promotional items and fact sheets.

Summary: The National Safe Kids Campaign promotes unintentional injury prevention through the development of local coalitions. The purpose of the local coalition is to bring about systematic and ongoing community response to childhood injury. Both the national office and local coalition share the common goal of safer communities for children. This goal is achieved by targeting injury problems prevalent in the community. The formation of a coalition enables the combining of resources of a wide variety of people and organizations, and the planning and implementing of a multifaceted strategy that combines community action, public awareness, education, technology and public-policy initiatives.

The national office acts as a coordinator-liaison. Its functions include organizing interested people or groups together within a community and combining efforts and resources to avoid duplication of services. The national office provides local coalitions with many resources including printed materials, training, publications, technical assistance and financial support.

Working Together for Rural Action

Organization: Center for Rural Health

Contact: Kimberly Praus, project director
University of North Dakota, School of Medicine
501 N. Columbia Road
Grand Forks, ND 58203
(701) 777-3848

Publication Date: 1992

Summary: Working Together for Rural Action is a program supported by the Northwest Area Foundation. The program is designed to empower rural communities through the use of self-help material to improve skills through educational programs and technical support.

The project has included four publications related to issues associated with the process of community empowerment and community decision-making. These publications include: "Diagnosing Community Need—Conducting Needs Assessment Surveys" "Seven Steps to Strategic Planning for Rural Health," "Conflict and Management Resolution," and "Network and Coalition-Building." Each booklet, written in a clear, concise and easy-to-follow style, focuses on the main issues related to each topic. Guidelines, "how-to" tips and additional resources information are provided with each publication. These publications provide a good foundation for the initiation of community empowerment activities within the rural community.

Crozer-Keystone Health System

Contact: Gregory W. Hunt, vice president of marketing

Organization: Crozer-Keystone Health System
Rose Tree Corporate Center II
1400 North Providence Road, Suite 4010
Media, PA 19063-2049
(215) 892-8021

Delaware County, Pa., completed a comprehensive health-status assessment under the sponsorship of Crozer-Keystone, with assistance from the county government, state health department, county medical society, health-care providers and national academicians. The assessment helped the com-munity identify health needs and assisted the community in setting priorities for future action.

Model Standards Peer Assistance Network

Contact: Claude Hall, project director

Organization: American Public Health Association
1015 Fifteenth Street, N.W.
Washington D.C. 20005
(202) 789-5618

Cost: Commitments of time and other support vary

Summary: The Model Standards project staff has organized a list of peers to share their experience and expertise with communities and agencies that apply for assistance. Public health professionals who have successfully implemented Model Standards will share their insights with individuals who are involved with the process. Those seeking assistance will select from an available pool of individuals. Interactions will include on-site visitations (air fare, accommodations, materials and per diem will be paid by the Model Standards project) and consultations via telephone, fax and other communications. Peers will have experience in community mobilization, organizing and building stronger constituencies for public health, selecting outcome and process objectives, strengthening health departments and using tools such as APEX-PH and PATCH.

California Healthy Cities Project

Contact: Gregory Shaffer, local program development specialist

Organization: California Healthy Cities Project, Health Promotion Section
P.O. Box 942732
Sacramento, CA 94234-7230
(916) 327-7017

Cost: Commitments of time and other support vary

Summary: The California Healthy Cities Project is a statewide program that helps cities and public health agencies promote healthful community environments. Through resource brokering and referral, technical consultation, sponsorship of educational programs and development and distribution of products and publications, the project works with cities to address the specific challenges confronting their communities.

D. Data Sources and Tools for Health Promotion and Planning

Environmental Assessment for Urban Hospitals 1992

Organization: American Hospital Association
840 North Lake Shore Drive
Chicago, IL 60611
(800) AHA-2626

Cost: Members, $30; Nonmembers $65

Publication Date: 1992

Summary: The Environmental Assessment for Urban Hospitals 1992 was developed to assist urban hospitals in their strategic planning efforts, specifically in analyzing opportunities and strategies for respon-ding to change. The assessment examines 14 critical issues that currently affect urban hospitals. These issues range from changing demographics, finances, health problems like AIDS and substance abuse, Medicare and Medicaid reimbursement issues, unsponsored care and health-care reform. Case studies focus on strategies developed by hospitals in response to specific problems within their communities. These case studies provide concrete examples on how urban hospitals develop and implement community benefit activities within their service area.

Environmental Assessment for Rural Hospitals

Organization: American Hospital Association
840 N. Lake Shore Drive
Chicago, IL 60611
(800) AHA-2626

Cost: Members, $30; Nonmembers, $65

Publication Date: 1992

Summary: The environmental assessment is a collection of data and information on various external factors influencing an organization and its ability to operate. The guide was developed to assist rural hospitals in their strategic planning efforts, specifically in analyzing environmental trends, assessing proposals for health care reform, and identifying opportunities and strategies for change. This guide focuses on 14 critical issues rural hospital leaders must face and identifies the steps that hospital leaders andother health care experts and organizations are taking to address those issues.

KIDS COUNT – Data Book

Developed by: Annie E. Casey Foundation
One Lafayette Place
Washington, D.C. 20005
(203) 661-2273

Center for Study of Social Policy
1250 Eye Street, N.W. Suite 503
Washington, D.C., 20005
(202) 371-1565

Available from: KIDS COUNT: Center for the Study of Social Policy

Cost: $12.50

Publication Date: 1992

Program Components: Manual of statistics

Summary: The Annie E. Casey Foundation is devoted exclusively to disadvantaged children. The foundation supports community based development projects which include state and local partnerships. The Foundation makes grants aimed at fostering public policy and human-service reforms that meet the changing needs of today's children and families. The annual KIDS COUNT data book documents how poor children are doing in the United States.

