Introduction

INTRODUCTION

Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy.

The Future of Public Health
Institute of Medicine, 1988

If we, as a society, are to improve the conditions that affect the health of all of us, we must begin in local communities, dealing with local conditions. Local health departments have a responsibility to take a key role in this effort. They should lead their communities in an examination of local health problems and in the development of plans to overcome those problems. This workbook provides a process by which a local health department can assume this leadership role and work with its community towards a common goal of improved health for its citizens.

The Role of a Local Health Department

Administering a public health department is a demanding responsibility. Rarely is there time to step back from daily concerns and assess the capacity, results, and overall direction of the department, or analyze the opportunities that lie in the future. Rarely is there time for a health department to involve its community in its planning processes, or to lead the society it serves in a collective effort to assure a healthy future for all its people. But, for a health department to fulfill its larger responsibility to its community, it must periodically take time for these activities.

The leadership role of a local health department will be substantially strengthened by periodic self-assessment and adherence to the following principles:

- Because government has a basic duty to assure the public's health, health departments must lead their communities in assessing health problems, setting appropriate policies, and assuring that health problems are effectively addressed.
- Because leadership comes with accountability, health departments must set and meet standards of competence and practice that are perceived by their communities as relevant to the protection and promotion of the public health.
- Because public health problems require hard choices, health departments must be willing to take risks and shape their programs according to the public health needs of the community.

- Because public health problems demand coordinated, authoritative responses, state and local health departments must find ways to work in partnership and to strengthen each other's resources and authority.
- Because scientific knowledge should be used in setting public health priorities, health departments should provide their communities with such information and should help them in using it to develop community-based health plans.
- Because public health problems are multi-dimensional, health departments must seek creative solutions from a wide range of community resources.
- Because improvements in the public's health require active community ownership and commitment, health departments must work in partnership with community agencies, community leaders, interest groups, and representatives of high risk population groups.

The *Assessment Protocol for Excellence in Public Health* (APEX*PH*) provides a method by which a local health department can take action to assume the leadership role defined above.

The APEX*PH* Process

How APEX*PH* Was Developed

APEX*PH* began in July 1987 as a cooperative project of the American Public Health Association (APHA), the Association of Schools of Public Health (ASPH), the Association of State and Territorial Health Officials (ASTHO), the Centers for Disease Control (CDC), the National Association of County Health Officials (NACHO), and the United States Conference of Local Health Officers (USCLHO). The two major groups that were instrumental in the development of the APEX*PH* workbook were the APEX*PH* Work Group and the APEX*PH* Steering Committee. The Work Group, consisting of representatives of ASTHO, CDC, NACHO, and USCLHO, was responsible for the initial development and review of all workbook materials and for subsequent revisions of those materials. The Steering Committee, consisting of representatives of all the cooperating organizations, provided overall direction and policy guidance to the project and was responsible for the review and ratification of all workbook materials.

Once the Work Group and Steering Committee were satisfied that the workbook was ready for more extensive review, Peer Reviewers from selected local health departments reviewed the workbook for content, relevance, readability, and format. Based on their comments, further revisions were made, after which ten local health departments were selected as Pilot Sites. Personnel in those health departments reviewed the entire draft and used Part I, the Organizational Capacity Assessment, to develop Organizational Action Plans. They also tested the data collection component of The Community Process portion of the workbook. These ten pilot tests were

completed in July of 1989; based on their results, additional workbook revisions were made.

Following those revisions, thirteen local health departments served as Demonstration Sites in a field test of the workbook. The Demonstration Sites were selected to include large, medium, and small health departments, using the National Profile of Local Health Departments, a comprehensive national database developed by NACHO. Participants at the Demonstration Sites reported that the APEX*PH* process was valuable and should benefit local health departments of all sizes. Based on recommendations from the Demonstration Sites, final revisions were made.

About the Process

APEX*PH* is a voluntary process for organizational and community self-assessment, planned improvements, and continuing evaluation and reassessment. It is not intended as a protocol for the evaluation of a local health department by an outside reviewer, such as a state or federal department. It should be most valuable when it is adapted to local circumstances and needs and when it is integrated into the ongoing operations of the health department.

Flexibility is one of the primary features of the APEX*PH* process. For example, it can involve a large number of staff in a highly structured process or very few people in a less formal approach; either can lead to greater teamwork and improved strategic planning. Examples of documents that were developed by several demonstration sites using earlier drafts of this workbook are provided in Sections I-C and II-C. These demonstrate that the APEX*PH* process as described in this workbook can be implemented to suit the needs of a particular health department and community.

APEX*PH* is fundamentally different from other assessment and evaluation protocols in the following ways:

- It is a true self-assessment and can be completed by its users in a form and manner designed to meet their needs.
- It leads to a practical plan of action.
- It focuses on a health department's administrative capacity, basic structure and role in its community, and on the community's actual and perceived problems, rather than on technical performance in specific programs or compliance with a set of objective standards.
- It provides an opportunity for a local health department to assess its relationships with local government agencies and with community, state and federal health agencies. It can assist in determining how to strengthen these relationships and how to obtain needed support.
- It provides a protocol through which a health department, by working with the community to assess health needs, set priorities, and develop policy, and assuring that health needs are met, will become recognized within the community as having a major role in the health of its citizens.

- It can easily be adapted to fit local situations and resources.

Overview of the Process

APEX*PH* is a three part process.

Part I, Organizational Capacity Assessment, calls for an internal review of a local health department. It provides for an assessment of a health department's basic administrative capacity and of its capacity to undertake Part II. It is conducted by the health department director and a team of key staff members.

Part II, The Community Process, is intended to be a more public endeavor, involving key members of a community as well as department staff in assessing the health of the community and identifying the role of the health department in relation to community strengths and health problems. It provides for the use of both objective health data and the community's perceptions of community health problems.

Part III, Completing the Cycle, integrates the plans developed during the Organizational Capacity Assessment and The Community Process into the ongoing activities of a health department and the community it serves. It discusses policy development, assurance, monitoring, and evaluation of plans developed in conducting Parts I and II.

Preparation

A first step in planning a self-assessment is assuring that the health department has the authority to undertake the assessment and to act on its results. This may not require any special action for some health departments; others may need to gain the formal approval of their policy boards before proceeding.

Before undertaking either Part I or II, the director and senior management of a health department should review the entire document. Neither the Organizational Capacity Assessment nor The Community Process should be initiated without a clear understanding of the commitment and resources they require and of their possible risks and benefits. Particularly important is the ability to collect and analyze the data needed in Part II, as well as a long-term commitment of time and resources.

Because of its potential for bringing about change, the decision to implement the APEX*PH* process should be made with the understanding and consent of those who hold a stake in the outcome. The consent of stakeholders does not always have to be formal, but it is essential. Some potential stakeholders are described in both Parts I and II.

Directors of local health departments may vary in the degree to which they choose to involve their communities in self-assessment, planning, policy development, assurance, monitoring, and evaluation called for by the APEX*PH* process. Although APEX*PH* does encourage health officials to involve their communities in all of these areas because of the community support which may result, the process can be modified. For example, the Community Health Committee, formed in Part II, may be more limited in size or composition than the workbook recommends. Similarly, the

scope of the community health plan developed by the Community Health Committee can be more limited than the text suggests. Such adaptations can make an initial APEX*PH* implementation more suitable to local circumstances.

Resources Needed

Users caution that the staff time required should not be underestimated. Organizational Capacity Assessment requires collecting and analyzing data, scheduling and conducting meetings, and ensuring adequate communication among all participants.

Typically, resources needed for The Community Process are substantially greater than those needed for the Organizational Capacity Assessment. Ideally, a health department should be able to establish and staff a Community Health Committee, and should have (1) the communication resources to maintain a highly public process, (2) access to appropriate health status data, and (3) staff who can analyze these data and prepare basic information for a Community Health Committee.

Again, it is recommended that a health department director review the entire process at the outset to get a full understanding of the time and resources needed to complete APEX*PH* satisfactorily. A resource bibliography in Appendix G lists references that may be helpful to workbook users in preparing to conduct the APEX*PH* process and for answering questions that may arise during implementation.

Results

The APEX*PH* process often produces recommendations for change in services and for improvements in functioning. Implementation of these recommendations may require funding and/or cooperation by other organizations.

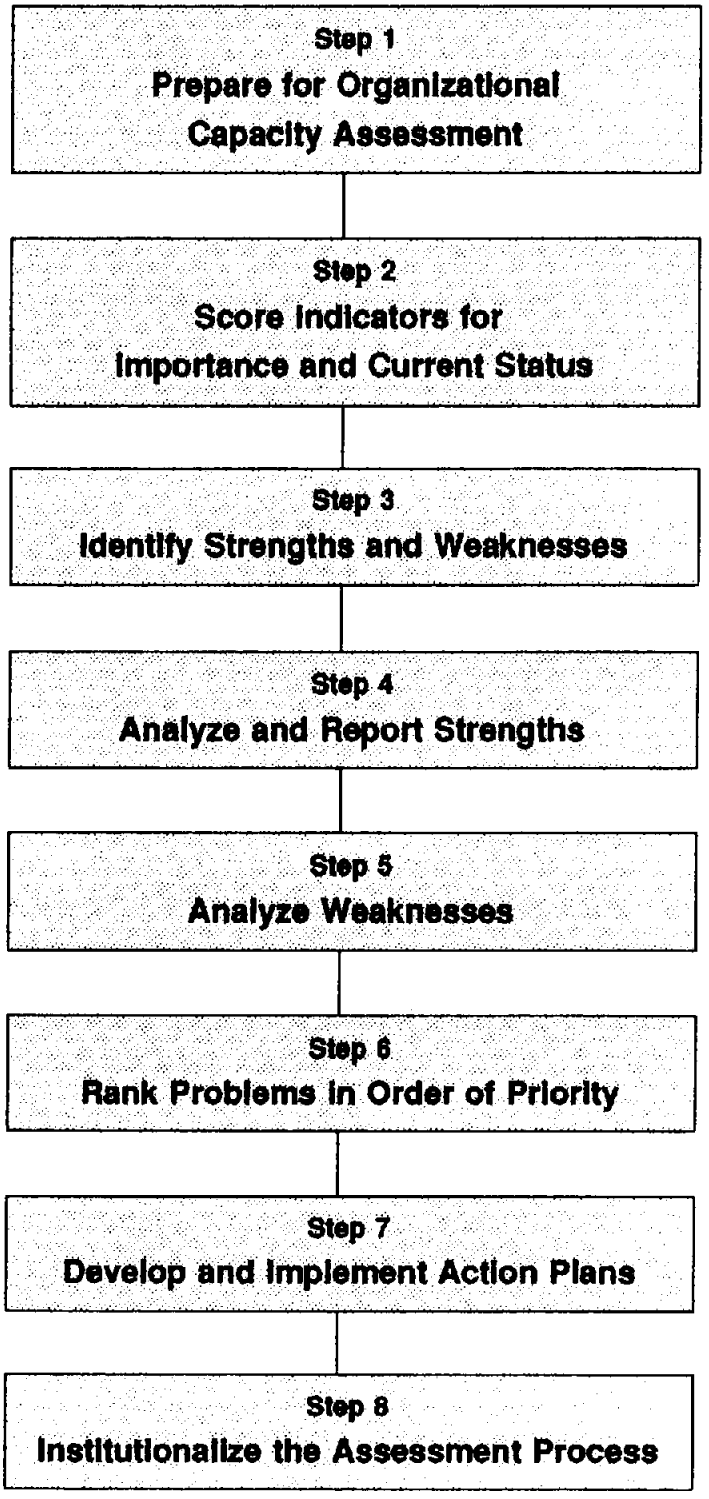
The annual budget process is a convenient way to pace the APEX*PH* process and use the results. During the budget process, key stakeholders come together to discuss priorities, options, and plans for the coming year. This is true for health departments and for other governmental, voluntary, and private agencies whose cooperation may be needed to implement recommendations that come out of the APEX*PH* process. Approaching these other agencies at the proper point in their budget process can be effective in gaining their cooperation on programs of mutual interest.

