



State Health Assessment Guidance and Resources

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How to Use This Guide

This guidance document includes four modules covering important components of the state health assessment (SHA) process:

1. Identifying and engaging system stakeholders.
2. Collecting and analyzing health status data.
3. Collecting and analyzing stakeholder and community input data.
4. Summarizing, presenting, and communicating findings.

Each module includes:

- Preview of content and key components included in the module.
- Information about the relevant Public Health Accreditation Board standards, measures, and guidance.
- Ideas for structuring the process and conducting assessment activities.
- Specific examples and lessons learned from states.
- Sample tools and links to additional resources.
- Summary of key products, deliverables, or processes resulting from the module activities.

We recommend reading through the entire guide before embarking on the process and planning assessment activities. The SHA process is a set of interconnected assessment and stakeholder engagement activities, rather than a set of linear steps. In particular, many state health departments and their partners simultaneously engage in “Collecting and Analyzing Health Status Data” and “Stakeholder and Community Input Data” as described in Modules 2 and 3. The strategies for “Identifying and Engaging System Stakeholders” in Module 1 will be relevant throughout the SHA process, and the guide also points to ways that activities for identifying and engaging stakeholders can be leveraged for data collection and analysis.

Introduction

This guide is intended to be a resource for state health departments developing a state health assessment. ASTHO has noted increased interest in the SHA and state health improvement planning (SHIP) processes in recent years with the development of national accreditation standards through the Public Health Accreditation Board (PHAB) and with grant initiatives such as CDC's National Public Health Improvement Initiative. This guidance document includes information and tips based on state health departments' experiences conducting a SHA. This guidance document is meant to complement and support existing ASTHO guidance for SHIP, available online at <http://www.astho.org/Accreditation-and-Performance/Developing-a-State-Health-Improvement-Plan-Guidance-and-Resources/Home/>.

This guide was written to be applicable both to state health departments seeking voluntary public health accreditation through PHAB and those that are conducting a SHA but are not seeking accreditation. Information provided in the guide is intended to support the PHAB requirements and documentation guidance and references to PHAB requirements and documentation guidance are included in this document. However, **ASTHO does not guarantee that states that follow the guidance in this document will meet PHAB requirements.**

State Health Assessment and National Accreditation

The SHA is one of three prerequisites for PHAB accreditation. For state health departments seeking accreditation, information about relevant PHAB requirements is highlighted throughout this guide in green boxes like the one below. *PHAB Standards and Measures Version 1.5* is available online at <http://www.phaboard.org/wp-content/uploads/SM-Version-1.5-Board-adopted-FINAL-01-24-2014.docx.pdf>.

PHAB Standards and Measures

PHAB Standard 1.1 – A state partnership that develops a comprehensive state community health assessment of the population of the state.

Measure 1.1.1 S – Participate in or conduct a state partnership that develops a comprehensive state community health assessment of the population of the state.

Measure 1.1.2 S – A state level community health assessment.

Measure 1.1.3 A – Accessibility of community health assessment to agencies, organizations, and the general public.

(PHAB Standards and Measures Version 1.5, pp. 15-29)

Principles to Guide State Health Assessment

Sara Rosenbaum of the George Washington University School of Public Health and Health Services, in collaboration with CDC, recently published *Principles to Consider for the Implementation of a Community Health Needs Assessment Process*.¹ Through a review of public health literature and resources from professional organizations, she was able to identify common principles for community health assessment and community health improvement. Though this list of principles was developed for nonprofit hospitals conducting community health needs assessments, the principles highlight

¹ Rosenbaum S. *Principles to Consider for the Implementation of a Community Health Needs Assessment Process*. The George Washington University School of Public Health and Health Services, Department of Health Policy. Available at <http://www.cdc.gov/policy/chna/2013>. Available at http://nnphi.org/CM-Suploads/PrinciplesToConsiderForTheImplementationOfACHNAPProcess_GWU_20130604.pdf. Accessed 12-24-2013.

A Summary of “Principles to Consider for the Implementation of a Community Health Needs Assessment Process”

Sara Rosenbaum, June 2013

- ***Multi-sector collaborations that support shared ownership of all phases of community health improvement, including assessment, planning, investment, implementation, and evaluation.***

Findings from the literature point to shared ownership during all phases as particularly important for maximizing collective impact. Successful multi-sector collaborations have a coordinating entity, often referred to as the “backbone,” that helps to facilitate shared commitment, shared measurement, continuous communication, and mutually reinforcing plans of action.

- ***Proactive, broad, and diverse community engagement to improve results.***

The literature suggests that it is essential to facilitate community engagement at each phase of the community health improvement process. It is particularly important to structure the assessment and planning process and resulting interventions so that stakeholders have a shared sense of ownership. Some important stakeholders to engage include civic and faith-based organizations, community hospitals, community-based healthcare providers, health consumers, businesses, private insurers and health plans, and education and social service agencies.

- ***A hospital’s definition of community that encompasses a significant enough area to allow for population-wide interventions and measurable results and includes a targeted focus to address disparities among subpopulations.***

Note: This principle is specific for hospitals conducting CHNA, and less relevant for SHA. See page 11 of this guidance document for more information on defining community for SHA.

- ***Maximum transparency to improve community engagement and accountability.***

The literature reveals a number of benefits that can result from maximum transparency throughout the collaborative community health improvement process, including more community buy-in and trust in the process and the resultant investments and actions, better decisionmaking based on identified needs and the evidence base, shared responsibility for outcomes, and enhanced evaluation of the effectiveness of investments and interventions.

- ***Use of evidence-based interventions and encouragement of innovative practices with thorough evaluation.***

Findings from the literature point to the effectiveness of evidence-based interventions in community health improvement. At the same time, innovative promising practices are important for furthering community health.

- ***Evaluation to inform a continuous improvement process.***

Evaluation of collaborative and innovative efforts in cities, regions, and states is critically important for continuing to build a strong evidence base for community interventions and for continuous improvement of local efforts to improve community health.

- ***Use of the highest quality data pooled from, and shared among, diverse public and private sources.***

The literature suggests that a key factor for success in collaborative assessment and planning efforts is the development of agreements for sharing data. Shared data is key for building a strong evidence base and for monitoring and evaluating community health improvement interventions. Agreements related to data sharing must ensure appropriate privacy and security safeguards.

foundational elements that are relevant for all community health assessments, including a SHA.

Process Steps and Products from the State Health Assessment

In many states, the process for conducting a SHA and creating a SHIP are linked, and system stakeholders are engaged in one continuous process that includes the SHA and the SHIP.

The full SHA and SHIP process includes the following steps; the steps covered in this guide are indicated with a check mark (✓). For all items not checked, see ASTHO's SHIP guidance at <http://www.astho.org/Accreditation-and-Performance/Developing-a-State-Health-Improvement-Plan-Guidance-and-Resources/Home/>.

- Establish a planning process or select model.
- Identify and engage stakeholders in planning and implementation.
- Engage in visioning and systems thinking.
- Collect or analyze data.
 - Health status.
 - Environmental scan and asset mapping.
 - Themes and strengths.
 - Forces of change.
 - SWOT.
 - System capacity.
- Summarize and present findings from the assessment.
- Communicate/vet priorities.
- Establish priorities and identify issues through priority setting.
- Develop objectives, strategies, and measures.
- Develop and implement workplan.
- Monitor, evaluate, and update the SHIP.

The SHA results in the following process deliverables or products, as described in this guide:

- Partnership, coalition, or committee engaged to lead the process.
- Profile or report on health status data for the state.
- Findings related to health disparities and inequities.
- Analysis of community and stakeholder input about important health outcomes and determinants.
- Identified resources to effectively address important health issues.
- Plan for disseminating and seeking public and stakeholder input on key findings.

MODULE 1

Identifying and Engaging System Stakeholders

Module Overview

This module provides guidance on stakeholder engagement, the essential foundation for beginning the work involved in a collaborative population health needs assessment. This includes determining the type and level of stakeholder engagement in the process and developing a strategic purpose or mission, guiding principles, and a vision.

To identify and engage stakeholders in the process in a variety of ways, guidance is provided on exploring the public health system and the health department role within the system. Opportunities explored range from information and data sharing, committee or partnership membership and leadership, and representation of key state health issues and population needs, as well as communication and dissemination of assessment results. This module also includes sample structures to support assessment activities through committees, partnerships, and groups. To ensure these groups are effective and maintain active involvement, guidance is provided with tools and strategies to lead effective and efficient meetings.

The strength and knowledge of the SHA staff can make the development of the SHA easier or more challenging. It is important that the team members at the table are both diverse and appropriate. Therefore, states should consider the components of the SHA and develop an appropriate staff team, including people with skills and experience in project management, data analysis, communication, community engagement, planning, facilitation, and evaluation.

Key Content and Components

- ◆ Defining the Public Health System
- ◆ State and Local Health Department Governance
- ◆ Designing and Structuring the SHA Partnership and Collaborative Process
- ◆ Opportunities for Stakeholder Engagement
- ◆ Stakeholder Engagement Analysis
- ◆ Developing Structures for Group Functionality
- ◆ Mission, Vision, and Values for the SHA Process
- ◆ Committee and Task Force Structure
- ◆ Meeting Methods and Tools
- ◆ Partnership Communication Strategies
- ◆ Effective and Neutral Facilitation
- ◆ Meeting Effectiveness Evaluation Tools
- ◆ Improvement Process Tools

Related PHAB Guidance

To conduct a comprehensive SHA, it is important to work in partnership and carry out a collaborative process. Each state will determine how to structure a SHA partnership or collaborative in a way that maximizes resources, capacity, and expertise. This forms a strong foundation for creation and implementation of the SHIP. This module provides guidance, approaches, and tools for structuring a collaborative process for the SHA, as well as ideas for engaging the broader community in the SHA activities. PHAB requirements related to the partnership and collaborative process are described below in PHAB Standard 1.1 and Measure 1.1.1 S.

Module 1: PHAB Standards and Measures

PHAB Standard 1.1 Participate in or lead a **collaborative process** resulting in a comprehensive community health assessment.

Measure 1.1.1 S A state **partnership** that develops a comprehensive state community health assessment of the population of the state.

Documentation 1: Participation of representatives of a variety of sectors.

Documentation 2: Regular meetings or communications with partners.

Guidance for Documentation 2: The state health department must document that the partnership meets or communicates throughout the process on a regular basis to consider new data sources, review newly collected data, consider changing assets and resources, and conduct additional data analysis. The frequency of meetings or communications is determined by the partnership and may change, as required by the process. Meetings and communications may be in person, via conference calls, or via other communication methods, such as email, listservers, or other electronic methods. Meeting agendas, minutes, and copies of emails could provide this documentation.

Documentation 3: Description of the process used to identify health issues and assets.

Guidance: The state health department must provide documentation of the collaborative process to identify and collect data and information, identify health issues, and identify existing state assets and resources to address health issues. The process used may be an accepted state or national model; a model from the public, private, or business sector; or other **participatory process model**. Examples of models include: Mobilizing for Action through Planning and Partnership (MAPP), Healthy Cities/Communities, or Community Indicators Project. Examples of other tools and processes that may be adapted for the assessment include: community asset mapping, National Public Health Performance Standards Program (NPHSP), Assessment Protocol for Excellence in Public Health (APEX/PH), Healthy People 2020, and Protocol for Assessing Community Excellence in Environmental Health (PACE-EH).

Defining the Public Health System

In most cases, the state health department will lead the SHA. PHAB recognizes that the structure and function of state health departments vary. PHAB defines state health department as: “The governing entity with primary statutory authority to promote and protect the public’s health and prevent disease in humans. This authority is defined by state constitution, statutes, or regulations, or established by executive order. State health departments may be part of an umbrella organization, super public health agency, or super agency that oversees public health functions as well as other government functions.”²

² PHAB. “PHAB Acronyms and Glossary of Terms.” In: Scutchfield FD, Keck CW. *Principles of Public Health Practice*. Delmare CENGAGE Learning. 2009. p. 29.

A Note on Defining Community for SHA

When defining the public health system, think strategically about the different communities that need to be engaged in the process to ensure representation of the various voices. Community can have a variety of meanings. Within the context of population and community health, community often refers to geographic areas: cities, counties, regions, states, and nations. Other types of community that are important to keep in mind are communities built around a shared sense of identity, culture, or interest.

For a SHA, the state “community” is composed of many communities. With hundreds of thousands or millions of people, no state is homogeneous. While the SHA describes the health of the state community, it is also important to be able to draw out the health concerns of communities by age, race/ethnicity, socioeconomic status, disease status, gender, and geographic region from within the larger state community. Therefore, in addition to presenting data on the health of the state’s population, the SHA should also provide information about the context for health in the state, including system capacity and the voices of the people speaking to the health priorities of their community. Special consideration should be made to ensure individuals with this understanding are engaged in the assessment process.

For the SHA and SHIP to be successful in assessing, planning, implementing, and monitoring health improvement, the public health system must be defined in a way that captures the myriad of partners and stakeholders that influence public health. It is important to build stakeholder engagement in a multisector systems approach to public health.

Both CDC and PHAB provide useful definitions of the public health system:

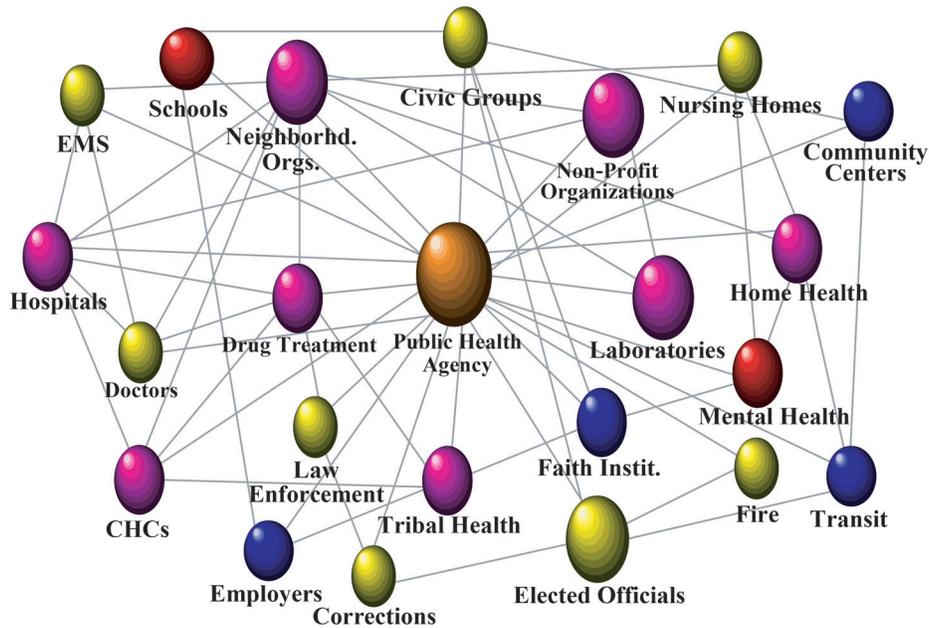
- **Public health system** is the constellation of governmental and nongovernmental organizations that contribute to the performance of essential public health services for a defined community or population.³ (PHAB)
- **State public health system** is the state public health agency working in partnership with other state government agencies, private enterprises, and voluntary organizations that operate statewide to provide services essential to the health of the public.⁴ (CDC)

At the beginning of the SHA process, it can be useful to create a diagram that outlines the public health system partners in the state. Figure 1.1 is one way to sketch out and define the public health system. Figure 1.2 (Sector and Stakeholder Wheel) on page 17 can also be beneficial in creating a more detailed diagram of the public health system. Developing such visuals is helpful in defining the collection of organizations, individuals, groups, and systems contributing to the public’s health. This visual can be used throughout the SHA and SHIP process as a way to define the public health system and maintain a system focus.

³ PHAB. “PHAB Acronyms and Glossary of Terms.” In: Scutchfield FD, Keck CW. *Principles of Public Health Practice*. Delmare CENGAGE Learning. 2009. p. 26.

⁴ CDC. “State Public Health System Performance Standards.” Available at <https://www.cdc.gov/stltpublichealth/publichealthservices/essentialhealthservices.html>. Accessed 1-15-2014.

FIGURE 1.1 PUBLIC HEALTH SYSTEM



Source: CDC. "The Public Health System and the 10 Essential Public Health Services." Available at <http://www.cdc.gov/nphsp/essentialservices.html>.

STATE HEALTH DEPARTMENT CLASSIFICATION

Local public health departments are undoubtedly important partners to include in the SHA/SHIP process. Therefore, consider the structure of the governmental public health system present in the state when identifying and engaging system stakeholders in the SHA. PHAB has identified three broad categories of governance relationships between state and local health departments.

State Health Department Classification

Centralized: Have a central office that provides administrative, policy, managerial direction, and support. The local health departments in centralized states are organizationally a part of the state health department.

Mixed: Describes a system where some local, district, or regional health departments are led by employees of the state and some health departments are led by employees of the local government. No one arrangement predominates the state.

Decentralized: Describes a system with independent local health departments where local government has direct authority over the local health departments, which may or may not have a board of health.

(PHAB Acronyms and Glossary of Terms, Version 1.5)

Centralized and largely centralized states tend to have more formal communications structures between the local level and the state level, because they operate under one organizational umbrella. Florida is an example of a largely centralized state that describes itself as an integrated system. Since all of the local Florida health departments conduct MAPP assessments, the Florida Department of Health was able to draw from the primary data they collected for the community health status assessments.

Decentralized or largely decentralized states may need to conduct outreach to partners in a different manner because the state health department does not have as much direct oversight of local communities. New York is an example of a decentralized state. When it conducted its SHA, it contacted local health departments for suggestions of area experts and partners. These experts and partners then became part of the SHA committees.

Using an Environmental Scan to Identify Existing Assessments and Plans

A preliminary step for the SHA is to conduct an environmental scan of existing assessments and information that can be a source for data inputs or process ideas. For the SHA, the purpose of the environmental scan is to inventory existing assessments and plans related to public health in the state, identify existing data to incorporate into the SHA, and identify opportunities for partnering and building on existing efforts.

When beginning a new assessment process, start with existing assessment data and progress on current plans. Take an inventory of assessments or plans in which the health department and other affiliated agencies and partners have been involved in the preceding five years—community health, systems capacity, and program-specific. The data from past assessments can be compared to current data for trend analysis on health indicators and issues.⁵ Many state agencies have conducted several types of assessments or engaged in some sort of improvement planning in the past. When looking at past assessments, also consider the Healthy People 2020 plan—the largest, most-used assessment and planning tool in public health. Most states participate in Healthy People and have identified coordinators who can be useful resources in the SHA/SHIP process.

As the health department begins work on the SHA, another important initial step is to analyze the progress made on any previous plans for community health, such as SHIP, Title V Maternal Child and Adolescent Health program needs assessment, coordinated chronic care plans required by CDC for all states, or other significant state-level plans. Identifying and understanding implementation progress and impact, including what is working and needs continued focus and what may not be working and needs to be re-evaluated or discontinued, is an important input to the current state health assessment.

While the state health department plays a unique role in assessing and monitoring the status of public health through the SHA and related processes, there are many organizations with complementary expertise that conduct assessments. Hospitals, the United Way, foundations, regional planning agencies, federally qualified health centers, other state agencies, and many other organizations conduct assessments. As part of the environmental scan, gathering the following types of information about other organizations' assessments and plans will lay the groundwork for maximizing partnership and alignment for the SHA:

- ◆ **Data and indicators:** Other assessments may report data that can be an input to the SHA or provide ideas for indicators that would be useful to include. This may be primary or secondary data.
- ◆ **Process ideas:** Process elements to learn from include systems and staffing for a lead agency, facilitating a stakeholder-engaged process for assessment, prioritization and planning, strategies and methods for outreach, and engagement of community-based organizations and residents across the state.
- ◆ **Resources tapped:** Understanding potential resources tapped by organizations for other assessments may include financial resources, institutional resources, human capital, etc.

⁵ In addition to looking at trends relative to indicators the department has been tracking, each new SHA should always be open to including new indicators to ensure health concerns are not being overlooked.

- ◆ **Alignment:** Note whether there are opportunities to build similar indicators and measures into assessments across sectors; this will make it more feasible to align strategies for community health improvement.
- ◆ **Partnership opportunities:** Note whether there are opportunities to partner on components of assessment for mutual benefit. One example might be partnering on a survey or other primary data collection to meet the data collection needs for both assessments.

These assessments can provide valuable information, and the organizations that conduct them may be valuable partners in the SHA process.

Identify Existing Surveillance and Data Systems

Identify what else might be incorporated in the SHA by conducting an environmental scan of existing surveillance and data systems, which collect and synthesize data on an ongoing basis. This includes:

1. Surveillance and data systems operated by the state health department, such as the Behavioral Risk Factor Surveillance System (BRFSS), the Pregnancy Risk Factor Monitoring System, state cancer registry, vital statistics, infectious disease monitoring, environmental health monitoring, and program evaluation within the health department.
2. Surveillance and data systems operated by local health departments.
3. Surveillance and data systems from external agencies and organizations.

The purpose of scanning external organizations' data systems is to identify two types of resources: (1) agencies or organizations that are sources of data (example: the state hospital association discharge database of diagnosed conditions), and (2) agencies or organizations that synthesize data from other sources and make it easier for data to be accessed and incorporated into an assessment (example: Annie E. Casey's KIDS COUNT data center). Do not duplicate efforts. If another organization has compiled data, it is more efficient to use that data than gather and analyze it again. Both ASTHO and the New York State Department of Health have published extensive lists of organizations that publish public health data.^{6,7,8} See Module 2 for more information about identifying and synthesizing data from these sources as part of the SHA.

Identifying Existing Community and Stakeholder Input Data

Many organizations collect community resident and stakeholder feedback that can be used in the SHA. Before potentially duplicating effort by collecting the same type of data again or, worse yet, frustrating residents and stakeholders because previous input has not been used, identify existing data from sources such as governors' initiatives, other government agencies' planning work, opinion surveys, community coalitions, and local health departments. Determine the voices represented in the existing data and how the existing data might benefit the SHA. Once all existing data has been identified, a gap analysis should be conducted to define additional data that will need to be collected for a more complete picture and representation of community and stakeholder voice.

⁶ ASTHO. "Public Health Data Sources & Assessment Tools: A Resource Compendium to Measure Access and Health Disparities." Available at <http://www.astho.org/Programs/Access/Public-Health-Data-Sources---Assessment-Tools/>. Accessed 1-15-2014.

⁷ New York Department of Health. "National Public Health Data Resources." Available at <http://www.health.ny.gov/statistics/chac/national.htm>. Accessed 1-15-2014.

⁸ New York Department of Health. "State Data Sources." Available at <http://www.health.ny.gov/statistics/chac/state.htm>. Accessed 1-15-2014.

Gap Analysis

The final step of the environmental scan is to identify gaps with respect to assessments and data systems in the state. The results of the gap analysis can be used to drive the work plan for completing the SHA. If there are gaps in information or data availability related to important health issues (social determinants, behaviors, or outcomes), those are potential opportunities for the SHA to fill an assessment need in the state. A gap might also indicate that there is no mechanism available to measure or track a given health issue or indicator. While that would likely affect the state's ability to include such an indicator in the current SHA process, the health department and system partners should consider that data gaps related to major health issues might point to the need for a SHIP strategy related to developing data collection methods or data systems. The environmental scan and resulting gap analysis provides a clear picture of what has already been done and provides an opportunity to develop plans to close the gaps through continued data compilation, collection, and analysis. Refer to module 3, page 62 for more information on how the Washington, DC, health department used an environmental scan to identify existing data and information for the SHA.

Structuring the SHA Partnership and Collaborative Process

The organizations leading the SHA will need to develop the partnership leading the process for determining the SHA partnership structure. Membership will look different in each state based on governance structures, executive and legislative guidance and appointments, and existing relationships with public health system partners. In all cases, it is important for the SHA partnership to include individuals representing a cross-section of public health system perspectives that are knowledgeable, influential, and have access to resources to support assessment activities. In addition, when designing the structure for the SHA partnership, it is important to think about skills, expertise, and populations represented and opportunities for additional stakeholder engagement in various assessment activities as described throughout this guide.

PHAB Guidance

1.1.1 S, Documentation 1: Participation of representatives of various sectors.

Guidance: The health department must document that the process for the development of a community health assessment includes participation of partners outside of the health department that represent Tribal/community populations and health challenges. The collaboration must include various sectors of the community, as appropriate. For example, local government (elected officials, law enforcement, correctional agencies, housing and community development, economic development, parks and recreation, planning and zoning, schools boards, etc.), for-profits (businesses, industries, employers, etc.), not-for profits (chamber of commerce, civic groups, hospitals and other healthcare providers, local childhood and women's death review organizations, public health institutes, environmental public health groups, groups that represent minority health, etc.), community foundations and philanthropists, voluntary organizations, healthcare providers (including hospitals), academia, the state health department and Tribal health departments located in the health department's jurisdiction, and military installations located in the health department's jurisdiction. Representation of two or more populations that are at higher health risk or have poorer health outcomes must be included. Documentation could be, for example, a membership list and meeting attendance records.

(PHAB Standards and Measures Version 1.5, pgs. 18-19)

Guidance for PHAB standard 1.1.1 S requires that state health departments include a variety of stakeholders in the development of the SHA. Stakeholders include any person or organization affected by a decision or policy or who may have information that affects the decision or policy. The stakeholders may be from other governmental agencies, academic institutions, healthcare providers, community

organizations, etc. Even if a state health department is not submitting its SHA for accreditation purposes, participation from diverse stakeholders enriches the SHA and brings depth to the document beyond the data collected. Broader participation capitalizes on the knowledge and insight of partners. This broad-based participation will also lay the groundwork for successful development of the SHIP.



Stakeholders can participate through a variety of roles, depending on the structure of the assessment process. The SHA partnership or steering committee provides oversight throughout the entire process and engages additional stakeholders through methods and activities such as work groups or subcommittees, focus groups, key informant interviews, asset mapping, and system self-assessment.

More information on ways to engage stakeholders throughout the process is available on page 18.

Aim to choose stakeholders from a variety of backgrounds, organizations, and positions. Sometimes the most engaged, active, and effective members of a partnership are those who are not at the highest level of an organization. On the other hand, interest alone is not sufficient for inclusion in a stakeholder group. The Healthy Minnesota Partnership, for example, looks for stakeholders who (among other things) have a group of people or a community that they can speak for and who

they can involve in action as the process moves forward.

The composition of these groups and the flexibility to add new members varies substantially from state to state. For example, the Washington State Department of Health's epidemiologists draft sections of the SHA. Feedback is then sought from partner organizations, especially those that represent vulnerable populations. In New York, partners from the public sector are engaged on every level of the assessment. The working groups are each co-chaired by a department of health employee and an external content expert. In Florida, a centralized state, the local health departments complete community health assessments and filter information about community partnerships on the local level up to the department of health to be included in the SHA. However the committees are constructed, structures need to fit the needs of the state and be clearly defined with a process for recruiting new members.

Research for the development of this guide, including interviews with members of the ASTHO State Health Assessment Advisory Group, reveals that states use many different methods for recruiting partners for the SHA/SHIP committees. Some examples include:

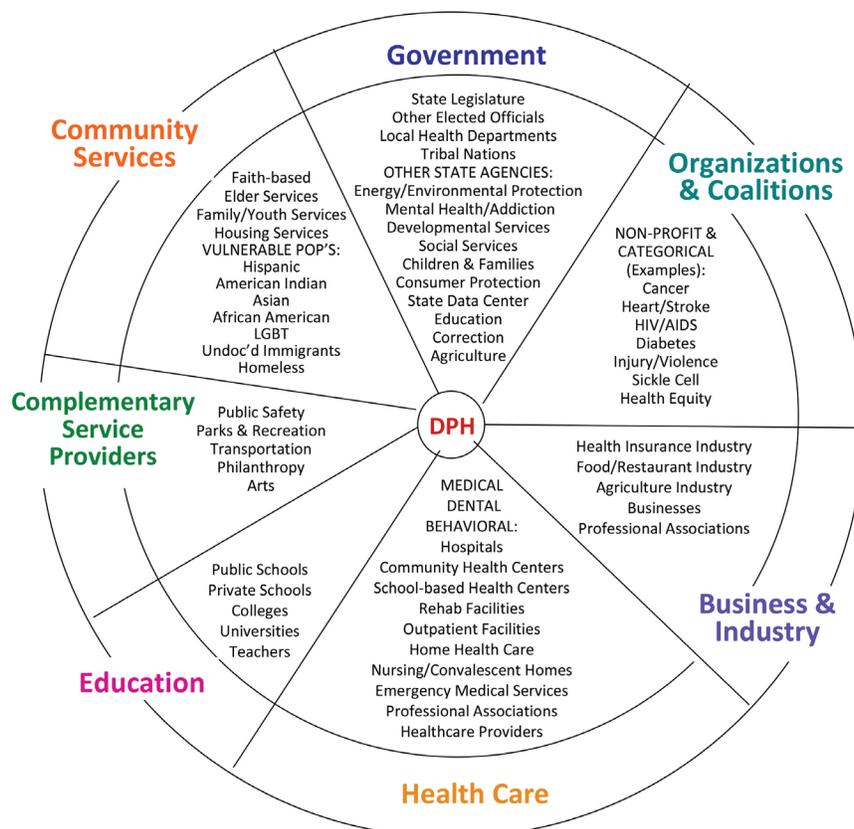
- The governor appoints the entire steering committee.
- The state health official selects the committee based on recommendations from the staff.
- The steering committee is composed entirely of state health department staff, and advisory committees are selected based on content expertise.
- Volunteers for committees are solicited through focus groups.
- Opportunities are offered for volunteers from public listening sessions throughout the state to participate in ongoing working groups.
- Local health departments are asked to recommend participants from their communities.

Some states might use a combination of volunteers, appointees, and persons solicited through focus groups and recommendations.

To ensure a diverse group of stakeholders for the SHA, the first step is to consider all of the sectors involved in public health in the state. Figure 1.2 shows a “Sector and Stakeholder Wheel,” developed by the Connecticut Department of Public Health (CDPH). In creating the stakeholder wheel, CDPH’s first step was to conceptualize the full range of stakeholders in public health, giving special attention to including vulnerable populations. CDPH then assessed which sectors and stakeholders would be easy to engage based on existing relationships and involvement with CDPH programs and where there was need for additional outreach and relationship-building to engage sectors lacking representation. The role of some sectors and stakeholders in the public health system, such as healthcare and community services, are well established. Other connections may not be as intuitive, but engagement of those stakeholders is essential for addressing social, economic, and environmental determinants of health. Public transportation systems affect air quality, community connectivity, and the ability of individuals to reach services. The food industry lobbies for legislation that affects nutrition. The parks department affects access to recreation and physical fitness opportunities. Including a variety of stakeholders from the beginning of the assessment process allows for a broader perspective and, ultimately, a more comprehensive view. Figure 1.1 on page 12 is also a useful tool for identifying stakeholders to engage in the SHA process.

FIGURE 1.2

SECTOR & STAKEHOLDER WHEEL



Source: Connecticut Department of Public Health

Matrices and Checklists

After identifying the sectors with a role in public health, the next step is to analyze the capacity of the stakeholders and the needs of the assessment process. Several approaches can be used for this purpose. CDPH used the matrix shown in Figure 1.3 to determine the best roles for partners. The left side of the matrix collects all the stakeholders' contact information and areas of expertise. The right side of the matrix can be used to proactively identify the optimal ways to engage a given stakeholder and to track how that stakeholder actually participated. Common engagement methods to include as categories for the matrix include advisory groups, working groups, key informant interviews, surveys, focus groups, and forums. This matrix provides a straightforward system to track multiple roles one individual may play in the assessment process and ensure comprehensive engagement and participation.