Specific data indices include median income, children living with their parents, children living outside the family, low birth weight, infant mortality, child death rate, teen violent death rate, juvenile custody rate, percent graduating high school and others. Data is provided on each state. Comparisons of data can be made from previous years and national averages. Separate sections are devoted to the year 2000 objectives and a minority profile (White, African-American and Hispanic).

Healthy People 2000: National Disease Prevention and Health Promotion Objectives for the Nation, 1991

Organization: Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402
(202) 783-3238

Cost: $31, stock number 017-001-00474-0, for full report
$9, stock number 017-001-00473-1, for summary

Publication Date: September 1990

Summary: "Healthy People 2000" was initiated from a document published in 1979 called "Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention." "Healthy People" expanded with a 1980 publication, "Promoting Health and Preventing Disease: Objectives for the Nation," which developed an agenda for the next 10 years leading up to 1990. "Healthy People" continues along a similar pathway. For the next 10 years, "Healthy People 2000" sets three broad public-health goals. These goals are to increase the span of healthy life for Ameri-cans, reduce health disparities among Americans and achieve access to preventive services for all Americans. To help meet these goals, 300 specific objectives were set in 22 specific priority areas. An attempt has been made to identify national data for tracking the progress of each objective.

Healthy Communities 2000: Model Standards, Third edition

Organization: American Public Health Association
Publication Sales
1015 15th Street N.W.
Washington, D.C. 20005
(202) 789-5636

Cost: $35 for nonmembers and $24.50 for members. Add $7 for shipping and handling

Publication Date: 1991

Summary: "Healthy Communities 2000 Model Standards" was prepared as the official state and local agency companion document for "Healthy People 2000: Model Standards," which encourages communities to develop attainable community health goals. The priority areas and age groups focused in "Healthy People 2000" are highlighted. National objectives are adapted for local needs, based on their own situation, using a fill-in-the-blank approach.

"Healthy Communities 2000: Model Standards" contains three sections: 1) a Quick Reference to Model Standards, 2) Community Implementation, and 3) Goals, Standards and Indicators for the 22 priority areas contained in "Healthy People 2000." The Quick Reference outlines the principles and values underlying Model Standards, 11 steps for using the standards, and examples and additional resources focusing on data issues and data sources. Case studies of several communities using "Model Standards"are highlighted.

The Guide to Implementing Model Standards: 11 Steps Toward a Healthy Community

Contact: Claude Hall, project director

Organization: American Public Health Association
1015 Fifteenth Street, N.W.
Washington D.C. 20005
(202) 789-5618

Cost: Free of charge

Publication Date: 1993

Summary: "The Guide to Implementing Model Standards" was prepared to help local health agencies and their communities use the model-standards process to translate national objectives into community health action plans that meet community needs and empower agencies and communities to work together to improve health status. The model-standards process involves 11 steps. The guide summarizes these steps, fits them into the context and the core functions of assessment policy development. It also shows how APEX-PH and PATCH facilitate their successful completion.

Healthy Communities 2000 (newsletter)

Contact: Claude Hall, project Director

Organization: American Public Health Association
1015 Fifteenth Street, N.W.
Washington D.C. 20005
(202) 789-5618

Cost: Free of charge

Publication Date: Bi-monthly

Summary: "Healthy Communities 2000" is published bi-monthly. Its 4,000 circulation is primarily state and local health-agency management and professional staffs. It features stories about the use of model standards, APEX-PH and PATCH, and includes project efforts and notices of future events and tool development.

Healthy People Publications

Healthy People 2000 Action Series: Public Health Service Action, State Action, Consortium Action

Organization: ODPHP–National Health Information Center
P.O. Box 1133
Washington, D.C. 20013-1133

Cost: $10 per set

Publication Date: 1992

Summary: "The Healthy People 2000 Action Series" lays out a baseline of current actions to accomplish the objectives being taken by the Public Health Service, individual states and national membership organizations of the Healthy People 2000 consortium. Each book has an appendix containing the Healthy People 2000 objectives. "Public Health Service Action" describes nearly 1,000 activities ranging from low-cost information to million-dollar health-services programs. "State Action" contains profiles from all 50 states and the District of Columbia, describing their objective-related actions, people involved in the action and future Healthy People 2000 activities. "Consortium Action" describes some of the private-sector actions that support national goals.

Additional Healthy People Publications

In response to "Healthy People 2000 Disease National Disease Prevention and Health Promotion Objectives for the Nation 1991" and "Healthy Communities 2000: Model Standards," many other organizations have excerpted the objectives from these documents and included additional materials and strategies for specific target populations. An example includes:

Healthy Youth 2000

Contact:	Kathy Voegtle
Organization:	American Medical Association
	Department of Adolescent Health
	515 N. State Street
	Chicago, IL 60610
	(312) 464-5575
Cost:	Free for single copies
Publication Date:	December 1990

Healthy People Publications
Promoting Healthy Traditions Workbook

Contact:	Sheri Scott
Organization:	American Indian Health Care Association
	245 East 6th Street
	Suite 499
	St. Paul, MN 55101
	(612) 293-0233
Cost:	Free for single copies
Publication Date:	1990

Summary: The "Promoting Healthy Traditions" workbook is a guide designed to assist in the development of programs to meet American Indian-specific objectives set forth in "Healthy People 2000." The workbook is organized in eight sections with each section focusing on a particular aspect of the process. The process includes organizing, planning, gathering data, involving the community, disseminating information, and developing implementing and evaluating health-promotion programs.