The director of a local health department can also use the results of APEX*PH* to strengthen the partnership with the state health department. The APEX*PH* process can pinpoint ways to improve communication and to collaborate on activities of mutual interest.

Part I
Organizational Capacity Assessment

Section A
How To Conduct the APEX*PH* Organizational Capacity Assessment

Flowchart of Steps In Assessing Organizational Capacity



How To Conduct the APEX*PH* Organizational Capacity Assessment

The flowchart on the opposite page shows the eight principal steps in assessing organizational capacity through the APEX*PH* process. Each step is described in detail below. The description is supported by examples in Section I-C. Terms are defined when first used; definitions are also given in the glossary in Appendix I.

The following terms will be used to refer to some of the principal participants in the APEX*PH* Organizational Capacity Assessment:

- **Director of a local health department**. The primary administrator of a health agency below the level of a state health agency. Synonym: City/County Health Officer
- **Local policy board**. The administrative and policy board established under state law, local ordinance, or other authority. Synonym: Board of Health

Step 1.
Prepare for Organizational Capacity Assessment

Overview

This step is primarily the responsibility of the director of a health department. It occurs in the following four stages, which in practice will overlap:

(a) Deciding to conduct an assessment

(b) Orienting the health department staff

(c) Forming a team to carry out the assessment

(c) Planning how the team will operate

Deciding To Conduct an Assessment

The decision to implement the APEX*PH* process should be made with the understanding and consent of stakeholders in the outcome. The following are some of the stakeholders in an organizational capacity assessment:

- The local policy board, which may need to take policy and budgetary actions as a result of the assessment
- Professional program staff, who may have to implement some of the recommended actions resulting from the assessment or may otherwise be affected by them
- The unit of government from which the local health department derives its basic authority, which—as a result of the assessment—may receive a recommendation to modify resources or to strengthen or modify the authority of the health department

A decision to use the APEX*PH* process to assess the capacity of a health department must be based on a good understanding of the time and commitment it requires, both in conducting the initial assessment and in acting on its findings. Nine of the 13 health departments that acted as demonstration sites provided information on the time required to complete Part I. They reported from 12 person-hours (for a health department with 2 staff members) to 198 person-hours for conducting the initial assessment only; three of the nine health departments, using teams of from 4 to 6 members, reported around 70 person-hours.

Although the decision to conduct an organizational capacity assessment is made by the director of a health department, senior management staff can provide helpful advice. If senior management staff members are not involved in making the decision, their support should be obtained before a positive decision is announced, because conducting an assessment will require a substantial amount of management and staff time. Everyone involved in the decision should review Part I in sufficient detail to estimate the resources that will be required.

ACTIONS (to be taken by all those involved in making the decision):

1. Skim the entire APEX*PH* Workbook to get an idea of the approach taken in each part.
2. Review Part I in enough detail to estimate the time and resources that would be needed for an organizational capacity assessment of the health department.
3. Before deciding to undertake an assessment, be sure that the decision is supported by senior management.

Orienting Health Department Staff

For an organizational capacity assessment to be successful, not only must senior management support the decision to undertake the assessment, but the health department's staff at all levels must also be committed to work for the success of the project. Communication is the key to gaining and holding their commitment. For example, their support can be enlisted initially through a department-wide orientation

for all or most staff members to explain the purpose, process, and potential benefits of the assessment. During the course of the assessment, regular staff briefings, status reports, or even a regular newsletter may be of substantial value. Sharing information in these ways can help keep staff members motivated throughout the process, thereby enhancing the ultimate success of the project.

As steps are taken to orient health department staff, the next stage of preparation, "Forming an Organizational Assessment Team," should get underway.

ACTIONS (to be taken by the director, and by others at the discretion of the director):

1. Orient all department staff to APEX*PH* in general and to the immediate plans of conducting an assessment of the health department's capacity.
2. Read the next section, "Forming an Organizational Capacity Assessment Team," and decide what skills you want on the team and what program areas you want to have represented.
3. Begin to identify specific individuals for the team who can provide the skills that will be needed.

Forming an Organizational Capacity Assessment Team

An organizational capacity assessment team is responsible for carrying out the APEX*PH* process described on the following pages. It is made up of staff from within the health department.

The team provides the core information and data for the assessment. It must achieve consensus on organizational problems and on priorities in the action plan, and coordinate the roles of the various organizational units, helping to ensure that limited resources are used effectively. It is critical to the success of the assessment and possibly to the development and implementation of the subsequent action plan for improving the capacity of the health department.

The APEX*PH* process calls for two subgroups on the team: (1) a senior group who can provide leadership and make policy judgements, and (2) a group who provides the wide range of skills and information required to conduct the assessment. It is possible for a health department director alone to make up the first subgroup, but directors may choose to enlist the assistance of senior management staff—the size of the health department, workloads, and other factors will influence this decision.

The size of assessment teams will vary from one health department to another. APEX*PH* test-site users report that involving a large number of staff in the process provides a broad perspective and is also valuable for departmental team-building. However, the process was successfully implemented in some very small test-site health departments by having only the director and one other staff member on the assessment team. The time required for test-site users to complete the process tended to increase with the size of the team.

In selecting team members, a health department director should consider what skills will be needed to guide and support the assessment process. Team members must be able to conduct frank and open discussion of the strengths and weaknesses of the health department, to analyze this information objectively, to develop realistic priorities and plans, and to communicate the implications to others in a clear and unbiased way.

Finally, to be of greatest value, a team should represent the staff for whom it will make recommendations. In general, the team should represent all levels of management and staff, and all program areas.

ACTIONS:

1. Assign or solicit staff to the organizational capacity assessment team, including a senior management component if the director does not choose to fill that role alone.
2. Distribute copies of the APEX*PH* workbook (it may be photocopied without permission) and have all team members become familiar with all parts of it in general, and with the process described in Part I in detail.

Planning How a Team Will Operate

Once team members have become familiar with the APEX*PH* process for assessing organizational capacity, the team should meet to plan how it will approach the work.

The work involved in organizational capacity assessment requires a substantial amount of time and support. Test-site users have recommended that the assessment be done in meetings separate from regular staff meetings, even in small health departments where the same persons may attend both meetings. Some test-site users have suggested that starting the assessment in a team retreat provides an excellent beginning.

Some teams may choose to establish subcommittees or task forces to work on specific aspects of the assessment. These subcommittees would then report back to the full team. When the larger team is divided in this way, supervisors and subordinates from the same program area should serve on different teams, if possible.

Once team members have been identified and a plan of work developed, the assessment should be incorporated into the entire work plan of the health department for the coming year to ensure that the necessary time and other resources are committed to the undertaking.

ACTIONS:

1. Develop a plan for carrying out the work described in the remainder of Part I. (*Assessment team action*)
2. Incorporate the assessment plans into other work plans of the health department, making sure that adequate staff time and resources are committed to its implementation. (*Departmental management action*)

Step 2.
Score Indicators for Importance and Current Status

Overview

In this step, an assessment team applies APEX*PH* organizational capacity indicators to assess the organizational capacity of a health department. Capacity Assessment Worksheets are provided in Section I-B for use in carrying out this step. Examples of worksheets completed by test-site users are provided in Section I-C.

In completing the worksheets, the two subgroups of an organizational capacity assessment team concurrently carry out the following activities:

- The senior management component of the assessment team scores the "perceived importance" of each organizational capacity indicator for the health department.
- The other members of the assessment team rate the "current status" of the health department on each indicator.

These activities are described in more detail below. In addition, an optional activity in which a policy board takes part in an abbreviated version of this step is described on page 17.

Scoring the Perceived Importance of the Indicators

On one copy of the Capacity Assessment Worksheets, the senior management component of the organizational capacity assessment team rates how important each indicator is for the successful functioning of the health department. This is done by assigning one of the following *importance ratings* to each indicator:

H = High importance
M = Moderate importance
L = Low importance
0 = Not relevant

Some scores of 0, "Not relevant," are to be expected, because not every indicator will apply to every health department.

The *importance rating* of an indicator should be independent of its current status in the health department. Care should be taken to avoid rating an indicator as important simply because the health department currently performs the activity described by the indicator.

Rating the Current Status of the Health Department

On a second copy of the Capacity Assessment Worksheets, the remainder of the organizational capacity assessment team rates the *current status* of the health department on each indicator. This is done by assigning one of the following scores to each indicator:

F = Fully met by the health department

P = Partially met by the health department

N = Not met at all by the health department

0 = Not relevant

? = Status unknown

The rating of a health department's status on an indicator should be independent of the importance of the indicator to the successful functioning of the health department. The assessment will be most valid if the group rating status does not know how the other group scored the indicators for importance.

The larger the size of the group involved and the broader its representation, the greater the possibility of experiencing difficulty in reaching consensus. Some test-site users reported success in reaching consensus by assigning a numeric score to each letter, averaging all team members' ratings on an indicator, and then converting the numerical average back to a letter score. An experienced group facilitator (who is not a member of the assessment team) can also be helpful in reaching consensus. The resource bibliography in Appendix G includes references that may provide other useful information on effective group process.