FIGURE 1.3

Stakeholder Engagement Matrix															
Connecticut State Health Assessment and State Health Improvement Plan															
STAKEHOLDER INFORMATION							ENGAGEMENT METHODS								
Organization	Contact Person	Address	Phone #	Email Address	Area of Expertise	Sector	Interview	SHA Advisory Group	SHIP Steering Committee	Survey	Inform via Email Updates	Structured Feedback via Internet	Leadership Decision Group	Public Feedback Forums 1 & 2	Topical Work Groups F=Facilitator M=Member

Source: Connecticut Department of Public Health, adapted from Health Resources in Action, Inc., 2012

A key factor for success is building a team that includes diverse stakeholders representing a variety of sectors that can contribute a range of perspectives and skills to the assessment. As representatives from various sectors are being sought, it is important to identify the skills and expertise that each stakeholder can contribute. The Florida Department of Health (FDOH) uses the checklist in Figure 1.4 at the state and local level to assess whether the SHA/SHIP committees and working groups have the necessary skills to be successful. FDOH engages the members of the committees and working groups in identifying the skills and expertise that are needed, and they can add to the checklist as necessary. This checklist is a helpful tool for identifying missing stakeholder skills.

FIGURE 1.4

Partner Roles and Skills/Expertise Checklist				
This grid can be used to identify partnership roles, skills needed, and if you need/have a person in that role.				
Roles	Skill or Area of Expertise Needed	Need	Have	Who?
Partnership Management				
• Fiscal manager	Budget management			
• Meeting planner	Event planning			
• Meeting facilitator	Facilitative leadership expertise			
• Recorder	Writing skills			
• Membership coordinator	Database management			
Planning				
• Planners	Strategic planning			
	Operational planning			
	Action planning			
• Program planning	Design educational materials, activities			
	Implement educational materials, activities			
• Policy development	Policy development, monitoring			
Evaluator				
• Goals, objectives	Writing measurable goals, objectives			
• Quality assurance	Performance improvement			
Communication				
• Marketing	Public relations			
	Social marketing			
• Spokesperson	Public speaking			
• IT	Social media			
	Policy development			
Health Content Specialist				
• Health status	Data analysis, interpretation			
	Writing, interpretation, communication			

Source: Florida Department of Health

Opportunities for Stakeholder Engagement

Beyond serving as a member of the SHA partnership, there are a number of activities that need stakeholder input and participation throughout both the assessment and planning process. The following is a list of some key activities that need or benefit greatly from stakeholder engagement. Additional information related to each item is found in subsequent modules.

1. Identifying Indicators and Priority Subpopulations

One of the first objectives of any assessment is to determine what should be measured. By including partners in identifying indicators, the state health department can consider new indicators of health that may make the SHA a more useful document to stakeholders and can potentially identify additional data sources that partners can contribute to the SHA. More information on identifying and selecting indicators can be found in Module 2 on page 33-44.

2. Primary Data Collection

In addition to providing feedback on the indicators used, some partners have the ability to collect primary data through existing programs or systems. More information on primary data collection—including community input, forces of change, and systems capacity assessment—can be found in Module 3.

3. Data Analysis

Data indicators are only useful for improving health once they are analyzed and interpreted. Partners can play a pivotal role in helping to interpret and contextualize the information in their communities, creating useful representations of the data, or providing insights into observed trends. Providing context is an essential element to interpreting data. More information on data analysis can be found in Module 2 on page 52.

4. Prioritization of Issues

As the SHA process moves into the SHIP process, the health issues identified through the assessment activities will need to be prioritized to determine the final set of health issues that will be addressed through the SHIP. By involving partners in this process, the state health department can create a more robust feeling of ownership from the community. A state health department cannot improve public health alone, and involving partners in the prioritization process can lead to more ownership in future programs and interventions.

5. Data Presentation and Dissemination

The magnitude of the SHA's impact is related to the extent to which people are knowledgeable about it. While a state health department can distribute the SHA through its customary channels, it will reach more people with every partner who is involved in dissemination. More information on communication can be found in Module 4 on page 74.

Developing a Structure for Group Functionality

Working collaboratively and through partnerships can be challenging and time consuming, despite the benefits. Defining and deploying strategies, such as communication plans, meeting structure, and establishing foundational principles, to support collaborative and group work is essential to success. In addition, PHAB guidance requires support documentation on the ways in which groups communicated, interacted, and worked collaboratively, as shown on page 10.

MISSION, VISION, AND VALUES STATEMENTS

With a diverse group of partners working on a SHA, it is critical to have a shared sense of purpose that can be referenced throughout the process. The first process step for establishing a high-functioning group is to develop a clear mission, vision, and values. Work on mission, vision, and values will help to solidify the purpose of convening the partnership and conducting the SHA. This is an opportunity to collectively define the charge of the project team, committees, and work groups. The vision, mission, and values will also be useful for outreach and engagement of new partners throughout the process.

VISION

The vision is a statement about the aspirational hopes of the group or desired outcome. It is future-oriented and describes the ideal state or conditions. The University of Kansas Community Tool Box⁹ recommends vision statements be limited to a short phrase, the length of a slogan or tagline. Other forms of vision statements are longer and may include additional information or a rationale of the vision. Given the connections between SHA and SHIP, the vision statement for the SHA will likely be related to the vision statement for the SHIP. Creating the vision statement can be as simple as answering the question, **“As a result of working collaboratively to identify and address the health needs of our state, we hope to create ...?”** The vision statement describes how the health of the state and the public health system will be different or improved.

Sample Vision Statements for SHA/SHIP Processes

New York: *New York is the healthiest state.*

Illinois: *Optimal physical, mental, and social well-being for all people in Illinois through a high-functioning public health system comprised of active public, private, and voluntary partners.*

Minnesota: *All people in Minnesota enjoy healthy lives and healthy communities.*

MISSION

Mission statements describe the purpose of a group in a form that can be broken down into achievable objectives and goals. Mission statements tend to be longer than vision statements and clearly define the rationale for existence of the group or initiative. The mission can easily be measured. Mission statements drive the action within a group and typically include three parts:

1. Purpose: What the group seeks to do.
2. Audience: For whom, with whom.
3. Impact: Significance, expected outcome.

Sample Mission Statements for SHA

New York: *The purpose of a state health assessment is to describe the health status of the state’s population, identify factors that contribute to health status and health challenges, and identify assets that can be used to improve population health.*

Washington: *The partnership is directed by the legislature to guide and strengthen the governmental public health system in Washington state. To accomplish that, we are responsible to ensure that our actions support a public health system that is accountable, continuously measures and improves performance and health outcomes, and reduces environmental and other health risks.*

⁹ Work Group for Community Health and Development at the University of Kansas. “Table of Contents: Community Tool Box.” Available at <http://ctb.ku.edu/en/table-of-contents>. Accessed 1-15-2014.

VALUES OR GUIDING PRINCIPLES

Values statements are the guiding principles a group establishes for itself and the overall process. The values are intended to guide interactions within the group and with the community and guide and influence the process and decisionmaking.

Value statements are distinct from rules of engagement (discussed in the next section). Rather than describing specific processes or actions, values are ethical guidelines and state core priorities that influence behavior. Ultimately, values statements serve as overarching principles that further define what the group is and what it is about. Groups, committees, and coalitions should be given time to think about values that are important to them for their participation in the assessment and engage in discussion with other members to agree on a shared set of values to guide their work.

Useful questions to ask when identifying values statements include:¹⁰

1. What are some of the values, beliefs, and principles that should guide our group's interactions with each other, the communities we serve, and the work we do?
2. What are the associated behaviors we should commit to doing in our work to support our values, beliefs, and principles?

For groups or committees that have already established a set of values some time ago, revisiting those may be helpful. Critical self-reflection regarding how the group has operated and what the group has done may provide useful insight into what the group demonstrates as values. If the group has a value of health equity but has not gathered data to identify disparities in health, the group might ask if they are truly demonstrating this value through actions.

Sample Values Statements for SHA

Public Health Improvement Partnership in Washington State:

We value public health research to better inform our efforts.

We acknowledge the importance of delivering results with the resources we have been given.

We treat each other as valued colleagues and partners.

Healthy Minnesota Partnership:

*We value ... **connection**. We are committed to strategies and actions that reflect and encourage connectedness across the many parts of our community.*

*We value ... **voice**. People know what they need to be healthy, and we need to listen.*

*We value ... **difference**. Our differences make us stronger together than we would be alone.*

PROCESS FOR DEVELOPING STATEMENTS

Ideally the full partnership group should participate in drafting the vision, mission, and values statements. Developing these statements in a collaborative manner is a good opportunity to engage participants, create shared understanding, and learn about how members work together. Often, the

¹⁰ Adapted from Allison M, Kaye J. *Strategic Planning for Nonprofit Organizations: A Practical Guide and Workbook*. John Wiley & Sons. 2011.

best process will be a hybrid involving initial drafting of vision and mission concepts by health department staff or a core group of partnership members, followed by group process to ensure a more holistic sense of purpose and values that reflect perspectives across the public health system. This hybrid process is effective because it provides the group with concepts to respond to and can help to address time and resource constraints often faced by state health departments and their partners. For the mission, vision, and values to be meaningful, it is important for group participants to comment, contribute, and offer revisions to the statements. The goal of these statements is to define the purpose of the group. If group members do not feel that their role or purpose is aligned with the vision and mission in some way, they may be less likely to fully participate and commit resources to the process.

In subsequent SHA processes, these statements may remain the same, but they should be reviewed and discussed at the beginning of each new SHA process. The process of developing these statements is often more important than the words ultimately decided on. The process allows for group development and leads to cohesiveness through a shared purpose, set of values, and vision for the future that defines the work. In addition, the mission, values, and vision are useful communication tools for engaging stakeholders.

RULES OF ENGAGEMENT

Rules of engagement are specific rules developed by a group to determine how they will function together. While the rules should be developed collaboratively, the state health department will have ultimate responsibility to ensure the SHA is completed. Therefore, the state health department may need to specify or adapt rules to ensure that the process is functional.

FIGURE 1.5: QUESTIONS TO CONSIDER WHEN DEVELOPING RULES OF ENGAGEMENT

- Is there one organization/division designated as the lead for meeting logistics for the SHA? (This could be internal or external to the health department.)
- What responsibilities do members of the group have?
- What is the required or expected level of attendance?
- What are the consequences if someone does not meet the responsibilities?
- Who is responsible for arranging meetings?
- What meeting locations are most accessible and comfortable for the group members? Where are neutral meeting locations?
- How is the agenda set?
- Who will take notes on the meeting?
- How are meeting logistics, minutes, and activities communicated to the group?
- Who facilitates meetings? (Include substitutes in case the lead facilitator is absent.)
- How will decisions be made?
- Who will make the final decision?
- What are our group norms?
- What are the expectations of behavior toward other group members?
- How do new partners become involved in the group?



For the SHA and SHIP, a single organization or group is often designated to handle the meeting planning and logistics. This can help to ensure consistency for meetings. It is also important to identify meeting locations that are perceived to be accessible, comfortable, and neutral to ensure that diverse stakeholders will participate. Further, in many states, face-to-face meetings may not always be feasible despite being the most effective type of meeting for this work. Therefore, an exploration of the most effective distance-based technology available is needed.

In some states, partnership committees adopt a formal charter or bylaws. Examples of a charter from Washington's Public Health Improvement Partnership¹¹ and bylaws from Illinois' State Health Improvement Plan Planning Team¹² are included in the appendices.

LEADERSHIP

For government-led assessment and planning efforts to be successful, it is essential to have the engagement and support of people in leadership positions. Even if health department staff and stakeholders are highly motivated, a lack of support from agency leadership will impede success, especially for the SHA, which spans all divisions of the health department. The leadership of influential people who can champion the effort can also add momentum to the SHA. These champions could include governors, legislators, the secretary of health and human services (or equivalent cabinet position), the state health official, or heads of private stakeholder groups such as the state medical society. Overall, buy-in and support from the leadership of influential public health system partners in the state will be critical to the success of the SHA and SHIP processes.

COMMITTEE AND TASK FORCE STRUCTURE

As stated previously, state health departments that have completed SHAs have used a number of different approaches in structuring the project. Some states formed a steering committee with representatives from a number of sectors. This steering committee was then involved in a number of working groups, each focused on different sets of indicators. Other state health departments tasked their epidemiologists with drafting the initial SHA and then formed committees to review and provide insight on the final draft. Figures 1.6 to 1.8 show three examples of organizational charts for SHA partnerships and process structures for collaboration.¹³ Health departments using the MAPP model for the SHA and SHIP often use a structure similar to the sample shown below in Figure 1.6.¹⁴

¹¹ Public Health Improvement Partnership. "Charter: February 2012." Available at <http://www.astho.org/programs/accreditation-and-performance/Washington-Public-Health-Improvement-Partnership-Charter/>. Accessed 1-15-2014.

¹² Illinois Department of Public Health. "State of Illinois State Health Improvement Plan Planning Team Bylaws." Available at http://www.idph.state.il.us/ship/09-10_Plan/SHIP%20Bylaws.pdf. Accessed 1-15-2014.

¹³ Organizational charts show the structure used to complete the SHA. If a committee also had oversight or involvement in the SHIP process, it is not depicted in these diagrams.

¹⁴ See ASTHO's SHIP guidance for more information on using the MAPP model for SHA/SHIP.

FIGURE 1.6 MAPP ORGANIZATIONAL CHART

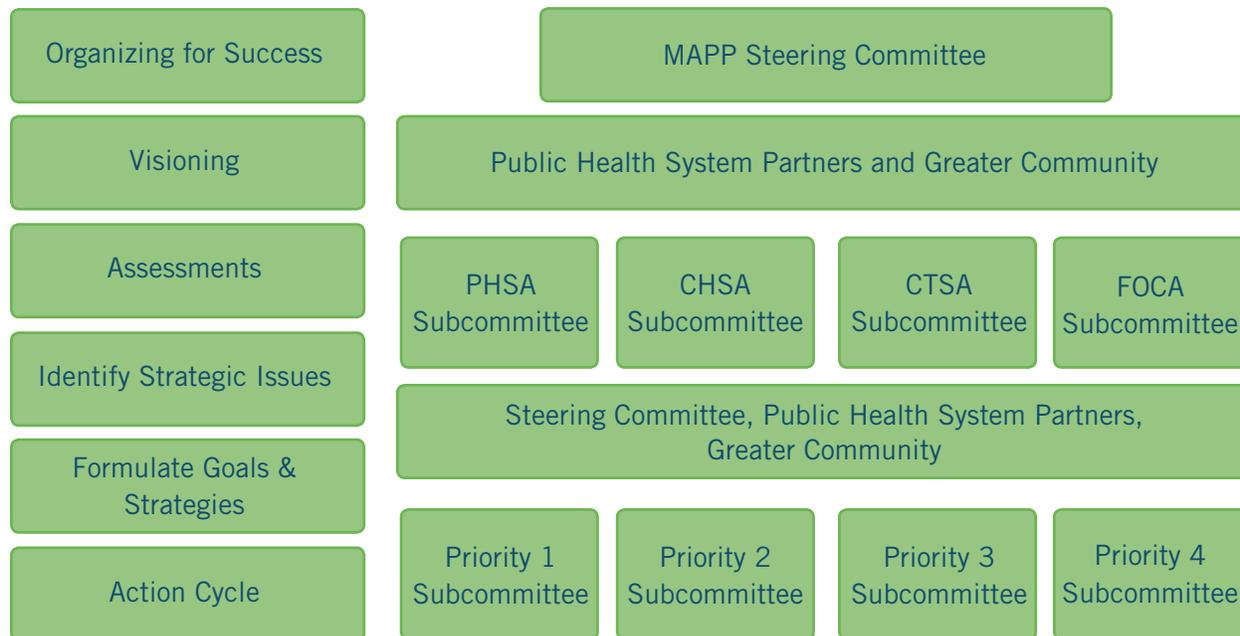


FIGURE 1.7 ORGANIZATIONAL CHART: FLORIDA STATE HEALTH ASSESSMENT

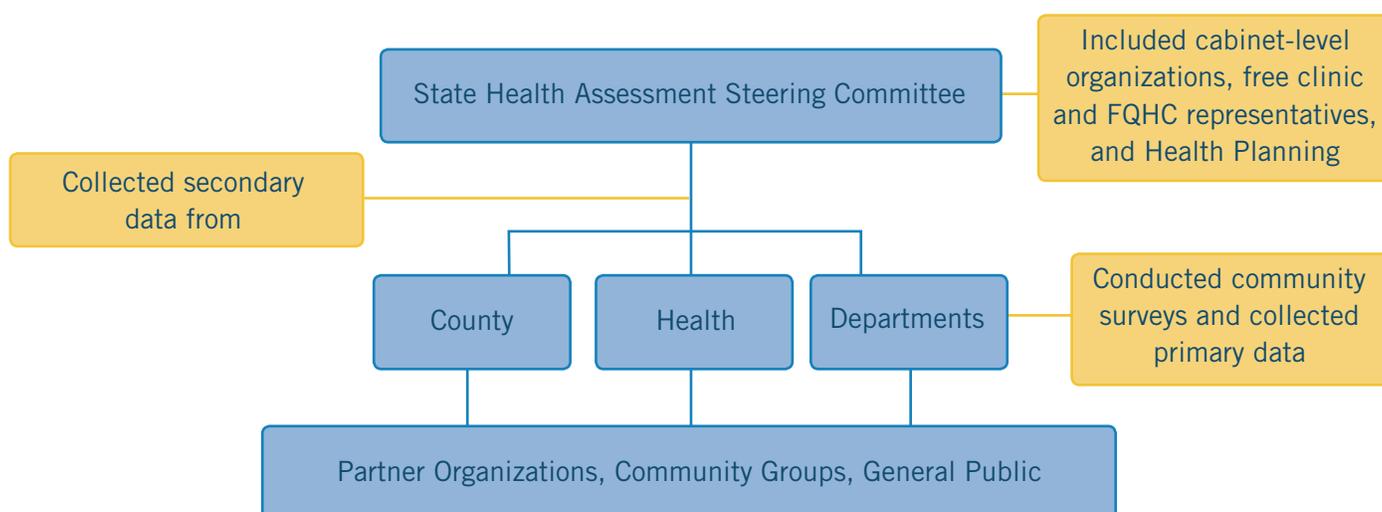
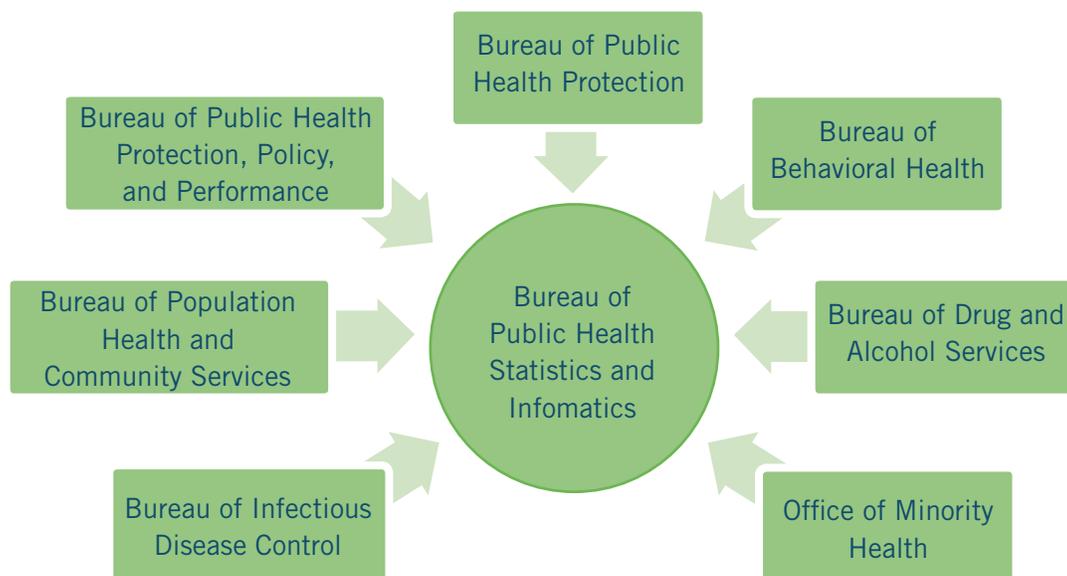


FIGURE 1.8 ORGANIZATIONAL CHART: NEW HAMPSHIRE STATE HEALTH ASSESSMENT



Regardless of how the committees or task forces' structure is chosen, some common elements include:

- Delineate clear structures, roles, and responsibilities for each committee and task force.
- Select a chair or co-chair to lead the committee or task force.
- Specify communication processes between different levels of project teams, committees, task forces, and working groups. If a task force does not have a representative from the steering committee, the points of contact and communication chain must be specified. See more information on communication strategies in Module 4.

Creating an organizational chart is one method of clarifying the structure and roles of the committees and task forces. Making these documents publicly available adds transparency and clarity to the SHA process.

MEETING METHODS AND TOOLS

There are many different functions and styles for meetings of a group, and the group culture will develop, evolve, and hopefully strengthen over time. Taking the time up front to work together on mission, values, and rules of engagement (pages 20-24) is key to establishing a strong group dynamic and successful meeting structure. Responding to suggestions from group members for process improvements should also be a standard procedure for continuous improvement and meeting effectiveness (see more detail on page 29). Under any circumstances, meetings should be purposeful, planned, and well facilitated to ensure active and sustained engagement.

FIGURE 1.9 TIPS FOR CONDUCTING A SUCCESSFUL MEETING

Adapted from the University of Kansas Community Tool Box

Phase 1: Planning the Meeting

- Develop clear goals and objectives for the meeting.
- Both meeting organizers and participants need to be clear on homework assignments and need to complete any assignments. (Collect necessary information and documents.)
- Determine who needs to be in attendance. Some meetings require specific levels of participation (e.g., decision meetings may require a quorum or representation from key areas).
- Plan the meeting with others. It is important to keep members engaged and be sure the meeting is not only addressing the goals and objectives of the organizers but of participants as well. Meetings jointly planned tend to be more successful; participants own the outcome for what they developed.
- Develop a clear agenda. A detailed process agenda for internal use is even more important than the public agenda that all participants receive. Good agendas count. Agenda development tools can be useful when designing a quality meeting. See Appendix F for one tool developed by the Illinois Public Health Institute.

Phase 2: Setting Up the Meeting

- Start and end on time. Work with the group to identify the time of day that works best. Engaged stakeholders are usually those with high demands on their time. Early morning meetings, lunch meetings, or even end of day meetings may be the best fit.
- Keep good attendance records. Create a sign-in sheet or attendance tracker that can be verified.
- Use comfortable and convenient meeting spaces with options for distance participation.
- Have informal time before and after the meeting. This helps meetings to stay focused and gives stakeholders important networking time that helps to develop relationships and overall group dynamics.
- Follow a regular cycle. Standing meetings allow members to block the dates on their calendars well in advance. Scheduling recurring meetings in Outlook or another software is highly recommended. Meeting reminders are also essential, and RSVPs help administrative staff know who to contact for followup.

- When using distance technology, work the kinks out in advance. Do a dry run to ensure a smooth meeting. Be sure to share clear instructions with all participants about how to join the meeting and rules for participation (e.g., mute line when listening, be mindful of those that are participating remotely, etc.).

Phase 3: Running the Meeting

- Always be sure that introductions are conducted. Don't assume everyone knows each other, and be sure to introduce those participating remotely.
- Before beginning the meeting, solicit agreement on the agenda and ground rules/group norms or rules of engagement.
- Use a quality facilitator who is able to maintain a somewhat objective position, can keep the discussion on track, and uses the power of the position wisely.
- Watch the time so all agenda items can be addressed and the meeting can be closed on time.
- Implement good active listening by either asking participants to summarize what they hear before speaking, or at a minimum, ensure that the facilitator frequently summarizes and checks for understanding and agreement.
- Encourage participation from all participants. To ensure this happens, facilitators should use a variety of techniques to engage less verbal participants.
- Develop new leaders by rotating facilitation roles when using internal facilitators.
- Assign someone to take quality notes indicating all follow-up assignments and timelines.

Phase 4: Ending and Following Up on the Meeting

- Gather feedback from the group at the end of each meeting to understand group needs, what works, and what needs to be improved.
- Send out meeting notes, with special attention paid to follow-up items.
- Make follow-up calls as needed to ensure follow-up items will be completed.
- Summarize the meeting, including the processes used for archived records.
- Summarize meeting feedback and evaluation results, and identify and plan for improvement actions.

PARTNERSHIP COMMUNICATION STRATEGIES

To be effective and efficient, it is essential to develop strategic approaches to communication when working with diverse partners. To have a process that is accessible to diverse stakeholders across the state, it is important to employ multiple communication strategies. In-person meetings are wonderful for building trust and fostering productive discussion, but they can be difficult to coordinate when people live across an area as large as a state. Conference calls can accommodate a large number of participants, but they can be difficult to facilitate. Webinars, online document managers, and other digital tools allow for easy sharing, but they can exclude people with limited Internet capacities. Some agencies, such as the Washington State Department of Health, produce newsletters to keep staff and external stakeholders informed and engaged in the assessment work.

Numerous tools are available to assist in communication efforts. Many are available free online in a basic form. It is important to know your agency's policy with regard to using online tools and whether any firewall settings might block emails from these tools. Some examples include:¹⁵

- **Document Managers:** Allow documents to be shared and edited collectively.
 - > Dropbox (www.dropbox.com)
 - > Google Drive (www.drive.google.com)
- **Online Video Conferences:** Allow for video conferences with individuals or groups. Some have the capacity to share screens and collectively edit documents.
 - > Skype (www.skype.com)
 - > Google Hangout (www.google.com/hangouts)
 - > Oovoo (www.oovoo.com)
- **Email Managers:** Increase capacity for sending mass emails. Some allow the sender to see how many times an email was opened and to track other usage.
 - > Constant Contact (www.constantcontact.com)
 - > IContact (www.icontact.com)
- **Meeting Scheduling:** These tools allow participants to provide feedback on potential meeting times.
 - > Doodle (www.doodle.com)
 - > Meeting Wizard (www.meetingwizard.com)
- **Online Surveys:** Allow participants to provide feedback; many provide analysis tools.
 - > Survey Monkey (www.surveymonkey.com)
 - > Survey Gizmo (www.surveygizmo.com)
- **Online Project Managers:** Allow the action plan to be uploaded and participants to select or delegate tasks. They also provide a platform for storing information and documents.
 - > ZoHo (www.zoho.com/projects)
 - > Wrike (www.wrike.com)
- **Websites:** Most state health departments already have their own website, which they should use to post documents and share information with the public. The information should be easy to find and searchable.

¹⁵ This list is intended to provide examples of commonly used tools; it is not intended to be comprehensive, nor are any of these tools endorsed by ASTHO.

A good communication strategy will incorporate several of these methods to allow partners multiple avenues of participation. On a regular basis, participants should be asked if they are able to access the necessary documents, feel free to participate in conversations, and receive notices about events in a timely manner. Meeting evaluations are one method of making these inquiries.

FIGURE 1.10 RESOURCES AND LINKS: GROUP FUNCTIONALITY

- University of Kansas Community Tool Box
<http://ctb.ku.edu/en/tablecontents/index.aspx>
- Florida Department of Health MAPP Field Guide
http://www.floridahealth.gov/provider-and-partner-resources/community-partnerships/floridamapp/florida-mapp-field-guide/introduction/_documents/facilitation-in-the-mapp-process.pdf
- The Human Leadership and Development Division of the American Society for Quality Basic Facilitation Skills
http://www.iaf-world.org/Libraries/Facilitation_Articles/ASQ-IAF_Facilitation_Primer.sflb.ashx
- The PARTNER Tool
<http://www.partnertool.net/>

Ensuring and Improving Effectiveness and Satisfaction with Stakeholder Engagement

EFFECTIVE AND NEUTRAL FACILITATION OF THE PROCESS

When conducting a SHA with diverse partners, work to ensure that every voice at the table is heard and represented throughout the process. This can be achieved through effective facilitation. The facilitator, whether internal or external to the state health department, should be trained in facilitation, be skilled at remaining neutral, and clearly communicate to the group that she or he will not take sides in the conversations. The actions and attitudes of a facilitator will always speak louder to partners than his or her words. The facilitator's role is to build commitment and a sense of inclusion with the partners to have buy-in and contributions; this is important both for collaboration across divisions at the health department and for collaboration with outside partners. The facilitator must balance being neutral with ensuring that all group members are able to participate in the process; this is particularly important for ensuring the inclusion of historically underrepresented populations. The facilitator must be able to assess group dynamics and determine whether there are any participants at the table whose voices are not being heard. The facilitator can then work with the project staff and group members to identify process changes to address any issues.

MEETING EFFECTIVENESS EVALUATION TOOLS

Ensuring the effectiveness of each meeting is key to the success of the process. There typically is limited time to gather process feedback during meetings, since time must be prioritized for decisionmaking and working to meet objectives. Therefore, meeting evaluation tools and brief feedback sessions should be incorporated to gather insight related to meeting effectiveness. The success of meetings and member

satisfaction is important for maintaining and strengthening relationships with partners represented on committees and work groups. Meetings that do not use time effectively or do not allow for open dialogue and contribution of ideas can lead to dissatisfaction with the process among key stakeholders; this can compromise relationships moving forward. Meetings that respect stakeholders' time and make them feel their input is valued can strengthen relationships and lead to greater partnership and participation in the future. For this reason, it is very important that facilitators keep meetings on track and create an effective group dynamic to maximize group satisfaction and productivity. A good facilitator will be cognizant of the dynamics at each meeting and will structure and guide meetings in a manner that keeps committee member satisfaction in mind.

FIGURE 1.11 PLUS-DELTA MATRIX

Worked Well +	Needs Improvement Δ
Small group work	Adhere to times on agenda; end on time
Pre-meeting assignments	Send data out prior to meeting for review
Strong facilitation	
Consensus building	

Checking in with the group during and at the end of each meeting is important to help the facilitator monitor satisfaction and make adjustments if some aspect of the meeting structure is not functioning. A simple "Plus-Delta" activity is a good way to check in with the group during meetings. Plus-Delta is a simple five-minute facilitated discussion to capture what worked well ("+") and what could be changed or improved ("Δ") for future meetings, capturing notes on chart paper.

In addition to the Plus-Delta activity, it can be helpful to distribute a written meeting effectiveness survey, so participants can share their feedback anonymously or focus in on specific areas. Figure 1.12 is an example of a meeting effectiveness survey that can be used to gather feedback from committee members on meeting effectiveness. The meeting effectiveness survey asks participants to rank the effectiveness of different aspects of the meeting on a scale from 1 to 5, with 5 being the most effective. The categories and questions can be revised to focus in on areas of importance to the group.

FIGURE 1.12

Meeting Effectiveness Survey		1	2	3	4	5
Committee Role	To what extent were the committee roles clarified at this meeting?					
Clear Goals	To what extent were the goals clear for this meeting?					
Communication	To what extent was the discussion open, with sharing of diverse ideas and perspectives?					
Commitment to the Group	To what extent was I committed to helping achieve the group's goals for this meeting?					
Participation	To what extent did I say or contribute what I thought was important to achieving our goals for this meeting?					
Effectiveness	Overall, how effective was the group in meeting its goals during this meeting?					
Value	How valuable was this meeting for success of the overall work for this committee?					
Satisfaction	Overall, how satisfied were you with today's meeting?					