Healthy People 2000: America's Hospitals Respond

Organization:	American Hospital Association
	840 North Lake Shore Drive
	Chicago, IL 60611
	(800) AHA-2626
Publication Date:	1991

Summary: This resource kit is designed to help hospitals mobilize their communitywide health promotion initiative linked to national objectives to be met by the year 2000. The resource guide includes case studies, program ideas, program components and key strategies to use when developing a community health promotion program. Also included are sample communication tools and a listing of additional health-promotion resources including products for community needs assessment strategies.

Healthy People Publications

Healthy People 2000 in Rural America:
Hospitals and Communities Rally

Contact: Kim Byas, Section for Small and Rural Hospitals

Organization: American Hospital Association
                      840 North Lake Shore Drive
                      Chicago, IL 60611
                      (312) 280-4422

Cost: Free for single copies

Publication Date: 1992

Summary: This document focuses on strategies and programs developed by rural hospitals to achieve Healthy People 2000 goals. Its emphasis includes efforts to increase the span of a healthy life, reduce disparities in health status, increase access to preventive services and develop a healthy community. Several case studies of hospital community benefit and health-promotion programs are highlighted on each topic area. The case studies include descriptions of individual programs and strategies to develop healthy communities.

Prevention Strategies in Ambulatory Care: A Manager's Guide

Contact: Lynn Jones

Organization: Division of Ambulatory Care
                      American Hospital Association
                      840 North Lake Shore Drive
                      Chicago, IL 60611
                      (312) 280-6000

Cost: For members, single copies are free; $25 for nonmembers

Publication Date: 1992

Summary: This document was developed to provide technical and operational guidance for ambulatory care managers. It includes case study examples and a step-by-step framework for planning and implementing preventive-care programs (based on Healthy People 2000 objectives) in a variety of ambulatory care settings. The manual contains many examples of creative ways hospitals have implemented preventive-service programs and linked them with hospital goals.

The manual provides step-by-step guidelines outlining the phases of program development. Phase I–Research, includes steps and activities which should be taken before implementation of a health prevention program. Components of Phase I include a needs assessment, analysis of existing levels of service, exploration of market potential, development of a task force, feasibility analysis, benefit assessment, development of goals and objectives, development and presentation of proposal to board. The manual stresses these steps should be taken to ensure a successful program, which combines meeting unmet needs and ensures strategic linkages with the hospital's goals.

Additional information includes program design, implementation, overcoming barriers, Healthy People 2000 objectives for primary-care providers, examples of prevention programs and a resource list.

National Center for Health Statistics

Organization: U.S. Department of Heath and Human Services, Public Health Service
Centers for Disease Control, National Center for Health Statistics
3700 East-West Highway
Hyattsville, MD 20782
(301) 436-8500

Summary: The National Center for Health Statistics publishes results of surveys such as the National Health Interview Survey, the National Health and Examination Survey and the Hospital Discharge Survey among other publications that list morbidity, mortality, and other vital statistics. While some information is community specific, this government agency can provide national information that communities can use as benchmarks for comparison.

State Data Centers

Organization: U.S. Bureau of the Census State Data Center Information
(301) 763-1580

In conjunction with the U.S. Bureau of Census, many states have established data centers that make census data available and assist state and local communities to interpret census materials. Services include community and census tract statistics, population projections and mortality statistics.

Life in Jacksonville: Quality Indicators for Progress

Contact: Amma Scheu, vice president of community affairs

Organization: Jacksonville Chamber of Commerce
3 Independent Drive
Jacksonville, FL 32202
(904) 366-6650

Summary: This project, commissioned by the Jacksonville Chamber of Commerce in 1983, gauges the quality of life in the Jacksonville metropolitan area. The purpose of the study was to determine indicators that contribute to the community's general feelings of well-being, fulfillment and satisfaction. Seventy-four indicators are identified in this annual study, providing important longitudinal data that allow citizens to set quality-of-life targets for the year 2000.

Pasadena's Quality of Life Index

Contact: Deborah Silver, Healthy Cities project coordinator

Organization: City of Pasadena
100 North Garfield Avenue, Room 136
Pasadena, CA 91109
(818) 405-4562

Summary: This index was developed for the City of Pasadena as part of Pasadena's own Healthy Cities project. The index can be used as a helpful tool for other communities that wish to develop their own quality-of-life scale. The index includes 11 key areas, ranging from the arts and health to the environment. The index can be particularly useful in monitoring progress toward healthier community goals and act as an excellent benchmark for determining current quality-of-life status.

Campbell Community Survey

Contact: Brenda Bernia

Organization: Center for Creative Leadership
P.O. Box 1559
Colorado Springs, CO 80901

Summary: This survey measures how people feel about their community and includes aspects of educational programs, environmental protection, health-care services, housing, safety, freedom from drugs, optimism and others. This survey was produced to assist communities in identifying strengths and weaknesses and those areas that are of highest concern to community members.

Health Indicator Workbook: A Tool for Healthy Communities

Organization: The Office of Health Promotion
British Ministry of Health and Ministry Responsible for Seniors
1520 Blanchard Street, First Floor
Victoria, BC V8W 3C8, Canada
(604) 356-7439

Summary: This workbook is designed to help communities determine and measure factors that impact individual and community health. Specific factors include socioeconomic status, social support and clean, safe physical environments. This workbook helps communities develop their own measures of a healthy community and uses both population data and community indicators.