ACTIONS:

1. Make two copies of the Capacity Assessment Worksheets (Section I-B, pages 31-63)—one for each of the two subgroups of the organizational capacity assessment team.
2. On its copy of the worksheets, the senior management subgroup of the assessment team should score the importance of each indicator for the successful functioning of the health department. It is suggested that members not communicate the *importance ratings* to the other subgroup until both subgroups have completed this step (i.e., Step 2 of the APEX*PH* Organizational Capacity Assessment).
3. On its copy of the worksheets, the other subgroup of the assessment team should rate the health department on how well the department currently meets each indicator on the worksheet. The group should take care not to be influenced by how important they believe an indicator to be for the health department's successful functioning.

Involving the Policy Board (optional)

Some test-site users of the workbook have suggested including the local policy board in the assessment process by having board members score the indicators for perceived importance. They found this to be a valuable experience and suggest that elected officials might also be included in such an exercise. Because the entire list of indicators contains far too much administrative detail to be of value in such a review, an abbreviated version of the Capacity Assessment Worksheets has been prepared for this purpose. This version of the worksheets, with instructions, is located in Appendix B.

It is suggested that the optional participation by the policy board occur after the organizational capacity assessment team has completed Step 2 of the APEX*PH* Organizational Capacity Assessment and before the team has reached Step 7. This sequence avoids having the ratings of the policy board influence those of the health department assessment team, yet permits the health department director and the assessment team to incorporate the policy board's work into the overall report of the assessment.

This optional assessment is not suggested as a means of generating a separate plan or as a substitute for an assessment by a team that is representative of the health department.

Step 3.
Identify Strengths and Weaknesses

Overview

The purpose of this step is to identify the major strengths and weaknesses of a health department. The organizational capacity assessment team uses the worksheets from Step 2, transcribing both sets of ratings onto a single copy of the worksheets. Examples of worksheets completed for this step at one of the test-sites is provided in Section I-C on pages 72, 73, and 75.

Identifying Strengths and Weaknesses

To identify indicators on which a health department is particularly strong or weak, an assessment team compares the *importance rating* with the *current status rating* assigned to each indicator in Step 2. How these two ratings correlate may indicate a strength or a weakness. For example, the combination HF, a "high importance" score with a "fully met" rating, clearly indicates a major departmental strength. Similarly, the combination HN, a "high importance" score with a "not met at all" rating, clearly indicates a major departmental weakness. However, the combinations MP and LP, scores of "moderate importance" or "low importance" with a "partially met" rating, may suggest a major or a minor weakness; the meaning of such combinations should be evaluated and classified by group consensus.

The matrix below identifies which correlations between the two sets of ratings clearly indicate strengths, which clearly indicate weaknesses, and which must be evaluated on an individual basis or investigated further.

		Perceived Importance Score			
		H	M	L	0
Current Status Rating	F	STRENGTH	evaluate	*evaluate*	WEAKNESS
	P	*evaluate*	*evaluate*	*evaluate*	WEAKNESS
	N	WEAKNESS	WEAKNESS	*evaluate*	STRENGTH
	0	*discuss*	*discuss*	*discuss*	
	?	*investigate*	*investigate*	*investigate*	

ACTIONS:

1. Transcribe the two sets of ratings to a single copy of the Organizational Capacity Assessment worksheets.
2. Discuss the current status rating for any indicator which was given an importance score of H, M, or L but was considered not relevant (0 rating) by the group rating status.
3. Make an effort to determine the current status of the health department on any indicators which were rated "Status unknown" (? rating).
4. Examine the combination of ratings for each indicator and decide whether it represents either a major strength or a major weakness. If it represents either, circle the two ratings and indicate in the margin whether it is a strength or a weakness.

Step 4.
Analyze and Report Strengths

Overview

In this step, an assessment team identifies areas in which the health department is doing well, and the factors that contribute to that success. The results potentially have the following benefits: (1) the factors that contribute to the strengths may be applicable to solving problems that will be identified when weaknesses are analyzed, and (2) the morale of the assessment team and the health department staff in general may be boosted by knowledge of departmental successes.

A worksheet for recording the results of the step, the "Analysis of Organizational Strengths/Problems Worksheet," is provided in Section I-B, page 65. An example of a completed worksheet is provided in Section I-C, page 72.

Defining Strengths

Assessment team members define strengths by carrying out the following activities:

- Reviewing the indicators that were identified as being "major strengths" on the Capacity Assessment Worksheets
- Discussing what strength is represented by an indicator and finding other indicators that are related to the same or similar strength
- Listing indicators that are related to a similar strength together on the "Analysis of Organizational Strengths/Problems Worksheet"
- Recording a definition for the strength represented

Identifying Related Factors

Assessment team members review the indicators that have been identified as major departmental strengths and discuss what factors contributed to each strength as they have defined it. They record those factors on the "Analysis of Organizational Strengths/Problems" worksheet.

Reporting Departmental Strengths

The record produced in this step focuses attention on the positive aspects of the organizational capacity assessment. It provides an opportunity to celebrate progress on the assessment and of the successes of the health department in general. Management may want to consider sharing these findings with the entire staff, the policy board, and the community.

ACTIONS:

1. Make copies of the worksheet "Analysis of Organizational Strengths/Problems;" circle the word *Strengths* in the title. (*Assessment team action)*
2. Follow the process described above to define the strengths and the related factors that contribute to them. (*Assessment team action)*
3. Report the results of the assessment to this point if doing so would be beneficial. (*Departmental management action.)*

Step 5.
Analyze Weaknesses

Overview

The purpose of this step is to prepare for correcting weaknesses by identifying the causes of the major weaknesses of the health department. Additional copies of the form that was used in Step 4 ("Analysis of Organizational Strengths/Problems" worksheet, Section I-B, page 65) are used for this analysis.

Defining Problems

An assessment team can define problems at one of three levels: (1) for weaknesses on individual indicators, (2) for weaknesses within principal sections, or (3) for cross-section clusters of weaknesses.

1. **Individual indicators.** At this level, an assessment team prepares a problem statement for each indicator scored as a major weakness. For example, at this level a team might enter the following on the worksheet:

   "1.A.2 The health department does not have authority to adopt local regulations when needed."

   Although this level of analysis requires less discussion about any one problem, it can result in a large number of problem statements and be more time-consuming in the long run. It has the additional weakness that it does not provide a good picture of the major problems in a health department unless further analysis and synthesis is done.

2. **Sections.** This is a higher level of analysis. An assessment team considers each of the major sections I—VIII as a unit, and develops the fewest problem statements possible to describe the section indicators that were identified as major weaknesses. For example, a team might look at section VIII, Program Management, and conclude that weaknesses in different subsections of VIII were actually manifestations of the same larger problem.

3. **Across section clusters.** At this level of analysis, an assessment team looks for all weaknesses, in any section, that seem to cluster around a common theme. The goal is to identify weaknesses in several sections that result from the same general problem. An analogy for this level of analysis is disease diagnosis: the weaknesses are like signs or symptoms, not the disease itself. Once the assessment team identifies a cluster of weaknesses, it lists the indicators for those weaknesses on the worksheet, and writes a single problem statement for them.

   For example, suppose a health department director considers the development of a community health plan to be highly important, yet most indicators related to this activity score low in current status. Discussions by the assessment team might reveal that the health department needs to focus on community involvement, or that it needs to gather data, or that it needs to get direction or authority from its policy board, or that it needs to develop its staff capacity in planning. (One test-site health department decided that it needed to hire a health planner.)

Analysis at the third level should result in the broadest and most thoughtful analysis of the health department and should allow the time invested to be more stimulating and productive.

Identifying Related Factors

Related factors are (1) the source of a problem, (2) resources which are available for addressing a problem/correcting a weakness, and (3) barriers which may make it difficult to correct a problem.

Sources are any factors that cause a problem; for example, they may include inadequate funding, inadequate staffing levels or the lack of personnel with specific

skills, inadequate data, a lack of other needed resources, or an inadequate authority to act.

Resources for addressing a problem may be powers or authorities, specific persons who would support or take action, or available funding. Strengths of the health department will often be resources for problem solving and may be recognized as such in this step. For example, if one of the identified strengths is that the policy board is active and supportive of the health department, this support can be identified here as a resource which can be used in correcting a weakness.

Barriers are factors that keep the problem at the current level; for example, they may include a lack of power or authority, persons who would oppose an action, a lack of needed funds, an insufficient number of staff, a lack of knowledge, or competing agendas. They can be the same factors listed above as sources, but are considered here as barriers because they tend to persist despite remedial efforts.

An assessment team can approach this activity in a number of ways. It may choose to participate in a simple brainstorming session, or it may decide to take a more involved approach, such as using the Nominal Group Planning Method developed by A. L. Delbecq and A. H. Van de Ven.[1] This method provides for getting the opinion of all members of a group, for orderly discussion of all issues, and for establishing priorities through a balloting process.

ACTIONS:

1. Make copies of the worksheet "Analysis of Organizational Strengths/Problems;" circle the word *Problems* in the title.
2. Decide what level of analysis to use for defining problems, and define problems following the process described above for the chosen level.
3. Decide what approach to take in identifying related factors and carry out that approach to complete that section of the "Analysis of Organizational Strengths/Problems" for all major weaknesses.

[1]A.L. Delbecq, A.H. Van de Ven, and D.H. Gustafson, *Group Techniques for Program Planning*. Glenview, Ill.: Scott Foresman and Co., 1985.

Step 6.
Rank Problems in Order of Priority

Overview

In this step, the senior management component of an assessment team reviews the problems that were defined in Step 5 and assigns a priority ranking of I, II, or III to each. Problems assigned a rank of I would be those on which corrective action could begin immediately and which need to be corrected immediately. These Priority I problems will be addressed in an action plan in Step 7, with the goal of achieving a significant improvement within 1 year. It is recommended that no more than 5 problems be classified as Priority I.

A column is provided on the "Analysis of Organizational Strengths/Problems" worksheet to record priority rankings.

Assigning Priority Ranks

There are three criteria to consider in setting priorities:

1. **Magnitude of a problem:** How much of the health department's ability to function does it affect? How much of the budget does it affect? Does it involve the entire staff or only an isolated work unit?
2. **Seriousness of the consequences of a problem:** What consequences would there be if the problem is not corrected immediately? Would *not correcting* the problem prevent the correction of other, larger, more serious problems? What benefits would accrue from correcting the problem? Would other problems be reduced in magnitude if the problem were corrected?
3. **Feasibility of correcting a problem:** Can the problem be solved with existing technology, knowledge, and resources?