Source: Illinois Public Health Institute

Ideally, the meeting effectiveness survey should be consistently used at the end of each meeting. Having committee members evaluate each meeting using the same criteria will allow facilitators to track effectiveness over time. This allows the survey to function as a quality improvement tool, producing data that can be monitored for trends and can highlight areas of improvement. Survey responses can be averaged for each category and entered into a chart following each meeting to allow facilitators to see areas that are meeting expectations and those that need improvement. Improvements can be addressed in the following meetings by creating process improvement and continuing to check in with meeting participants.

IMPROVEMENT PROCESS TOOLS: APPLYING QUALITY IMPROVEMENT TO MEETINGS

The SHA project team can follow the Plan, Do, Check, Act cycle to maximize meeting effectiveness. Using the same feedback mechanism consistently after each meeting creates baseline data that the project team can use to monitor meeting effectiveness and identify areas for improvement; this will enable participants to make the most of each meeting.

FIGURE 1.13 APPLYING QUALITY IMPROVEMENT TO COMMITTEE MEETINGS

Plan: The project team and facilitator collect data following each meeting to track meeting satisfaction. If a particular aspect of the meetings has not met participants' needs, the problem is analyzed to try to understand the root cause and develop a plan to improve. When analyzing the problem, more information may need to be gathered from participants before or during the next meeting.

Do: The project team and facilitator implement a change to the meeting structure or process that they believe will resolve the lack of satisfaction.

Check: Facilitators check in with participants during the meeting for reactions. The project team compares the meeting effectiveness surveys to determine whether scores improved.

Act: If the implemented changes are successful, the project team standardizes the new process improvement.

MODULE 2

Collecting and Analyzing Health Status Data

Module Overview

This module provides guidance on the collection and analysis of health status data, including both health outcomes and health determinants.

To aid in selecting indicators, guidance is provided on sources for data and compilations of indicators, as well as processes for prioritizing and selecting the indicators to include in the SHA. This module also includes guidance on data management, analysis, and presentation, as well as tools and processes for developing key findings from the health status data. Some of the collection and analysis of stakeholder and community input data—described in Module 3—will likely occur simultaneously. Module 4 provides guidance for integrating the key findings from the health status assessment with findings from the stakeholder and community input data.

Related PHAB Guidance

PHAB Standards 1.1, 1.2, and 1.3 all refer to the state health department’s important functions related to collection and maintenance of health status data. Standard 1.1 refers to the need for a collaborative health assessment process. Measure 1.1.1 S requires that the health department leads or participates in a state partnership to conduct a comprehensive health assessment for the state population. Measure 1.1.2 S outlines documentation requirements for this process to demonstrate that the assessment was sufficiently broad in scope and informed by data from multiple sources. Standard 1.2 provides more specific guidance regarding the collection of data on population health status. Standard 1.3 requires the data to be analyzed to determine trends in population health.

This module is focused on data collection and analysis for the state health status assessment, or state health profile. Much of the data for the health status assessment will be *secondary data*.¹⁶ PHAB describes primary and secondary data (p. 35 of Standards and Measures v.1.5):

“Primary data are data that did not exist before the health department gathered it. The collection of primary quantitative data need not be complicated or costly. The data collection is intended to enhance the knowledge and understanding of the population the health department serves. Data can be obtained from surveys of target groups (e.g., teenagers, the jobless, residents of a neighborhoods with higher risks of poorer health outcomes). Vital records are considered primary data for state health departments, if the state health department collects them.’ It describes secondary data (p. 22): ‘Examples of sources of state secondary data include Federal, Tribal, state and local health department data, hospitals and

Key Content and Components

- ◆ Identifying Indicators
- ◆ A Note on the Importance of Social Determinants of Health
- ◆ Prioritizing and Selecting Indicators
- ◆ Criteria and Criteria Matrices
- ◆ Nominal Group Technique
- ◆ Data Collection and Data Sources
- ◆ Data Management and Presentation
- ◆ Data Analysis and Interpretation
- ◆ Developing Key Findings from the Health Status Assessment

¹⁶ PHAB. “PHAB Acronyms and Glossary of Terms.” In: Scutchfield FD, Keck CW. *Principles of Public Health Practice*. Delmare CENGAGE Learning. 2009. 29.

healthcare providers, schools, academic institutions, other departments of government (departments of education, transportation, community and economic development, etc.), and statewide not-for-profits.”

The required documentation and guidance for Measure 1.1.2 S provides the framework for this module, and the guidance for Measure 1.2.3 A describes the pivotal importance of including both health status data and other primary data in the SHA.

PHAB Guidance

Measure 1.1.2 S, Guidance 1.d: A discussion of the contributing causes of the health challenges, such as behavioral risk factors, environmental factors (including the built environment), socioeconomic factors, policies (e.g., taxation, education, transportation, insurance status, etc.), injury, maternal and child health issues, infectious and chronic disease, or the unique characteristics of the state that impact health status.

Multiple determinants of health, particularly social determinants, must be included. Health status disparities and high health-risk populations must be addressed. Factors that contribute to higher health risks and poorer health outcomes in specific populations must be considered.

(PHAB Standards and Measures Version 1.5, p. 23)

Identifying Indicators

The health status assessment process starts with identifying data that describe the health status, health determinants, community perspectives, and assets of the community. Health indicators, or health metrics, are measurements of health status or health determinants. Because health outcomes and disparities are impacted by determinants of health, the SHA should use a holistic model of population health that includes data on health status as well as major modifiable determinant categories, including healthcare access and quality, personal behaviors, social factors, community conditions and resources, and the physical environment.¹⁷

As a first step in identifying indicators for the SHA, it is useful to have a conceptual framework that presents the different types of health determinants and outcomes that the assessment will cover. Figure 2.1 shows one example of a social-ecological model that may be useful as a conceptual framework for health determinants.

¹⁷ McGinnis JM, Foegen WH. “Actual causes of death in the United States.” *Journal of the American Medical Association*. 1993. 270(18): 2207-2212.

Module 2: PHAB Standards and Measures

PHAB Standard 1.1 Participate in or lead a collaborative process resulting in a comprehensive community health assessment.

Measure 1.1.1 S A state partnership that develops a comprehensive state community health assessment of the population of the state.

Measure 1.1.2 S A state level community health assessment.

1.1.2 S, Documentation 1: A state level community health assessment dated within the last five years that includes:

- a. Data and information from various sources contributed to the community health assessment and how the data were obtained.
- b. Demographics of the population.
- c. Description of health issues and descriptions of specific population groups with particular health issues and health disparities or inequities.
- d. Description of factors that contribute to the state populations' health challenges.
- e. Description of existing state assets or resources to address health issues.

1.1.2 S, Guidance 1.a: Evidence that comprehensive, broad-based data and information from a variety of sources were used to create the state health assessment. Qualitative data as well as quantitative data must be utilized. Qualitative data may address, for example, the population's perception of health, factors that contribute to higher health risks and poorer health outcomes, or attitudes about health promotion and health improvement. Data collection methods include, for example, surveys, asset mapping, focus groups, town forums, and state listening sessions. Quantitative data may, for example, include vital statistics; graduation rates; morbidity and mortality numbers and rates; and rates of behavioral risks, such as tobacco use. The assessment must include both primary and secondary data. (See PHAB Standards and Measures for additional guidance, 1.b to 1.e.)

PHAB Standard 1.2 Collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population.

Measure 1.2.1 A 24/7 surveillance system or set of program surveillance systems.

Measure 1.2.3 A Primary data.

Measure 1.2.4 S Data provided to Tribal and local health departments located in the state.

PHAB Standard 1.3 Analyze public health data to identify trends in health problems, environmental public health hazards, and social and economic factors that affect the public's health.

Measure 1.3.1 A Health conclusions drawn.

FIGURE 2.1 SOCIAL-ECOLOGICAL MODEL



Source: CDC. "Community Health Assessment and Group Evaluation (Change)." 2010. Available at <http://www.cdc.gov/nccd-phd/dch/programs/healthycommunitiesprogram/tools/change/pdf/changeactionguide.pdf>. Accessed 1-27-2014.

As emphasized in social-ecological models, addressing the social determinants of health is imperative in improving population health and reducing health disparities. The social-ecological model is important for both identifying and selecting indicators.

The process of identifying health indicators for a SHA can easily result in many more issues and indicators than can be reasonably used. Each SHA effort will be different, but a few of the standard indicator categories that are almost always incorporated include demographic information, health status and health outcomes, behavioral risk factors, environmental conditions, morbidity and mortality data, injury, maternal and child health measures, communicable and chronic disease, and socioeconomic factors. Guidance for Measure 1.1.2 S below reiterates the importance of maintaining a broad scope of data to inform the SHA and describes required data categories to ensure this breadth.

PHAB Guidance

Measure 1.1.2 S, Guidance 1.d: A discussion of the contributing causes of the health challenges, such as behavioral risk factors, environmental factors (including the built environment), socioeconomic factors, policies (e.g., taxation, education, transportation, insurance status, etc.), injury, maternal and child health issues, infectious and chronic disease, or the unique characteristics of the state that impact health status. Multiple determinants of health, particularly social determinants, must be included. Health status disparities and high health-risk populations must be addressed. Factors that contribute to higher health risks and poorer health outcomes in specific populations must be considered.

(PHAB Standards and Measures Version 1.5, p. 23)

CDC recently completed a literature review of 10 authoritative source documents and found that some indicators are recommended more frequently in guidance documents, as shown below in Figure 2.2.

FIGURE 2.2

Community Health Assessment for Population Health Improvement: Most Frequently Recommended Health Metrics					
HEALTH OUTCOME METRICS			HEALTH DETERMINANT AND CORRELATE METRICS		
Mortality	Morbidity	Healthcare (Access & Quality)	Health Behaviors	Demographics & Social Environment	Physical Environment
Mortality - Leading Causes of Death (9)	Obesity (6)	Health Insurance Coverage (6)	Tobacco Use/Smoking (8)	Age (9)	Air Quality (4)
Infant Mortality (6)	Low Birth Weight (3)	Provider Rates (PCPs, Dentists) (5)	Physical Activity (5)	Sex (6)	Water Quality (3)
Injury-Related Mortality (3)	Hospital Utilization (4)	Asthma-Related Hospitalization (4)	Nutrition (4)	Race/Ethnicity (9)	Housing (5)
Motor Vehicle Mortality (3)	Cancer Rates (4)		Unsafe Sex (3)	Income (9)	
Suicide (4)	Motor Vehicle Injury (4)		Alcohol Use (4)	Poverty Level (6)	
Homicide (4)	Overall Health Status (4)		Seatbelt Use (3)	Educational Attainment (6)	
	STDs (chlamydia, gonorrhea, syphilis) (4)		Immunizations and Screenings (5)	Employment Status (6)	
	AIDS (3)			Foreign Born (3)	
	Tuberculosis (4)			Homelessness (3)	
				Language Spoken at Home (3)	
				Marital Status (3)	
				Domestic Violence and Child Abuse (3)	
				Violence and Crime (4)	
				Social Capital/Social Support (4)	

Source: CDC. Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants. Atlanta, GA: Office of Surveillance, Epidemiology, and Laboratory Services. 2013.

Figure 2.3 shares online resources and guidance documents that are useful for identifying indicators; it is advisable to review several different indicator lists during the initial stages of identifying and selecting indicators.

FIGURE 2.3 RESOURCES AND LINKS: INDICATOR LISTS

- **County Health Rankings and Roadmaps (CHR)***
<http://www.countyhealthrankings.org/>
- **Healthy People 2020 Leading Health Indicators***
<http://www.healthypeople.gov/2020/LHI/default.aspx>
- **National Association of County and City Health Officials (NACCHO) Core Indicator Lists**
<http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/upload/Worksheet-CHSA-Indicator-List.pdf>
- **NACCHO Extended Indicator List**
<http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/upload/Worksheet-CHSA-Extended-Indicator-Lists.pdf>
- **Community Health Status Indicators, U.S. Department of Health and Human Services**
<http://wwwn.cdc.gov/CommunityHealth/>
<http://healthindicators.gov/>
- **Community Indicators Consortium**
<http://www.communityindicators.net/publications>
- **Canadian Index of Wellbeing**
<https://uwaterloo.ca/canadian-index-wellbeing/our-products/framework>
<https://uwaterloo.ca/canadian-index-wellbeing/resources/reports>

* More information on these data sources is included below.

In addition to looking at state and federal indicator lists, be aware of other assessments, plans, and projects in the state that are also tracking health and social indicators, and think strategically about both alignment and filling gaps. The Minnesota Department of Health started the process of identifying indicators by using an environmental scan¹⁸ to look at existing program plans, reports, and evaluations in the state, including:

- Existing metrics and priority needs from program plans for cancer, asthma, oral health, maternal and child health, injury and violence, HIV, lead poisoning, rural health, etc.
- Key findings from recently released state reports on a range of public health issues, such as the annual Populations of Color Health Status Reports and the Minnesota Student Survey.
- Priority issues submitted to Minnesota Department of Health by local health departments from the most recent cycle of the local public health assessment and planning process.
- Priority issues identified in other state department plans, such as housing, transportation, natural resources, and education.

¹⁸ For more information on conducting an environmental scan, see pages 13-15 in Module 1.

Through the environmental scan, the Minnesota Department of Health identified existing mechanisms for collecting and compiling data and tracking indicators—some managed by the department and some by system partners—that could be leveraged for analysis and reporting in the SHA. They also identified gaps in terms of indicators that were not being collected, compiled, or tracked. The information about availability of data, data management and tracking systems, and gaps in data collection and analysis were invaluable inputs into the process of prioritizing and selecting indicators.

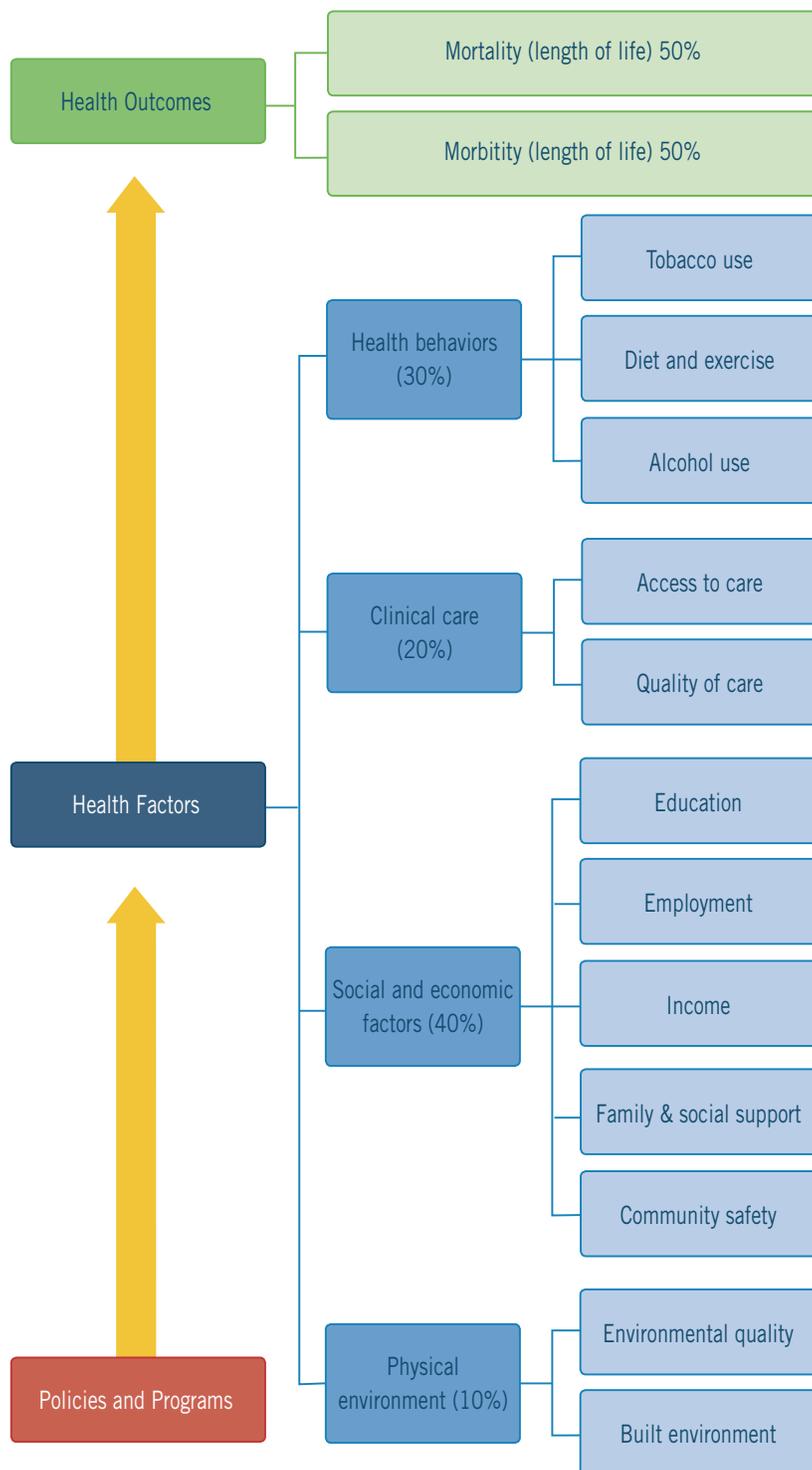
COUNTY HEALTH RANKINGS

CHR is one example of a set of indicators that has been built around a social ecological model. Figure 2.4 shows the CHR model. CHR is an example of a relatively short list of indicators (30) that covers a range of social determinants, health behaviors, and health outcomes. The indicators associated with each of the factors in the CHR model and the sources of data are available at <http://www.countyhealthrankings.org/>.

HEALTHY PEOPLE 2020 LEADING HEALTH INDICATORS

The Institute of Medicine (IOM) and other stakeholders have worked to distill a set of Leading Health Indicators for Healthy People 2020—a relatively succinct set of 26 indicators associated with 12 topic areas, as shown in Figure 2.5.

FIGURE 2.4 COUNTY HEALTH RANKINGS MODEL



Source: County Health Rankings model ©2012 UWPHI

FIGURE 2.5

Healthy People 2020 Leading Health Indicators	
Access to Health Services	
	Persons with medical insurance
	Persons with a usual primary care provider
Clinical Preventative Services	
	Adults who receive a colorectal cancer screening based on the most recent guidelines
	Adults with hypertension whose blood pressure is under control
	Adult diabetic population with an A1c value greater than 9 percent
	Children aged 19 to 35 months who receive the recommended doses of vaccines
Environmental Quality	
	Air Quality Index exceeding 100
	Children aged 3 to 11 years exposed to secondhand smoke
Injury and Violence	
	Fatal injuries
	Homicides
Maternal, Infant, and Child Health	
	Infant deaths
	Preterm births
Mental Health	
	Suicides
	Adolescents who experience major depressive episodes
Nutrition, Physical Activity, and Obesity	
	Adults who meet federal physical activity guidelines for aerobic physical activity and muscle-strengthening activity
	Adults who are obese
	Children and adolescents who are considered obese
	Total vegetable intake for persons aged 2 years and older
Oral Health	
	Persons aged 2 years and older who used the oral healthcare system in the past 12 months
Reproductive and Sexual Health	
	Sexually active females who received reproductive health services in the past 12 months
	Persons living with HIV who know their serostatus
Social Determinants¹⁹	
	Students who graduate with a regular diploma 4 years after starting 9 th grade
Substance Abuse	
	Adolescents using alcohol or any illicit drugs during the past 30 days
	Adults engaging in binge drinking during the past 30 days
Tobacco Use	
	Adults who are current cigarette smokers
	Adolescents who smoked cigarettes in the past 30 days

¹⁹ Healthy People 2020 has few indicators related to social factors and social determinants of health. See “A Note on the Importance of Social Determinants of Health” on page 40.

Many groups find the Healthy People 2020 Leading Health Indicators to be an advantageous starting point for a few reasons:

- Alignment with the national efforts of Healthy People 2020.
- Many of the indicators have available benchmark data.
- A relatively short list; this is important since additions to the list will almost certainly occur.

The following questions may be useful to consider as the SHA partnership develops a shared sense of the SHA's possible data indicators:

- What issues might be overlooked by the current indicators we are tracking?
- Do existing data collection methods and data systems allow new indicator(s) to be measured and tracked?
- Is the health department measuring a given health issue in such a way that it is comparable to recommended measurement and definition?
- How can the SHA teams use these existing indicator lists as a starting place for information and still consider local knowledge and context in determining which resources are most valuable?

A Note on the Importance of Social Determinants of Health

A 2011 IOM report, "For the Public's Health: The Role of Measurement in Action and Accountability," discussed some of the challenges in selecting indicators. While IOM had sought in the past to create a core set of indicators, it recognized that each of these sets was incomplete. One area IOM identified as needing improvement was indicators measuring social determinants of health. While there has been much progress, IOM reported that more research is needed to connect specific determinants to health outcomes. Once these connections are established, indicators of health determinants can be used to identify causes and possible intervention points for health outcomes. IOM emphasized that indicators measuring social determinants of health are particularly important for understanding and tracking health inequities found across population subgroups.

Selecting Indicators

While using standard indicator sets can serve as a good starting point, after additional indicators from the partnership are added, it is likely there will be a need for narrowing down and selecting indicators to keep the scope manageable and ensure that the indicators reflect the mission, vision, and values of the SHA partnership. Narrowing down or prioritizing health issues and indicator lists to a manageable number is important for development of the SHA, data analysis, and tracking. The narrowing process should be transparent and based on a clear set of criteria. The following pages (pp. 41-43) include some suggestions for criteria, and tools and processes that will be helpful for the narrowing process. As noted previously, there are a number of helpful resources for identifying health indicators; however, it is also important to take state and local context into account when selecting indicators. For example, a state with a high rate of fatal auto crashes might want more information on seatbelt use. The guidance below provides information and examples of commonly used methods to select indicators for inclusion in the SHA.

CRITERIA AND CRITERIA MATRICES

Each SHA partnership prioritizing and selecting indicators will devise a unique set of criteria to reflect the mission, vision, and values of the SHA/SHIP process. Some commonly used criteria include:

a. Magnitude (size)

Does the health indicator measure health issues that affect a large proportion of the population?

b. Seriousness

Does the health indicator reflect health issues with high severity, such as high mortality or morbidity rate, severe disability, or significant pain and suffering?

c. Ability to change (feasibility)

Does the health indicator measure health issues that are feasible to change, taking into account resources, evidence-based interventions, and existing groups working on it?

d. Health equity

Does the health indicator measure issues that disproportionately affect population subgroups?

e. Root cause or social determinant that affects multiple health issues

Is the health indicator a measure of a social determinant that affects multiple health issues?

f. Quality of the data

Are there quality data available to measure and track the health indicator?

g. Trend data available

Are there trend data available or is there an opportunity to track the health indicator over time?

h. Comparison data available

Does the indicator have data available for comparing with other states and/or comparing regions within the state?

A commonly used method for selecting indicators is a matrix. It allows for ratings of each indicator or health issue using multiple factors and the summation of those ratings into a *ranking* for each.

Perhaps the simplest method for ranking health indicators is to use a two-by-two table, in which the rows relate to the ability to change the issue and the columns relate to the importance of the issue. Definitions are very important here; participants need to have a clear understanding about what “importance” and “ability to change” mean. For instance, high importance could be defined as having a high morbidity or mortality rate along with having serious consequences. Ability to change could factor in the availability of evidence-based interventions and an acceptance on the part of the community that the issue should be addressed.

FIGURE 2.6 TWO-BY-TWO TABLE

	High Importance	Low Importance
High Ability to Change	A	B
Low Ability to Change	C	D

In the case shown in Figure 2.6, the indicators—or health issues—that reside in cell A would be the highest priority, those in cell D would have the lowest priority, while those in cells B and C would be intermediate priorities. For instance, an issue in cell C might be worth pursuing if an effective intervention can be established.

At the stage of selecting indicators, it is advisable to consider additional criteria from the list on page 49. Figure 2.7 shows an example criteria matrix template for considering multiple criteria, and Figure 2.8 shows a sample matrix that was used in Oklahoma.

FIGURE 2.7 SAMPLE CRITERIA MATRIX

Health Issue/ Indicator	Magnitude	Trend	Severity/ Seriousness	Benchmark Comparison	Data Availability	Social Determinant	Effect on Youth	Total	Rank

Figure 2.7 shows an example of a criteria matrix. When using such a matrix, the health indicator is rated on an agreed-on scale (e.g., 1-5 or 1-10), and the ratings are added to give a total score. Then, the indicators are ranked according to their total score. It is essential that the group members have a clear and common understanding of what the scores they assign “mean.” For example, on a 4-point scale for magnitude, points could be given the following values:

- 1 = Very rare
- 2 = Rare
- 3 = Common
- 4 = Very common

Ensuring that all group participants have the same understanding of the rating scale requires clear instructions and thorough discussion.

Having multiple participants complete the matrix and aggregating the responses allow for calculation of total scores and assignment of rankings. While this may result in an array of rankings that is acceptable to the group, more discussion may be needed to come to agreement on the final rankings.

Both Oklahoma and New Hampshire used variations of the criteria matrix method for prioritizing indicators to include in the health status assessment of the SHA. A sample matrix from Oklahoma is shown below in Figure 2.8. One benefit to this method is that the criteria for indicators can be determined before indicators are suggested. This can help to build consensus around indicators because every indicator is being judged by the same set of standards. Oklahoma was able to narrow hundreds of potential indicators (suggested by both health department staff and public health system partners) down to 33 and still maintain consensus. The matrix also provides strong documentation of the process used to select the SHA indicators. This is important both for public transparency and for meeting PHAB standards and documentation requirements. In New Hampshire, health department staff used the matrix to determine the indicators before releasing the list to the public. This allowed for a more streamlined process.

FIGURE 2.8 EXCERPTED CRITERIA MATRIX, OKLAHOMA SHA/SHIP PROCESS

Criteria Matrix - Health Indicators									
Health Status Indicator	Data Availability [Ntl, St, Co, Frequency]	Data Source	Impact	Ability to Affect Change	Importance Aspect	Measurable	Links to Other Measures	Demographic Availability	Trend Data
Heart Disease Deaths	X	OK2SHARE/CDC WONDER	H	H	H	X	X	M	X
Cancer Deaths	X	OK2SHARE/CDC WONDER	H	H	H	X	X	M	X
Chronic Lower Respiratory Deaths	X	OK2SHARE/CDC WONDER	H	H	H	X	X	M	X
Cerebrovascular Deaths	X	OK2SHARE/CDC WONDER	H	H	H	X	X	M	X
Unintentional Injury Deaths	X	OK2SHARE/CDC WONDER	H	H	H	X	X	M	X
Diabetes Deaths	X	OK2SHARE/CDC WONDER	H	H	H	X	X	M	X
Influenza/ Pneumonia Deaths	X	OK2SHARE/CDC WONDER	H	H	H	X	X	M	X
Alzheimer's Disease Deaths	X	OK2SHARE/CDC WONDER	H	H	H	X	X	M	X
Nephritis Deaths	X	OK2SHARE/CDC WONDER	H	H	H	X	X	M	X
Suicides	X	OK2SHARE/CDC WONDER	H	H	H	X	X	M	X
Infant Mortality	X	OK2SHARE/CDC WONDER	H	H	H	X	X	H	X
Total Mortality	X	OK2SHARE/CDC WONDER	H	H	H	X	X	M	X
Diabetes Prevalence	X	BRFSS	H	H	H	X	X	H	X
Asthma Prevalence	X	BRFSS	H	H	H	X	X	M	X
Cancer Incidence	X	OK Cancer Registry	H	H	H	X	X	H	X
Fruit/Veg Consumption	X	BRFSS	H	H	H	X	X	H	X
Usual Source of Care	X	BRFSS	H	H	H	X	X	H	X
Uninsured Adults	X	BRFSS	H	H	H	X	X	H	X
Poverty	X	CPS/ACS	H	H	H	X	X	H	X
H=High	M=Med	L=Low				X=Meets Criteria			

Source: Oklahoma State Department of Health

NOMINAL GROUP TECHNIQUE

The Nominal Group Technique can be used in combination with a criteria matrix to select a manageable set of indicators. The Nominal Group Technique is a method for making group decisions that helps to ensure that all participants have input into the process and have their voices heard and reduce the possibility that a few particularly vocal members dominate the discussion and decisionmaking process. When using

the Nominal Group Technique for narrowing the list of indicators, emphasize the time spent in discussion to explore the most meaningful indicators for the SHA, an understanding of the criteria and how it applies to the indicators. Multiple rounds of voting may not be needed when using this technique to narrow and select the indicator list. Nominal Group Technique involves:

- **Round-robin brainstorming of health indicators** allows everyone an opportunity to nominate indicators or issues without discussion. This ensures everyone has a chance to raise an indicator they think is important without discussion or criticism at this initial step. A facilitator records each of the ideas on a whiteboard or flip-chart paper.
- **First round of discussion.** After participants have exhausted their candidates for the indicator list, a round of discussion takes place in which people can ask clarifying questions about the various indicators. This discussion could result in some items being combined or others being reworded for clarity. This will also be an opportunity to brainstorm specific indicators that can be used to measure health issues or determinants that are raised.
- **Present criteria that will be used to select indicators.** It is crucial that all participants understand the criteria. It may be helpful to share a copy of the criteria matrix and definitions of the criteria with each participant.
- **Initial round of voting.** Following the establishment of the full list of health indicators, an initial round of votes is cast based on the criteria. (Each participant receives a set number of votes, which they can cast in any manner they see fit. A participant could choose to cast all of their votes for one issue/indicator or spread them across multiple choices.)
- **Second round of discussion.** After tallying votes, participants discuss the results and reduce the list according to the number of votes and the consensus of the group discussion. After reducing the list, another round of combining items may be appropriate or necessary depending on the discussion.
- **Final round of voting.** In the final round of voting, participants are usually given just one vote in an attempt to further narrow the list. The process and number of votes will be different in each situation depending on the number of indicators the group is trying to reach. Additional rounds of voting or discussion may be needed.

The Nominal Group Technique is often used when a group wants to generate ideas and then narrow them to a more concise set. In the case where a long list of indicators has been prepared in advance and the group is not attempting to generate new items for the list, the round-robin brainstorming step may not be necessary, but the remaining steps can be useful in getting to the final list or a prioritized list.

A skilled facilitator, supplies for recording and voting, and a clear understanding of the ground rules for the process are critical for success with the Nominal Group Technique.

FIGURE 2.9 RESOURCES AND LINKS: NOMINAL GROUP TECHNIQUE

- University of Wisconsin Extension
<http://www.uwex.edu/ces/pdande/resources/pdf/Tipsheet3.pdf>
- CDC Evaluation Brief: Gaining Consensus Among Stakeholders Through the Nominal Group Technique
<http://www.cdc.gov/HealthyYouth/evaluation/pdf/brief7.pdf>
- University of Wisconsin Business School
http://www.sswm.info/sites/default/files/reference_attachments/DUNHAM%201998%20Nominal%20Group%20Technique%20-%20A%20Users%27%20Guide.pdf



Data Collection and Data Sources

PHAB Guidance

Measure 1.2.3 A Primary data.

Documentation 1: Collection of primary quantitative health data.

Guidance: ... Primary data are data that did not exist before the health department gathered it... Data can be obtained from surveys of target groups (e.g., teenagers, the jobless, residents of a neighborhood with higher risks of poor health outcomes). Vital records are considered primary data for state health departments, if the state health department collects them.

Documentation 2: Collection of primary qualitative health data.

Documentation 3: The use of data collection instruments.

(PHAB Standards and Measures Version 1.5, excerpted from pp. 35-36)

As part of selecting and prioritizing indicators for inclusion in the SHA, sources of data for those indicators must be identified. Four characteristics of data that you should be aware of as you look at data sources and collect data are:

1. Availability of data at the appropriate geographic level(s).
2. Availability of trend data over time.
3. The option to disaggregate, or crosstab, data by demographic variables to identify health inequities.
4. Validity and reliability of the data.