E. Community Collaboration and Health Promotion and Planning: Background Materials and Guidelines for Program Implementation

Health Promotion in Diverse Cultural Communities

Organization: Health Promotion Resource Center
Stanford University
1000 Welch Road
Palo Alto, CA 94304-1885
(415) 723-0003

Cost: $9.50

Publication Date: 1991

Summary: The manual focuses on techniques and strategies designed to aid health edu-cators to access, design and implement a health-promotion program within a diverse cultural community. The manual provides a step-by-step process to follow as a guide to development and implementation of a health-promotion program. The process includes gathering background information, establishing contacts and building relationships within the community. A central feature of the manual is developing cultural sensitivity and the importance of cultural sensitivity when working with diverse cultural communities. Specific tips and examples are discussed in detail throughout the manual. Specific techniques include:

1. Conducting a needs assessment (specific strategies included)
2. Establishing contacts
3. Effectively planning meetings
4. Determining community priorities
5. Developing program strategies
6. Establishing focus groups
7. Developing Community Contacts
8. Producing and implementing a survey
9. Forming an advisory council

"How to" Guides on Community Health Promotion

Organization: Health Promotion Resource Center
Stanford University
1000 Welch Road
Palo Alto, CA 94304-1885
(415) 723-0003

Cost: $2.25 per guide

Publication Date: Individual guides were published in 1991 and 1992

Summary: The guides can be characterized as providing the "nuts and bolts" of a certain topic area. Each how-to guide provides a wealth of information on a specific topic in a short amount of space (the guides are between five and 12 pages long). While the purpose of the guide is not designed to make the reader an expert, it does provide background information and how-to examples. The how-to guides are designed for the lay person, with all jargon and technical terms defined. Each guide is organized in a similar format including background information, definition or summary of the subject, guidelines for using the workbook and more. Each guide provides a bibliography of additional resources.

Currently there are 21 health-promotion how-to guides with topics that include volunteers, focus groups, working with the media, press releases, conducting a community resource inventory, writing effective survey questions, building and maintaining coalitions, running effective meetings and many more.

Community Health Promotion Kit

Contact: Karen McComas, health educator
Jim Bluhm, project director

Organization: Minnesota Department of Health
717 Delaware Street, S.E.
P.O. Box 9441
Minneapolis, MN 55440-9441
(612) 623-5000

Cost: To be determined

Publication Date: 1993

Program Components: The Community Health Promotion Kit is essentially a manual which contains a collection of resources, tip sheets, activities and technical-assistance tools that have been developed and used by communities across the United States.

Summary: The Minnesota Health Promotion Kit is a well-developed comprehensive resource guide. The key features of the program include data assessment and coalition-building strategies, program design and techniques on how to involve the media. The kit is user friendly and provides a well documented resource bibliography and numerous appendices with graphs, charts and other finished products. The Community Health Promotion Kit was designed to be used in conjunction with *A Guide for Promoting Health in Minnesota: A Community Approach*. The guide contains the theory and process of community health promotion. The kit was developed for organizations or groups to establish health-promotion activities within their communities.

The program and manual are divided into five sections. These sections correspond to the five phases of community-health promotion, which include: Community Assessment, Community Organization, Program Design and Implementation, Evaluation and Sustaining the Effort. Each phase provides technical assistance, background information and tips on how to achieve the specific objectives associated with each phase of health promotion.

Don't Visit Us by Accident:
Hospital Initiatives in Injury Prevention

Contact: Ronn Kukan

Organization: American Hospital Association
                      840 N. Lake Shore Drive
                      Chicago, IL 60611
                      (312) 280-6362

Cost: Free for single copies

Publication Date: 1992

Summary: This publication is a resource guide for injury prevention. The guide includes statistics and facts on the occurrence of unintentional injuries including: motor vehicle fatalities, falls, poisoning and others. Several national injury-prevention programs are highlighted. Special attention is focused on children and the elderly, including specific programs and guidelines for the development of your own injury-prevention program. Within the guide is a resource listing of national and local injury-prevention initiatives.

HEALTHWORKS!
Guide for Conducting a Community-Based Health Risk Appraisal Program

Contact: John Korn

Organization: National Center for Health Promotion
                      Centers for Disease Control
                      1600 Clifton Drive
                      Mailstop K-46
                      Atlanta, GA 30333

Cost: Free for single copies

Publication Date: 1992

Summary: The manual was designed to help small or rural communities take a planned approach to health promotion and disease prevention and raise community awareness of lifestyle-related health risks. The intervention is technically not a community health assessment, but rather an organized attempt to gather information on the health promotion needs and interests of people in a small community. The manual provides practical information that will help set priorities for conducting risk reduction-health promotion activities for weight control, smoking cessation, nutrition, exercise and seatbelt use. The Community Health Assessment consists of a health-risk appraisal, health knowledge and opinion survey, and four simple health-screening measures (height, weight, blood pressure, and cholesterol).

Specific components of the manual include sections on selecting a target community, gaining community support, planning meetings, publicity, program implementation and samples of materials used in the intervention like promotional fliers, overheads, press releases, letters, etc. This manual is ideal for a for a community that through prior community health needs-assessment activities has already *identified a need* for the development of risk reduction-health promotion awareness and intervention activities related to cardiovascular disease.

The Youth Opportunity Planning Process

Contact: William Lofquist

Organization: AYD–Associates for Youth Development
P.O. Box 3678
Tucson, AZ 85740
(602) 297-1056

Cost: $3

Publication Date: 1990

Summary: Youth Opportunity Planning Process (YOPP) is a systematic approach to involving community groups in strategic planning. Its purpose is to guide groups through a clear and logical process of looking at their community and variables which affect the lives of young people. An outcome of YOPP is to develop a democratic-participatory approach to community betterment. Specific guidelines are provided for each step including techniques to organize discussion material and keep the group focused. The three-step process includes:

1. Identification of factors that contribute to the problems of young people. This section includes step-by-step instructions detailing a technique for "brainstorming" and leading organized discussion for identification, classification and prioritization of specific problems or issues.