Every effort should be made to prioritize problems carefully to avoid the trap of ending up with more Priority I problems than can realistically be addressed immediately.

Several methods for setting priorities are described by Spiegel and Hyman[1] The following is a simplified version of one of those methods (the Hanlon Method[2]):

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[1]A.D. Spiegel and H.H. Hyman, *Basic Health Planning Methods* (Germantown, Md.: Aspen Systems Corp., 1978), pp. 179—238.

[2]J.J. Hanlon, "The design of public health programs for underdeveloped countries." *Public Health Reports*, Vol. 69 (Nov. 1954) p. 1028, and G.E. Pickett and J.J. Hanlon, *Public Health Administration and Practice*, 9th ed. (St. Louis: The C.V. Mosby Company, 1990), pp. 226—227.

1. Assign a score of 1 to 10 to each problem on each of the 3 criteria listed above. A problem with a score of 10 on each criterion would indicate that it was of the greatest magnitude, had the most serious consequences, and was most feasible to correct.
2. Add together the three criteria scores for each problem.
3. Assign a priority rank of I, II, or III to each problem based on where the total of its criteria scores fall in the table below.

Total Criteria Score	Priority Rank
21 — 30	I
11 — 20	II
3 — 10	III

ACTIONS (to be taken by the senior management subgroup of the assessment team):

1. Decide what approach to take to assigning priority ranks to the problems identified on the "Analysis of Organizational Strengths/Problems" worksheet.
2. Assign priority ranks to the problems using the chosen approach.
3. If more than 5 problems receive a priority rank of I, reevaluate the ratings.

Step 7.
Develop and Implement Action Plans

Overview

In this step, an assessment team plans how to address the problems with a priority of I—the goal being to substantially strengthen the health department's status on the related indicators within 12 months. Only Priority I problems should be addressed at this time in order to ensure that adequate time and resources are available.

An assessment team develops a separate action plan for each problem. Each action plan describes the goals and objectives for correcting the problem, who is responsible for implementing the plan, what methods will be used to correct the problem, and when it will be accomplished.

Depending on its size and the number of problems to be addressed, an assessment team may find that establishing a number of work groups and assigning one or two problems to each group is an efficient way to manage this step. A

worksheet, "Organizational Action Plan," is provided on page 66 in Section I-B. It can provide documentation of the plan for future reference. Clearly documenting all aspects of the plan will greatly facilitate evaluation at a later date.

Establishing Goals and Objectives

A **goal** defines a desired change in the status of a problem. **Objectives** state what will be accomplished in changing the status of a problem. Objectives are measurable and have deadlines. The wording of both should be concrete and specific.

The following are examples of goals and objectives:

Goal: *"Staff will be aware of the health department's budget structure as it affects their ability to implement departmental programs."*

Objective: *"By* (date within 12 months) *, all staff will have received budget structure training from their division managers."*

The more thorough the work done to this point, the easier it will be to define goals and objectives. Review earlier worksheets and consider how departmental strengths can be used, what barriers must be overcome, what resources are available, and what related efforts may impact on the problem.

Assigning Responsibility and Specifying Methods

An action plan should specify how the goal and objectives will be achieved (i.e., what methods will be used), what resources (including time) will be required, and how responsibility for achieving objectives will be assigned. Documenting each action plan on the "Organizational Action Plan" worksheet will provide guidance to those implementing the plan and will be useful when the action plan is evaluated.

The health department director should assure that responsibility for attaining goals and objectives is clearly assigned to individuals or to designated work teams. This assignment should be documented to facilitate monitoring progress in implementing the plan.

Implementing Action Plans

As action plans are implemented, they should come under the regular managerial structure of a health department. The person or team responsible for implementing each plan will develop more detailed plans for conducting the activities called for by the particular plan. It will be crucial that activities and results are documented for management review and evaluation.

ACTIONS:

1. Make a copy of the "Organizational Action Plan" worksheet for each priority I problem.
2. Draft goals and objectives for correcting each problem.
3. Decide on and document methods to be used in accomplishing the objectives for each problem.
4. Ensure that responsibility for implementing the action plan for correcting each problem is assigned and documented (*Departmental management action)*
5. Assign a date for evaluating the accomplishments resulting from the action plan for each problem. (*Departmental management action*)
6. Implement the action plans.

Step 8.
Institutionalize the Assessment Process

Evaluation of the achievements of an organizational action plan begins a continuing cycle of improvement in a health department. The first round of organizational capacity assessment using the APEX*PH* process identifies a number of areas in which a health department can improve. The health department selects the highest priority problems for correction, leaving the others for a later date. It then measures, through regular and frequent evaluation, the results of this first effort to improve the health department's organizational capacity. The results of these evaluations should serve as the planning phase for the next cycle of organizational improvement. If goals and objectives are reached for correcting priority I problems, problems with priority levels of II and III may be selected and addressed in new action plans. Or, if insufficient progress is made toward achieving some goals and objectives, the methods used should be reconsidered, and a new action plan developed for correcting the particular problem. If the new plan does not bring progress, then it may be necessary to reconsider the goal or objective itself. This should be a continuing process for the organization.

This cycle is similar in many ways to The Community Process, to be introduced in Part II of the APEX*PH* workbook. Further recommendations for incorporating assessment into the broader functions of a health department are made in Part III, Completing the Cycle.

ACTIONS:

1. At set intervals, evaluate progress toward achieving the goals and objectives established for each action plan.
2. Develop and implement action plans for correcting priority II and III problems when the health department can handle them.
3. For continued improvement of the health department's capacity to serve the community, repeat the organizational capacity assessment every year or two.

Part I

Organizational Capacity Assessment

Section B

Worksheets for

Organizational Capacity Assessment

Read This Before Using the Worksheets

Do not write on the worksheets provided here.

Only one copy of each worksheet is provided and more than one copy will be needed. Use the worksheets in this workbook as originals for making the number of copies you need. Be sure to return the originals to the proper place in the workbook for future reference.

CAPACITY ASSESSMENT WORKSHEETS

I. Indicators for Authority To Operate	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
A. Legal Authority		
1. The health department has clear authority to act as a law enforcement office for public health problems.	1. _____	_____
2. The health department has authority to develop and introduce local regulations when needed.	2. _____	_____
3. The health department has the authority to delegate public health duties to municipalities within its jurisdiction.	3. _____	_____
4. The health department has agreements for the joint exercise of public health powers with neighboring jurisdictions.	4. _____	_____
5. The health department exercises authorities delegated to it by the state or federal government.	5. _____	_____
Other:		

*Perceived Importance Codes:
- H = High importance
- M = Moderate importance
- L = Low importance
- 0 = Not relevant

**Current Status Codes:
- F = Fully met
- P = Partially met
- N = Not met at all
- 0 = Not relevant
- ? = Status unknown

I. Indicators for Authority To Operate	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
B. Intergovernmental Relations		
1. At least once every two years (biennially), the health department reviews its joint powers agreements, memoranda of understanding, and other agreements with units of government within its jurisdiction or in neighboring jurisdictions to identify problems, propose solutions, and look for areas for further development.	1. _____	_____
2. At least biennially, the health department reviews and discusses its formal relationship with the state health authority to identify problems, propose solutions, and look for areas for further development.	2. _____	_____
3. The health department is represented on a state public health committee or other body advisory to the state health authority.	3. _____	_____
4. Units of government within the jurisdiction of the health department are represented on a committee, subcommittee, or other body advisory to the local department of health.	4. _____	_____
5. The health department is regularly consulted by the local elected officials about aspects of local policy relating to health issues.	5. _____	_____
6. The health department is regularly consulted by the state elected officials about aspects of local policy relating to health issues.	6. _____	_____
7. The director or a representative communicates appropriately and regularly with state legislators who represent the district the health department serves.	7. _____	_____
8. The health department is regularly consulted by the local schools when setting health policy.	8. _____	_____
9. The health department has a formal and productive working relationship with the state health authority.	9. _____	_____
Other:		

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I. Indicators for Authority To Operate	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
C. Legal Counsel		
1. The health department has legal counsel sufficient to provide advice as needed on administrative practices; department powers, duties, policies, and procedures; relevant laws and ordinances; contracts; and other legal matters.	1. _____	_____
2. The health department maintains a current file or library of all relevant federal, state, and local statutes and regulations.	2. _____	_____
3. At least biennially, the director and the management staff of the health department review with legal counsel the specific authorities of the department to operate pubic health programs and to enforce public health laws, ordinances, and regulations, as well as the specific responsibilities these entail.	3. _____	_____
a. As a part of this review, the director and management staff identify the public-health-related legal authority and responsibilities of other organizations in the community.	3a._____	_____
b. The director and management staff of the health department continuously maintain documentation of the scope of the department's powers to adopt its own regulations and the specific responsibilities these entail.	3b._____	_____
4. Procedures for the enforcement of board authorities and responsibilities are documented and are reviewed at least biennially with legal counsel.	4. _____	_____
5. The health department maintains current files documenting the legal status of all health-related organizations operating within its jurisdiction (department of government, private nonprofit corporation, private unaffiliated and unincorporated group, etc.).	5. _____	_____
Other:		

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II. Indicators for Community Relations	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
A. Constituency Development		
1. The health department has a system that actively involves individuals and groups affected by its planning of services, its methods of service delivery, and its service results.	1. _____	_____
2. At least every four years, the health department actively involves all key individuals and organizations within its jurisdiction that might be engaged in public-health- related activities to determine their goals and their perceptions of their roles, authorities, and needs, including:	2. _____	_____
a. Units of government with authority within the jurisdiction of the health department, including the governmental unit from which the department derives its basic authority.	2a._____	_____
b. The general public of the community, at least through some form of community health committee or representation on an advisory body.	2b._____	_____
c. Interest groups, such as environmental protection and conservation groups, local business organizations, the local medical and dental societies, religious organizations, and other key organizations in the community.	2c._____	_____
d. Representatives from hospitals, community health centers, the Visiting Nurse Association, and other health and human service agencies.	2d._____	_____
e. Educational institutions, such as university schools of public health, medicine, and nursing; colleges, private schools, and local school districts.	2e._____	_____
f. Other potential stakeholders in local public health.	2f._____	_____
3. The health department cooperates and collaborates with other community agencies that have similar or overlapping ***missions***.	3. _____	_____
4. The health department cooperates and collaborates with other agencies that deliver similar ***programs*** in the same service area.	4. _____	_____