Many of the indicator lists in Figure 2.3 on page 37 compile data and link to data sources. Additional data sources are listed in Figure 2.10.

FIGURE 2.10 RESOURCES AND LINKS: SAMPLE DATA SOURCES

State Specific Sources of Data

- State boards of education
- State environmental agencies
- State and regional planning agencies
- State law enforcement, such as state police
- State vital statistics offices
- State worker’s compensation bureaus
- State-run BRFSS/Youth Risk Behavior Surveillance System (YRBSS) systems
- Hospital discharge data

CDC

- BRFSS <http://www.cdc.gov/brfss/>
- YRBSS <http://www.cdc.gov/HealthyYouth/yrbs/>
- CDC WONDER <http://wonder.cdc.gov/>
- Healthy People 2020 and Data2020 <http://www.healthypeople.gov/2020/default.aspx>
- National Center for Health Statistics <http://www.cdc.gov/nchs/>

Health Resources and Services Administration (HRSA)

- HRSA Health Data Center <https://bphc.hrsa.gov/datareporting/>
- Data Resource Center for Child and Adolescent Health <http://www.childhealthdata.org/>

U.S. Department of Health and Human Services

- Health Indicators Warehouse <https://www.healthdata.gov/dataset/health-indicators-warehouse>

U.S. Department of Labor

- Bureau of Labor Statistics Data Page <http://www.bls.gov/data/>
- OSHA’s Statistics and Data Page <https://www.osha.gov/oshstats/>

U.S. Environmental Protection Agency (EPA)

- EPA Data Finder <http://www.epa.gov/datafinder/>

Federal Bureau of Investigation

- Violent Crime http://www2.fbi.gov/ucr/cius2009/offenses/violent_crime/index.html

U.S. Census and American Communities Survey <http://www.census.gov/>

- American Fact Finder <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>
- Small Area Health Insurance Estimates <https://www.census.gov/programs-surveys/sahie.html>
- Small Area Income and Poverty Estimates <https://www.census.gov/programs-surveys/saipe.html>

Annie E. Casey Foundation KIDS COUNT Data Center <http://datacenter.kidscount.org/>

County Health Rankings and Roadmaps <http://www.countyhealthrankings.org/>

Community Commons <http://www.communitycommons.org>

Dartmouth Atlas of Health Care <http://www.dartmouthatlas.org/data/region/>

If there are no existing data sources for a health issue or indicators of interest, the assessment activities for collecting stakeholder and community input described in Module 3 provide opportunities to collect primary data to understand the issue. The SHA partnership should also look to the capacity of stakeholders to identify whether there are opportunities to leverage existing systems or projects to collect data on health status or health determinants of interest. If it is determined that there are no resources or feasible processes for collecting data on a priority indicator or issue, the partnership should document the reasons the issue or indicator was not included to develop mechanisms for collecting and tracking data for that indicator to allow for inclusion in future SHAs.

Continually compile notes on any data that are not being collected or ways data are not currently being analyzed to improve ongoing data collection. The health department should review how data are collected and steps needed to ensure that the SHA is able to illuminate health inequities. To have a comprehensive understanding of health inequities, it will also be important to engage in primary data collection as described in Module 3, because members of vulnerable populations have information about the health status of their populations that the state may not have.

Data Management and Presentation

ONLINE DATA MANAGEMENT TOOLS

Online data management tools have proliferated in recent years, and using those tools can meet many of the needs of the SHA project team and SHA partnership; however, most health assessment teams also encounter the need to use other tools, such as Excel, Access, or statistical software such as SPSS, to manage the data from some sources. Figure 2.11 provides links to some useful online data analysis and management tools.

FIGURE 2.11 RESOURCES AND LINKS: SAMPLE ONLINE DATA ANALYSIS AND MANAGEMENT TOOLS

- CDC Data Analysis Tools
http://www.cdc.gov/brfss/data_tools.htm
(See the example of using one of these tools in Figures 2.16 and 2.17 below)
- U.S. Census Bureau Data Tools
<https://www.census.gov/data/data-tools.html>
- NACCHO Data Worksheets
<http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/upload/Data-Worksheet-Compilation-for-Health-Indicators.PDF>
- Community Commons and CHNA.org
<http://www.chna.org>

OTHER DATA MANAGEMENT TOOLS

There are a plethora of data management tools available, in addition to the online resources listed in Figure 2.11 above.



Excel can be a useful part of the data management toolkit, allowing for relatively easy management of data and production of tables and graphics. Most online data sites allow for downloading datasets into Excel for further analysis and to create tables and charts for presentation. See the example under “Data Analysis and Interpretation” beginning on page 52 for an example of cutting and pasting data from the CDC WONDER online tool into Excel to produce trend graphs.

Statistical software programs, such as SPSS, SAS, and STATA, and sophisticated database programs, such as Access and Oracle, are very powerful tools but require a good deal of technical knowledge or training. They

can also be quite expensive. If the group has access to someone with this type of training and access to the software, these statistical programs can be very useful in completing the SHA and for ongoing data management. Engaging in partnerships with universities may provide the necessary expertise and resources to use these programs.

Methods of Data Presentation

The information provided in this section is applicable to the health status data compiled as well as any additional primary data and community/stakeholder input collected as described in Module 3. Data presentation is an important consideration to ensure understanding of data and ease of use. Multiple methods are usually necessary to display the SHA data, including narrative, tables, and charts. Making these report elements clear and concise is important, particularly when members of various audiences may not be accustomed to working with data or interpreting tables and graphs.

Making Data Accessible to People with Disabilities

Make sure data reports will be accessible to people with disabilities. Information about ensuring accessibility of web-based information and reports and ADA compliance is available at <http://www.w3.org/WAI/Resources/>.

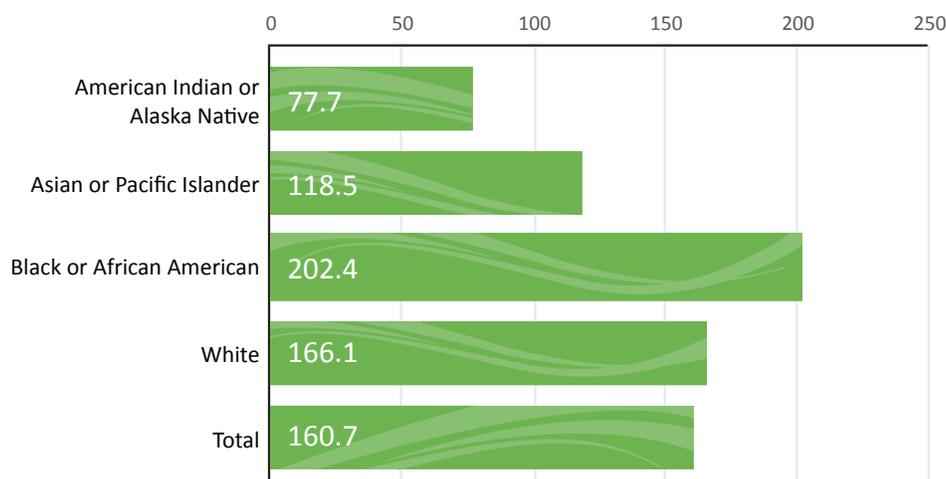
TABLES, CHARTS, AND MAPS

Tables are best used to list or look up data points as opposed to making comparisons to other data or looking for patterns in the data. For example, Figure 2.12 below shows the deaths due to all cancers by race in 2010. One can look up the rate for any of the race categories and make comparisons. However, a bar chart created from the table will make it much easier to see the relationship between the rates for the race categories. In addition, charts and graphs are often the best choice for displaying data for comparison purposes, as Figures 2.13 and 2.14 illustrate.

FIGURE 2.12 AGE ADJUSTED MORTALITY RATE DUE TO ALL CANCERS PER 100,000 BY RACE, 2010

Race	Deaths	Population	Crude Rate per 100,000	Age Adjusted Rate per 100,000 (95% Confidence Interval)
American Indian or Alaska Native	300	739,342	40.6	77.7 (68.3-87.1)
Asian or Pacific Islander	5,971	5,515,120	108.3	118.5 (115.4-121.5)
Black or African American	4,340	2,718,779	159.6	202.4 (196.2-208.6)
White	47,209	28,280,715	166.9	166.1 (164.6-167.6)
Total	57,820	37,253,956	155.2	160.7 (159.4-162.0)

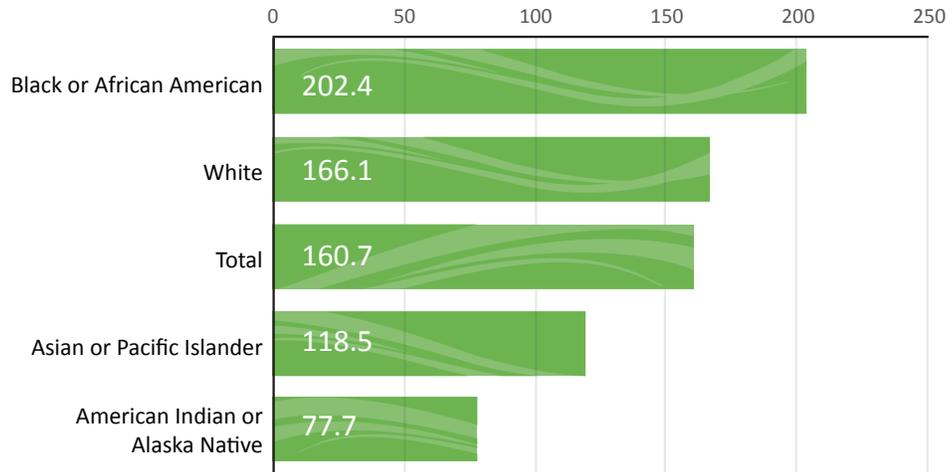
FIGURE 2.13 AGE ADJUSTED MORTALITY RATE DUE TO ALL CANCERS PER 100,000 BY RACE, 2010
(Sorted Alphabetically)



The relationship between the rates of cancer incidence for the different race categories is more apparent when the data are displayed in this type of bar chart.

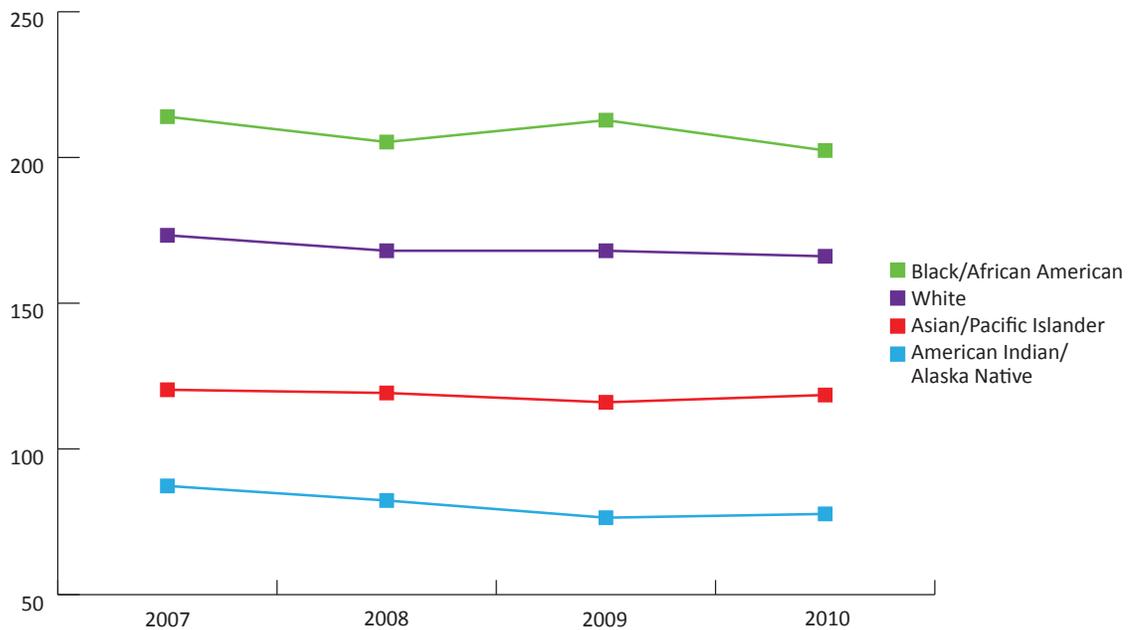
When the rates are arranged in order of magnitude, as in Figure 2.14, the disparities between the categories are even more apparent.

FIGURE 2.14 AGE ADJUSTED INCIDENCE RATE OF ALL CANCERS PER 100,000 BY RACE, 2010
(Sorted by Magnitude)



While the bar charts above are comparing multiple categories at one point in time, Figure 2.15 illustrates how to display data for multiple categories over time when the interest is finding trend data.

FIGURE 2.15 AGE ADJUSTED INCIDENCE RATE OF ALL CANCERS PER 100,000 BY RACE, 2007-2010



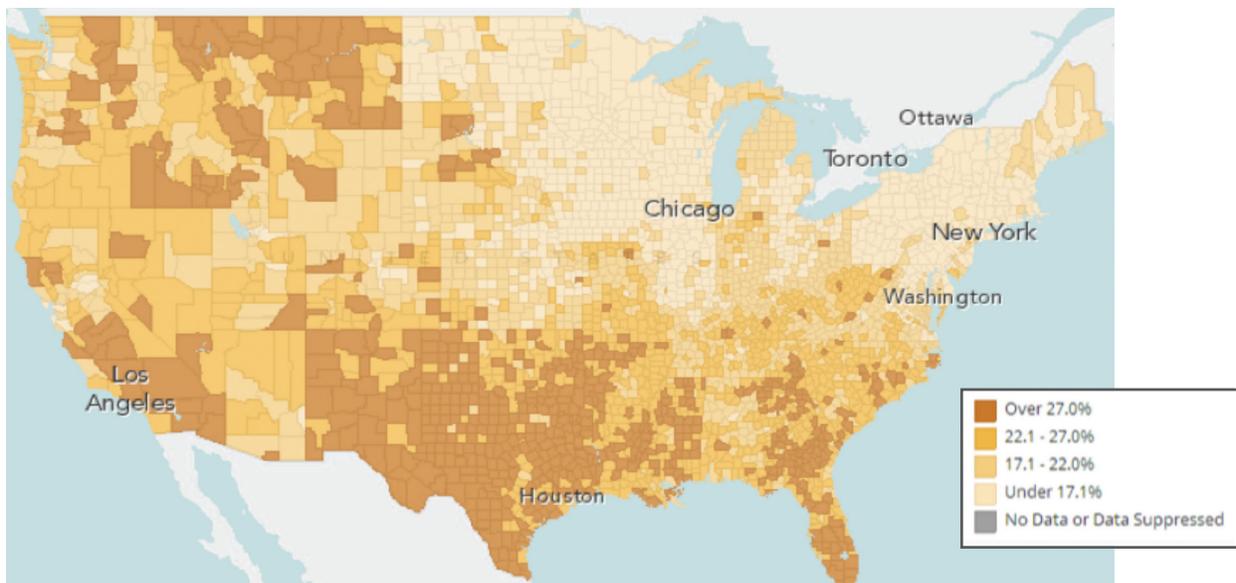
The important thing to consider when creating tables and visual displays of data is: *What is the information we are trying to convey?* Data become more useable when visually displayed in a chart or table so the viewer can easily extract the information.

Another increasingly common method for presentation and analysis of data in public health is GIS mapping. According to CDC, “GIS helps us analyze spatially-referenced data and make well-informed decisions based on the association between the data and the geography.” Two key resources for learning more about mapping for public health are:

- CDC’s GIS Resources Page at <https://www.cdc.gov/gis/index.htm>
- Community Commons Interactive Mapping Tools at <http://www.communitycommons.org>

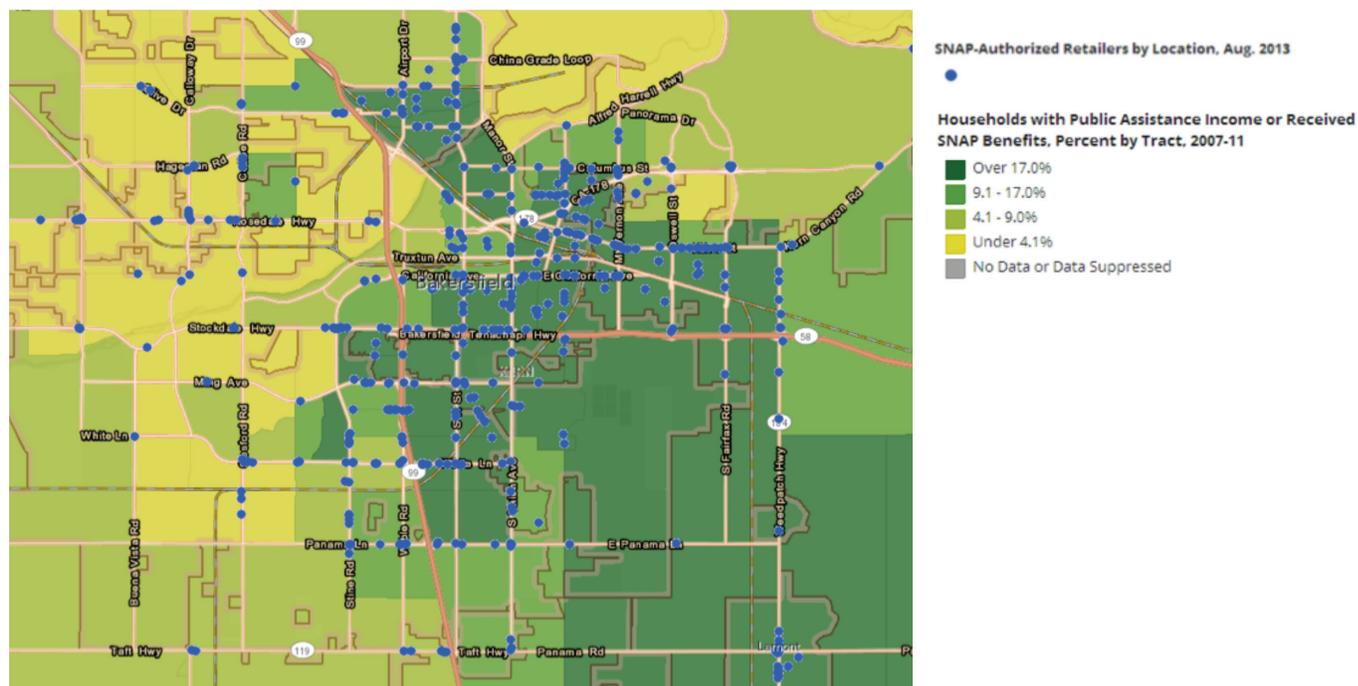
Maps are valuable for comparing one indicator across geographies, as shown in the map of uninsured adult population by county in Figure 2.16.

FIGURE 2.16 UNINSURED POPULATION, ADULTS 18-64, PERCENT BY COUNTY, 2011



Maps are also valuable for looking at the spatial relationship between two or three variables, as shown in the map of households receiving public assistance and SNAP-authorized retailers in Figure 2.17.

FIGURE 2.17 SNAP-AUTHORIZED RETAILERS AND HOUSEHOLDS RECEIVING PUBLIC ASSISTANCE



The maps in Figures 2.16 and 2.17 were both made using the online mapping tools at Community Commons. In recent years, open source software has expanded the possibilities for mapping public data, and sites like Community Commons are easy and accessible for use by state health departments and public health system partners.

Data Analysis and Interpretation

PHAB Guidance

Standard 1.3 Analyze public health data to identify trends in health problems, environmental public health hazards, and social and economic factors that affect the public’s health.

Measure 1.3.1 A Data analyzed and public health conclusions drawn.

Significance: Valid analysis of data is important for assessing the contributing factors, magnitude, geographic location(s), changing characteristics, and potential interventions of a health problem. Data analysis is critical for problem identification, program design, and evaluation of programs for continuous quality improvement.

(PHAB Standards and Measures Version 1.5, p. 42)

Ensuring valid analysis and interpretation of the data collected is indispensable and should include acknowledgment of a number of factors, including engaging staff and partners with quantitative analysis skills, issues of statistical significance, illustrating trends and patterns, and disaggregation of data to understand health issues and disparities among important population subgroups.

FIGURE 2.18 RESOURCES AND LINKS: DATA INTERPRETATION

- Tuftte ER, Graves-Morris PR. *The Visual Display of Quantitative Information*. Vol. 2. Cheshire, CT: Graphics Press. 1983.
- Data Interpretation for Public Health Professionals, Northwest Center for Public Health Practice (online training)
<http://www.nwcphp.org/training/opportunities/online-courses/data-interpretation-for-public-health-professionals>
- Data Utilization and Interpretation Training and Resources
http://www.health.ny.gov/statistics/chac/training_data.htm
- Online Epidemiology Courses and Related Resources
<https://www.samhsa.gov/capt/tools-learning-resources/online-epidemiology-courses-resources>
- Principles of Epidemiology in Public Health Practice (CDC self-study course)
<https://www.cdc.gov/ophss/csels/dsepd/ss1978/index.html>
- Public Health Training Center Network
<https://bhwh.hrsa.gov/grants/publichealth/regionalcenters>

ENGAGING STAFF AND PARTNERS WITH QUANTITATIVE ANALYSIS SKILLS

States that have conducted comprehensive SHA/SHIP processes routinely point to the importance of having staff and partners with the necessary skills and expertise to analyze and interpret the health indicator data that is collected for the health status assessment. In most cases, epidemiologists and statisticians from the state health department take the lead in analyzing the health status data. Often, members of the SHA partnership with expertise in quantitative data will advise on analysis and be more fully engaged in interpretation of the data.

ISSUES OF STATISTICAL SIGNIFICANCE

Having data that provide confidence intervals around the point estimate is invaluable when making comparisons to data from other states or to national data regarding statistically significant differences. For example, if one of the SHA indicators is mortality due to all cancers and state data shows an age adjusted mortality rate of 180.2 per 100,000 with a 95 percent confidence interval of 176.9-183.5 and the national data shows a rate of 177.4 with a 95 percent confidence interval of 176.9-177.8, one would conclude that even though the state rate is higher than the national rate (180.2 compared to 177.4), the state rate is not statistically significantly different from the national rate because the confidence intervals overlap. This type of information is valuable in making decisions about which indicators to include and for tracking progress over time on the data.²¹

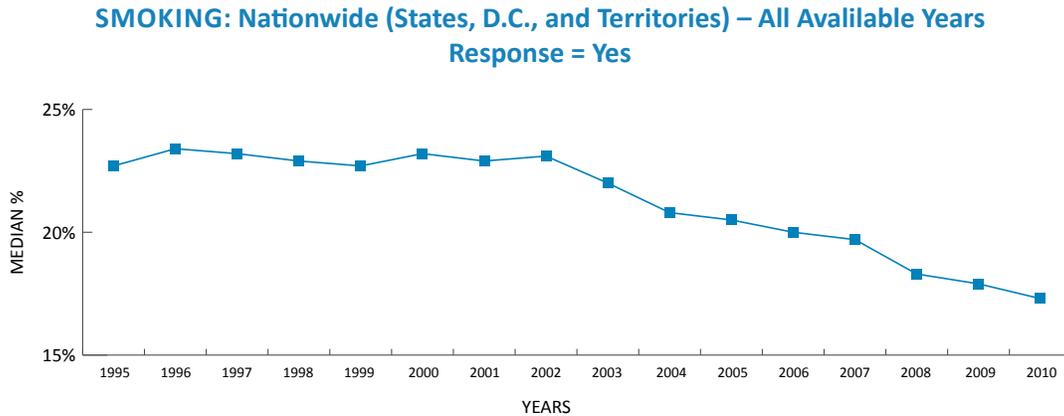
ILLUSTRATING TRENDS AND PATTERNS IN THE DATA

Having data that show trends over time is important in developing a SHA in a number of ways. First, trend data can be taken into account during the phase of choosing indicators and issues (issues with indicators that show stable or improving trends might be excluded from the final set). Second, trend data can be used in the SHIP prioritization process (e.g., a worsening trend may be more highly prioritized). Third, reviewing trend patterns over time is a mechanism for tracking progress on the health issue in question.

²¹ Note: This example was developed from a search of the data on CDC WONDER (<http://wonder.cdc.gov>).

To illustrate this, we can use CDC’s BRFSS Data Analysis Tool to look at prevalence and trend data regarding current smoking for both the nation and states. The BRFSS Data Analysis Tool produces the graph and table in Figure 2.19 that illustrate the declining trends in current smoking at the national level.

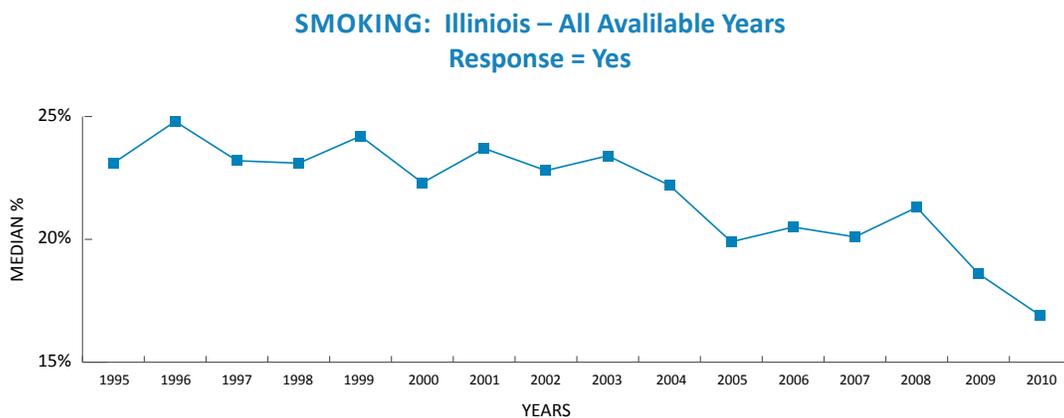
FIGURE 2.19 EXAMPLE TREND 1: NATIONWIDE SMOKING 1995-2010



Nationwide (States, DC, and Territories)																
Year	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Median %	22.7	23.4	23.2	22.9	22.7	23.2	22.9	23.1	22.0	20.8	20.5	20.0	19.7	18.3	17.9	17.3

Repeating the process for a single state provides the output in Figure 2.20:

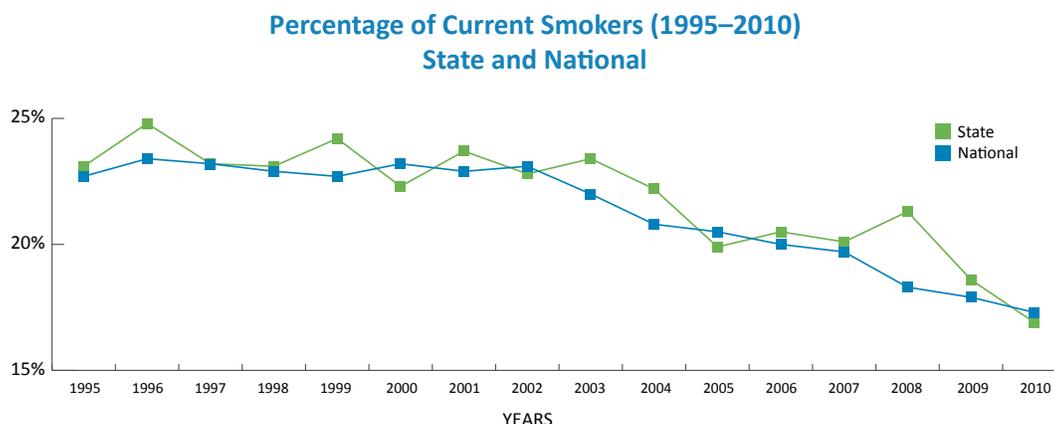
FIGURE 2.20 EXAMPLE TREND 2: ILLINOIS SMOKING 1995-2010



Illinois																
Year	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Median %	23.1	24.8	23.2	23.1	24.2	22.3	23.7	22.8	23.4	22.2	19.9	20.5	20.1	21.3	18.6	16.9
Confidence Interval	(21.3-24.9)	(23.0-26.6)	(21.5-24.9)	(21.3-24.9)	(22.4-26.0)	(20.7-23.9)	(22.2-25.2)	(21.4-24.2)	(22.0-24.8)	(20.6-23.8)	(18.5-21.3)	(18.9-22.1)	(18.7-21.5)	(19.6-23.0)	(17.1-20.1)	(15.3-18.5)

In this case, the state data also include confidence intervals that can be used to determine if there are statistically significant differences between the state and national data. While the two separate graphs are helpful, it is relatively easy to copy the data out of the tables provided and paste them into an Excel file to produce a graph that shows the two trend lines together. A very simple example is shown in Figure 2.21, which can be produced very quickly and easily with basic Excel skills.

FIGURE 2.21 EXAMPLE TREND 3: STATE AND NATIONAL SMOKING 1995-2010



DISAGGREGATION OF DATA TO DEMONSTRATE DIFFERENCES IN SUBPOPULATIONS

The ability to disaggregate data is essential in uncovering disparities by age, race, ethnicity, geography, and other variables that might be masked in the overall population data. Commonly available data can mask health inequities unless efforts are made to analyze the data by population groups, such as age, race/ethnicity, socioeconomic status, income level, urban/rural, etc.

Figure 2.22 shows an example of how to examine differences in cancer mortality rates by race. Querying the CDC WONDER Compressed Mortality Database for mortality from all cancers by race for the nation and State A provides the following output with point estimates for each race category, along with the 95 percent confidence interval around the point estimate.

FIGURE 2.22 DATA TABLE FROM CDC WONDER, CANCER MORTALITY RATES, BY RACE

Race	State A Age Adjusted Rate per 100,000 (95% Confidence Interval)	Nation Age Adjusted Rate per 100,000 (95% Confidence Interval)
American Indian or Alaska Native	226.1 (208.5-243.7)	129.7 (128.1-131.3)
Asian or Pacific Islander	106.2 (96.8-115.6)	115.7 (115.1-116.3)
Black or African American	252.2 (245.1-259.4)	229.5 (228.9-230.0)
White	186.3 (185.3-187.3)	189.4 (189.2-189.5)
Total	188.3 (187.3-189.3)	190.5 (190.4-190.7)

This data can now be used to make comparisons in a number of ways. For instance, we can see that for the total population, the state rate is significantly lower than the national rate, while the state rate for American Indians or Alaska Natives is significantly *higher* than the national rate.²²

For some indicators, it will not be possible to disaggregate data to compare across subpopulation groups. To have a comprehensive understanding of health inequities, it will also be important to engage in primary data collection, as described in Module 3, because members of vulnerable populations have information about the health status of their population that the state may not have.

Developing Findings from the Health Status Assessment

Once initial analysis and interpretation of the data is completed, members of the SHA partnership or the health status assessment subcommittee should develop the key findings from the assessment. This set of preliminary key findings is a core component of the SHA findings that PHAB requires the state to disseminate for public input (see Module 4 for more information on communicating findings); the key findings are also an essential input into the SHIP.

The first step for collaboratively developing findings is to share preliminary tables and charts for the health status indicators with the SHA partnership or subcommittee and facilitate a discussion. The health department may wish to share the tables and charts electronically so the partners have an opportunity to review and reflect on the data before any meetings.

The members of the SHA partnership are likely to have a wide range of expertise and comfort with quantitative public health data. It is essential to have someone with a strong grasp of the data's technical aspects and the ability to translate complex data sets for a "lay" audience present the data. This presenter must also be open to hearing different perspectives and interpretations of the data and be interested in how the partnership's insights inform analysis of the data and key findings.