2. Analysis of the factors. This section is designed as an opinion survey. It involves the gathering of participant perspectives and interaction around responses to specific questions. Different discussion techniques are described in this section.

3. Application of the factors to the community for action planning. This section suggests steps which will lead to the shaping of a strategic plan for the factors identified in the prior steps.

The Community Collaboration Manual

Organization: The National Assembly of Voluntary Health and Social Organizations
1319 F Street, Suite 601
Washington, D.C. 20004
(202) 347-2080

Cost: $10.50

Publication Date: January 1991

Summary: The Community Collaboration Manual was developed in response to the growing need among communities and non-profit organizations interested in building community collaborations. The Community Collaboration Manual is a hands-on resource that details how to develop and explore options for building and sustaining collaborations. The manual provides step- by-step guidelines outlining the formation of a collaboration. Also included is reference material related to the definition of collaboration along with practical how-to information on developing and maintaining community-based collaborations.

Each chapter focuses on different topics related to the collaboration process. These chapters include:

- Defining and Understanding Successful Collaboration
- Starting a Collaboration
- Building the Collaboration
- Maintenance (How to overcome barriers and avoid "pitfalls")
- Working with other organizations or special groups
- Involving the media

This manual is a how-to and reference manual: Within each chapter are guidelines, descriptions of specific techniques, tips, sample work plans and additional resources that have been proven successful in community collaboration. This manual is an excellent resource for organizations interested in developing a collaboration within their community.

Building Healthier Communities – The United Way

Contact: Martin Scherr

Organization: United Way of America
                              701 North Fairfax Street
                              Alexandria, VA 22314-2045
                              (703) 836-7100

Cost: $7.50

Publication Date: May 1990

Summary: This is a report developed by the Special Study Committee on Health Care to examine the status of health for both the country's delivery system and people. Specifically, the United Way was interested in discovering how it could make a significant contribution toward improving the health of America's citizens. The report examines health-care trends, rising costs, hos-pital closures, access to health care and continuing challenges of the uninsured and underinsured.

The report concludes by discussing possible community-based solutions to health-care problems. The Healthier Communities–Healthy Cities concept, which was originally developed by the World Health Organization, is now being promoted by the University of Indiana School of Nursing, the California State Department of Health Services, U.S. Office of Disease Prevention and Health Promotion and the National Civic League. It is identified as a community-based solution that the United Way can support and allocate resources.

Community Partnerships:

Taking Charge of Change Through Partnership

Organization: Voluntary Hospitals of America Inc.
                              Community Health Improvement
                              1150 17th Street, N.W., Suite 300
                              Washington, D.C. 20036
                              (202) 429-0508

Cost: $5 for VHA organizations (minimum 2 copies); $15 for non-VHA organizations

Publication Date: 1993

Summary: The document is designed to assist hospitals establish partnerships with community organizations. The guide is a concise resource that combines theoretical background, rationale for participating in partnership activities, as it relates to health-care reform, along with current examples of hospital and community partnerships. The information presented was derived from an extensive review of the literature, site visits, and interviews with numerous institutions involved in community partnerships.

Key topics include: Benefits of Partnership, Critical Success Factors, Potential Barriers and Getting Started. Getting Started provides a list of ideas, tips and strategies to assist organizations with the often difficult task of beginning a new process. Additional components include a sample community-perception survey and Partnership Profiles. The survey can be used to determine the public's perception on how community-focused the hospital is. The 12 profiles focusing on partnerships that have been developed between hospitals and other community organizations to address a particular community health problem and/or vision provide working examples of partnership activities that have been successful.

F. References and Recommended Readings

1. Community Health Assessment Theory and Practice

Andersen, Ronald M., and Edward F. Lawlor. "Progress in Needs Assessment: Appearance or Substance?" Center for Health Administration Studies Working Paper #2 (May 1992).

Basch, C.E. "Assessing Health Education Needs." Handbook of Health Education Chapter 3, Rockville, MD: Aspen Publishers, 1987.

Bell, Roger, et al. Assessing Health and Human Service Needs. New York: Human Science Press, 1983. (Proceedings of the Louisville National Conference, 1976).

Bloom, Bernard, Sr. "Assessing Health and Human Service Needs Concepts, Methods and Applications." Community Psychology Series Vol. 8 Chapters 11, 15, 16.

Bradshaw, Jonathan. "The Concept of Social Need." New Society (March 1972): 640-643.

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Glossary of Data-Related Terms

Case fatality rate– the number of people who die from a disease divided by the total number who get the disease.

Cohort group– a study group of individuals who have a statistical factor (e.g., age, education, socioeconomic class) in common in a demographic study.

Community– a group of people who share a common characteristic, interest, commitment or living condition within a larger group. See below for some specific ways of thinking about communities.

Geographic– a community defined by proximity or physical boundaries (e.g., neighborhood/district/ county/state/people in areas between clear geographic lines such as rivers, mountains, etc.).

Enrolled population– the community within a given program or project as defined as: 1) client as an individual, not a family; 2) client has given consent to keep records (including demographic and clinical information); and 3) client receives ongoing services from program.

Social interaction– a community defined by people who congregate in a particular setting (e.g. school, work, place of worship).

Political district– a community defined by the area comprising a defined political/congressional district.

Mindset/beliefs– a community defined by all those people who share a distinctive mindset and set of beliefs (i.e., cultural groups, political parties, religious sects, people with a particular philosophy of health such as the alternative therapy "community").

Shared experience– a community defined by the shared experiences of individuals (i.e., those with AIDS, those in poverty, war veterans, etc.

Control group– study subjects to whom experimental variable manipulations are not applied, or who are exposed to a constant group of features within an experiment (e.g., testing is done in the same experimental room, by the same experimenter, and with the same tools and procedures).