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II. Indicators for Community Relations	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
A. Constituency Development (continued)		
5. The health department has formed a citizens' or community committee or has established another formal method of involving the people it serves in the identification of community health problems and the development of a community health plan.	5._____	_____
6. The health department has established mechanisms to guide and ensure active and cooperative relationships with community and professional groups.	6._____	_____
7. Health department staff are aware of relevant programs, policies, and priorities of the federal Department of Health and Human Services (HHS), Environmental Protection Agency (EPA), and other related federal agencies.	7._____	_____
8. The health department has a physician health officer, medical adviser(s), or consultant(s) to assist in maintaining relationships with the private medical community.	8._____	_____
9. The health department has established relationships with a university school of public health, medicine, or nursing, or with other educational institutions within or near its jurisdiction for staff development, internships, consultation, and other capacity-building purposes.	9._____	_____
Other:		

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II. Indicators for Community Relations	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
B. Constituency Education		
1. The health department has a documented plan for informing the public about the current health status of the community.	1. _____	_____
2. The local media looks to the health department as a source of information about the health of the community.	2. _____	_____
3. The health department regularly provides background information and news information to the local media.	3. _____	_____
4. At least once a year, the director or a representative of the director meets with the representatives of health-related community organizations to define inter-organizational roles and responsibilities (see item A2 above for a brief list of potential representatives).	4. _____	_____
5. Professional staff members of the health department participate in or serve on councils, boards, or committees of public-health-related organizations at the state and local level.	5. _____	_____
6. The health department has current mailing lists (no older than 1 year) of the directors, chairs, and other officials of all citizen groups, service organizations, health care professional organizations, business groups, and other community organizations within its jurisdiction.	6. _____	_____
7. The health department has a means of regular public communication, such as a regular newsletter or column in a community newspaper.	7. _____	_____
8. The health department makes its own information systems and databases available to interested community groups for their health-related activities.	8. _____	_____
9. The health department has an established program for community volunteers and student interns in departmental programs.	9. _____	_____

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II. Indicators for Community Relations	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
B. Constituency Education (continued)		
10. The health department widely disseminates reports regarding public health issues to the community.	10. _____	_____
Other:		
C. Documentation		
1. The health department maintains files documenting relations and communications with other organizations related to the public health.	1. _____	_____
2. The health department maintains current information on the needs of health-related organizations.	2. _____	_____
3. In all cases in which a potential duplication of significant public health activities might exist between the health department and another local organization, the director has established a written agreement with the executive officer or board of that organization clarifying functional relationships and identifying areas of collaboration.	3. _____	_____
Other:		

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III. Indicators for Community Health Assessment	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
A. Mission and Role		
1. The health department has a clear and concrete mission statement that all staff are capable of stating and explaining in relation to their duties.	1. _____	_____
2. The health department has established a process for community health assessment and the development of a community health plan.	2. _____	_____
3. At least every four years, the health department conducts a public review and discussion of its mission and role, its public health goals, its accomplishments, past activities, and plans in relation to community health.	3. _____	_____
4. At least every two years, the health department formally requests all units of government within its jurisdiction to comment on the department's programs, plan, and budget.	4. _____	_____
5. The health department has and uses a prepared presentation for informing the community and community groups of its role and authority in relation to the community's health.	5. _____	_____
6. The health department maintains a current description (no older than two years) of the public health services, programs, and authorities of the municipalities in its jurisdiction.	6. _____	_____
Other:		

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III. Indicators for Community Health Assessment	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
B. Data Collection and Analysis		
1. The health department maintains a database of existing health resources and community health status.	1. _____	_____
2. The health department receives reports of communicable disease in the community on a daily basis.	2. _____	_____
3. The health department has qualified professionals to review and analyze reported morbidity and mortality data.	3. _____	_____
4. Morbidity and mortality data are reviewed and analyzed for appropriate action on a regular schedule.	4. _____	_____
5. The health department is responsible for collecting, processing, analyzing, and reporting birth and death certificates, or is part of a state-wide system for obtaining such information.	5. _____	_____
6. The health department conducts appropriate statistical analysis of birth and death records and reports these results to the policy board, staff, and community on a regular basis.	6. _____	_____
7. The health department conducts or supports periodic risk factor surveys to identify community risk factors, their prevalence, and interrelationships.	7. _____	_____
8. The health department regularly collects or requests and receives from the state health authority locally specific data needed for assessing the health of the community.		
a. The data includes at least those data sets suggested in Part II of this Workbook.	8a. _____	_____
b. The health department collects or receives additional locally specific data sets such as those included in Part II, Section B.	8b. _____	_____
Other:		

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III. Indicators for Community Health Assessment	Perceived Importance Codes: H M L 0 *	Current Status Codes: F P N 0 ? **
C. Resource Assessment		
1. The health department has joint powers agreements with other units of government in neighboring jurisdictions or within its own jurisdiction for the shared funding and operation of enforcement and service delivery programs where economies of scale and efficiency are possible.	1. _____	_____
2. The health department maintains a current roster of qualified health professionals employed by units of government within its jurisdiction for reference in the development of technical study groups, activities related to professional development, and other personnel-related purposes.	2. _____	_____
3. The health department participates in joint efforts to pool training needs with neighboring health agencies.	3. _____	_____
4. The health department has agreements with health-related organizations operating programs within its jurisdiction for sharing staff expertise.	4. _____	_____
5. The health department annually compiles or updates a listing of health-related information systems and data bases maintained by community organizations that operate within its jurisdiction.	5. _____	_____
6. The health department has an established program for the development of in-kind contributions from private industry, private nonprofit organizations, churches, and other community organizations.	6. _____	_____
Other:		

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III. Indicators for Community Health Assessment	Perceived Importance Codes: H M L 0 *	Current Status Codes: F P N 0 ? **
D. Planning and Development		
1. The health department has staff with education and experience in planning and evaluation.	1. _____	_____
2. The health department uses health data, including vital records, in its community health planning process.	2. _____	_____
3. The health department has a standard, ongoing process to examine internal and external trends, to make forecasts, and to systematically develop long term plans for its future.	3. _____	_____
4. The health department has a published strategic plan that includes the current year.	4. _____	_____
Other:		
E. Evaluation and Assurance		
1. The health department monitors program impact indicators on a regular basis.	1. _____	_____
2. The health department has community health objectives that are time limited and measurable.	2. _____	_____
3. The health department reviews and revises community health programs on the basis of the community health plan.	3. _____	_____
Other:		

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IV. Indicators for Public Policy Development	Perceived Importance Codes: H M L 0 *	Current Status Codes: F P N 0 ? **
A. Community Health Assessment and Planning		
1. The health department director assures and facilitates the completion of a community health assessment process.	1. _____	_____
2. The health department and the community identify and set priorities for addressing health problems based on the results of the community health assessment.	2. _____	_____
3. The health department and the community develop a community health plan based on the results of the community health assessment and priority-setting processes.	3. _____	_____
4. The health department director and the community involve the policy board in the review and revision, if necessary, of the proposed community health plan.	4. _____	_____
5. The policy board adopts the community health plan.	5. _____	_____
6. The policy board acts as an advocate on behalf of the health department for allocation of resources needed to implement the community health plan.	6. _____	_____
7. The policy board monitors the implementation of the community health plan.	7. _____	_____
Other:		

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IV. Indicators for Public Policy Development	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
B. Community Health Policy		
1. The policy board obtains information from an established citizens' advisory group and from the health department regarding public policy issues affecting the public health.	1. _____	_____
2. The policy board identifies any additional public policy issues affecting public health and analyzes those issues.	2. _____	_____
3. The policy board establishes priorities and formulates strategies for action on high priority health policy issues.	3. _____	_____
4. The health department facilitates the formulation of public health policy in the community.	4. _____	_____
5. The policy board and the health department director monitor and evaluate the impact of public policy on specific health problems.	5. _____	_____
6. The policy board advocates changes in public policy to correct the public health problems of the community.	6. _____	_____
Other:		

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IV. Indicators for Public Policy Development	Perceived Importance Codes: H M L 0 *	Current Status Codes: F P N 0 ? **
C. Public Policy and Public Health Issues		
1. The local governmental unit collaborates with the policy board and the health department director in developing public policy which may impact public health.	1. _____	_____
2. The elected officials at the local level actively solicit the opinions of the professional staff and/or health department director on scientific issues in policy development.	2. _____	_____
3. The health department director and policy board participate at both the state and local levels in governmental decision making which may have an impact on local health issues.	3. _____	_____
Other:		

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V. Indicators for Assurance of Public Health Services	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
A. Public Policy Implementation		
1. The policy board uses its authority to assure necessary services to reach agreed upon goals for its constituents.	1. _____	_____
2. The policy board assists the health department in utilizing all resources in the community to assure the desired services to all its citizens.	2. _____	_____
3. The health department assures or provides direct services for priority health needs identified in the community health assessment.	3. _____	_____
4. The health department assures and implements legislative mandates and statutory responsibilities.	4. _____	_____
5. The health department maintains a level of service without interruption to avoid crises affecting the health of the community.	5. _____	_____
Other:		

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V. Indicators for Assurance of Public Health Services	Perceived Importance Codes: H M L 0 *	Current Status Codes: F P N 0 ? **
B. Personal Health Services		
1. The health department monitors the availability of personal health services and assures an appropriate level of those health services in the community.	1. _____	_____
2. The health department seeks to assure that all citizens receive the level of personal health services referred to in B1, above, regardless of their ability to pay.	2. _____	_____
3. The health department identifies barriers to access to health care and develops plans to minimize them.	3. _____	_____
4. The health department provides the services necessary to assure a clean, safe, and secure environment for the community.	4. _____	_____
Other:		
C. Involvement of Community in the Public Health Delivery System		
1. The policy board and senior management of the health department work with employee groups in assessing health risks of employees and in managing those risks.	1. _____	_____
2. The policy board and senior management participate in the development of health policy issues in colleges, schools, and industry to assure an optimum, healthy environment for special groups.	2. _____	_____
3. The policy board and the health department director assure health protection and health promotion services utilizing community-based organizations.	3. _____	_____
Other:		

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VI. Indicators for Financial Management	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
A. Budget Development and Authorization		
1. A department budget is adopted annually by the policy board.	1. _____	_____
2. The budget accurately reflects the priorities established in the organizational action plan.	2. _____	_____
3. Budget justifications reflect health department programs and health problems within its jurisdiction.	3. _____	_____
4. Professional or community groups help the health department present and justify its budget.	4. _____	_____
5. Health department management staff are involved in developing the proposed budget.	5. _____	_____
6. The health department receives locally assessed tax funds from the unit of government to which it is responsible.	6. _____	_____
7. The health department has the authority to recommend and charge fees for the services it provides.	7. _____	_____
8. The health department has an adequate contingency fund for dealing with public health emergencies.	8. _____	_____
Other:		