For the meetings related to developing findings and identifying issues, the guidance in Module 1 about facilitation and meeting effectiveness will be particularly helpful. It is important to have a strong neutral facilitator who can help guide interpretation of the data and collaborative thinking resulting in key findings from the data.

At this stage, it may be useful to employ a decision matrix tool to aid collaborative decisionmaking about which issues are most important. Figure 2.23 shows such a tool that was used by the health status assessment subcommittee in Illinois to score the indicators on seven criteria:

- **Comparison criterion.** How do the Illinois values for the various indicators related to each category compare to the HP 2010 objectives and the national value?
- **Trend criterion.** Does there appear to be a trend moving in the right direction, no trend/stable, or a trend moving in the wrong direction?
- **Disparities criterion.** Are there disparities by the categorization variables of age, race, ethnicity, gender, socioeconomic status, geography, and education?
- **Magnitude criterion.** What proportion of the population is affected?
- **Youth criterion.** To what degree do the health issues included in the category affect young people (under 18 years of age)?
- **Severity criterion.** How severe are the consequences regarding mortality, morbidity, years of potential life lost, years lived with a disability, or a chronic disease?
- **Data criterion.** What is the availability, timeliness, and accuracy of the data for each of the indicators included in a category?

²² Statistical significance here is determined by the fact that the 95 percent confidence intervals do not overlap.



As shown in the coding scheme description on the following page the matrix in Figure 2.23, each health indicator was given a numerical score of 1, 2, or 3 on each of the criteria by each member of the committee. Project staff then calculated the mean score for each health indicator to arrive at a ranking. The partnership or committee may also choose to weight some criteria—for example, the partnership may decide to weight the disparities or severity criterion more heavily—and project staff can use those weights when calculating the rankings.

Findings from the assessment were then derived from the ranking of health status categories overall, their ranking within each criterion, and overall findings related to the availability, quality, and lack of data integration. During the SHIP process of identifying priorities, the SHIP team synthesized these findings with those from other components of the SHA (e.g., Themes and Strengths, Public Health System Assessment) to develop the SHIP strategic priorities.

FIGURE 2.23: EXCERPTED DECISION MATRIX TOOL USED IN ILLINOIS SHA/SHIP PROCESS

Category	Comparison	Trend	Disparities	Magnitude	Magnitude by Age	Severity	Data Quality	Total Score (of 1 st six criteria)
General Health								14
Access to Healthcare								13
Arthritis								10
Asthma								15
Cancer								14
Diabetes								14
Environmental Health	?	?	?	?	?	?		N/A
Heart Disease & Stroke								15
HIV								15
Immunizations								14
Injury & Violence								16
Maternal Infant & Child								16
Mental Health								13
Occupational Health	?	?	?	?	?	?		N/A
Oral Health								15
Overweight & Obesity								18
Physical Activity								15
Public Health Infrastructure	N/A	N/A	N/A		N/A	N/A		N/A
Responsible Sexual Behavior								18
STDs								14
Substance Abuse								15
Tobacco Use								16

Coding Scheme			
Comparison	Better than comparison	Comparable/no difference	Worse than comparison
Trend	Moving in right direction	Stable	Moving in wrong direction
Disparities	No discernible disparities	Disparities in at least at 1 group	Disparities in multiple groups
Magnitude	Few affected	Moderate number affected	Large number affected
Magnitude by Age	Affects very few young people	Affects equally across age spectrum	Affects many young people
Severity	Not life threatening/causes little chronic disease/disability	Causes a moderate amount of morbidity/disability and/or mortality	Causes many deaths and/or many years of chronic disease/disability/years of life lost
Data	Good quality and availability	Improvements needed in availability and/or quality	No data/poor quality data/poor timeliness/lack of subpopulation data
Score	1	2	3
N/A = not applicable ? = insufficient data			

MODULE 3

Collecting and Analyzing Stakeholder and Community Input Data

Module Overview

This module provides guidance on collecting primary data from stakeholders, including state residents, to understand how the community perceives health, quality of life, and community resources that support health and healthy living. This portion of the assessment provides an opportunity to collect data to supplement the information compiled for the health status assessment (see Module 2). The community input data helps present a more complete picture of the health of the state by including perspectives from the community that may not be apparent in other data collected.

Tools and methods used to gather community input that are explored in this module include an environmental scan, asset mapping, surveys, focus groups, SWOT analysis or Forces of Change Assessment, and public health system self-assessment.

Some of the collection and analysis of health status data (Module 2) will likely occur simultaneously, and Module 4 provides guidance for integrating the key findings developed from the diverse assessment components.

Related PHAB Guidance

PHAB Standard 1.2 refers to the collection and maintenance of data that provide information on conditions of public health importance and health status of the population. Measure 1.2.3 A requires that the data collected and maintained should include both primary and secondary data. This module focuses on gathering primary data collected and developed based on the knowledge, experience, and understanding of stakeholders. Primary data is defined in the PHAB Glossary of Terms as data observed or collected from original sources, ranging from more scientifically rigorous approaches such as randomized controlled trials to less rigorous approaches such as case studies.²³ Module 2 focuses more on the collection and presentation of primary and secondary quantitative measures of health outcomes and health status. Findings from the information collected must be reported to tribal and local health departments as defined in Measure 1.2.4 S.

Key Content and Components

- ◆ Engaging Stakeholders in Collection of Community Input Data
- ◆ Collecting Community Input Data
- ◆ Qualitative Data Analysis
- ◆ Environmental Scan for Community Input Data
- ◆ Asset Mapping
- ◆ Exploring Strengths, Weaknesses, Opportunities, and Threats
- ◆ Collecting Data on Forces of Change
- ◆ Assessing Public Health System Capacity
- ◆ Developing Findings from Stakeholder and Community Input

²³ "PHAB Acronyms and Glossary of Terms," p. 29, from Scutchfield FD, Keck CW. *Principles of Public Health Practice*. Delmare CENGAGE Learning. 2009.

Module 3: PHAB Standards and Measures

PHAB Standard 1.2 Collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population.

Measure 1.2.3 A Collect additional primary and secondary data on population health status.

Documentation 1: Documented aggregated primary and secondary data collected and the sources of each.

Guidance: ... Primary data are collected by or on behalf of the health department. Examples of primary data include: communicable disease reports, healthcare provider reports of occupational conditions, and environmental public health hazard reports. Other primary data sources include: community surveys, registries, vital records, and other methods of tracking chronic disease and injuries, as well as focus groups and other methods for qualitative data.

Documentation 2: Documentation of standardized data collection instruments.

Guidance: The health department must provide two examples of standardized data collection instruments that they have used. These two examples must collect data in two different program areas. Standardized instruments are those that are recognized as national, state-wide, or local collection tools. They may also be standardized from the standpoint that the same tool was used with all respondents, such as a local survey developed and distributed to a representative sample of potential respondents. The tool may collect quantitative or qualitative data. The health department can provide the tools used for the required documentation listed under the first required documentation for this measure. Or they can be examples from different data collection activities, showcasing four different data sets.

(PHAB Standards and Measures Version 1.0, excerpted from pp. 24-25)

Primary community input data are used to supplement data in the state health assessment to create a richer understanding of the health status and lived realities of state residents. This data can be used to address gaps in the health status data and can help provide a context and frame through which to interpret the data. This type of data can also be used to achieve an understanding of community perceptions and priorities and gain an understanding of the broader forces and contributing factors influencing health. Primary stakeholder input data collection can also yield insights into how different sectors and stakeholders contribute to the public health system. PHAB guidance for Measure 1.2.3 A further describes the rationale for this data collection. The insight gained directly from stakeholders and residents can be helpful in understanding and further defining the issues that may have surfaced in the data collection on health issues across the state and within specific subpopulations.

PHAB Guidance

Measure 1.2.3 Significance:

Data collected by the health department (primary data) provides data specific to the health department's priorities and plans. It is important that health departments collect primary data to provide insights into particular health issues in the community. Data collected by others (secondary data) can be very useful in assessing the health status of the population. These two types of data used together can provide a robust comprehension of the contributing factors to specific health issues of the community or state, as well as provide information about the overall health of the population.

The scope of public health data assessment is broad and includes collection of information by other Tribal, state, and local departments, health agencies, and partners on communicable disease (food/water/air/waste/vector-borne), injuries (including needle-stick injuries), chronic disease/disability, and morbidity/mortality for the purpose of analysis and use in health data reports.

(PHAB Standards and Measures Version 1.0, p. 24)

One of the keys to gathering rich primary stakeholder input data is leveraging existing relationships the health department has with agencies and stakeholders across the state; this encourages participation and engagement in the data collection process. Local health departments play a particularly important role in this phase of the SHA because they can offer a local perspective on health status and the public health system. They can also leverage their own local relationships to facilitate greater community engagement in the process.

Engaging Stakeholders in Collection of Community Input Data

As described in Module 1, "Identifying and Engaging System Stakeholders," many sectors are encompassed within the public health system, so a robust SHA will engage a broad range of stakeholders across the state in collection of primary data. In Module 1, guidance was provided on analyzing the best roles for stakeholders within the assessment. Refer to pages 15-20 for more information and consider:

- Which stakeholders were identified to participate in data collection activities such as stakeholder interviews, system self-assessment, focus groups, or SWOT analysis?
- Which stakeholders were identified as conduits to gathering community and subpopulation input?

For an extensive list of potential stakeholders to involve, refer to the Sector and Stakeholder Wheel on page 17 in Module 1.

In addition to ensuring the involvement of a diverse range of sectors within the public health system, the health department may also want to consider seeking representation from vulnerable populations when collecting stakeholder input data. Because vulnerable populations may be hard to reach, the health department should seek the assistance of advocacy organizations that represent particular populations. These advocacy organizations can offer guidance and insight into the unique needs and considerations for those groups and can engage them directly to be sure their voices are represented.

Vulnerable populations to consider engaging in the primary data collection phase include:

- Uninsured individuals.
- Racial and ethnic minorities.
- Economically disadvantaged individuals.
- Undocumented immigrants.
- LGBT individuals.
- Homeless individuals.
- Incarcerated/formerly incarcerated individuals.
- Disabled individuals.
- Elderly individuals.
- Veterans.

Collecting Community Input Data

Gathering input from state residents is an important component of the SHA because it offers insight into how people who live in the state experience the health determinants, community conditions, and resources, behaviors, and health outcomes described in the state health assessment. Primary data collected from state residents not only sheds light on the health issues to build a fuller understanding of health status in the state, but also reveals important insights on issues that may not have surfaced in other data compiled. Community input builds an understanding of people's perceptions of health and well-being and will highlight their health concern priorities. This data can also provide insight into the factors residents consider most influential in contributing to health and illness in their communities. This data is often referred to as community themes and strengths, which is how the MAPP model defines it.

Environmental Scan for Community Input Data

An environmental scan proved to be particularly useful to the Washington, DC, health department as they decided to collect existing assessments and plans throughout the area. It was clear that many government agencies, including the health department's own programs (e.g., Title V, cancer registry, etc.) had already conducted numerous focus groups and stakeholder meetings to collect feedback from hundreds of participants. Thus, they decided not to resurvey the same people. Instead they acknowledged what they had learned from the previous participants and capitalized on what was learned from recently conducted stakeholder engagement activities. See Module 1, pages 13-15 for more information on conducting an environmental scan, an important step in understanding data available to contribute to the SHA.

Primary data from state residents can be collected in a variety of ways, including but not limited to:

- Surveys.
- Community forums/listening tours.
- Focus groups.
- Key informant interviews.

As mentioned, collection of primary data is often done in partnership with local health departments, which have easier access to community members and data collected through community engagement activities. In addition to direct partnerships on primary data collection, the state health department can also work with local health departments to share existing primary data collected for local community health assessment and planning (CHA/CHIP) or hospital system community health needs assessments and to look for common themes across this data. In centralized states, the state health department might consider requiring all local health departments to complete a common assessment to facilitate collection of consistent data from across the state.

Another way to differentiate types of data is quantitative vs. qualitative. Most of the methods for data collection in this module result in more qualitative than quantitative data. The chart below describes each data type in more detail. Both are important to understanding the community perspective and ultimately identifying themes.

FIGURE 3.1 ATTRIBUTES OF QUANTITATIVE AND QUALITATIVE DATA

Quantitative	Qualitative
<ul style="list-style-type: none"> • Use of mathematical formulas, theories, and hypotheses to measure and quantify phenomena. • The application of statistical models to quantify phenomena. • Attempts to generalize findings to larger audience through samples. • Focuses on counting and ordering what and when of phenomena. 	<ul style="list-style-type: none"> • Use of observation and categorization for in-depth analysis in understanding phenomena. • The application of research methods to qualify phenomena. • Attempts to discover human response in specific context through discrete samples. • Focuses on classifying and understanding why and how of phenomena.

Surveys are one data collection tool that may yield both qualitative and quantitative data fairly easily.

SURVEYS

One robust but also resource-intensive way to collect primary data from residents across the state is to create a random sample survey. A survey is a method of gathering information from a sample of individuals by a standardized procedure so that every individual is asked the same question in more or less the same way. Surveys can be conducted via mail, phone, web, or in person. Expertise is required for sampling and survey development. Refer to page 64 for resources related to using survey methodology. Some of the benefits to using surveys for this work include:

- Ability to reach a large population.
- Allows for generalizable results.
- Assurance of privacy.
- Ability to standardize responses.

These benefits make surveys a useful tool in gathering statewide input into the assessment. The ability to standardize responses is important because the data can be quantified quickly and are often easier to analyze and compare.

A few common barriers to using surveys to collect data include:

- Time and resource intensive for data collection, entry, and analysis.
- Limited to no opportunity to clarify information for or from the respondents.
- Location-specific sampling may skew results.

When conducting a survey for the SHA, the health department should identify priority populations to survey and design a sampling methodology that oversamples those key demographics. Survey development and sampling is a complex subject and requires expertise to ensure it is handled accurately and professionally. From maintaining confidentiality to ensuring valid, culturally competent survey questions to appropriate sampling, expertise is needed. Reaching out to stakeholders or partners with expertise in this area is highly recommended. Following are links to useful resources and sample surveys.

FIGURE 3.2 RESOURCES AND LINKS: SURVEYS

- Survey Methodology for Public Health Researchers
http://www.oxfordjournals.org/our_journals/poq/collectionspage.html
- Surveys and Tools, RAND Health
http://www.rand.org/health/surveys_tools.html
- National Surveys for Public Health Surveillance
<http://www.cdc.gov/alcohol/surveillance.htm>
- American Community Survey (ACS), annual survey conducted by U.S. Census Bureau
http://www.census.gov/acs/www/about_the_survey/american_community_survey/
- BRFSS, established by CDC in 1984, conducted by each state
<http://www.cdc.gov/brfss/questionnaires/pdf-ques/2011brfss.pdf>
- California Health Interview Survey (CHIS), Adult Questionnaire, conducted by UCLA Center for Health Policy Research
<http://healthpolicy.ucla.edu/chis/design/Documents/CHIS2009adultquestionnaire.pdf>
- National Health Interview Survey (NHIS), Sample Adult Questionnaire, administered by National Center for Health Statistics
ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2011/english/qadult.pdf
- New Jersey Family Health Survey, 2009, conducted by Rutgers Center for State Health Policy
<http://www.cshp.rutgers.edu/Downloads/8620.pdf>
- YRBSS
http://www.cdc.gov/healthyyouth/yrbs/pdf/questionnaire/2011_hs_questionnaire.pdf
- State Health Access Data Assistance Center
 - Database of state surveys
<http://statehealthcompare.shadac.org/Data>
 - Report on seven national health surveys (ACS, CPS, NHIS, MEPS-HC, BRFSS, NSCH, SIPP)
http://www.shadac.org/files/shadac/publications/SHADAC_Brief24.pdf
- UCLA National Network of State and Local Health Surveys
<http://www.statelocalhealthsurveys.net/resources/categories>

COMMUNITY FORUMS OR LISTENING SESSIONS

A state health department can also engage in primary data collection through community engagement by holding community forums or listening sessions. While also resource intensive, there is much potential value to be gained through this process. Community forums and listening sessions are often referred to as town hall meetings. The purpose of these public events is to provide residents the opportunity to explore and share issues, such as health problems. Qualified facilitators lead the discussion to identify the community strengths and potential problems, while the meeting is recorded or transcribed to gather qualitative data to analyze and summarize.²⁴

Refer to the case study on Oklahoma in Module 4 on page 80 for one example of how a state has capitalized on the value of a listening tour. Oklahoma used the listening tour methodology to gather feedback on the completed SHA; the same process can be replicated to gather feedback on health issues, assets, priorities, etc.

FOCUS GROUPS

With this method, a qualified facilitator works with a group of people in an interactive setting to gather perceptions about health issues, quality of life, assets, etc. Focus groups are used to gather a variety of responses and gauge the variance in responses. Some of the benefits of using focus groups include:

- Natural environment; the emphasis is on interaction to get information.
- Increased comfort level; enjoyable experience.
- When others share, it promotes new ideas and sharing.
- Ability to get in-depth information on sensitive issues.
- Empowerment process; the ability to gather data from some groups that have challenges or trust issues with other forms of research methods.
- Can be less time consuming and more cost effective than individual interviews.

Focus groups can be a great tool to engage residents in the assessment beyond data gathering. However, there are some barriers as well, which include:

- Results may produce a single theme, or perhaps single voice, depending on the group.
- Lacks the one-on-one opportunity in interviews.
- Strong facilitation skills are critical to success.
- Facilitator may influence groups' interactions.
- Facilitator or trust issues may prevent true issues being expressed by participants.
- Limitation of data; this is not meant to quantify or statistically represent the community.
- Produces large amounts of data; analysis is time consuming.

²⁴ Work Group for Community Health and Development at the University of Kansas. "Section 3. Conducting Public Forums and Listening Sessions." Available at <http://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/conduct-public-forums/main>. Accessed 1-15-2014.

KEY INFORMANT INTERVIEWS

Interviews involve a trained interviewer asking questions and recording respondents' replies through ticking boxes in closed questions, writing down answers verbatim or as a summary, or by using an audio recorder (usually for in-depth interviews) that allows data analysis to be conducted later. Key informant interviews are used to obtain information from an interviewee who has unique knowledge. In the case of the SHA, such interviews are frequently conducted with key stakeholders who may have specific knowledge about the health issues facing the state or certain populations. Interviews might be conducted with elected officials, community leaders, program managers, or anyone with a unique perspective to help understand the health needs and priorities of state residents.

A few benefits to consider when determining if key informant interviews should be incorporated in the SHA process include:

- Provides depth to issues discussed.
- Facilitates discovery of issues/problems from the perspective of those dealing with them.
- Allows for the give and take of a discussion.
- Ensures the incorporation of context into the findings.

A few barriers should also be considered in the decisionmaking process:

- Time intensive to conduct and transcribe.
- Limited sample size.
- Findings are contextualized; not always replicable.
- Data gathering relies on the quality/understanding of those conducting the interviews.



Whether using community forums, focus groups, or key informant interviews, gathering primary community input data takes time and planning. Working with partners who have expertise with these methodologies can be helpful in designing a quality process with organized questions that yield useful information. Data can be captured through audio recording (either verbatim transcripts or notes from the recording) or notetaking during or right after the meeting or interview. To ensure accuracy, make sure that all notes are completed as soon as possible, preferably within a day of the collection. Prior to analysis, all data need to be compiled electronically.

Qualitative Data Analysis

Analyzing the data gathered from open-ended survey questions, focus groups, community forums, and interviews can be challenging, and working with a trained qualitative data analyst is recommended. Statistical data analysis tools may be used, such as ATLAS.ti and NVivo. Interpretive analysis involves reviewing the data and making initial observations about how and where questions were answered. Next, the data is coded by grouping answers to similar questions together, sorting quotes and notes into common themes, and assigning codes to the various themes. For each theme, summarize in a few sentences what was said that exemplifies that theme. Organize by each question or topic. Once all themes have been identified, begin to link common themes across all questions. Finally, step back and take an overall look at the implications of the findings. What do the findings say about the issues of importance?

Directly engaging state residents in the SHA process through primary data collection can serve two critical functions:

1. Supplementing health status data with direct community input will result in a more robust SHA that more accurately reflects the realities and experiences of state residents.
2. The process of community engagement can be used as a mechanism to spread awareness of the SHA and to build buy-in and energy around development and implementation of the SHIP.

Asset Mapping

Another important step in the SHA process is to identify and map resources that can be leveraged to improve health. The U.S. Department of Housing and Urban Development defines a community asset as “a quality, person, or thing that is an advantage, a resource, or an item of value to an organization or community.”²⁵ Public health assets can include individuals, organizations, institutions, and environmental assets. Some assets are mobile while others are stationary. A farmer willing to go to schools and community centers to teach children about nutrition is mobile within the region; however, the schools the farmer visits remain stationary.

The goal of asset mapping is to focus on the strengths rather than the deficits of communities and regions, draw participation from citizens, and empower communities to be drivers of positive change rather than relying solely on outside forces for change.

An asset map is an inventory of all of the assets available to a community. Some assets can easily be designated on a geographical map, while others are more easily organized through charts or tables. An asset map can be comprehensive or can target assets related to a particular topic. Because of the size of a state, it would be challenging to collect and organize data for a comprehensive asset map for the entire state; for this reason, it may be best to use this tool for topical analyses. This will make the data collection both more manageable and more useful. See below for tips for using asset mapping at the state level. While asset mapping processes can take many forms, Figure 3.3 outlines the core components to complete as part of any asset mapping process.

²⁵ U.S. Dept. of Housing and Urban Development. “Connecting to Success: Neighborhood Networks Asset Mapping Guide.” Available at [http://lnshhq05w.hud.gov/NN/websites.nsf/AttachmentsA/456E7EEFD772500C8525703F00614E6A/\\$File/assetmapping.pdf?OpenElement](http://lnshhq05w.hud.gov/NN/websites.nsf/AttachmentsA/456E7EEFD772500C8525703F00614E6A/$File/assetmapping.pdf?OpenElement). Accessed 3-1-2014.

FIGURE 3.3 CORE COMPONENTS OF ASSET MAPPING

- 1. Define the scope of the asset map.** It is unlikely that a state health department would need an asset map covering all assets in the state. The amount of data would be overwhelming. Decide what topic(s) the asset map is needed for and create an asset map based specific to that need.
- 2. Define the community.** Similar to the health assessment, the boundaries of an asset map must be clear. It could be a county, a region, the whole state, or another form of community.
- 3. Identify assets I: Initial scan.** Information on assets can be found in a variety of ways. A good place to start is to collect information from internet searches or other public databases. Another important source of information can be media reports. (Note: Another common method for asset mapping at a local level is surveying a community. While this method may be better suited for asset mapping at the local level, it could be useful in some situations on the state level.)
- 4. Identify assets II: Snowball.** Following initial information gathering, it is useful to take a snowball approach by contacting assets you have already identified and asking for referrals to other assets.
- 5. Assess the strengths and weaknesses of assets.** In assessing assets, it is important to remember the purpose of the asset map and use that to guide the examinations. One fundamental question to ask at this stage is, “Do the assets meet the needs of the community?” It is likely that additional questions will arise related to the specific purpose of a given asset map.
- 6. Identify the gaps.** What needs are left unmet? What assets would meet this need?

Comprehensive assessment: For a more advanced understanding of community assets, map the relationships between assets and map leadership capacities and cultures. The comprehensive assessment examines the interrelatedness of the assets present in a community.

Per PHAB guidance, identifying state assets is important to understanding the resources that can be leveraged and mobilized to address the health issues that surface in the SHA.

PHAB Guidance

Measure 1.1.2 S, Documentation E: A description of state assets or resources to address health issues.

Measure 1.1.2 S, Guidance E: A listing or description of state assets that can be mobilized and employed to address health issues. These may include other sectors. For example, a state parks system can encourage physical activity. Similarly, a department of agriculture can promote healthful eating, and a state educational policy can encourage the provision of health education.

(PHAB Standards and Measures Version 1.0, p. 16)

USING ASSET MAPPING FOR STATE-LEVEL WORK

Asset mapping can be beneficially adapted for state-level assessment. Here is one example of how to use asset mapping for a state-level process: A state is beginning its SHA process and conducts an environmental scan to identify any assessment activities that have taken place in the past year. On reviewing the results, the state finds that the Chronic Disease Program was funded to conduct a comprehensive assessment on the impact of obesity on chronic disease. Data collected show that the state has a rapidly growing obesity epidemic. Membership in the SHA partnership does not include anyone working on obesity or childhood obesity. The state health department searches for organizations working on childhood obesity and identifies six obesity councils in the state. These organizations work primarily in urban areas, and when their areas of service are mapped, more than half the state is not served by an obesity council. After the initial information gathering, the state health department asks the obesity councils for referrals to their common partners. The councils respond that schools and parks departments are their most frequent partners. The state health department adds those organizations to the map. Additionally, two councils name former employees who now work at local health departments in the underserved areas of the state. While there are still gaps, the state health department is aware of potential partners across the state with expertise or capacity on the topic of childhood obesity.

One resource that may be used to contribute to asset mapping by state health departments is the Certificate of Need (CON) or State Health Planning and Development Agency (SHPDA). CON represents the application process that healthcare providers must go through with the state to make a capital investment in their healthcare system. A capital investment could range from a hospital planning to purchase an MRI machine to a provider planning to start a home-health agency. It typically covers any real enhancements to existing health care services that are available to residents. The role of the SHPDA is to review the plans and ensure that they meet public need and other criteria. The information collected with CON is helpful to jurisdictions in identifying what services exist, where services are available, and the capacity of the healthcare system to meet the projected need of its residents. This resource can greatly contribute to asset mapping.

FIGURE 3.4 RESOURCES AND LINKS: ENVIRONMENTAL SCANS AND ASSET MAPPING

- ASTHO Assessment Data Sources
<http://www.astho.org/Programs/Access/Public-Health-Data-Sources---Assessment-Tools/?terms=state+health+assessment>
- New York State Department of Health Data Sources
<http://www.health.ny.gov/statistics/chac/national.htm>
<http://www.health.ny.gov/statistics/chac/state.htm>
- University of Wisconsin Extension Asset Mapping
<http://www.uwex.edu/ces/lmcourse/PDFs/assets.pdf>
- UCLA Center for Health Policy Asset Mapping (registration required)
http://healthpolicy.ucla.edu/programs/health-data/trainings/Documents/tw_cba20.pdf

Exploring Strengths, Weaknesses, Opportunities, and Threats

Common to most assessments is some level of identification and exploration of public health system strengths and weaknesses and external opportunities and threats. Often referred to as a SWOT analysis, this can be accomplished through a variety of individual or combined methods, including facilitated discussions, surveys, interviews, and review of data inputs, that are sorted into strengths, weaknesses, opportunities, and threats by the SHA partnership or other key stakeholders. A SWOT analysis highlights:

- **Strengths** within the public health system that should be leveraged.
- **Weaknesses** that may need to be addressed to improve health issues.
- **Opportunities** to take advantage of and consider (similar to assets and resources as referenced on page 67).
- **Threats** to prepare for that could potentially impact the public health system or the health of state residents.

Participants contributing to this portion of the assessment typically include the public health system representatives who engage in thoughtful reflection and sharing of perspectives and experiences related to system strengths and weaknesses and potential opportunities and threats. A skilled facilitator can lead a group of system representatives such as the SHA partnership members through a dialogue exercise to define SWOT that includes brainstorming issues, synthesizing the results, and identifying the key strengths, weaknesses, opportunities, and threats.

Alternatively, a state could use one or more standardized tools for exploring strengths, weaknesses, opportunities, and threats such as those described in the following sections. The Forces of Change Assessment is a MAPP tool used to identify potential forces that may present an opportunity or threat. The second tool is the National Public Health Performance Standards (NPHPS) State Public Health System Assessment. This tool, also used in the MAPP process, assesses the capacities of the state to address performance measures related to the 10 Essential Public Health Services. System strengths and weaknesses emerge from this assessment.

Collecting Data on Forces of Change

Information on forces influencing health and quality of life across the state is another key element of primary data to include in the SHA. Forces of change are assessed by bringing together key public health leaders who can discuss trends affecting state health and explore opportunities or threats the public health system faces as a result. Since the SHA steering committee should be comprised of leaders from key public health sectors, the committee can be an appropriate group to collect data on perceived forces of change. Additional leaders from key sectors across the state can also be invited to participate to fill any gaps of sectors or populations not represented on the steering committee. This helps ensure a broad range of forces from various perspectives are identified and explored.

Three Types of Forces: Trends, Factors, and Events

Trends: Patterns over time, such as population shifts or growing mistrust with government.

Factors: Discrete elements, such as a community's large ethnic population, an urban setting, or the jurisdiction's proximity to a major waterway.

Events: One-time occurrences, such as a natural disaster or the passage of new legislation.

The Forces of Change Assessment can be thought of as a part of a SWOT analysis for public health across the state. This assessment helps generate an understanding of the factors and trends that shape health and that must be considered when looking toward the future. Forces may include a wide variety of categories:

- Societal
- Economic
- Political
- Technological
- Environmental
- Scientific
- Ethical
- Legal

Impending changes or forces that are out of the control of the state's public health system need to be identified and understood to explore how the forces may affect state residents or the state system. Further analysis by the group includes identification of potential threats or opportunities generated by these occurrences. Strategic thinking includes the identification of threats and opportunities and is an important data input to the SHA.

STEPS FOR ASSESSING FORCES OF CHANGE

There are many ways the forces of change can be identified. One effective process that maximizes participation from a representative group of diverse state strategic thinkers and leaders is described below.

1. Arrange a meeting space that allows participants to meet and discuss in small groups and to comfortably move throughout the space. Tables can be positioned in clusters around the room with flip charts and markers next to each cluster. For groups of 25 or more, split into eight groups. For groups of fewer than 25, split into four groups.
2. Identify a facilitator who can introduce the assessment process and divide the group into diverse clusters or small groups. Ideally, each small group would be assigned a facilitator and recorder. At a minimum, there must be at least one facilitator providing guidance to the whole room with a volunteer in each small group keeping the group moving and recording discussion items.
3. Assign a category or two (two for groups of four and one for groups of eight) to each group. Categories (also listed above) include societal, economic, political, technological, environmental, scientific, ethical, and legal.
4. Review the definitions (page 70) of events, trends, and factors, and provide examples of each as they relate to a potential force of change on the state public health system or the health of the state.
5. Allow 20 to 30 minutes for small groups to brainstorm and document forces of change, the potential threat posed by each force, and the potential opportunity posed by each force.
6. Ask group members to rotate clockwise, spending five to 10 minutes reviewing the previous group's work and adding any additional forces and corresponding threats/opportunities. Groups should rotate through all categories.

7. Once groups have rotated and reviewed/added to all categories, they will return to their original category. Groups review the additions.
8. Facilitate a large group discussion to allow group members to clarify anything that may not have been clear and identify themes and observations regarding the greatest forces.
9. Create a list of the themes and priority forces.

FIGURE 3.5 CASE STUDY: FORCES OF CHANGE ASSESSMENT IN ILLINOIS

The Illinois Department of Public Health wanted to include a Forces of Change Assessment in their state health assessment to determine external factors that might affect the implementation of the 2010 SHIP. The SHIP Planning Team, composed of representatives of public health agencies, healthcare providers, community organizations, faith-based organizations, businesses, and academia, conducted the assessment. They sought forces of change in one of three forms: trends (patterns over time), factors (discrete elements), and events (one-time occurrences). The planning team was divided into five small groups, which each independently examined forces of change. Following the small group work, the whole planning team reconvened and compared the findings of each group. The forces of change were categorized, and those forces noted by at least two groups were included in the final assessment report. In Illinois, the forces that rose to the top out of the Forces of Change Assessment were:

- Economy and the recession.
- Health disparities and demographic shifts.
- Healthcare/insurance reform.
- Leadership crisis in public health.
- Access to care.
- Funding and system fragmentation.
- Illinois political culture.
- Chronic disease.
- Technology.
- Educational system.
- Workforce.
- Emergent/current issues.