Cross-tabulation– the number of individuals/observations in a combination of variables (e.g., if a survey questions smoking and drinking habits of individuals, the cross-tabulations would include the segments of the population that: 1) drinks and smokes; 2) drinks but does not smoke; 3) does not drink but smokes; and 4) does not drink or smoke).

Data bias– information gained from a sample that was not random (i.e., representative of the population as a whole). Types of biased samples include:

Measurement bias– error in the manner in which the observation is made (e.g., misrecorded information, influential wording of questions, inaccuracies with self-reporting);

Nonresponse bias– certain groups in a population may be more predisposed to responding than others;

Selection bias– favors the selection of population members with distinct traits that differ from the other members of the population;

Volunteer bias– individuals decide for themselves whether or not to respond (the topic of the survey is strongly related to the participant's decision).

Deductive analysis– reasoning from a known principle to an unknown, from the general to the specific or from a premise to a logical conclusion.

Demographics– the vital statistics (e.g., age, births, deaths, marriages, income, education, etc.) of a population.

Distribution– the position, arrangement or frequency of occurrence over an area or throughout a space or unit of time.

Empirical data– information originating in or based on observation or experience.

Epidemiology– science concerned with defining and explaining the interrelationships of factors that determine disease frequency and distribution.

Etiology– the study of the causes of diseases.

Experimental study– a research method in which the experimenter deliberately manipulates one or more variables to determine their effect on another variable.

Health status goal– expressions of desired conditions of health status expressed as quantifiable, timeless aspirations.

Health status objective– a specific health status outcome that is projected for a specific point in time.

Health utilization data– information regarding the patterns and frequency of use of health services for various health conditions by different groups of individuals in the population.

Incidence rate of disease or other phenomena– the number of new cases of a disease or other phenomena occurring during a particular period of time divided by the number of people at risk for the disease.

Index of health– a composite measure, summarized from two or more variables, which is meant to reflect the health status of an individual or defined group.

Health indicators– a single measure that can represent the health status of a defined group (e.g., infant mortality).

Inductive analysis– inference of a generalized conclusion from particular instances.

Interval data– items characterized by identical distance between adjacent points on a scale that reflects the difference in value between items as well as direction.

Mean– quantity with a value intermediate between the values of two or more other quantities (i.e., the average) obtained by dividing the sum of two or more of these quantities by the number of these quantities.

Median– the middle number (or the value mid way between the two middle numbers) in a series.

Mode– the value or number that occurs most frequently in a series.

Mortality rate– The number of people dying from a disease in a particular period of time divided by the average number of people alive during that time period.

Nominal data– distinguishes one item from another without implying a direction (e.g., male and female; areas A, B, C).

Normal distribution– an approximation of the distribution of data from a very large sample. The normal curve is bell-shaped (i.e., symmetric), with most of its data near the mean; the farther a data point is from the mean, the less likely it is to occur (e.g., an approximate normal distribution exists when examining IQ scores across the general population).

Observational study– a research method that does not use the experimental method; therefore, researchers do not produce effects directly but rather observe them (e.g., in an effort to study the effects of pre-natal malnutrition on a child's IQ, researchers would test the IQs of children whose mothers were malnourished during pregnancy rather than purposely malnourish pregnant women for the study).

Odds– ratio of the probability that an event occurs divided by the probatility that the event does not occur.

Ordinal data– ranked items showing that one value is more or less than another value without revealing the amount of the difference between the values (e.g., health services areas may be ranked according to high, medium or low socioeconomic status).

Population-based health status data– information on the various dimensions of health of an entire population or subgroups of the populations.

p-value– the probability that a sample value would be as large as the value actually observed if the null hypo-thesis (i.e., when a new process produces a population that is no different from the old) is true.

Prevalence rate of disease or other phenomena– the total number of existing cases of a disease or other phenomena existing in a population during a time period or at one point in time (point-prevalence), divided by the total number of deaths in that time period.

Primary data– information gained or learned from an original source (e.g., interviews, transcripts, personal journals, original experimentation/studies, etc.).

Proportional mortality– The number of people who die from a particular disease during a particular time period divided by the total number of deaths in that time period.

Qualitative data– information expressed in terms of words, deeds or concepts.

Quantitative data– information expressed in terms of numbers or statistics.

Random sample– each item or individual in a population has an equal chance of being chosen (e.g., a jury is drawn by lot from all of the voters in a district).

Rates of disease or other phenomena– a quantity of individuals with a disease or other phenomena measured per unit of something else (e.g., the number of resident infant deaths divided by total resident live births. multiplied by 1,000).

Regression analysis– examines how and to what degree variations in an outcome variable of interest (i.e., health status) may be explained by variations in various explanatory variables (i.e., income, age, sex, race) hypothesized to affect that outcome variable. For example, variations in health status may be used to explain variations in the effectiveness of a medical intervention. Requires advanced statistical knowledge and skill to obtain valid results.

Retrospective analysis– a study of a phenomenon of interest using historical information.

Secondary data– information gained or learned from an intermediary source (e.g., government agencies, academic journals, newspapers, studies conducted by other individuals or groups, etc.).

Statistical significance– a phenomenon that is probably caused by something other than chance. The statistical significance is tested by calculating the p-value and t-value for a data set.

t-value– measures how large a parameter estimate is relative to the typical deviation (or standard error) of the mean value of the sample from which it was estimated.

Years of life lost– health indicator using the number of deaths at different ages from a specific cause to estimate the years of potential life that were lost due to the condition.