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VI. Indicators for Financial Management	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
B. Financial Planning and Financial Resource Development		
1. The health department has a predictable source of funds to allow the development and implementation of a long range plan (minimum, 5 years).	1. _____	_____
2. The health department has a financial management capacity that provides for securing funding for, or the orderly phasing out of, discretionary programs for which funds are not available.	2. _____	_____
3. The health department has a diverse funding base to lessen disruption of services caused by withdrawal of funds from any one source.	3. _____	_____
4. The health department maintains or has access to a foundation directory and other information about sources of public and private funding for public health activities.	4. _____	_____
5. The health department has a current description of state and federal funding sources available to it and to organizations within its jurisdiction.	5. _____	_____
6. The health department maintains current information on the health-related budgets and expenditures of all units of government within its jurisdiction.	6. _____	_____
7. The health department has staff skilled in writing successful grant applications.	7. _____	_____
8. The health department has agreements with units of government within its jurisdiction that allow the use of local expenditures to be documented as "match" in its grant requests.	8. _____	_____
9. The health department has contracts to provide public health services to or for community organizations, private nonprofit corporations, and health care organizations.	9. _____	_____
Other:		

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H = High importance
M = Moderate importance
L = Low importance
0 = Not relevant

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? = Status unknown

VI. Indicators for Financial Management	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
C. Financial Reporting and Administration		
1. Expenditures follow the budget and financial plan of the health department.	1. _____	_____
2. A description of the health department financial management system is a part of orientation for new policy board members and staff.	2. _____	_____
3. Financial reports are understood by policy board members and administrative and supervisory staff.	3. _____	_____
4. The financial position of the health department is routinely reviewed by the policy board and administrative and supervisory staff.	4. _____	_____
5. An administrative officer or finance director is designated by the policy board to oversee all finances of the health department, including meeting all legal financial requirements, adherence to department fiscal policies, and reporting to the policy board regularly on financial matters.	5. _____	_____
6. The policy board and staff understand their legal accountability and liability, as well as their general responsibility to the public for wise financial management.	6. _____	_____
Other:		

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VI. Indicators for Financial Management	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
D. Audit		
1. The health department has an independent, outside, annual financial and performance audit which conforms with requirements stipulated by general accounting principles.	1. _____	_____
2. The annual audit is reviewed and clearly understood by the policy board and key department staff.	2. _____	_____
Other:		
E. Documentation		
1. A written standard budget development and review procedure is authorized by the policy board, and is available to staff and the public.	1. _____	_____
2. Appropriate journals, ledgers, registers, and financial reports are kept, using generally accepted accounting procedures.	2. _____	_____
3. Copies of the health department annual financial audit are available to policy board members, department staff, and the public.	3. _____	_____
4. A written procedure for participating in state and federal grants, and public and private foundation funding awards, is authorized by the policy board and available to department staff and the public.	4. _____	_____
Other:		

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VII. Indicators for Personnel Management	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
A. Policy Development and Authorization		
1. A written job description, including minimum qualifications, exists for each position in the health department.	1. _____	_____
2. Written personnel policies and procedures are developed or revised with staff input.	2. _____	_____
3. Personnel recruitment, selection, and appointment procedures are documented.	3. _____	_____
4. If another unit or department of government carries out personnel functions for the health department, the relationships with that unit or department are clearly defined and documented in a written agreement.	4. _____	_____
5. If labor unions represent department staff, there is an established working relationship and labor contract between the health department policy board and each respective labor union.	5. _____	_____
6. Both the policy board and senior management of the health department have input into any labor union contract negotiations.	6. _____	_____
7. There is a documented procedure, authorized by the policy board and developed with input from senior management of the health department and staff where appropriate, for employee grievances, reprimands, suspensions, and dismissals.	7. _____	_____
8. There is a documented, structured salary administration plan that is authorized by the policy board and that is designed to attract and retain competent staff.	8. _____	_____
Other:		

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VII. Indicators for Personnel Management	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
B. Personnel Administration and Reporting		
1. The health department director is responsible for internal administration of the department.	1. _____	_____
2. The policy board employs the health department director and conducts a periodic, written appraisal of the director's performance.	2. _____	_____
3. Written staff performance appraisals are conducted by supervisors with employees at established intervals.	3. _____	_____
4. The performance appraisal system is monitored by the health department director.	4. _____	_____
5. Union contract provisions are administered in a well-coordinated manner with documented provisions for non-union employees.	5. _____	_____
6. Health department announcements and program information are distributed to all employees via a standard mechanism.	6. _____	_____
7. There are regularly scheduled meetings by work group, work site, division, and department.	7. _____	_____
8. The policy board receives routine reports from the health department director relative to new employees, staffing changes, dismissals, grievances, etc.	8. _____	_____
9. The health department director selects qualified individuals as staff for the department.	9. _____	_____
10. The health department provides appropriate confidentiality for all personnel records.	10. _____	_____
Other:		

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VII. Indicators for Personnel Management	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
C. Staffing Plan and Development		
1. Staffing patterns and levels match policy board authorized programs and services and current levels of demand for services.	1. _____	_____
2. The health department has a written plan or policy regarding staff recruitment, selection, development, and retention.	2. _____	_____
3. All employees have structured, routine, group opportunities to discuss program methods and procedures, current levels of demand for services, and quality of work issues with their respective supervisors.	3. _____	_____
4. The health department staff have access to training provided by the state health authority in areas relevant to local health problems.	4. _____	_____
5. The health department has access to the staff development resources of a school of public health or of other relevant educational institutions.	5. _____	_____
6. The health department has clearly expressed its staff development needs to schools of public health or to other educational institutions.	6. _____	_____
7. The health department uses volunteers to support programs where possible, and manages its volunteer program through clearly defined policies and procedures.	7. _____	_____
8. There are adequate provisions for liability insurance protection for department board members, staff, and volunteers.	8. _____	_____
9. The health department has a documented staff development program, monitored by the department director, which includes employee-supervisor annual plan development and cost projections, with routine review and update.	9. _____	_____

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VII. Indicators for Personnel Management	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
C. Staffing Plan and Development (continued)		
10. The health department personnel administration system and personnel policies and procedures are reviewed with each new policy board member and department staff member.	10. _____	_____
11. The health department encourages and supports staff participation in professional organizations.	11. _____	_____
12. The health department staffing plan includes provisions for "backup staff" to enable critical scheduled operations to continue without interruption when temporary vacancies occur.	12. _____	_____
13. The health department has the ability to fill new and vacant positions in a timely manner.	13. _____	_____
Other:		
D. Personnel Policy and Procedure Audit		
1. A periodic personnel administration audit is performed by a department team to determine if authorized personnel policies and procedures are being followed.	1. _____	_____
2. The findings of the personnel administration audit are reported to the policy board.	2. _____	_____
3. There is a written, standard employee exit interview conducted with every employee leaving the health department, which includes identification of reasons for resignation.	3. _____	_____
4. The health department director monitors all employee exit interview results, and periodically reports such information to the policy board.	4. _____	_____
Other:		

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VII. Indicators for Personnel Management	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
E. Documentation		
1. There is a standard, written description of the health department personnel management system which is available to policy board members, department staff, and the public.	1. _____	_____
2. All personnel transactions are documented.	2. _____	_____
3. An up-to-date coordinated, structured, and confidential file is maintained for every employee and volunteer.	3. _____	_____
4. All job descriptions, policies, and procedures are consolidated and available to policy board members, department staff, and the public.	4. _____	_____
5. All recruitment, selection, appointment, and applicant grievance procedures are available in writing to policy board members, department staff, and the public.	5. _____	_____
6. The salary administration plan is written and available to policy board members, department staff, and the public.	6. _____	_____
Other:		

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VIII. Indicators for Program Management	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
A. Organization and Structure		
1. Operating programs are authorized by the policy board.	1. _____	_____
2. The director regularly reviews and discusses with the health department's management staff the perceived roles and authorities of units of government within its jurisdiction.	2. _____	_____
3. There is a current organizational chart which shows all functional elements of the organization and their relationship to each other.	3. _____	_____
4. Staff meetings are held at reasonable frequencies, include appropriate staff, and are called and structured by appropriate individuals.	4. _____	_____
5. The health department maintains emergency contact staff (on site or on call) to respond to local public health emergencies.	5. _____	_____
Other:		

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VIII. Indicators for Program Management	Perceived Importance Codes: H M L 0*	Current Status Codes:F P N 0 ?**
B. Evaluation		
1. The health department collects and regularly analyzes information describing program administration and funding, program activities, workload, client characteristics, and service costs needed to evaluate the ***process*** of program activities.	1. _____	_____
2. The health department collects and regularly analyzes information that is needed to evaluate the ***impact and outcome*** of program activities on risk factors and health status.	2. _____	_____
3. Program objectives are time limited and measurable.	3. _____	_____
4. Operating programs are reviewed or revised on a regular periodic schedule.	4. _____	_____
5. The health department routinely examines the working environment to ensure that it facilitates program objectives and that the physical plant is "barrier free" and meets state and local building standards.	5. _____	_____
Other:		

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- ? = Status unknown

VIII. Indicators for Program Management	Perceived Importance Codes: H M L 0*	Current Status Codes:F P N 0 ?**
C. General Information Systems		
1. The health department has a management information system that allows the analysis of administrative, demographic, epidemiologic, and utilization data to provide information for planning, administration, and evaluation.	1. _____	_____
2. The health department has a plan for the introduction and/or expansion of computer-based systems.	2. _____	_____
3. The health department has a technical library of books and other publications relevant to its public health activities for immediate reference by its staff, and a method for keeping materials current.	3. _____	_____
4. The health department annually compiles or updates a listing of health-related information systems and data bases maintained by units of government within its jurisdiction.	4. _____	_____
5. The health department subscribes to an on-line, computer-based data system that provides direct access to health-related data or that has direct access to public health and population data compiled by state agencies.	5. _____	_____
6. The health department maintains current information on federal data bases and information systems relevant to its programs.	6. _____	_____
Other:		

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VIII. Indicators for Program Management	Perceived Importance Codes: H M L 0*	Current Status Codes:F P N 0 ?**
D. Shared Resources		
1. The health department has formal or informal agreements with other units of government within or surrounding its jurisdiction for sharing expensive, less-used equipment (e.g., mainframe computer systems).	1. _____	_____
2. The health department participates in shared service or purchase agreements where volume purchasing can reduce costs, such as for printing, supplies, and other materials.	2. _____	_____
3. The health department has agreements with community organizations for sharing space, clerical support, and other resources.	3. _____	_____
Other:		