This list contained both the forces acting on the public health system and the way in which they endangered the public health system. The list also provided potential for action.

One benefit of conducting the Forces of Change Assessment as part of the overall SHA is that changes external to the health department that affect the state population's health can be noted and included to better understand and contextualize other data gathered in the SHA. When Illinois conducted its Forces of Change Assessment in 2009, one of the key findings was that the recession occurred between the

2007 SHIP and the 2009 assessment. This presented the threat of higher numbers of unemployed and uninsured individuals and greater reliance on safety-net institutions, but it also presented opportunities created by stimulus funding and greater government involvement in public health.

Assessing Public Health System Capacity

When conducting a health assessment, whether at the state or local level, defining the strengths, weaknesses, capacities, and gaps of the public health system contribute to understanding the issues impacting the health of the state. If a public health system is deficient or lacking in an important public health service or capacity area, the health of the state related to that area might suffer. Therefore, conducting some sort of self-assessment with members of the public health system is an important addition to any SHA.

As previously described, the public health system includes all public, private, and voluntary entities that contribute to the public health activities within the state. While all of these entities may not operate as a system, the organizations, groups, and institutions are all part of a state public health system or network of entities with differing roles, relationships, and interactions. All of the entities within a public health system contribute to the health and well-being of the community, and assessing the overall capacity of the system provides valuable information.

CDC offers NPHPS,²⁶ one standardized tool that can be used to assess the capacity of the public health system. The framework for the state NPHPS is the 10 Essential Public Health Services. With the NPHPS instrument, each of the 10 Essential Services corresponds to an individual chapter, with a description of the related public health activities and common stakeholders or system sector representatives typically engaged in the activities described. The list of stakeholders in each chapter of the NPHPS instrument is helpful for identifying appropriate stakeholders to engage in the public health system assessment.

Each chapter is assigned four consistent model standards:

- Planning and implementation.
- State-local relationships.
- Performance management and quality improvement.
- Public health research capacity and resources.

Each of these model standards is defined as it relates to the corresponding essential public health service. In addition, a series of discussion questions are provided to lead a group of public health system representatives in a robust discussion of how the model standard is addressed within the state public health system. The standards in each section describe an optimal level of performance and capacity to which all public health systems should aspire. Once stakeholders fully discuss the model standard, attention is moved to discussing and scoring related performance measures. Scoring is facilitated with the goal of reaching consensus to arrive at an agreed-on score and a compilation of comments, discussion points, and feedback related to the strengths, weaknesses, opportunities for partnership or improvement, and any specific long-term goals.

In addition to conducting a self-assessment related to how well the overall public health system is addressing the 10 Essential Public Health Services, the standards are intended to stimulate continuous quality improvement. The standards serve as a guide for learning about activities throughout the system and facilitating discussions about potential and necessary improvements. The dialogue that occurs while answering the questions in the assessment helps state system partners identify the

²⁶ CDC. "National Public Health Performance Standards (NPHPS)." Available at <http://www.cdc.gov/nphps/index.html>. Accessed 1-15-2014.

components, competencies, and capacities of their state’s public health system. This understanding is an important component of a state health assessment.

FIGURE 3.6 RESOURCES AND LINKS: ASSESSING FORCES OF CHANGE AND PUBLIC HEALTH SYSTEMS CAPACITY

- NACCHO MAPP Clearinghouse
<http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/>
- ASTHO National Public Health Performance Standards State Implementation Guide
http://www.astho.org/National-Public-Health-Performance-Standards/NPHPS-Implementation-Guide-Version-3_0/
- CDC National Public Health Performance Standards
<http://www.cdc.gov/nphps/>
- Florida Department of Health MAPP Field Guide on Forces of Change
http://www.floridahealth.gov/provider-and-partner-resources/community-partnerships/floridamapp/florida-mapp-field-guide/the-four-assessments/_documents/forces-change-assessment.pdf
- Florida Department of Health MAPP Field Guide on Local Public Health System Assessment
http://www.floridahealth.gov/provider-and-partner-resources/community-partnerships/floridamapp/florida-mapp-field-guide/the-four-assessments/_documents/local-ph-system.pdf

Developing Findings from Stakeholder and Community Input

Once initial analysis and interpretation of each type of the data is completed, members of the SHA partnership or stakeholder and community input subcommittee should develop the key findings from the assessment of primary data. Similar to developing key findings from the health status assessment, creating visual depictions of the findings may help with interpretation when the data can be quantified. Often, the stakeholder and community input data is more qualitative and can be challenging to analyze. The key to analyzing this data is identifying themes and key findings for each data collection method (e.g., surveys, focus groups, SWOT) or assessment (e.g., themes and strengths, Forces of Change, public health system assessment). Cross-cutting issues are then identified across all data gathered through stakeholder and community input to identify the overall findings.

The stakeholder and community input data collected often yields a great deal of qualitative data. For these data to be user-friendly as the assessment results are shared, they should include appropriate charts and graphs and summaries of key findings, including a description of the context in which the data were collected. Displaying the summary of key findings in a chart or graph accompanied by direct quotes from stakeholder and community input provides a good mix of visual and narrative context. For more information about presenting data effectively, refer to the guidance in Module 2.

During the SHIP process of identifying priorities, the SHIP team synthesizes these findings with those from the health status assessment to develop the SHIP strategic priorities.²⁷

²⁷ See ASTHO’s SHIP guidance at <http://www.astho.org/Accreditation-and-Performance/Developing-a-State-Health-Improvement-Plan-Guidance-and-Resources/Home/>.

MODULE 4

Summarizing, Presenting, and Communicating Findings

Module Overview

This module provides guidance on communicating initial findings and seeking feedback, as well as distributing the completed SHA.

The SHA is intended to be a resource and tool for the public and stakeholders as well as the health department. Awareness and understanding of the SHA among public health professionals, partners, and the public can help garner support for the priority issues to be addressed through the SHIP. Therefore, the SHA should be made available and accessible to the public and distributed among key stakeholders. This module provides guidance to support this activity, including sample approaches and tips.

Related PHAB Guidance

As the PHAB standards indicate, communicating the findings from the SHA is a critical part of the process. For state health departments seeking accreditation, PHAB requires the health department to seek public input on the key SHA findings as part of the distribution of the key findings. PHAB also requires that public feedback is received and considered before the final version of the SHA is published. Guidance from Measures 1.1.2 S and 1.1.3 A describe the documentation requirements demonstrating that the health department has sought public input in the SHA process.

Key Content and Components

- ◆ Synthesizing Health Status and Community Input Data Findings
- ◆ Communicating Information to the Public
- ◆ Engaging the Public to Gather Community Feedback
- ◆ Summarizing and Presenting Findings for Publication
- ◆ Selecting and Incorporating Benchmark Data
- ◆ Report Card Approaches

PHAB Guidance

Measure 1.1.2 S, Guidance 2: The health department must provide documentation that preliminary findings of the state level community health assessment were distributed to the population at large and that their input was sought. Methods to seek input include: publication of a summary of the findings in the press with feedback or comment forms, town forums, listening sessions, website comment forms, newsletters, etc. (PHAB Standards and Measures Version 1.0, p. 16)

Measure 1.1.3 A, Guidance 2: Health departments must provide two examples of how they communicated the community health assessment results to the public. Documentation of distribution to libraries could provide evidence, as could the publication of the community health assessment on the department's websites. Summaries of the findings could also be published in newspapers. (PHAB Standards and Measures Version 1.0, p. 19)

Synthesizing Health Status and Community Input Data

Health status data findings and key findings from all stakeholder and community input data collection methods, including asset mapping, should be synthesized and presented as the results of the state health assessment. Synthesizing the results from the health status and stakeholder/community input data is similar to pouring all the key findings from the data into a sifter to pull out the overall themes surfacing through the data. As the data is sifted through, the story begins to emerge through key findings, cross-cutting themes, and strategic issues. The data synthesis process sheds light on relationships between the data and offers insight on public health system issues and health problems.

Communicating Information to the Public

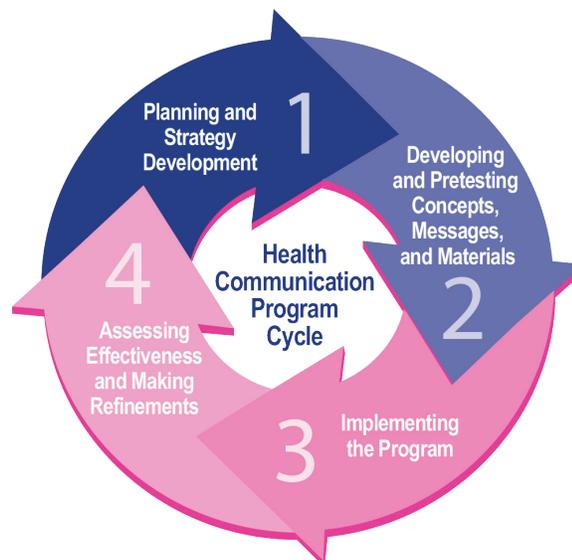
The state health department should communicate the SHA findings in ways that speak to a range of audiences who have an interest in community health throughout the state. Specifically, the SHA should be presented in a manner that is useful to (a) public health professionals working at state, local, and tribal health departments; (b) public health system partners across a range of sectors from education to transportation to economic development; and (c) the general public.

CDC recommends a four-step process for communicating health information, which is applicable for communicating the results of the SHA (Figure 4.1).

When communicating the key SHA findings to the public, the first step for the state health department and the SHA partnership is to create a communications plan. It can be challenging to develop a plan that communicates with a statewide audience with varying interests and knowledge. Identify specific audiences for the SHA findings as well as approaches and tactics to communicate findings and seek input. Some questions to consider while developing the communications plan include:

- Who is the SHA partnership trying to reach?
- How will the SHA be distributed?
- What materials need to be developed?
- What can be done to reach populations that are harder to reach?
- How can the data and information be most effectively presented and communicated to the range of audiences?
- What are our strategies and approaches to communicating findings and seeking input?

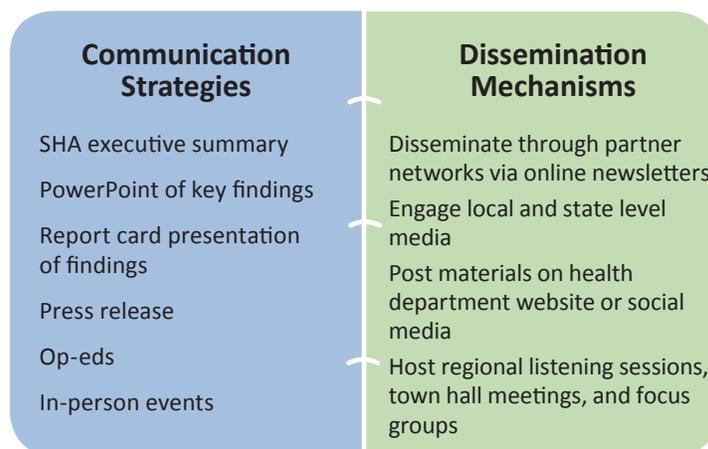
FIGURE 4.1 STAGES OF THE HEALTH COMMUNICATION PROCESS



Source: U.S. Department of Health and Human Services National Cancer Institute. "Making Health Communication Programs Work." 2008. Available at <https://www.cancer.gov/publications/health-communication/pink-book.pdf>. Accessed 1-5-2014.

There are many communication strategies and tactics that can be useful for disseminating the SHA findings; those strategies and tactics can vary based on the different target audiences.

SUMMARY OF COMMUNICATION STRATEGIES AND DISSEMINATION MECHANISMS



Many states develop an executive summary or introduction directed to the general public, while a longer document with more detailed information on indicators is targeted to public health professionals and other public health system partners. Consider whether the executive summary will be a stand-alone document or included at the beginning of the full SHA report. Some states find it preferable to publish the executive summary as a stand-alone document for easier dissemination and to ensure that both the summary and the full SHA are of manageable length. When putting together the executive summary, it is also important to decide whether it will only be disseminated electronically or in hard copy as well.

In addition to the executive summary, it can be beneficial to develop other materials for communicating the SHA findings. For example, New Hampshire published a PowerPoint of key findings on their website, which is used by partners to lead presentations for constituents or clients. Sending out press releases and using social media to share findings can be useful ways to raise awareness about the SHA/SHIP project and can be used to advertise opportunities for public feedback.²⁸

Engaging the Public to Gather Community Feedback

PHAB guidance specifies that health departments should engage with the broader public to solicit participation in two stages of the SHA process: First, by collecting community input during the primary data collection phase, and second, by seeking public feedback on initial findings during the draft dissemination phase. PHAB standards require that the preliminary SHA findings be reported to the public and that public feedback be received and considered before the final version of the SHA is published. PHAB encourages the use of multiple approaches to communicate findings and solicit feedback from the public.

ELECTRONIC COMMUNITY FEEDBACK

The Internet is an excellent tool for soliciting feedback from a wide range of community members. One way to gather feedback is through posting preliminary findings on the health department website and enabling comments. Accepting feedback online is an economical way to make the findings available to a

²⁸ One good resource for information on drafting press releases and other public communication pieces is the University of Kansas Community Tool Box at http://ctb.ku.edu/en/tablecontents/chapter_1005.aspx.



broad audience. However, there are several caveats. The health department must consider how it will inform the public that the SHA findings are available for review and comment online so the public is aware of the opportunity to participate. This can be done by disseminating a link to the findings through social media, email newsletters that can be widely shared with partners, or through media press releases. To facilitate wide participation, it is best to prominently display the opportunity on the main page of the health department website or to create a simple URL so it is easy for the public to navigate to the site. The health department should also take advantage of expertise that other system partners have in online posting and social media to maximize the effectiveness of web outreach.

Another challenge with Internet posting that should be anticipated and taken into account in the communications plan is that not all feedback will be polite or professional, especially in the anonymous comments submitted online. The health department should have a protocol in place in case of hostile comments. A final caveat that is important to consider is that although Internet posting is a good way to engage a broad audience, some populations may be less likely to have access to the Internet and thus may not have an equal opportunity to provide feedback through this platform. Remember to leverage relationships with stakeholders representing vulnerable populations that may lack Internet access to ensure that these populations have the opportunity to provide feedback.

FOCUS GROUPS

Focus groups can also be a good way to garner rich community feedback and are particularly useful for engaging target populations. The health department may want to set up focus groups with populations most directly affected by the issues identified during the preliminary prioritization process. Gathering feedback on the SHA findings can help to ensure that health issues are framed appropriately and resonate with the lived experience of community members. When conducting focus groups, experienced facilitators and note takers are needed to maximize the efficacy of the sessions. The health department should also keep in mind that while focus groups yield rich data, the perspectives of individuals in focus groups cannot be presumed to be representative of the broader community. For further information on benefits and barriers of focus groups, refer to the focus group section in Module 3 on page 65.

COMMUNITY FORUMS OR TOWN HALLS

Another way to engage a wide range of community members and public health system partners in the feedback process is by hosting a series of regional community forums (also referred to as listening sessions or town hall meetings). A community forum can open with a presentation of the preliminary findings of the SHA, and then allow community members to share brief oral testimonies with the group to share their reactions to the findings and initial priorities in the SHA draft. The health department may want to consider restricting the length of each oral testimony to ensure that all community members have the opportunity to speak. Recording and transcribing these sessions is likely the best way to capture the community feedback, though note takers can be used as well.

Common ways the health department can advertise the opportunity for public participation in the SHA feedback process include publishing a press release, sending an email announcement to public health system partners, and posting information on the health department main page prior to the events. Consider ways to engage hard-to-reach populations that may not have Internet access to ensure all communities have an opportunity to participate in the feedback process. When planning regional community forums, ensure that public meetings are held in accessible facilities and take place at convenient times to allow for maximum community participation.



LISTENING SESSIONS

Health departments can also seek public feedback through a series of listening sessions, or facilitated dialogue among community members on the health issues, priorities, and community assets discussed in the SHA. A strong facilitator is key to ensuring that dialogue stays on track and that everyone has a chance to be heard.

The World Café method is one approach to conducting an effective listening session. Following this methodology, participants are seated in small groups at tables, and each table is assigned a question for the group to discuss. Participants discuss the question for twenty minutes, and then each member of the group moves to a different table to form a new small group and repeats the process. After rotating three times, participants convene as a large group and share key points and ideas from their small conversations, and these ideas are recorded at the front of the room on flipcharts. For more information on the World Café method, visit <http://www.theworldcafe.com/method.html>.

Refer to the case study below in Figure 4.2 to learn about how Oklahoma conducted a series of listening session to gather feedback on its SHA.

FIGURE 4.2 CASE STUDY: STAKEHOLDER ENGAGEMENT AND COMMUNITY FEEDBACK IN OKLAHOMA

The Oklahoma State Department of Health (OSDH) took a very robust approach to soliciting resident feedback to the SHA by carrying out a series of listening sessions across the state to hear directly from Oklahomans about the health issues most important to them.

OSDH began by selecting 10 regions across the state to focus its stakeholder engagement efforts and reached out to the Turning Point coalitions in those areas to begin identifying people to include in listening tours. The department then expanded its reach to ensure representation from a wide range of sectors across the public health system, including state agencies, local health departments, hospitals, schools, universities, elected officials, tribes, fire, police, community associations, and faith-based organizations. OSDH then contracted facilitators to lead listening sessions with these groups across the state.

Each listening session was jointly introduced by a local public health system partner and a state-wide public health official (such as the state health commissioner or board of health president). The opening speakers emphasized the importance of hearing feedback from the community to inform the SHA and SHIP. This sent a strong message to community members that their perspectives and input were valued, which helped to build investment among participants. A facilitator then shared the data from the state health assessment, highlighting data broken down into the geographies and demographics most relevant to the group, and led a discussion on residents' impressions of the data, including what resonated most strongly and what seemed to be missing. Using this discussion of the data as a starting point, participants then engaged in a conversation about the most pressing health concerns in their communities, and shared information about local initiatives to address these issues. The health department recorded notes at each listening session and then compiled the data from the sessions to look for themes across the sessions.

While most community engagement efforts end after data collection is completed, OSDH instead used the listening tours as a launching point to build investment in the SHA. Following the listening tours, OSDH incorporated ideas and feedback and followed up with groups to show them how their input had been integrated into both the SHA and SHIP to ensure that the SHA and SHIP resonated with the experiences and perspectives of Oklahomans. OSDH continued communication with these groups throughout the process until these important community products were complete.

This robust community engagement process not only resulted in valuable data and a more relevant SHA, but also cultivated a sense of ownership and investment in the SHA/SHIP, leading Oklahomans to feel that the end result was not just OSDH's assessment and plan, but rather the whole state's health assessment and improvement plan, reflecting the voices and priorities of communities across Oklahoma.

Communication and dissemination efforts should be evaluated so that successes and areas for improvement can be documented. If this information is recorded, it will be invaluable in SHIP implementation and for the next SHA process. Effective communication efforts will make it easier for a state health department to recruit future partners, receive feedback on the SHA, and gain support and buy-in for planning and implementation.

Summarizing and Presenting Findings

Once you have collected and analyzed the SHA data and compiled key findings, the primary communication goal is that people understand the key findings. When summarizing and communicating findings, present the data in formats that are easy to read and understand. Figures 4.3 and 4.4 below provide some tips for presenting data. When presenting findings, include information about methods and any data or process limitations. Some states develop a separate appendix or technical report that presents the information on methods, statistical significance, and data limitations. This separate appendix is a way of making sure the presentation of key findings is accessible while still fully documenting and distributing the more technical information. This will also be important to meet PHAB requirements. Clearly communicating the findings is important both for public dissemination and input as well as for use by the partnership in developing and implementing the SHIP.

FIGURE 4.3 TIPS FOR PRESENTING DATA IN WRITTEN REPORTS

- Use an attractive and colorful layout. Be mindful of strategies and guidelines for making publications accessible for people with disabilities.
- Keep the community and media updated throughout the process. Consider launching with a press release or newsletter or publishing information in a report.
- Highlight only the important facts or findings. Don't waste space on details for a public report.
- Use clear, simple charts. The easier they are to understand, the better.
- Summarize major findings in as many places as possible.
- Write in a clear, simple style that can be understood by readers without a public health background.
- Acknowledge community perceptions of public health. If there is a specific area of interest, address it.
- Know your audiences and consider developing specific reports or summaries for different stakeholders. The public community report may be shorter than one shared with stakeholder agencies, who may want to reference data. Carefully select visual aids and language that will be understandable and interesting to the various audiences.
- Double check all data, links, and information presented. Incorrect data can affect the perceived credibility of the presenter and the entire process.
- Ensure that the report is available in a variety of languages that reflect the linguistic diversity of the state population.

Adapted from NACCHO. "Tip Sheet – Presenting Data." Available at <http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/upload/Tip-Sheet-CHSA-Presenting-Data.pdf>.

FIGURE 4.4 TIPS FOR PRESENTING DATA IN ORAL PRESENTATIONS

- Determine key audiences and tailor presentations to the audience in terms of length, quantity of information, and language level.
- Keep presentations as brief as possible to meet the needs of your audience—less than 30 minutes per issue.
- Invite special interest groups and representatives from all stakeholder groups.
- Cover only the highlights. What is unusual, either in number or by trend? What finding may be of particular concern to community residents and other stakeholders?
- Use visual aids that highlight important information. Clear, simple charts convey information better than numbers alone.
- Stimulate interaction. Encourage discussion about areas of specific interest.
- Be able to easily access backup data, methods, or other information that may be necessary to answer questions that audience members may present.
- Use everyday language. Scientific or statistical jargon may be unnecessary and confusing.
- Keep it simple. Be clear and concise.
- Summarize. Spend the last two minutes reviewing the major findings so that participants don't get lost among all the facts.
- Give participants summary handouts and fact sheets to complement and reinforce the presentation. Be sure to accurately cite the sources of data and information shared.
- Check equipment in advance to ensure it functions properly. Have backups available in case of equipment failure.
- Use maps of geographic areas to show what the information means to different regions or communities.

Adapted from NACCHO. "Tip Sheet – Presenting Data." Available at <http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/upload/Tip-Sheet-CHSA-Presenting-Data.pdf>.

SELECTING AND INCORPORATING BENCHMARK DATA

When communicating the SHA findings to the public, present benchmark data for comparison when available. Benchmarks are points of reference that allow for easier understanding of how the state compares to the country as a whole or how regions within the state compare to statewide data. A very basic benchmark is the national average (either median or mode).

Benchmarks often serve to motivate statewide partners to seek better outcomes for health metrics where the state fares poorly. For this reason, the mean or median alone may be insufficient (because about half of the states are already above the median or mode). As shown below, both New Hampshire and Oklahoma chose to use the states with the best and worst rank on the indicator. This presents a goal to aspire to for each indicator.

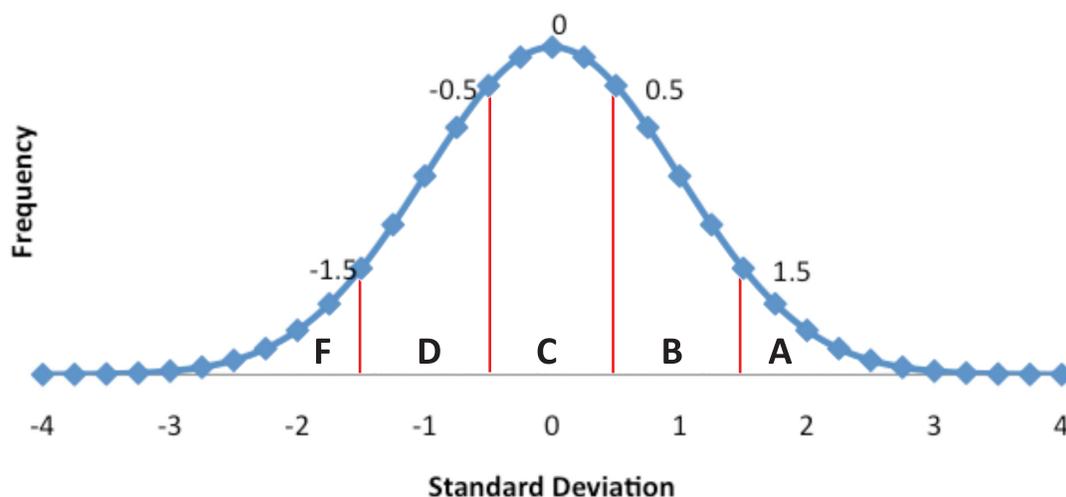
Healthy People 2020 and County Health Rankings are good sources for public health benchmarks. While County Health Rankings does not present state-level benchmarks for its indicators, it does set a national benchmark at the 90th percentile of all counties in the country (90 percent of counties have scores below the benchmark, 10 percent have scores above the benchmark). Because this is such a comprehensive look at the indicators, it may be a useful benchmark for states to use. Healthy People 2020 provides a benchmark for each of the Leading Health Indicators mentioned in Module 2. For each benchmark, Healthy People 2020 provides information about the methods for setting benchmarks, so the SHA partnership can work to set appropriate benchmarks given the local context.

For states that have a previous SHIP, the previous goals and objectives can help inform the benchmarking process. By using past goals as a comparison point, the state can see how much progress has been made on an indicator.

REPORT CARD APPROACH

Oklahoma is one state that presents its data as a report card. On each indicator, the state and counties are given a letter grade, using the mean of the United States as a baseline. An A is given if the standard deviation is above 1.5. B is between 0.5 and 1.5 standard deviations. C is between -0.5 and 0.5 standard deviations. D is -1.5 and -0.5 standard deviations, and F is below -1.5 standard deviation. When using indicators where lower numbers are considered better, the scale is reversed so that A will always refer to the best possible score (i.e. $A < -1.5$; $-1.5 < B < -0.5$; $-0.5 < C < 0.5$; $0.5 < D < 1.5$; $F > 1.5$).

FIGURE 4.5 HEALTH INDICATOR GRADING SCALE



This form of report card requires indicators for which national, state, and county level data are available. The standard deviations can be calculated from this information and presented in an easy-to-read format. Figure 4.6 shows an example of the report card presentation that Oklahoma uses in its SHA.

The New Hampshire Division of Public Health Services shows both trends and comparisons to other states in the “Key Indicators At-A-Glance” format shown in Figure 4.7. The division uses thumbs-up and thumbs-down symbols to indicate trends. Thumbs-up indicates a statistically significant favorable trend in the state data. Thumbs-down indicates a statistically significant unfavorable trend in the state data. An indicator with no significant trend is not given a symbol.

FIGURE 4.6 OKLAHOMA REPORT CARD EXAMPLE

Seniors Influenza Vaccination			
(PERCENT)	2006	2009	2009 GRADE
STATE COMPARISON			
US	69.6	70.1	C
MINNESOTA (best)	73.8	76.8	A
OKLAHOMA	76.1	72.3	B
ALASKA (worst)	62.5	62.1	F
AGE IN YEARS			
18 - 24	NA	NA	
25 - 34	NA	NA	
35 - 44	NA	NA	
45 - 54	NA	NA	
55 - 64	NA	NA	
65 +	76.1	72.3	B
GENDER			
MALE	69.8	71.7	C
FEMALE	71.2	72.7	B
RACE/ETHNICITY			
WHITE (NH)	71.9	74.2	B
BLACK (NH)	49.2	58.3	F
AMER INDIAN (NH)	71.9	68.5	C
HISPANIC	-	-	
INCOME			
< \$15k	62.4	69.6	C
\$15k - 25k	73.0	71.6	C
\$25k - 49k	73.3	70.6	C
\$50k - 75k	71.5	75.4	A
\$75k +	72.3	72.9	B
EDUCATION			
< HS	67.0	66.6	D
HS	70.3	72.4	B
HS+	70.1	72.5	B
COLLEGE GRADUATE	75.7	75.5	A
HISTORIC			
OK 1993		58.5	F
OK 1995		61.1	F
OK 2001		72.7	B
OK 2005		73.2	B
OK 2009		72.3	B
STATE REGION			
CENTRAL	68.8	72.3	B
NE	69.8	73.2	B
NW	69.8	73.8	B
SE	73.0	71.7	C
SW	70.1	70.3	C
TULSA	74.0	71.7	C

Note: A "-" is used to denote <5 events in mortality fields and <5 observations or <50 in the sample population for BRFSS data, which result in unstable rates. NH= Non-Hispanic

FIGURE 4.7

New Hampshire State Health Report KEY INDICATORS AT-A-GLANCE				
Key Indicators	NH Trend	NH Rank	Other State Ranks #1	#50
Demographics				
Education (percent 25 or older with high school diploma or GED) ¹	2000 87.4% 2008 90.9% 	4	Wyoming 91.7%	Texas 79.6%
All persons in poverty (percent) ¹	2000 6.5% 2009 8.5% 	1	New Hampshire 8.5%	Mississippi 21.9%
Children in poverty (percent children) ¹	2005 9.4% 2009 10.8%	1	New Hampshire 10.8%	Mississippi 31.0%
Unemployment (percent adult, seasonally adjusted) ²	9/2000 2.6% 9/2010 5.5%	4	North Dakota 3.7%	Nevada 14.4%
Health Behaviors				
Current smoking, (percent of adults) ³	2000 25.4% 2009 16.0% 	9	Utah 9.8%	Kentucky 25.6%
Youth current smoking (percent) ⁴	2003 19.1% 2009 20.8%	32	Utah 8.5%	Kentucky 26.1%
Fruits and vegetables five or more times per day, (percent of adults) ³	2000 26.2% 2009 27.7%	4	Vermont 29.3%	Oklahoma 14.6%
Childhood obesity, (percent children ages 10 to 17) ⁵	2003 12.9% 2007 12.8%	13	Oregon 9.6%	Mississippi 21.9%
Obesity, high school youth (percent high school students) ⁴	2003 9.9% 2009 12.4%	NA	NA	NA
Obese (percent of adults) ³	2000 18.1% 2009 26.4% 	21	Colorado 19.0%	Mississippi 35.4%
Overweight (percent of adults) ³	2000 36.5% 2009 36.2%	28	Louisiana 33.7%	Iowa 38.7%
Moderate or vigorous physical activity (percent of adults) ³	2001 50.7% 2009 53.2%	12	Alaska 60.7%	West Virginia 35.2%
Physical activity, high school youth (percent high school students) ⁴	2005 57.2% 2009 54.7%	NA	NA	NA
Heavy drinking (percent of adults) ²	2001 6.3% 2009 5.5%	30	Tennessee 1.9%	Vermont 8.1%
Binge drinking (percent of adults) ³	2006 14.9% 2009 15.8%	26	Tennessee 6.8%	Wisconsin 23.9%
Drank alcohol in past 30 days (percent high school students) ⁴	2003 47.1% 2009 39.3%	NA	NA	NA
Used marijuana in past 30 days (percent high school students) ⁴	2003 30.6% 2009 25.6%	NA	NA	NA

Rankings in "At-A-Glance" were determined by listing the value for each (participating) state indicator in order. The state with the "healthiest" value was ranked 1. Rankings do not take into account sampling error or other sources of statistical variation. "Thumb" symbols are used to identify only trends that are statistically significant. A "thumbs up" graphic is used for a favorable trend while a "thumbs down" is used for an unfavorable trend. Trends were determined by comparing the earliest year (2000 where available) to the latest (2009 where available). No comparisons were done for any years between 2000 and 2009. Rankings are based on data that came from New Hampshire surveys and databases, America's Health Rankings or Trust for America's Health (see references in At-A-Glance).