Catholic Health Association of the United States Standards for Community Benefit

1. The organization should assure that mission statements and philosophy reflect a commitment to benefit the community and that policies and practices are consistent with these documents, including:

   - Consideration of operational and policy decisions in light of their impact on the community served, especially the poor, the frail elderly and the vulnerable

   - Adoption of charity care policies that are made public and are consistently applied

   - Incorporation of community health care needs into regular planning and budgeting processes

2. The governing body should adopt, make public, and implement a community benefit plan that:

   - Defines the organization's mission and the community being served

   - Identifies unmet health care needs in the community, including the needs of the poor, frail elderly, minorities and other medically underserved and disadvantaged persons

   - Describes how the organization intends to take a leadership role in advocating communitywide responses to health care needs in the community

   - Describes how the organization intends to address, directly and in collaboration with physicians, other individuals and organizations:

        particular or unique health care problems of the community

        health care needs of the poor, the frail elderly, minorities and other medically underserved and disadvantaged persons.

        describes how the organization sought the views of the community being served and how community members and other organizations were involved in identifying needs and the development of the plan.

3. The health care organization should provide community benefits to the poor and the broader community that are designed to:

   - Comply with the community benefit plan,

   - Improve health status in the community,

   - Promote access to health care services to all persons in the community,

   - Contain health care costs.

4. The organization should make available to the public an annual community benefit report that describes the scope of community benefits provided directly and in collaboration with others.

Formerly New York University-based, Kellogg Foundation-Funded Hospital Community Benefit Standards Program
Overview of Community Benefit Standards

Standard CB.1: *There is evidence of the hospital's formal commitment to a community benefit program for a designated community.*

This "umbrella" Standard and its required characteristics focus on the hospital's overall community benefit program. It outlines structural and procedural components that assure that the hospital's commitment to its community service mission is community-specific and an integral part of its governance and operations.

For HCBSP purposes, "community" is defined as all persons and organizations within a reasonably circumscribed geographic area with a sense of interdependence and belonging.

In developing a community benefit program, a hospital needs to determine–with appropriate interaction with community representatives and others serving the community–the proper size of its community.

This decision is important because no hospital can set up an effective community benefit program without the active participation of a targeted community.

An approved community benefit program includes commitments by the hospital to:

- Carry out projects to improve health status in the target community, address problems of the underserved and contain the growth of the community's health care costs

- Provide leadership to stimulate other organizations and individuals outside the hospital to join together in carrying out a broad health agenda for the target community

- Foster an internal hospital environment that encourages widespread involvement in the program for the target community within the hospital and among its various constituencies

Standard CB.2: *The scope of the program includes hospital-sponsored projects for the designated community in each of the following areas:*

- Improving health status

- Addressing the health problems of minorities, the poor and other medically underserved populations

- Containing the growth of community health care costs

This Standard requires the hospital to sponsor projects that address three essential aspects of a community's health care system. The Standard also requires that each project have measurable objectives to be achieved within a specified time frame. This approach is similar to the format of the U.S. Public Health Service's *Healthy People 2000* objectives and provides a framework that hospitals can use to participate in the attainment of local public health goals.

While the required characteristics suggest alternative projects, at least one in each of the three areas must be designed to increase community awareness and understanding of the underlying issues.

A hospital may not need to initiate projects to meet the requirements of this Standard if it already is carrying out projects that can be continued and extended to the community's benefit.

In addition, a single project may meet requirements for two or more of the required areas. For example, a hospital-sponsored project to encourage full-term obstetrical care might fulfill requirements for all three areas by having the objective of improving health status, being designed to address special problems of an underserved population and reducing overall costs of obstetrical and pediatric care for the community.

Standard CB.3: *The hospital's program includes activities designed to stimulate other organizations and individuals to join in carrying out a broad health agenda in the designated community.*

This Standard emphasizes the leadership role that a hospital often plays as the leading health organization in the designated community. The hospital is asked to join in partnership with all of the important elements of its designated community. Such a coalition should allow each partner to play an appropriate role in helping to address the community's health care problems.

With the current health care emphasis on competition rather than collaboration, meeting this Standard will require many hospitals to plan group activities carefully and to carry them out with a great deal of patience.

The initial emphasis in meeting this Standard generally will not be on showing concrete results, but rather on a pragmatic process that shows some promise of success. Without appropriate hospital leadership, however, the community cannot achieve optimum results in health status, access or costs, regardless of the significance of individual hospital-sponsored projects.

Targets of this outreach effort include a broad range of health care providers and other individuals and organizations. Since the hospital has the least control over the elements for success in community outreach, meeting this Standard will be the most difficult in many community situations.

Standard CB.4: *The hospital fosters an internal environment that encourages hospitalwide involvement in the program.*

This Standard calls for activities and mechanisms to assure appropriate involvement in the community benefit programs by the medical staff organizations and individual physicians, various departments of the hospital, the volunteer program and employees–especially those living in the designated community.

These activities assure that the hospital's program of community benefit is fully integrated with the hospital's more traditional activities and not viewed as an isolated "add-on."