***Perceived Importance Codes:**
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- **M** = Moderate importance
- **L** = Low importance
- **0** = Not relevant

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IX. Indicators for Policy Board Procedures	Perceived Importance Codes: H M L 0*	Current Status Codes:F P N 0 ?**
1. Health department policy board members attend policy board and committee meetings.	1. _____	_____
2. New policy board members routinely receive orientation through an established and documented orientation program of the health department.	2. _____	_____
3. Policy board meetings are scheduled on a regular basis, with sufficient frequency to ensure board control and direction of the health department.	3. _____	_____
4. Policy board materials, including agenda and study documents, are mailed to members no less than three days in advance of board meetings.	4. _____	_____
5. Policy board meetings deal primarily with policy determination, review of plans, making board authorizations, and evaluating the work of the health department.	5. _____	_____
6. There are written board and administrative policies consistent with the mission statement.	6. _____	_____
7. The health department publishes the schedule of regular policy board meetings in local news media.	7. _____	_____
8. Minutes of board and committee meetings are written and circulated to board members and the health department staff, and are available to the public.	8. _____	_____
Other:		

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ANALYSIS OF ORGANIZATIONAL STRENGTHS/PROBLEMS

Worksheet

APEX/PH Indicator Reference Number(s)	Definition of Strength or Problem Briefly state any strengths or problems suggested by the scoring of the indicators.	Related Factors Briefly describe the sources of each strength or problem; list resources and barriers to the solution of each problem.	Action Priority I = Top II = Middle III = Lowest

ORGANIZATIONAL ACTION PLAN Worksheet

Develop an action plan for each of the top priority problem areas identified on the *Analysis of Organizational Strengths/Problems Worksheet.* Initially, address the top priority problems **only.** Below the table, enter the date for evaluating the effectiveness of the actions taken.

Problem Area: _____ **APEX*PH* Indicator Reference No(s):** _____

Goals and Objectives Define the goals and objectives for the problem area indicated above.	**Responsibilities and Methods** For each goal or objective indicate (1) what individual or "work team" is responsible, (2) what methods will be used, and (3) when it will be accomplished

Evaluation date: _____

Part I
Organizational Capacity Assessment

Section C
Examples of Completed Worksheets

EXAMPLE: TEST-SITE WORKSHEETS AND PLANS

This section contains sample worksheets based on documents from one of the test sites that applied the Organizational Capacity Assessment. They show only a portion of the work carried out by the health department concerned. Please note also that the health department represented by these sample worksheets is not among the health departments described in Appendix A.

Outline of Example (with page references)

II. Indicators for Community Relations	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**	
A. Constituency Development (continued)			
4. The health department cooperates and collaborates with other agencies that deliver similar ***programs*** in the same service area.	4. H	P	
5. The policy board has formed a citizens' or community committee or has established another formal method of involving the people it serves in the identification of community health problems and the development of a community health plan.	5. H	P	
6. The health department has established mechanisms to guide and ensure active and cooperative relationships with community and professional groups.	6. H	N	W
7. Health department staff are aware of relevant programs, policies, and priorities of the federal Department of Health and Human Services (HHS), Environmental Protection Agency (EPA), and other related federal agencies.	7. H	N	W
8. The health department has a physician health officer, medical adviser(s), or consultant(s) to assist in maintaining relationships with the private medical community.	8. H	F	S
9. The health department has established relationships with a university school of public health, medicine, or nursing, or with other educational institutions within or near its jurisdiction for staff development, internships, consultation, and other capacity-building purposes.	9. H	F	S
Other:			

EXAMPLE

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V. Indicators for Assurance of Public Health Services	Perceived Importance Codes: H M L 0*	Current Status Codes: F P N 0 ?**
A. Public Policy Implementation		
1. The policy board uses its authority to assure necessary services to reach agreed upon goals for its constituents.	1. H	P
2. The policy board assists the health department in utilizing all resources in the community to assure the desired services to all its citizens.	2. H	N
3. The health department assures or provides direct services for priority health needs identified in the community health assessment.	3. H	F
4. The health department assures and implements legislative mandates and statutory responsibilities.	4. H	F
5. The health department maintains a level of service without interruption to avoid crises affecting the health of the community.	5. H	F
Other:		

EXAMPLE

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ANALYSIS OF ORGANIZATIONAL STRENGTHS/PROBLEMS

Worksheet

EXAMPLE

APEX/PH Indicator Reference Number(s)	Definition of Strength or Problem Briefly state any strengths or problems suggested by the scoring of the indicators.	Related Factors Briefly describe the sources of each strength or problem; list resources and barriers to the solution of each problem.	Action Priority I = Top II = Middle III = Lowest
II. A. 8	Department has a physician health officer who maintains a good relationship with the private medical community.	Health officer is a practicing physician in the community.	
II. A. 9.	Major cooperation via College of Nursing, Medicine, and Allied Health for student placement and faculty support. Department has strong relations with community institutions.	Health officer actively pursues relations with educational and community institutions and promotes mutual benefits of cooperative activities.	

ANALYSIS OF ORGANIZATIONAL STRENGTHS/PROBLEMS

Worksheet

APEX/PH Indicator Reference Number(s)	Definition of Strength or Problem Briefly state any strengths or problems suggested by the scoring of the indicators.	Related Factors Briefly describe the sources of each strength or problem; list resources and barriers to the solution of each problem.	Action Priority I = Top II = Middle III = Lowest
II. A. 6 and 7	Department is isolated from federal level as well as community level information and or relationships.	Employee attitudes and perceptions about community is a barrier for cooperation. Lack of dedicated staff time to public relations and community relations. Communication problems: poor dissemination of information. Fragmentation of services and responsibilities. Lack of coordination.	I I

EXAMPLE

ORGANIZATIONAL ACTION PLAN Worksheet

Develop an action plan for each of the top priority problem areas identified on the *Analysis of Organizational Strengths/Problems Worksheet*. Initially, address the top priority problems **only**. Below the table, enter the date for evaluating the effectiveness of the actions taken.

Problem Area: Community Relations

APEX*PH* Indicator Reference No(s): II-A, 6 & 7

EXAMPLE

Goals and Objectives Define the goals and objectives for the problem area indicated above.	**Responsibilities and Methods** For each goal or objective indicate (1) what individual or "work team" is responsible, (2) what methods will be used, and (3) when it will be accomplished
G: To reduce the isolation of the health department, and promote the awareness of federal and communities priorities O: 1. Mechanisms will be established so that information from the federal government regarding specific programs, policies and priorities will be summarized and distributed to appropriate personnel.	1. Responsibility: Individual Program Directors to prepare and distribute quarterly updates on any federal policies, programs or priorities relevant to the department (these consist of already prepared material received from the Federal government). As needed, should be addressed at program level meetings and at meetings with the director. Date 2/1/90
2. Mechanisms will be established so that information from the community via relationships with community and professional groups will be reviewed and acted upon (as appropriate). Objectives to be met by 3/1/90	2. Director will appoint liaison to every appropriate community and professional group. Letters to each group will be sent informing them of the department interest in their work, and the appointment of a liaison (liaison's name and telephone number). Date 2/1/90 3. Liaisons to attend meetings (as appropriate) and report to the director proceedings and recommended actions (if needed). Director will update senior staff at monthly staff meeting. Date 3/1/90

Evaluation date: _____

ANALYSIS OF ORGANIZATIONAL STRENGTHS/PROBLEMS

Worksheet

APEX/PH Indicator Reference Number(s)	Definition of Strength or Problem Briefly state any strengths or problems suggested by the scoring of the indicators.	Related Factors Briefly describe the sources of each strength or problem; list resources and barriers to the solution of each problem.	Action Priority I = Top II = Middle III = Lowest
V. A. 1 and 2	Policy board's role is more limited than it is defined by recently enacted law. Legal authority allows the policy board to take a larger role.	The policy board historically has worked in a reactive manner. They have the ability to develop ordinances, set policies, etc. but have not done so proactively. Heretofore, the idea of "constituents" has been interpreted in a narrow manner.	I

EXAMPLE

ORGANIZATIONAL ACTION PLAN Worksheet

Develop an action plan for each of the top priority problem areas identified on the *Analysis of Organizational Strengths/Problems Worksheet.* Initially, address the top priority problems **only.** Below the table, enter the date for evaluating the effectiveness of the actions taken.

Problem Area: Public Policy Implementation **APEX*PH* Indicator Reference No(s):** V. A. 1 & 2

EXAMPLE

Goals and Objectives Define the goals and objectives for the problem area indicated above.	**Responsibilities and Methods** For each goal or objective indicate (1) what individual or "work team" is responsible, (2) what methods will be used, and (3) when it will be accomplished
G: The policy board exercises authority and influence to facilitate the delivery of programs/services per mission of the department. The policy board actively promotes conditions in which people can be healthy.	The policy board, with the assistance of the department director, to explore and formulate a strategy for exercising authority on a variety of health issues, especially priority issues, through many mechanisms available to it by 6/90.
O: 1. Clarify and expand the understanding of actual constituency groups; develop an outline concerning the proactive expression of the board's responsibilities, authority and power, with regard to its role as a governmental entity and within the context of its enabling legislation by next meeting. (6/15/90)	For use by policy board, department director and senior management staff will develop outline of constituency groups and blueprint for increasing communications, and will outline mechanisms for use by policy board to effect more healthy conditions by 6/90.
2. Policy board to update and adopt a mission and purpose; to clarify the parameters of its responsibility and authority by 7/15/90.	Department director to draft a mission statement for policy board as well as other guidelines for operation by 6/90.