FIGURE 4.8 RESOURCES AND LINKS: COMMUNICATION

- National Cancer Institute *Making Health Communication Programs Work*
<https://www.cancer.gov/publications/health-communication/pink-book.pdf>
- Florida Department of Health MAPP Field Guide on Engaging the Community
http://www.floridahealth.gov/provider-and-partner-resources/community-partnerships/floridamapp/florida-mapp-field-guide/introduction/_documents/engaging-the-community.pdf
- Florida Department of Health MAPP Field Guide on Engaging the Media
http://www.floridahealth.gov/provider-and-partner-resources/community-partnerships/floridamapp/florida-mapp-field-guide/introduction/_documents/engaging-the-media.pdf
- NACCHO Marketing and Communication
<http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/marcomm.cfm>

Effective communication and sharing of SHA results leads to rich dialogues and opportunities for additional feedback to help interpret and understand the public health system and health issues for the state. This level of understanding is necessary for development of the SHIP. Guidance and resources for developing a SHIP is provided by ASTHO at <http://www.astho.org/Programs/Accreditation-and-Performance/Accreditation/SHIP-G-R/>.

CONCLUSION

Building on public health systems research, identified best practices from the public health and other fields, and the experience of states that have already conducted a SHA, this guide is designed to assist states in launching an initial SHA, or improve the next one. ASTHO hopes that this guide has offered insights, resources, strategies, and tools that are practical and useful in the SHA process.

This guide presents approaches to applying key principles of a SHA, including:

- Multi-sector collaborative processes that support shared ownership of all phases of community health improvement.
- Proactive, broad, and diverse community engagement to improve results.
- Maximum transparency to improve community engagement and accountability.
- Use of the highest quality data pooled from, and shared among, diverse public and private sources.

Applying these principles to produce a multi-faceted assessment that gathers and presents both health status and stakeholder-derived assessment data and findings should enable states to deliver a robust and comprehensive picture of the health of their residents. By aligning the guide with the PHAB standards, measures, and guidance, ASTHO hopes that this guide will be useful to those states planning to seek accreditation. The SHA, and stakeholders' engagement in it, can also form a strong foundation for the production of a SHIP, the second of the three PHAB prerequisites. However, this guide should be useful to any state that wishes to assess the health of residents and use that information to set priorities, plan programs, and develop policy, whether or not it intends to pursue accreditation in the near future.

As more states undertake the production of a SHA, ASTHO hopes to support continuous learning and quality improvement to build on this guide for the long term.



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APPENDIX A: [LINKS TO EXISTING STATE HEALTH ASSESSMENTS AND STATE HEALTH IMPROVEMENT PLANS](#)

- Arizona State Health Improvement Plan
<http://www.azdhs.gov/documents/operations/managing-excellence/azhip.pdf>
- Colorado Public Health Improvement Planning
https://www.colorado.gov/pacific/sites/default/files/OPP_2015-CO-State-Plan.pdf
- Connecticut State Health Assessment/State Health Improvement Plan
<http://www.ct.gov/dph/cwp/view.asp?a=3130&Q=515380&PM=1>
- Florida CHARTS: Community Health Assessment Resource Tool Set
<http://www.flhealthcharts.com/charts/Default.aspx>
- Illinois State Health Improvement Plan
<http://www.idph.state.il.us/ship/index.htm>
- Indiana State Health Improvement Plan
http://www.in.gov/isdh/files/Indiana_State_Health_Plan_FINAL_6_23_11.pdf
- Healthy Iowans: Iowa State Health Improvement Plan
<https://idph.iowa.gov/healthy-iowans/plan>
- Maryland State Health Improvement Process
<https://pophealth.health.maryland.gov/Pages/SHIP.aspx>
- Michigan's State Health Assessment and State Health Improvement Plan
http://www.michigan.gov/documents/mdch/MDCH_SHIP_FINAL_8-16-12_400674_7.pdf
- Minnesota Statewide Health Improvement Program
<http://www.health.state.mn.us/ship/>
- Nebraska: A Strategic Plan to Strengthen and Transform Public Health in Nebraska
http://dhhs.ne.gov/publichealth/Documents/TP_Exec_Summ.pdf
- New York State Health Improvement Plan
http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/
- New Hampshire State Health Improvement Action Plan
<http://www.dhhs.nh.gov/dphs/iphnh/publications.htm>
- North Carolina Public Health Improvement Plan
http://publichealth.nc.gov/taskforce/2008/improvement_plan_2008.pdf
- Ohio State Health Improvement Plan
<http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/lhd/Ohio%202012-14%20SHIP.ashx>
- Oklahoma State Health Profile
https://www.cdc.gov/nchstp/stateprofiles/pdf/oklahoma_profile.pdf
- Oregon State Health Improvement Plan
http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/OregonHealthImprovementPlan/Documents/hip_plan.pdf

- Pennsylvania State Health Improvement Plan: Special Report and Plan to Improve Rural Health Status
http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/Health%20Planning/Documents/SHIP/2015-2020_PA_SHIP.pdf
- Vermont State Health Improvement Plan
<http://www.healthvermont.gov/about-us/how-are-we-doing/state-health-improvement-plan>
- Public Health Improvement Partnership (Washington State)
<http://www.doh.wa.gov/PublicHealthandHealthcareProviders/PublicHealthSystemResource-andServices/PublicHealthImprovementPartnershipPHIP.aspx>
- Healthiest Wisconsin 2020
<http://www.dhs.wisconsin.gov/hw2020/>

APPENDIX B: PLANNING MODELS MATRIX, FLORIDA

Community Health Assessment and Health Improvement Planning Models Matrix*

ESSENTIAL STEPS IN COMMUNITY HEALTH ASSESSMENT AND HEALTH IMPROVEMENT PLANNING								
MODEL	DEVELOP PLAN	ASSESS HEALTH OF THE COMMUNITY				GET RESULTS, TAKE ACTION		
		GATHER INPUT	REVIEW DATA	PUBLIC HEALTH SYSTEM	SWOT ANALYSIS	PRIORITIZE	SET GOALS	ACTION PLAN
PATCH (Planned Approach to Community Health) CDC 1985		Mobilizing the Community	Collecting Data			Choosing Health Priorities		Developing a Plan Evaluating PATCH
PACE EH (Protocol for Assessing Community Excellence in Environmental Health) NACCHO 2000	Task 1 – Determine community capacity Task 2 – Define community Task 3 – Assemble team	Task 4 – Define goals, objectives, scope Task 5 – Generate list of community-specific environmental health issues	Task 6 – Analyze issues with system framework Task 7 – Develop locally appropriate indicators Task 8 – Select standards			Task 9 – Create issue profiles Task 10 – Rank issues Task 11 – Set priorities		Task 12 – Develop action plan Task 13 – Evaluate progress and plan for future
APEX PH (Assessment Protocol for Excellence in Public Health) NACCHO 1991		Part II: Community Process (identify health problems, set health status goals; programmatic objectives and identify resources)		Part I: Organizational Capacity Assessment (internal self-assessment of local health dept.)		Part III: Completing the Cycle (implement action plan and community health plan, review policy development and assurance functions of local health department)		
MAPP (Mobilizing for Action through Planning and Partnerships) NACCHO 2000	Organize for Success Partnership building Visioning	Community Themes and Strengths Assessment	Community Health Status Assessment	Local Public Health System Assessment	Forces of Change Assessment	Identify Strategic Issues	Formulate Goals and Strategies	Action Cycle Evaluation Celebrate Success
Healthy People in Healthy Communities (HP2010) CDC 2001		Mobilize Key Individuals and Organizations	Assess Community Needs, Strengths and Resources		Assess Community Needs, Strengths and Resources	Plan for Action		Implement Action Plan Track Progress and Outcomes

*Terminology for steps matches language in each model

APPENDIX C: STAKEHOLDER ENGAGEMENT MATRIX, CONNECTICUT

Stakeholder Engagement Matrix															
Connecticut State Health Assessment and State Health Improvement Plan															
STAKEHOLDER INFORMATION							ENGAGEMENT METHODS								
Organization	Contact Person	Address	Phone #	Email Address	Area of Expertise	Sector	Interview	SHA Advisory Group	SHIP Steering Committee	Survey	Inform via Email Updates	Structured Feedback via Internet	Leadership Decision Group	Public Feedback Forums 1 & 2	Topical Work Groups F=Facilitator M=Member

Source: Connecticut Department of Public Health, adapted from Health Resources in Action, Inc., 2012

APPENDIX D: STATE HEALTH IMPROVEMENT PLAN STEERING COMMITTEE BYLAWS AND CHARTER, ILLINOIS

STATE OF ILLINOIS State Health Improvement Plan Planning Team BYLAWS

ARTICLE I

Membership:

Section 1-1. The members of the State Health Improvement Plan Planning Team (the “SHIP Team”) are appointed by the Director of the Illinois Department of Public Health (the “Department”), in accordance with Section 5-565 (a-10) of the Administrative Civil Code (P.A. 93-0975).

Section 1-2. Members shall serve until the submission of the SHIP Team’s final report to the General Assembly. Vacancies in membership shall be filled by the Director of the Department.

Section 1-3. The Director of the Department or his or her designee shall chair the SHIP Team.

Section 1-4. Absent SHIP Team members may be represented by surrogates, who may participate in SHIP Team meetings but are not entitled to vote.

ARTICLE II

Meetings:

Section 2-1. Regular meetings shall be scheduled by the SHIP Team. It shall be the responsibility of the Department to give notices of the location, date and time of said regular meetings to each member of the SHIP Team at least ten (10) days prior to each of the said meetings.

Section 2-2. Special meetings may be called by the Chair or by request of 12 members of the SHIP Team, in accordance with the Open Meetings Act. It shall be the responsibility of the Department to give notices of the location, date and time of said regular meetings to each member of the SHIP Team at least ten (10) days prior to each of the said meetings.

Section 2-3. A meeting may be rescheduled by the Chair.

Section 2-4. All SHIP Team meetings shall be open to the public unless a meeting or portion thereof qualifies for a closed session in accordance with the Open Meetings Act. Minutes of SHIP Team meetings shall be kept in accordance with the Open Meetings Act.

Section 2-5. The Chair shall prepare an Agenda of business scheduled for deliberation prior to each meeting. The approval of Minutes from the previous meeting shall be included on each Agenda. The Agenda shall be distributed to the members of the SHIP Team at least five days prior to a scheduled meeting.

ARTICLE III

SHIP Team Officers:

Section 3-1. The Director of the Department shall select a Co-Chair from among the SHIP Team members. The Chair and Co-Chair shall have the duties and responsibilities described in these Bylaws.

Section 3-2. If the Chair’s membership on the SHIP Team is vacated for any reason, or the Chair resigns from that office, the Co-Chair shall serve in place of the Chair until the designation of a new Chair by the Director of the Department.

ARTICLE IV

Conducting Business:

Section 4-1. All business shall be conducted in a manner consistent with the intent of Robert’s Rules of Order.

Section 4-2. It is the intent of the SHIP Team to reach consensus on decisions brought to it for action. In the event that goal cannot be attained, each SHIP Team member shall have one vote on a contested motion. A contested motion shall be passed by a majority vote of the members present, except as otherwise provided in these bylaws. A member is present to conduct business if attending a meeting

in person, or by audio or video conference, if such audio or video conferencing is available. Physical presence at the SHIP Team meetings, however, is strongly encouraged and is preferred by the SHIP Team.

Section 4-3. The Chair shall preside at all SHIP Team meetings. In the Chair's absence, the Co-Chair shall preside over that meeting and assume the Chair's duties related to that meeting. In the absence of both the Chair and Co-Chair, the SHIP Team shall appoint a presiding officer for that meeting, by majority vote.

Section 4-4. The presiding officer shall be responsible for conducting the meeting in accordance with the Bylaws and the Agenda, and may recognize nonmember attendees who wish to comment during the meeting. The duration of public comments shall be at the presiding officer's discretion.

ARTICLE V

Committees:

Section 5-1. The SHIP Team may form standing committees or ad hoc committees.

Section 5-2. SHIP Team members will be asked to express their committee preferences for consideration. The Chair shall appoint the membership of the committees, taking into consideration the expressed preferences. The Chair of each committee shall be appointed by the Chair of the SHIP Team. Each committee may elect a Vice-Chair. Persons who are not members of the SHIP Team may serve as adjunct, non-voting members of a Committee, appointed by the Committee Chair. The Committee Chair shall be available to report on committee activities.

Section 5-3. Each committee Chair shall promptly notify, through SHIP Team staff, all SHIP Team members and the Department of all dates, times and locations for all regularly scheduled, rescheduled or special meetings of the committee.

Section 5-4. All committee meetings shall be open to the public unless a meeting or portion thereof qualifies for a closed session in accordance with the Open Meetings Act. Minutes of committee meetings shall be kept in accordance with the Open Meetings Act.

Section 5-5. All committee business shall be conducted in a manner consistent with the intent of Robert's Rules of Order.

Section 5-6. Each committee member shall have one vote on a contested motion. Contested motions shall be passed by a majority vote of the members present. A member is present to conduct business if attending a meeting in person, or by audio or video conference, if audio or video conferencing is available.

ARTICLE VI

Bylaws:

Section 6-1. Adoption or amendment of these Bylaws requires a two-thirds vote of the SHIP Team members present and voting. Amendments shall be proposed at a meeting of the SHIP Team and voted upon during the next subsequent meeting.

APPENDIX E: STATE HEALTH IMPROVEMENT PARTNERSHIP CHARTER, WASHINGTON

State Public Health Improvement Partnership Charter, Washington

February 2012

PURPOSE

The Partnership is directed by the legislature to guide and strengthen the governmental public health system in Washington State. To accomplish that, we are responsible to ensure that our actions support a public health system that is accountable, continuously measures and improves performance and health outcomes, and reduces environmental and other health risks.

GUIDING PRINCIPLES

The 7 principles below reflect our belief about our role and the impact we want to have on the health of Washington's residents. The principles guide who we are, what we do, why and how we do it.

1. We represent governmental public health (local, tribal, state and federal)
2. Our vision is for a public health system that improves and protects the health of the people in Washington State
3. We know that health outcomes are improved through innovative strategies and evidence based public health interventions
4. We identify and respond to population-based health issues and trends
5. We value public health research to better inform our efforts
6. We acknowledge the importance of delivering results with the resources we have been given
7. We treat each other as valued colleagues and partners

PARTNERSHIP

The Public Health Improvement Partnership (PHIP) is comprised of representatives from the governmental public health system:

- Washington State Board of Health
- Washington State Department of Health
- Washington State Association of Local Public Health Officials
- Local Public Health Agencies
- Local Boards of Health
- Tribal Nations
- American Indian Health Commission
- Centers for Disease Control/DHHS Region X

SCOPE

Over the next 5-7 years, we will provide leadership and engage the public health community in the following efforts to improve the health of the residents of Washington State:

- Develop a clear vision and plan for a sustainable, results-oriented public health system
- Guide the public health work to better respond to the changing needs of preventable illness and disease in our state

- Identify and count the activities and services provided by the governmental public health system (local, state, tribal) in Washington State and begin to develop performance measures
- Determine public health system capacity and assess performance, using the Public Health Standards for Washington State and help prepare the public health system for voluntary accreditation
- Identify and implement strategies and actions to strengthen the governmental public health system
- Identify, propose, and promote public health policies to improve the health of our communities
- Promote quality improvement of the governmental public health system, focusing on short- and long-term results
- Promote population based and systems work that reduces health disparities

STRUCTURE

Partner representation will consist of a diverse group of governmental public health professionals across multiple disciplines. These individuals will also play a critical role in understanding the factors that impact local, state and national public health. Replacement of partner representatives may occur in a fashion to maintain the continuity of the partnership.

LEADERSHIP

- *Co-Chairs*
 - Secretary of Health
(Washington State Department of Health)
 - Partner Representative – 2-year term
(Local Public Health Jurisdiction)

MEMBERSHIP

- *Partner Representation*
 - Washington State Board of Health – 1 seat
(Nominated by the State Board of Health)
 - Washington State Department of Health – 6 seats
(Representatives appointed by Secretary of Health from the following and other program areas – deputy secretary, performance and accountability, community and family health, epidemiology and public health lab, environmental health, health systems quality assurance)
 - Washington State Association of Local Public Health Officials – 3 seats
(Representatives nominated by WSALPHO Chair)
 - Local Public Health Agencies – 3 seats
(Targeted recruitment of LHJ leaders)
 - Local Boards of Health – 1 seat
(Targeted recruitment)
 - Tribal nations representative – 1 seat
(Targeted recruitment of a representative of a tribal nation that delivers public health services)
 - American Indian Health Commission – 1 seat
(Nominated by the Commission)
 - DHHS Region X – 1 seat
(Region X representative)
The Secretary of Health will appoint all partner members including the partnership co-chair.
- *Ad Hoc/Advisory Members*

Ad hoc/Advisory members will be informed on a regular basis of partnership work. Their input will be solicited and their participation requested and valued as workgroup members. They will not be voting members of the partnership.

 - Washington Health Foundation

- University of Washington/Northwest Center for Public Health Practice
- Washington State Public Health Association
- Individuals/organizations with expertise in areas of information technology, communications, workforce development, finance, and legislative policy

RESPONSIBILITY

Partnership representatives will be expected to use their experience, expertise, and insight (and those of other individuals from their organizations) to strengthen and build professionalism in the public health system. Representatives will need to have a broad understanding of public health practice, be genuinely interested in the partnership initiatives, and understand the strategic implications and outcomes of the efforts being undertaken.

Member responsibilities will be to:

- Set vision and direction
- Advocate for outcomes of the Partnership and its workgroups
- Advocate for the Partnership with LHJs, DOH and other stakeholders
- Bring ideas and solicit input from stakeholders
- Engage in workgroup activities and provide two-way communication between the partnership and the specific workgroup; may serve as a workgroup co-chair
- Approve work plan for workgroups
- Approve major products, actions, initiatives
- Approve the PHIP plan
- Attend quarterly meetings and additional meetings if required (sending substitutes is not recommended unless under special circumstances approved by the partnership co-chairs)

DECISION-MAKING PROCESS

Members present at a meeting will be formally polled on critical issues. Decisions will be based on consensus or the majority vote of the members present at the meeting, as determined by the co-chairs. If there is a tie, the Secretary of Health will vote.

MEETING SCHEDULE

The Partnership will meet quarterly. The intent is that no more than two of these meetings will be held in person. The remaining meetings will be held using available technology. As specific efforts and other business needs require, special meetings may be called.

APPENDIX F: AGENDA DEVELOPMENT TOOL

Agenda Development Tool

Overall Group Goal:			
SESSION OBJECTIVES		CORRELATING OUTCOMES	
<ul style="list-style-type: none"> • • • • 		<ul style="list-style-type: none"> • • • • 	
Members Needed	Role	Specific Needs	
Information or Pre-work for Participants (List Items/Info)	Person Responsible	Target Date	
What Specific Group Norms Need to Be Established?			
Norm Needed	Why?	How?	Interventions

What Type of Opener Is Needed? Purpose?			
Activity Steps	Person Responsible	Time	Materials
Discussion Items (Consider Information Sharing Needed, Planning Discussions, Problem-Solving, Relationship Building or Process and Conflict Resolution)			
Discussion Items	Purpose/Outcome Desired	Special Contributors or Reference Material	Time Needed/% of Meeting
Decision Items (Consider Difficulty Level and Empowerment Level)			
Decisions to Be Made	Type of Decision Needed	Materials Needed	Time Needed/% of Meeting
Potential Barriers/Solutions			
Potential Resistance or Barrier	Where?	Who?	Solutions
Measuring Effectiveness			
Element to Measure	How? Question?		Method

APPENDIX G: MEETING EFFECTIVENESS SURVEY TEMPLATE

Meeting Effectiveness Survey						
		1	2	3	4	5
Committee Role	To what extent were the committee roles clarified at this meeting?					
Clear Goals	To what extent were the goals clear for this meeting?					
Communication	To what extent was the discussion open, with sharing of diverse ideas and perspectives?					
Commitment to the Group	To what extent was I committed to helping to achieve the group's goals for this meeting?					
Participation	To what extent did I say or contribute what I thought was important to achieving our goals for this meeting?					
Effectiveness	Overall, how effective was the group in meeting its goals during this meeting?					
Value	How valuable was this meeting for success of the overall work for this committee?					
Satisfaction	Overall, how satisfied were you with today's meeting?					

APPENDIX H: HEALTH INDICATOR MATRIX (IN DRAFT), OKLAHOMA

Overall Health Indicators Matrix									
Health Status Indicator	Data Availability [Ntl, St, Co & Frequency]	Data Source	Impact	Ability to Affect Change	Importance Aspect	Measurable	Links to Other Measures	Demographic Availability	Trend Data
Heart Disease Deaths	X	OK2SHARE/CDC WONDER	H	H	H	X	X	M	X

APPENDIX I: FLORIDA MAPP FIELD GUIDE, CONDUCTING A COMMUNITY DIALOGUE

Nov. 2008 update

Conducting a Community Dialogue

The following process is a useful method for structuring community dialogue.

Preparing for the Dialogue

Select a site that can readily accommodate 20-35 persons. The room should be set up with participants seated in a circle. This encourages participation by all persons in attendance.

Notification should be clear and given in a timely manner so as to avoid confusion. Care should be taken that the time and place facilitate as broad attendance as possible. In some communities, several different venues and schedules will be required to engage stakeholders with differing schedules or lifestyles.

Beginning the Dialogue

Set the tone prior to opening the dialogue session by greeting participants when they arrive, arranging for clear signage and offering light refreshments. Helping people feel comfortable upon arrival and communicating to participants the importance of their presence can go a long way toward the more difficult work of building trust and commitment.

Open the meeting with an explanation of MAPP and why dialogue is important. The meeting should then be turned over to the facilitator(s). Skilled facilitation will play a particularly large role in helping to create an environment of trust, commitment and openness at the outset. It will also provide for timely introduction of dialogue skills and practice when required.

Checking-in is a very simple way of breaking tension and encouraging broad participation. This may be as simple as beginning the meeting with a question such as “Why is this meeting important to you?” or “What needs to happen here today in order for this meeting to be a success to you?” and allowing each person in the room to introduce themselves and briefly respond. The value is to honor the various voices that are present in the room, rather than allowing the meeting agenda to drive the outcome. Observing a similar protocol at the end of the meeting (check-out) helps to bring closure and ensure that all voices have an opportunity to be heard.

Content of the Dialogue

A trained facilitator will broadly frame the focus of the group and help important themes and issues to emerge. For instance, a dialogue around quality of life issues or the mapping of community assets may stimulate participants’ ideas of community assets or quality of life. Through discussion, participants will be able to identify areas of agreement and disagreement. As new insights emerge, they should be captured and clarified.

Follow-up and Sustaining the Dialogue

Sustain the dialogue over time by using sign-in sheets to facilitate follow up, summaries of brainstorming or other types of sessions and possible outside information sources. For example, the Community Health Status Assessment may reveal some data that are surprising to the community, and having that data clearly available in a timely way will make the community dialogue more productive. In all likelihood, this responsibility will fall to a lead agency or community partner at the outset, but as the process continues, the participants will increasingly assume this role.

References:

- Coalition for Healthier Cities and Communities. *Healthy People in Healthy Communities: A Dialogue Guide*. Chicago, IL: 1999
- Daniel Martin. *The Spirit of Dialogue. International Communities for the Renewal of the Earth*: 1999.

APPENDIX J: KANSAS COMMUNITY HEALTH SURVEY



Healthy Kansans 2020 - Opinion Survey

The Kansas Department of Health and Environment is asking people their opinions on health issues in Kansas. Your responses will help Kansas leaders plan programs and policies to better meet the needs of Kansans for the next ten years.

Please note that your individual responses will be kept anonymous; everyone's answers will be combined to give us information about what the health priorities in Kansas should be for the next ten years. **Thank you for your time and cooperation.**

1. Thinking about **injury and safety issues**, which **one** of the following do you think Kansas leaders should give the top priority for the next ten years?
 - Fires
 - Accidental poisonings
 - Falls
 - Drowning
 - Motor vehicle crashes
 - Farm or machinery accidents
 - Don't know

2. Thinking about **violence**-related issues, which **one** of the following do you think Kansas leaders should give top priority for the next ten years?
 - Bullying in schools
 - Child abuse or neglect
 - Sexual or domestic violence
 - Homicide
 - Suicide
 - Terrorism
 - Don't know

3. Thinking about **environmental** issues, which **one** of the following do you think Kansas leaders should give top priority for the next ten years?
 - Indoor air quality
 - Outdoor air quality
 - Adequate clean water supply
 - Waste management (e.g., landfills, waste reduction, recycling)
 - Response to and clean up from natural disasters
 - Don't know

4. Thinking about **chronic diseases**, which **one** of the following do you think Kansas leaders should give top priority for the next ten years?

- Diabetes
- Cancer
- Heart disease and stroke
- Obesity
- Asthma
- Don't know

5. Thinking about **health issues affecting women, infants, and children**, which **one** of the following do you think Kansas leaders should give top priority for the next ten years?

- Healthy women before, during, and after pregnancy
- Infant death reduction including premature births and safe sleep practices**
- Young children ready to learn (i.e., "school readiness")
- Adolescent health (e.g., behavioral health and teen pregnancy)
- System supports for families with children who have special health or developmental needs
- Don't know

6. Thinking about **lifestyle behaviors**, which **one** of the following do you think Kansas leaders should give top priority for the next ten years?

- Lack of exercise
- Lack of proper nutrition
- Tobacco use
- Alcohol use
- Illegal drug use
- Lack of child car set, booster set, and/or seat belt use
- Lack of motorcycle and/or bicycle helmet use
- Don't know

The next few questions ask for a little more information about yourself.

7. What is your **sex**?

- Male
- Female

8. What is your **age**?

- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65+

9. Are you **Hispanic or Latino**?

- Yes
- No

10. Which **one or more** of the following would you say is your **race**? (Check all that apply.)

- White
- Black or African American
- Asian
- Native Hawaiian or Other Pacific Islander
- American Indian or Alaska Native
- Other (please specify): _____

11. In what **county** do you live? _____

12. What is the **highest grade** or year of school you completed?

- Never attended school or only attended kindergarten
- Grades 1 through 8 (Elementary)
- Grades 9 through 11 (Some high school)
- Grade 12 or GED (High school graduate)
- College 1 to 3 years (Some collage or technical school)
- College 4 years or more (College graduate)
- Advanced professional degree (Masters or Doctorate)
- I'd rather not say

13. Is your **annual household income** from all sources...?

- Less than \$10,000
- \$10,000 to less than \$15,000
- \$15,000 to less than \$20,000
- \$20,000 to less than \$25,000
- \$25,000 to less than \$35,000
- \$35,000 to less than \$50,000
- \$50,000 to less than \$75,000
- \$75,000 to less than \$100,000
- \$100,000 or more
- Don't know/I'd rather not say

14. Are you currently...?

- Employed for wages
- Self-employed
- Out of work for less than 1 year
- Out of work for more than 1 year
- A homemaker
- A student
- Retired
- Unable to work
- I'd rather not say

15. If employed, which of the following best describes your **work setting**?

- Public Health Agency (state or local)
- Academic/Educational Institution (i.e., Pre-K/Childcare, K-12, University/Higher Education)
- Crime and Justice
- Transportation
- Other Government Agency (e.g., city/county planner, city/county manager, council person/commissioner, etc.)
- Healthcare Service (e.g., Hospital, Laboratory, FQHC, Dentist Office, Home Care, etc.)
- Social Service
- Non-Profit Organization (except Healthcare)
- Private Industry (except Healthcare)
- Not currently in workforce
- Other (please specify): _____

Next, we'd like to ask about more issues impacting the health and well-being of Kansans.

16. Thinking about **infectious diseases**, which **one** of the following do you think Kansas leaders should give top priority for the next ten years?

- HIV/AIDS
- Other sexually transmitted diseases
- Tuberculosis
- Flu (Seasonal, H1N1, and/or pandemic)
- Immunization (child and adult)
- Hepatitis
- Don't know

17. Thinking about **health issues encountered by Kansans living with a disability** (e.g., physical, cognitive, or mental illness), which **one** of the following issues do you think Kansas leaders should give top priority for the next ten years?

- Increasing access to healthcare
- Educating healthcare providers about how to effectively communicate with people with disabilities
- Increasing access to physical activity
- Decreasing obesity
- Decreasing sexual and domestic violence
- Don't know

The next few questions are about other conditions that may cause illness or disability among Kansans.

18. In your opinion, how big of a problem is **oral (dental) health**, on a scale of 1 to 5 (e.g., cavities, gum disease, and access to dental health care)?

	Not a problem	-----	Somewhat of a problem	-----	A big problem
	1	2	3	4	5
Oral (dental) health					

19. In your opinion, how big of a problem are **disabling conditions**, on a scale of 1 to 5 (e.g., chronic back pain, visual or hearing impairment, and other conditions that limit people's daily activities)?

	Not a problem	-----	Somewhat of a problem	-----	A big problem
	1	2	3	4	5
Disabling conditions					

20. In your opinion, how big of a problem are **mental health issues**, on a scale of 1 to 5 (e.g., anxiety, depression, or other issues that affect people's ability to deal with everyday life)?

	Not a problem	-----	Somewhat of a problem	-----	A big problem
	1	2	3	4	5
Mental health issues					

21. In your opinion, how big of a problem is **lack of access to a primary care doctor**, on a scale of 1 to 5?

	Not a problem	-----	Somewhat of a problem	-----	A big problem
	1	2	3	4	5
Lack of access to a primary care doctor					

22. In your opinion, how big of a problem is **lack of or inadequate health insurance**, on a scale of 1 to 5?

	Not a problem	-----	Somewhat of a problem	-----	A big problem
	1	2	3	4	5
Lack of health insurance					

23. The next question relates to the influence of **social factors** on a person’s health. On a scale of 1 to 5, how much do you think each of these factors can **influence the health of an individual?**

	Not an influence 1	----- 2	Somewhat of an influence 3	----- 4	A big influence 5
Safe and affordable housing					
Level of education					
Income level					
Social connections (e.g., friends, family, and involvement in clubs or faith-based organizations)					
Neighborhood conditions where you work and live (e.g., walk-able sidewalks, adequate street lighting, bike lanes, walking trails, parks and recreation facilities in close proximity, and access to grocery stores or healthy foods)					

These last few questions are to determine how much influence you believe the 12 topics we’ve covered have on a person’s health.

24. Which **three** do you feel are the most important issues for **Kansas leaders to give top priority** for the next ten years? Put a “1” by the topic you feel is most important, a “2” by your second priority, and then a “3” by your third priority.

Topic	Rank 1 st , 2 nd , and 3 rd priorities
Injury and safety	
Environment (e.g., air and water quality)	
Chronic diseases (e.g., diabetes, cancer, heart disease, obesity, asthma)	
Health issues affecting mothers, infants, and children	
Lifestyle behaviors	
Violence	
Infectious diseases	
Oral (dental) health	
Health issues among Kansans living with disabilities	
Mental health issues	
Access to care	
Social factors (e.g., housing, education, income, social connections, and neighborhood conditions)	

25. Which **one** topic do you feel is most important for **elected leaders in Kansas to focus on** in developing policy to improve health? Put a “✓” by your choice.