STANDARD #1: DEMONSTRATE LEADERSHIP AS A CHARITABLE INSTITUTION
Minimum guidelines:
- Assert leadership in organizing communitywide efforts for the needy
- Reach out to the underserved to provide needed primary and preventive health care services and health education
- Attract and use donated funds to serve the needy
- Participate in Medicaid and other federal, state and local health care reimbursement programs for the needy
- Formally plan for and provide charity care or maintain an open door policy to the extent of financial ability

STANDARD #2: PROVIDE ESSENTIAL HEALTH CARE SERVICES
Minimum guidelines:
- Cooperate with other community health care providers to maximize the meeting of essential community health needs
- Render health care services and educational services that are specifically designed to meet assessed community needs and improve community health status
- Operate a 24-hour emergency room to the extent needed by the community

STANDARD #3: BE ACCOUNTABLE TO THE COMMUNITY
Minimum guidelines:
- Have a volunteer governing board composed of members of the community the hospital serves
- Invite and respond to community input and involvement in the planning and review of hospital activities
- Voluntarily disclose information on hospital services, financial status, community benefit activities and charity care to the public
- Advocate health care cost containment efforts and promote the efficient use of health care resources within the community

STANDARD #4: EVIDENCE COMMITMENT TO COMMUNITY BENEFIT
Minimum guidelines:
- Embrace a mission statement and bylaws that reflect a commitment to a charitable purpose and community benefit
- Provide leadership for organizing communitywide efforts for enhancing community health
- Integrate a community benefits plan based on assessments of community health needs into overall strategic plan
- Educate and involve employees and medical staff in the provision of community benefits

STANDARD #5: OPERATE FREE FROM PRIVATE PROFIT
Minimum guidelines:
- Maintain a corporate and legal structure that meets all requirements for not-for-profit status
- Ensure that affiliated business enterprises serve the hospital's charitable purpose and present no conflicts of interest with the not-for-profit, charitable mission of the hospital
- Employ financial surpluses to further the institution's charitable purpose and not to promote private inurement to any individual

NOTE: For a copy of VHA's introductory guide to these community benefits standards, "Voluntary Standards: A Framework For Meeting Community Needs," please call VHA's Washington, D.C., office at (202) 822-9750.

Selected Sources of National Data

Adult Use of Tobacco Survey, Office of Smoking and Health, Centers for Disease Control,
   Public Health Service, U.S. Department of Health and Human Services, Atlanta, GA.

AIDS Surveillance System, Center for Infectious Diseases, Centers for Disease Control,
   Public Health Service, U.S. Department of Health and Human Services, Atlanta, GA.

Annual Survey of Occupational Injuries and Illnesses, U.S. Department of Labor, Washington, D.C.

Behavioral Risk Factor Surveillance System, Centers for Disease Control, Public Health Service,
   U.S. Department of Health and Human Services, Atlanta, GA.

Birth Defects Monitoring System, Center for Environmental Health and Injury Control, Centers for Disease
   Control, Public Health Service, U.S. Department of Health and Human Services, Atlanta, GA.

Current Population Reports, Bureau of the Census, U.S. Department of Commerce, Washington, D.C.

Food Safety Survey, Food and Drug Administration, Public Health Service, U.S. Department of Health and
   Human Services, Washington, D.C.

Head Start Bureau, U.S. Department of Health and Human Services, Washington, D.C.

Health and Diet Survey, Food and Drug Administration, Public Health Service, U.S. Department of Health
   and Human Services, Rockville, MD.

Health Knowledge Survey, Human Nutrition Information Service, U.S. Department of Agriculture,
   Beltsville, MD.

Hepatitis, Gonorrhea, STD and Syphilis Surveillance Systems, Center for Prevention Services, Centers for
   Disease Control, Public Health Service, U.S. Department of Health and Human Services, Atlanta, GA.

Hispanic Health and Nutrition Examination Survey, National Center for Health Statistics, Centers for Disease
   Control, Public Health Service, U.S. Department of Health and Human Services, Hyattsville, MD.

Linked Birth and Death Data Set, National Center for Health Statistics, Public Health Service,
   U.S. Department of Health and Human Services, Hyattsville, MD.

Maternal Mortality Surveillance System, Center for Chronic Disease Prevention and Health Promotion,
   Centers for Disease Control, Public Health Service, U.S. Department of Health and Human
   Services, Atlanta, GA.

National Health Interview Survey, National Center for Health Statistics, Centers for Disease Control,
   Public Health Service, U.S. Department of Health and Human Services, Hyattsville, MD.

National Health and Nutrition Examination Survey (NHANES) II, National Center for Health Statistics,
   Centers for Disease Control, Public Health Service, U.S. Department of Health and Human
   Services, Hyattsville, MD.

National High School Seniors Survey, National Institute of Alcohol, Drug Abuse and Mental Health Admin-
   istration, Public Health Service, U.S. Department of Health and Human Services, Rockville, MD.

National Household Survey on Drug Abuse, National Institute of Alcohol, Drug Abuse and Mental Health
   Administration, Public Health Services, U.S. Department of Health and Human Services, Rockville, MD.

National Maternal and Infant Health Survey, National Center for Health Statistics, Public Health Service, U.S. Department of Health and Human Services, Hyattsville, MD.

National Survey of Worksite Health Promotion Activities, Office of Disease Prevention and Health Promotion, Public Health Service, U.S. Department of Health and Human Services, Hyattsville, MD.

National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control, Public Health Service, U.S. Department of Health and Human Services, Hyattsville, MD.

NIMH Community Support Program Client Follow-up Study, National Institute of Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, U.S. Department of Health and Human Services, Rockville, MD.

National Crime Survey, Bureau of Crime Statistics, U.S. Department of Justice, Washington, D.C.

Oral Health in United States Adults, National Institute of Dental Research, National Institutes of Health, Public Health Service, U.S. Department of Health and Human Services, Bethesda, MD.

Pediatric and Pregnancy Nutrition Surveillance Systems, Centers for Disease Control, Public Health Service, U.S. Department of Health and Human Services, Atlanta, GA.

Seven State Study, National Heart, Lung, and Blood Institute, National Institutes of Health, Public Health Service, U.S. Department of Health and Human Services, Bethesda, MD.

Study of the National Incidence of Child Abuse and Neglect, National Center on Child Abuse and Neglect, Administration for Children, Youth and Families, Office of Human Development Services, U.S. Department of Health and Human Services, Washington, D.C.