Topic	Check (✓) one
Injury and safety	
Environment (e.g., air and water quality)	
Chronic diseases (e.g., diabetes, cancer, heart disease, obesity, asthma)	
Health issues affecting mothers, infants, and children	
Lifestyle behaviors	
Violence	
Infectious diseases	
Oral (dental) health	
Health issues among Kansans living with disabilities	
Mental health issues	
Access to care	
Social factors (e.g., housing, education, income, social connections, and neighborhood conditions)	
None	

26. Relating these topics to the organization you work for, on which **three does your organization spend the most time and resources?** Put a “1” by the topic you feel your organization spends the most time and resources on, a “2” by the second, and a “3” by the third.

Topic	Rank 1 st , 2 nd , and 3 rd priorities
Injury and safety	
Environment (e.g., air and water quality)	
Chronic diseases (e.g., diabetes, cancer, heart disease, obesity, asthma)	
Health issues affecting mothers, infants, and children	
Lifestyle behaviors	
Violence	
Infectious diseases	
Oral (dental) health	
Health issues among Kansans living with disabilities	
Mental health issues	
Access to care	
Social factors (e.g., housing, education, income, social connections, and neighborhood conditions)	
Other (please specify)	
Not applicable	

27. Which **three** topics **do you feel the organization you work for should invest more time and resources?** Put a “1” by the topic you feel your organization should invest more time and resources on, a “2” by the second, and a “3” by the third.

Topic	Rank 1 st , 2 nd , and 3 rd priorities
Injury and safety	
Environment (e.g., air and water quality)	
Chronic diseases (e.g., diabetes, cancer, heart disease, obesity, asthma)	
Health issues affecting mothers, infants, and children	
Lifestyle behaviors	
Violence	
Infectious diseases	
Oral (dental) health	
Health issues among Kansans living with disabilities	
Mental health issues	
Access to care	
Social factors (e.g., housing, education, income, social connections, and neighborhood conditions)	
Other (please specify)	
Not applicable	

Thank you for completing this survey! If there are health-related topics that were not covered in this survey that you feel Kansas leaders should invest time and resources in addressing please list them in the space provided.

APPENDIX K: CDC COMMUNITY HEALTH SURVEY

Instructions to Survey interviewers:

- The demographic categories in this survey match the categories from the 2010 Census.
- Instructions for the interviewers are in red type. Do not read these instructions out loud when administering the surveys.

Introduction:

Hello,

I am representing the **(insert organization name)**. My name is **(insert name)**. I am conducting an opinion survey to learn more about the health and quality of life in **(insert community name)**. If you agree to participate, I will ask you some questions about major health and community issues in our community. The survey is completely voluntary, and it should take around 20 minutes to complete. Your answers will be completely confidential. The information you give me will not be linked to you in any way. You may refuse to take part in the survey or refuse to answer any of the questions.

Are you at least 18 years or older?

If “yes,”

Then you are the person I need to speak with.

If “no,”

Is there someone I could speak with who is at least 18 years old?

[ONCE A PERSON AT LEAST 18 YR OLD HAS BEEN IDENTIFIED.]

[READ INTRODUCTION OF SCRIPT AGAIN.]

Would you be willing to participate in our survey?

[WAIT FOR RESPONDENT TO CLEARLY ANSWER YES OR NO.]

Thank you very much for your time. Let’s begin.

Part 1. Quality of Life Statements

These first questions are about your general wellbeing in your community. Please tell us whether you “strongly agree”, “agree”, “neutral”, “disagree” or “strongly disagree” with each of the next six statements. Your answers will remain anonymous. If participant answers, “not applicable or I don’t know” – mark “neutral”.

Statements	Circle the number that best represents your opinion of each statement below.				
	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
<p>1. How do you feel about this statement, “There is good healthcare in my community”? <i>Consider the cost and quality, number of options, and availability of healthcare in the community.</i></p>	1	2	3	4	5
<p>2. How do you feel about this statement, “My community is a good place to raise children”? <i>Consider the quality and safety of schools and child care programs, after school programs, and places to play in this community.</i></p>	1	2	3	4	5
<p>3. How do you feel about this statement, “My community is a good place to grow old”? <i>Consider the community’s elder-friendly housing, transportation to medical services, recreation, and services for the elderly.</i></p>	1	2	3	4	5
<p>4. How do you feel about this statement, “There is plenty of economic opportunity in my community”? <i>Consider the number and quality of jobs, job training/ higher education opportunities, and availability of affordable housing in the community.</i></p>	1	2	3	4	5
<p>5. How do you feel about this statement, “My community is a safe place to live”? <i>Consider how safe you feel at home, in the workplace, in schools, at playgrounds, parks, and shopping centers in the community.</i></p>	1	2	3	4	5
<p>6. How do you feel about this statement, “There is plenty of help for people during times of need in my community”? <i>Consider social support in this community: neighbors, support groups, faith community outreach, community organizations, and emergency monetary assistance.</i></p>	1	2	3	4	5

Part 2. Health Outcomes

The next question is about health issues in your community. Remember, your answers will remain anonymous.

7. Please look at this list of community health issues. *(Give person the handout #1 of community health issues.)* In your opinion, which of the following community health issues requires the most attention? (Check all that apply.) If there is a community health issue that you consider important that is not on this list, then please let me know and I will write it in. If you would like, I can read these out loud as you think about them. *(Read health issues if they prefer to have them read.)*
- a. Asthma and other respiratory diseases
 - b. Cancer
 - c. Heart Disease
 - d. HIV/ AIDS
 - e. Homicide
 - f. Infant deaths
 - g. Injury-related deaths
 - h. Low birth weight
 - i. Motor vehicle-related deaths or injuries
 - j. Obesity
 - k. STDs (chlamydia, gonorrhea, syphilis)
 - l. Suicide
 - m. Tuberculosis
 - n. Other, please specify: _____ *(Write in response.)*

Part 3. Child Health Information

The next questions apply to parents or guardians about the information needs regarding children in your community.

8. Do you have a child or children between the ages of 9 and 19 for which you are the caretaker? *(Includes step-children, grandchildren, or other relatives.)*

- a. Yes *(Go to #9.)*
- b. No *(Skip to #10.)*
- c. Refuse to answer *(Do not read.)*

9. Please look at this list of children's health topics. *(Give person the handout #2 of children's health topics.)* In your opinion, which of the following health topics does(do) your child/children need more information? (Check all that apply.) If there is a health topic that you consider important that is not on this list, then please let me know and I will write it in. If you would like, I can read these out loud as you think about them. *(Read children's health topics if they prefer to have them read.)*

- a. Alcohol
- b. Asthma Management
- c. Dental hygiene
- d. Asthma management
- e. Diabetes management
- f. Drug Abuse
- g. Eating Disorders
- h. Mental health issues
- i. Nutrition
- j. Physical Inactivity
- k. Reckless driving/speeding
- l. Sexual intercourse
- m. STDs
- n. Suicide prevention
- o. Tobacco
- p. Other, please specify: _____ *(Write in response.)*

Part 4. Personal Behaviors

These next questions are about your own personal habits and health activities. Remember, your answers will remain anonymous.

10. During a normal week, other than in your regular job, do you exercise or engage in any physical activity (e.g. walking, cycling, participating in sports) that lasts at least 30 minutes?
- Yes *(Go to #11.)*
 - No *(Skip to #13.)*
 - Don't know/ Not sure *(Skip to #13.)*
 - Refuse to answer *(Do not read.)*
11. How many times do you exercise or engage in physical activity during a normal week? *(If you exercise more than once a day, count each separate physical activity that lasts for at least 30 minutes to be one "time.")* _____ *(Write number.)*
12. Where do you go to exercise or engage in physical activity? *Check all that apply. (DO NOT read the options. Mark only the ones they say. If they really can't think of one, then mark "Somewhere else".)*
- Church *(Skip to #14.)*
 - Gym or recreation center *(Skip to #14.)*
 - Home *(Skip to #14.)*
 - Neighborhood *(Skip to #14.)*
 - Part of your daily travel/commute *(Skip to #14.) (IF ASKED: For example, do you walk or bike to work, school or other places?)*
 - Public parks or trails *(Skip to #14.)*
 - Workplace *(Skip to #14.)*
 - Somewhere else? _____ *(Write in response.) (Skip to #14.)*
 - Refuse to answer *(Do not read.)*
13. What are the reasons that you don't exercise for at least 30 minutes during a normal week? *Check all that apply. (DO NOT read the options. Mark only the ones they say. If they really can't think of one, then mark "I don't know".)*
- My job or daily routine is physical or hard labor.
 - Exercise is not important to me.
 - I don't have access to a facility that has the things I need to exercise.
 - I don't have enough time to exercise.
 - I would need child care and I don't have it.
 - I don't know how to find exercise partners.
 - I don't like to exercise.

- h. It costs too much to exercise.
- i. There is no safe place to exercise.
- j. I'm too tired to exercise.
- k. I'm physically disabled.
- l. I don't know.
- m. Other, please specify: _____ *(Write in response.)*

These next questions are about how many servings of fruits and vegetables you eat during a normal week. Please think about all forms of fruits and vegetables including cooked or raw, frozen or canned.

14. During a normal day, how many cups of fruits and vegetables would you say you eat? Think about all meals, snacks and food that you eat at home and away from home. *Check one box that best represents the answer for each category, fruits and vegetables.*

1 apple = 1 cup

1 large banana = 1 cup

12 baby carrots = 1 cup

2 stalks of celery= 1 cup

<p>FRUITS</p> <ul style="list-style-type: none"> a. <input type="checkbox"/> _____ cups <i>(Write in response.) (Skip to #16.)</i> b. <input type="checkbox"/> None <i>(Go to #15.)</i> c. <input type="checkbox"/> Don't know/ Not sure <i>(Go to #16.)</i> <p>VEGETABLES</p> <ul style="list-style-type: none"> a. <input type="checkbox"/> _____ cups <i>(Write in response.) (Skip to #16.)</i> b. <input type="checkbox"/> None <i>(Go to #15.)</i> c. <input type="checkbox"/> Don't know/ Not sure <i>(Go to #16.)</i>

15. What are the reasons that you don't eat fruits and vegetables? *Check all that apply. (DO NOT read the options. Mark only the ones they say. If they really can't think of one, then mark "I don't know".)*

- a. I don't like eating fruits and vegetables.
- b. Fruits and vegetables are too expensive.
- c. The selection and quality of fruits and vegetables is poor.
- d. Grocery store is too far away.
- e. I do not have transportation to grocery store.
- f. It is some other reason: _____ *(Write in response.)*
- g. I don't know.

These next questions are about your exposure to secondhand tobacco smoke.

16. Have you been exposed to secondhand smoke in the past year?

- a. Yes *(Go to #17.)*
- b. No *(Skip to #18.)*
- c. Don't know/ Not sure *(Skip to #18.)*
- d. Refuse to answer *(Do not read.)*

17. Where do you think you were exposed to secondhand smoke most often? *Check only one box. (DO NOT read the options. Mark only the ones they say. If they really can't think of one, then mark "Other".)*

- a. Home
- b. Hospital
- c. Restaurant
- d. School
- e. Workplace
- f. Other, please specify: _____ *(Write in response.)*

These next questions are about mental health services. Remember, your answers will remain anonymous.

18. During the past 12 months, was there any time when you needed mental health treatment or counseling for yourself but didn't get it?

- a. Yes *(Go to #19.)*
- b. No *(Skip to #21.)*
- c. Don't know/ Not sure *(Skip to #21.)*
- d. Refuse to answer *(Do not read.)*

19. Why did you not get the mental health treatment or counseling that you needed? Choose one answer. *(DO NOT read the options. Mark only the ones they say. If they really can't think of one, then mark "Some other reason".)*

- a. I couldn't afford the cost. *(Skip to #21.)*
- b. I was concerned that getting mental health treatment or counseling might cause your neighbors or community to have a negative opinion of me. *(Skip to #21.)*
- c. I was concerned that getting mental health treatment or counseling might have a negative effect on my job. *(Skip to #21.)*
- d. My health insurance does not cover any mental health treatment or counseling. *(Skip to #21.)*
- e. My health insurance does not pay enough for mental health treatment or counseling. *(Skip to #21.)*

- f. I did not know where to go to get services. *(Skip to #21.)*
- g. I was concerned that the information I gave the counselor might not be kept confidential. *(Skip to #21.)*
- h. I was concerned that I might be committed to a psychiatric hospital or might have to take medicine. *(Skip to #21.)*
- i. Some other reason or reasons *(Go to #20.)*

20. Please look at this list of statements. *(Give person the handout #3 of statements for not receiving mental health treatment.)* Which of these statements explain why you did not get the mental health treatment or counseling that you needed? (Please choose only one.) If there is a statement that you consider the most important and it is not on this list, please let me know and I will write it in. If you would like, I can read these out loud as you think about them. *(Read statements if they prefer to have them read.)*

- a. I didn't think I needed treatment at the time.
- b. I thought I could handle the problem without treatment.
- c. I didn't think treatment would help.
- d. I didn't have time (because of job, childcare, or other commitments).
- e. I didn't want others to find out that I needed treatment.
- f. I had no transportation, or treatment was too far away, or the hours were not convenient.
- g. Some other reason or reasons: _____ *(Write in response.)*

Part 5. Community Related Behaviors

These next questions are about behaviors of the community. Your answers will remain anonymous.

- 21. In your opinion, how much of a concern are each of the following community related behaviors? Is it a “Major Concern”, “Concern”, “Minor Concern”, or “Not a Concern” in your community?**
If participant answers, “not applicable or I don’t know” – mark “not a concern”.

Community Related Behaviors	Circle the number that best represents your opinion of each statement below.			
	MAJOR CONCERN	CONCERN	MINOR CONCERN	NOT A CONCERN
Binge Drinking	1	2	3	4
Illegal Drug Use	1	2	3	4
Inadequate Medical Screenings	1	2	3	4
Lack of Seatbelt Use	1	2	3	4
Low Immunization Rates	1	2	3	4
Physical Inactivity	1	2	3	4
Poor Nutrition	1	2	3	4
Prescription Drug Overuse	1	2	3	4
Tobacco/ Smoking	1	2	3	4
Unsafe Sex	1	2	3	4

- 22. In your opinion, how large a problem are each of the following community related behaviors? Is it a “Major Problem”, “Problem”, “Minor Problem”, or “Not a Problem” in your community?**
If participant answers, “not applicable or I don’t know” – mark “not a problem”.

Community Related Behaviors	Circle the number that best represents your opinion of each statement below.			
	MAJOR CONCERN	CONCERN	MINOR CONCERN	NOT A CONCERN
Child Abuse	1	2	3	4
Community Support/ Neighborliness	1	2	3	4
Crime	1	2	3	4
Domestic Violence	1	2	3	4
Homelessness	1	2	3	4
Poverty	1	2	3	4
Violence	1	2	3	4

Part 6. Physical Environment

These next set of questions ask about your environment where you live, work and play.

23. In your opinion, how large a problem are each of the following issues related to your home and environment? Is it a “Major Problem”, “Problem”, “Minor Problem”, or “Not a Problem” in your community? *If participant answers, “not applicable or I don’t know” – mark “not a problem”.*

Physical Environment	Circle the number that best represents your opinion of each statement below.			
	MAJOR PROBLEM	PROBLEM	MINOR PROBLEM	NOT A PROBLEM
HOME	1	2	3	4
Health hazards within the home (mold, ventilation, excess moisture)	1	2	3	4
Pests within the home (cockroaches, mice, termites)	1	2	3	4
Physical hazards within the home (no handrails, poor lighting, loose rugs)	1	2	3	4
ENVIRONMENT	1	2	3	4
Air pollution	1	2	3	4
Drinking water quality	1	2	3	4

24. Do you (or anyone in your household) ever use public transportation? By public transportation, we mean bus, subway/ light rail/ trolley, commuter shuttle or commuter rail such as Amtrak.

- a. Yes
- b. No *(Skip to # 26.)*

25. What type(s) of public transportation do you (or people in your household) use? *Check all that apply. (DO NOT read the options. Mark only the ones they say. If they really can’t think of one, then mark “I don’t know”.*

- a. Bus
- b. Subway, light rail, trolley
- c. Commuter shuttle
- d. Commuter rail such as Amtrak
- e. Other, please specify: _____ *(Write in response.)*
- f. I don’t know

26. In a typical week, do you (or anyone in your household) walk or bicycle to any place inside or outside your neighborhood?

- a. Yes
- b. No *(Skip to # 28.)*

27. Which is it - walk, bicycle or both?

- a. Walk
- b. Bicycle
- c. Both *(Skip to # 30.)*

28. Are there any reasons why you (or anyone in your household) don't walk or bicycle in your neighborhood?

- a. Yes
- b. No *(Skip to # 30.)*

29. What are the reasons? *Check all that apply. (DO NOT read the options. Mark only the ones they say. If they really can't think of one, then mark "Other".)*

- a. No sidewalk *(If yes, don't answer #30-31.)*
- b. Inadequate sidewalks or crosswalks, i.e.. they are not wide enough or need to be repaired
- c. No bicycle lanes *(If yes, don't answer #32.)*
- d. Do not have a bicycle
- e. Too much traffic
- f. Traffic is too fast
- g. Not enough lighting
- h. Crime or other safety concerns
- i. No destinations close enough to walk or bicycle to
- j. Health does not permit walking or biking
- k. Do not have time to walk or bicycle
- l. Other, please specify: _____ *(Write in response.)*
(Put skip at end after all boxes checked)

30. Does your neighborhood have sidewalks that are wide enough for two adults to walk side by side?

- a. Yes
- b. No

31. Do the sidewalks have adequate lighting at night?

- a. Yes
- b. No

32. Does your neighborhood have any lanes on the roads that are reserved for bicycling? These lanes are also known as bike lanes.

- a. Yes
- b. No

33. Do you have grocery stores, drug stores, both, or neither within 15 minutes of driving from your home?

- a. Grocery and drug store
- b. Grocery store only
- c. Drug store only *(Skip to #35.)*
- d. Neither *(Skip to #35.)*

34. Is the grocery store a full-service grocery store or a convenience store?

- a. Full-service grocery store
- b. Convenience store

35. Are there any vandalized or abandoned buildings (e.g. deserted structures with broken windows) within a half block of where you live?

- a. Yes
- b. No *(Skip to # 37.)*

36. Is there more than one vandalized or abandoned building?

- a. Yes
- b. No

37. Is there trash, litter, or junk in the streets within a half block of where you live?

- a. Yes
- b. No

38. Think about the condition of the streets within a half block of where you live. Do these streets need major repairs, minor repairs, or no repair work?

- a. Major repair work
- b. Minor repair work
- c. No repair work
- d. No streets within half a block

Part 7. Health Care

These next set of questions are about access and barriers to receiving health care in your community.

39. Where do you go most often when you are sick? (*DO NOT read the options. Mark only the one they say. If they cannot think of one, read: Here are some possibilities. Read responses.*) Check only one box.

- a. Doctor's Office
- b. Health Department
- c. Hospital
- d. Medical Clinic
- e. Urgent Care Center
- f. Other, please specify: _____ (*Write in response.*)

40. What is your primary health insurance plan? This is the plan which pays the medical bills first or pays most of the medical bills. (*DO NOT read the options. Mark only the one they say. If they answer with the name of their insurance company then read : Is that private insurance from your employer or privately purchased? If they cannot think of one, read: Here are some possibilities. Read responses.*) Check only one box.

- a. Private health insurance plan (Blue Cross/ Blue Shield, Kaiser, Aetna, etc.) purchased from employer or workplace
- b. Private health insurance plan (Blue Cross/ Blue Shield, Kaiser, Aetna, etc.) purchased directly from an insurance company
- c. Medicare
- d. Medicaid
- e. Military, Tricare, CHAMPUS, or the VA
- f. Indian Health Service
- g. No health plan of any kind
- h. Don't know/Not sure
- i. Refuse to answer (*Do not read.*)

41. In the past 12 months, did you have a problem getting the health care you needed for you personally or for a family member from any type of health care provider, dentist, pharmacy, or other facility?

- a. Yes (*Go to #42.*)
- b. No (*Skip to #44.*)
- c. Don't know/ Not sure (*Skip to #44.*)
- d. Refuse to answer (*Do not read.*)

42. What type of provider or facility did you or your family member have trouble getting health care from? ***Check all that apply. (DO NOT read the options. Mark only the ones they say. If they really can't think of one, then mark "I don't know".)***

- a. Dentist
- b. Eye care/ optometrist/ ophthalmologist
- c. General practitioner
- d. Health department
- e. Hospital
- f. Medical Clinic
- g. OB/GYN
- h. Pediatrician
- i. Pharmacy/ prescriptions
- j. Urgent Care Center
- k. Specialist (What type?): _____ *(Write in response.)*
- l. I don't know.

43. What problems prevented you or your family member from getting the necessary health care? ***Check all that apply. (DO NOT read the options. Mark only the ones they say. If they really can't think of one, then mark "I don't know".)***

- a. I/we have no health insurance.
- b. Insurance didn't cover what I/we needed.
- c. My/our share of the cost (deductible/co-pay) was too high.
- d. Doctor would not take my/our insurance or Medicaid.
- e. Hospital would not take my/our insurance.
- f. Pharmacy would not take my/our insurance or Medicaid.
- g. Dentist would not take my/our insurance or Medicaid.
- h. There was no way to get there.
- i. I/we didn't know where to go.
- j. I/ we couldn't get an appointment.
- k. The wait was too long.
- l. Other: _____ *(Write in response.)*
- m. I don't know.

44. Where do you go for preventive services (annual checkup, mammography, colonoscopy, prostate screening)? *(DO NOT read the options. Mark only the one they say. If they cannot think of one, read: Here are some possibilities. Read responses). Check all that apply.*

- a. Doctor's office
- b. Health department
- c. Hospital
- d. Medical clinic
- e. Urgent care center
- f. Never use these services
- g. Other: _____ *(Write in response.)*

45. A flu vaccine is either a shot or mouth/ nasal spray product that is given to protect you from getting the flu. Do you get vaccinated against the flu annually?

- a. Yes *(Skip to #47.)*
- b. No *(Go to #46.)*

46. Which of these reasons prevents you from getting the flu vaccination? *Check all that apply. (DO NOT read the options. Mark only the ones they say. If they really can't think of one, then mark "Other".)*

- a. The vaccine costs too much
- b. I am concerned that the vaccine will make me sick.
- c. I am healthy and do not need the vaccine.
- d. I don't know where to go to get the vaccine.
- e. I don't know which vaccine I need.
- f. Other: _____ *(Write in response.)*

Part 8. Emergency Preparedness (optional)

These next questions are about actions that can be taken during disaster or emergency before they happen.

47. Does your household have working smoke and carbon monoxide detectors? Check only one box.

- a. Yes, smoke detectors only
- b. Yes, carbon monoxide detectors only
- c. Yes, both
- d. No
- e. Don't know/ Not sure
- f. Refuse to answer *(Do not read.)*

48. Does your family have a basic emergency supply kit?

(These kits include water, non-perishable food, any necessary prescriptions, first aid supplies, flashlight and batteries, non-electric can opener, blanket, etc.)

- a. Yes *(Go to #49.)*
- b. No *(Skip to #50.)*
- c. Don't know/ Not sure *(Skip to #50.)*
- d. Refuse to answer *(Do not read.)*

49. How many days do you have supplies for? _____ *(Write number of days.)*

50. What would be your main way of getting information from authorities in a large-scale disaster or emergency? *(DO NOT read the options. Mark only the one they say. If they cannot think of one, read: Here are some possibilities. Read responses).* Check only one box.

- a. Internet
- b. Neighbors
- c. Print media (ex: newspaper)
- d. Radio
- e. Social networking site
- f. Television
- g. Text message on phone (emergency alert system)
- h. Don't know/ Not sure
- i. Refuse to answer *(Do not read.)*
- j. Other: _____ *(Write in response.)*

51. If public authorities announced a mandatory evacuation from your neighborhood or community due to a large-scale disaster or emergency, would you evacuate?

- a. Yes *(Skip to #53.)*
- b. No *(Go to #52.)*
- c. Don't know/ Not sure *(Go to #52.)*
- d. Refuse to answer *(Do not read.)*

52. What would be the main reasons you might not evacuate if asked to do so? *Check all that apply. (DO NOT read the options. Mark only the ones they say. If they really can't think of one, then mark "Don't know/ Not sure".)*

- a. Lack of transportation
- b. Lack of trust in public officials
- c. Concern about leaving property behind
- d. Concern about personal safety
- e. Concern about family safety
- f. Concern about leaving pets
- g. Concern about traffic jams and inability to get out
- h. Health problems (could not be moved)
- i. Don't know/ Not sure
- j. Refuse to answer *(Do not read.)*
- k. Other: _____ *(Write in response.)*

Part 9. Demographic Questions

The last set of questions ask general questions about you, which will only be reported as a summary of all answers given by survey participants. Remember, your answers will remain anonymous.

Please fill out this list of demographic questions. *(Give person the handout #4 of demographic questions.)* If you would like, I can read these out loud as you think about them I can fill in the answers. *(Read demographic questions if they prefer to have them read.)*

53. What is your current age in years? _____ *(Enter number.)*

54. What is your date of birth? _____ *(Enter date.)*

55. What was your total household income last year, before taxes?

- a. Less than \$10,000
- b. \$10,000 to \$14,999
- c. \$15,000 to \$24,999
- d. \$25,000 to \$34,999
- e. \$35,000 to \$49,999
- f. \$50,000 to \$74,999
- g. \$75,000 to \$99,999
- h. \$100,000 or more
- i. Refuse to answer (Do not read.)

56. How many people does this income support? _____ *(Enter number.)*

(If you are asked about child support: If you are paying child support but your child is not living with you, this still counts as someone living on your income.)

57. What is the zip code of your home? _____ *(Enter zip code.)*

58. Are you of Hispanic, Latino/a, or Spanish origin? *(One or more categories may be selected.)*

- a. No, not of Hispanic, Latino/a, or Spanish origin
- b. Yes, Mexican, Mexican American, Chicano/a
- c. Yes, Puerto Rican
- d. Yes, Cuban
- e. Yes, another Hispanic, Latino, or Spanish origin

59. What is your race? *(One or more categories may be selected)*

- a. White
- b. Black or African American
- c. American Indian or Alaska Native
- d. Asian Indian

- e. Chinese
- f. Filipino
- g. Japanese
- h. Korean
- i. Vietnamese
- j. Other Asian
- k. Native Hawaiian
- l. Guamanian or Chamorro
- m. Samoan
- n. Other Pacific Islander

60. What is the highest level of school, college or vocational training that you have finished?
(Check only one box.)

- a. Less than 9th grade
- b. 9-12th grade, no diploma
- c. High school graduate (or GED/ equivalent)
- d. Associate's degree or Vocational Training
- e. Some college (no degree)
- f. Bachelor's degree
- g. Graduate or professional degree
- h. Refuse to answer *(Do not read.)*
- i. Other: _____ *(Write in response.)*

61. What is your occupation? _____ *(Write in response.)*

62. What is your sex?

- a. Male
- b. Female

63. How well do you speak English?

- a. Very well
- b. Well
- c. Not well
- d. Not at all

64. What is your marital status? Check only one box. (Read categories. No explanation needed for "Other".)

- a. Divorced
- b. Married

- c. Separated
- d. Single/ Never Married
- e. Unmarried partner
- f. Widowed
- g. Other
- h. Refuse to answer (*Do not read.*)

65. Were you born in the United States?

- a. Yes
- b. No
- c. Don't know/ Not sure
- d. Refuse to answer (*Do not read.*)

66. Are you deaf or do you have serious difficulty hearing?

- a. Yes
- b. No

67. Are you blind or do you have serious difficulty seeing, even when wearing glasses?

- a. Yes
- b. No

68. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

- a. Yes
- b. No

69. Do you have serious difficulty walking or climbing stairs?

- a. Yes
- b. No

70. Do you have difficulty dressing or bathing?

- a. Yes
- b. No

71. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

- a. Yes
- b. No

Thank you for your participation.

END.

Survey References

Centers for Disease Control and Prevention (CDC). Behavioral Risk Factor Surveillance System Survey Questionnaire. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, [2011].

National Survey On Drug Use and Health: SAMSHA. Available at: <http://www.samhsa.gov/data/nsduh/2k8mr-b/2k8Q.pdf>

North Carolina Division of Public Health Community Health Assessment Initiative. Community Health Opinion Survey. Raleigh, North Carolina: NC Division of Public Health. Available at: <http://publichealth.nc.gov/lhd/cha/docs/guidebook/CommunityHealthOpinionSurveyEnglish.doc> [download link].

Orange County Health Department and Healthy Carolinians of Orange County. Available at: <http://www.orange-countync.gov/healthycarolinians/Publications.asp>.

U.S. Census Bureau. 2013 American Housing Survey Neighborhood Module. Washington, D.C. Available at: <http://www.census.gov/srd/papers/pdf/ssm2012-07.pdf> Access on [2013].

Accreditation, Quality, and Performance Resources

ASTHO is dedicated to increasing state and territorial health agency capacity to improve the performance and quality of the public health system. ASTHO does this by providing technical assistance and resources to states and territories in the areas of accreditation preparation, national performance standards assessment, and quality improvement.

Organizational Self Assessments and PHAB Accreditation

ASTHO has resources and guidance to aid states and territories in the process of applying for Public Health Accreditation Board (PHAB) accreditation. These resources can also be used as an initial self-assessment of the health department's capacity for performance and quality work. For more information, visit ASTHO's website at www.astho.org/Programs/Accreditation-and-Performance/Resources-and-Tools/.

State/Territorial Health Assessment, State/Territorial Health Improvement Plan, and Strategic Planning Resources

PHAB's accreditation process requires applicants to submit three prerequisites: a community health assessment; a community health improvement plan; and a health department strategic plan. ASTHO has compiled resources to help states and territories with these accreditation prerequisites. The collection of resources can be found at www.astho.org/Programs/Accreditation-and-Performance/Accreditation/PHAB-Pre-requisites/.

Performance and Quality Tools

To help state and territory health departments integrate quality improvement and performance tools into their agencies, ASTHO has collected resources available at www.astho.org/Programs/Accreditation-and-Performance/Resources-and-Tools/.

National Public Health Performance Standards

The National Public Health Performance Standards are a collaborative effort to enhance the nation's public health systems. Seven national public health organizations have partnered to develop national performance standards for state and local public health systems. While they have not been tested for use in the territories, these resources provide a structure for a system assessment.

ASTHO hosts the resources developed for the state assessment and implementation of these standards at www.astho.org/Programs/Accreditation-and-Performance/National-Public-Health-Performance-Standards/.

Quality Improvement Toolkit

ASTHO's Quality Improvement Plan Toolkit is designed to assist state and territorial health agency staff with developing an agency-wide quality improvement plan and to facilitate preparation for PHAB accreditation. This toolkit is available at www.astho.org/Accreditation-and-Performance/Quality-Improvement/QI-Plan-Toolkit/Home/.

State and Local Collaboration White Paper

This report provides a wide range of collaborative strategies that facilitate overall system readiness for public health accreditation, including the areas of: providing consultation and technical assistance, developing and using community health data and assessments, establishing relationships with academia and sharing best practices and models between states and local agencies. This resource is available at <http://www.astho.org/Accreditation-and-Performance/Accreditation-Collaborative-Partnerships/White-Paper/Home/>.

Measuring Customer Satisfaction: 9 Steps to Success

Measuring satisfaction is a valuable way to obtain feedback from a range of customers and stakeholders to improve services. This toolkit walks the user through the nine steps of planning, implementation, and acting upon results. Examples and lessons learned are provided along with helpful tips. This resource is available at www.astho.org/Accreditation-and-Performance/Measuring-Customer-Satisfaction/Home/.

For further information on any of these resources or for technical assistance requests, please contact any member of the Performance and Quality team:

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