Evaluation date: _____

Part II

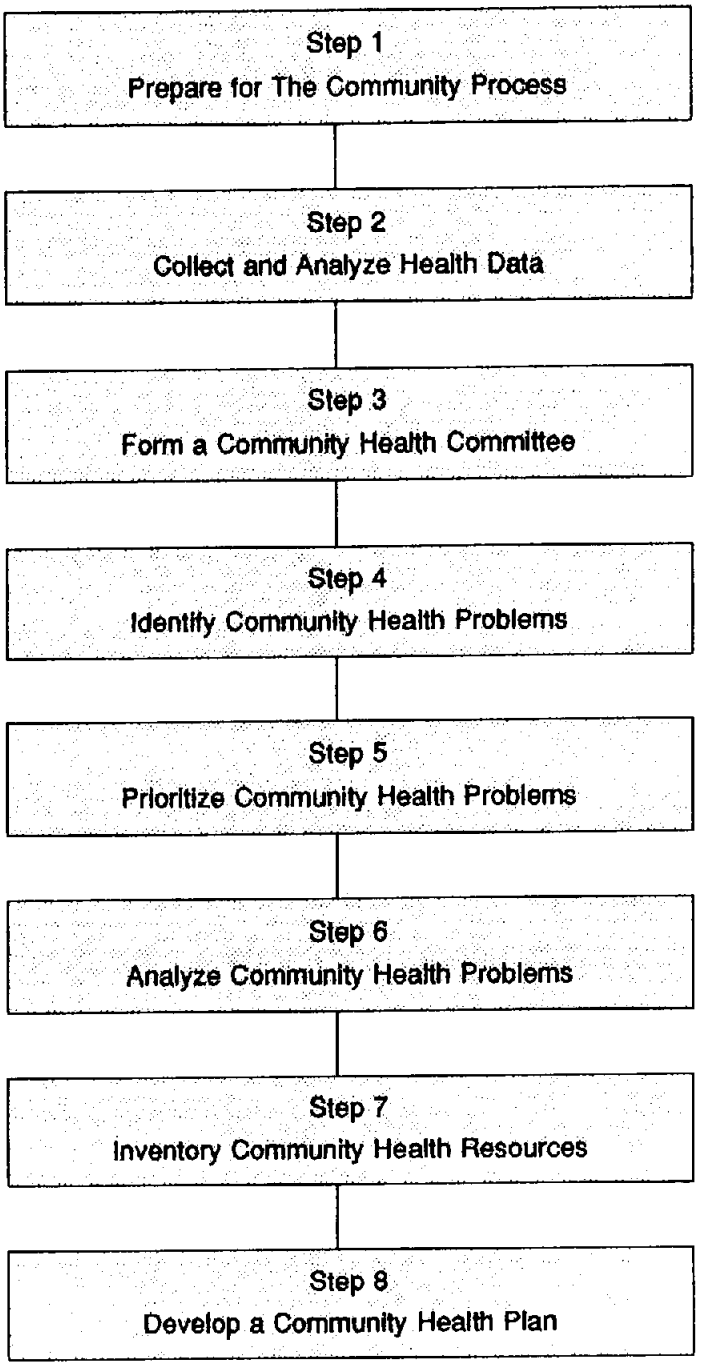
The Community Process

Section A

How To Implement

The APEX*PH* Community Process

Flowchart of Steps
In The APEX*PH* Community Process



How To Implement The APEX*PH* Community Process

The eight principal steps in implementing The APEX*PH* Community Process are shown in the flowchart on the opposite page. Each step is described in detail below. The description is supported by examples in Section II-C. Terms are defined on their first use; definitions are also given in the glossary in Appendix I.

Step 1.
Prepare for The APEX*PH* Community Process

This step is primarily the responsibility of the director of a health department. It occurs in the following three stages, which in practice will overlap:

(a) Deciding to implement The Community Process

(b) Committing the needed resources

(c) Assessing the community structure

Deciding To Implement The Community Process

Effectively conducted, The Community Process provides both the scientific knowledge and the political support necessary for the identification and management of health problems. The decision to implement The Community Process must be made by the director of a health department, but senior management staff can provide helpful advice. A health department director should decide ***not*** to implement The Community Process if one of the following circumstances exists:

- The health department already has an equivalent process in place.
- When the health department conducted the APEX*PH* Organizational Capacity Assessment, it found weaknesses that would act as barriers to implementing The Community Process, and those weaknesses have not yet been addressed.
- The health department or the community for other reasons is unable to make a commitment at this time to implementing The Community Process.

Equivalent processes. Local health departments and communities have used several models similar to this one—for example, PATCH, Healthy Cities, Healthy Communities, and Model Standards. Typically, effective models contain the following elements:

- Assessing the community organizational structure
- Involving the community for problem-solving and action
- Assessing health needs using science-based data
- Setting priorities in light of local resources
- Developing intervention strategies
- Implementing intervention strategies
- Using a system of monitoring and evaluation

If the health department or community has an equivalent process in place, it may be substituted for The APEX*PH* Community Process. For a process to be equivalent, it must incorporate recent health statistics and the active participation of the community.

Barriers. If an organizational capacity assessment has disclosed serious inadequacies that would hamper carrying out The Community Process, these inadequacies should be remedied before the health department undertakes this section of the APEX*PH* process.

Commitment. It is the purpose of APEX*PH*, through The Community Process, to help the local health department define and fulfill its leadership role in the community. There must be citizen participation and sustained community support to gain long-range results. The challenge of community health assessment is significant, both for the health department and for the members of the community who take part in it.

It is essential to include those who have a stake in the outcome of the APEX*PH* process in the decision to undertake the process. The following are some of the stakeholders in The Community Process:

- The board of health or other administrative and policy board, if any, established under state law, local ordinance, or other authority, since implementation of the results of the process may well require policy and budget action by this body
- Professional program staff, since they will be affected by or may need to put into effect some of the recommended actions resulting from the process
- The unit of government from which the local health department derives its basic authority, since one of the outcomes of The Community Process might be a recommendation to increase community resources
- The general public, as represented by some form of community health committee or advisory body, since ownership of the collective health of a community, by the community, is key to improving health status

- Special interest groups, such as groups supporting environmental protection and environmental health, local business organizations, local medical and dental societies, community organizations, religious organizations, and other key community organizations, since the interests of these groups may be crucial to the successful implementation of a community-based health plan
- Representatives from hospitals, community health centers, the Visiting Nurse Association, and other health and human service agencies, since involvement of these providers is key to better coordination of health care services
- Educational institutions, such as university schools of public health, medicine, or nursing; colleges; private schools; and local school districts, since each may have a specialized role to play or a particular interest or potential contribution that should be taken into account during the APEX*PH* process

Committing the Needed Resources

A decision to implement The Community Process must be based on a good understanding of the time and commitment it requires. Typically, resources needed for The Community Process are substantially greater than those needed for the Organizational Capacity Assessment. The health department must be able to establish and guide a Community Health Committee, have the communication resources to maintain a highly public process, have access to appropriate health status data, and have access to staff who can analyze these data and prepare information for a Community Health Committee. Computer time and report production costs may be required.

The Community Process is dependent on data that are often prepared and distributed by state health authorities. In some locations, this data capacity may not yet exist. A local health department that faces this handicap should work with the policy board and with state health officials to support the creation of this capacity at the state level. Where state level data is available but is not easily usable in the format provided by the state, a local health director may find it helpful to work with the state health authority to reformat or to create data sets that support a locally relevant community health assessment.

Careful thought should be given to the skills needed to guide and support The Community Process. The ability to analyze data and communicate the implications of the analysis in a clear, concise, and unbiased way is essential.

The number of staff involved in the process can vary, depending on what phase of the process is underway. For example, one or two staff members might be required to collect and analyze all data. The health department director or one or two senior staff members could be involved in presenting a summary list of health problems to the community and helping the community incorporate its perceptions into the list, set

priorities, and develop action plans. Also, substantial secretarial support will be required during some phases of the process.

Assessing The Community Organizational Structure

No health department exists in a vacuum. A myriad of other organizations and individuals in the community have a direct impact on health status and the provision of services. There are numerous and diverse stakeholders who may potentially derive benefits from the implementation of The Community Process. There may also be barriers to an effective implementation of the Process. For example, the leaders of other highly visible and successful community programs may be resistant to The Community Process unless they are informed and invited to participate. Business investors in a major new health care facility may resist community determination of health needs. Community leaders concerned about scarce local tax money and already committed to supporting a non-health related activity may not recognize the value of undertaking The Community Process without detailed explanation of its intent.

Each community has a unique history, political structure, business and social development, and values and perspectives. An assessment of the community structure must provide the context within which The Community Process is implemented. Meeting with formal and informal leaders can provide insights into the community and will do much to ensure the success of the endeavor. At a minimum, the policy board, the health department director, and senior health department management staff should assess the community's organizational structure to determine the best timing and methods to ensure success.

Orienting Health Department Staff

Health department staff members must be prepared for the roles they will play in The Community Process. All staff who will participate either directly in face-to-face contacts with members of the Community Health Committee or indirectly by providing data collection and analysis, or in other supporting roles, should understand the purpose of The Community Process, the benefits that are expected from it, and the roles to be played by all concerned.

Health department staff play a crucial role in The Community Process, especially in providing information to the Community Health Committee. The precise definition of that role will differ in different communities. In some communities, a health department staff member will be a member of the Community Health Committee. It will be necessary in every community for health department staff to attend meetings of the Committee in order to provide information and to assist the Committee in its work.

It is recommended that in interacting with the Committee, whether as a member or in attending a meeting to present information, health department staff should try to take a back seat. The role of health department staff should be to

facilitate the interaction of the community representatives, to clarify the task of the Committee, and to act as an information resource which the Committee may use.

ACTIONS (*to be taken by the director, and by others at the discretion of the director*):

1. Review the section of the Introduction to this APEX*PH* workbook that describes Part II, The Community Process.
2. Review Part II in enough detail to be able to estimate the time and resources that would be needed to implement The Community Process; assess the availability of data; and take action to ensure that the needed data will be available, if it is not now available.
3. Review the results of the Organizational Capacity Assessment to determine whether the health department is capable of implementing The Community Process.
4. Meet with senior management staff, with the policy board, and with significant community leaders to assess the community organizational structure.
5. Orient all health department staff members who will participate in The Community Process.
6. Review steps 2 and 3, below, and prepare to proceed with those simultaneously.

Step 2.
Collect and Analyze Health Data

The requirement for data has been kept to a minimum, because most local health departments have difficulty in getting data. If the data specified below are not available at all, the health department director should work with the state health department and local peers to solve this problem. It is recommended that a local health department proceed with this step only if there is some scientific data with which to work.

Collecting the Data

Data collection may take considerable time and effort. Staff should be allowed sufficient lead time to prepare data and material that is to be presented to the Community Health Committee.

At a minimum, the following classes of data are needed:

- demographic
- socioeconomic
- mortality

Worksheets for collecting these classes of data are provided in Section II-B, pages 103-108. Health departments are also strongly urged to provide more than the basic set of data, if they can do so. Worksheets for additional data that would be valuable supplementary information are provided in Section II-B, pages 109-123. Where worksheets use the word "*county*," local health departments that serve some other jurisdiction should substitute their jurisdictional level.

Data acquisition may involve working with the state health department, the Centers for Disease Control, or with other local, state, federal, or private agencies. The most recent community-specific data available should be used. When the local population is too small, it may be necessary to use such techniques as averaging three or more years of data, making synthetic estimates, or analyzing individual cases or events to identify probable community risk factors or health problems. Consult with a state or academic epidemiologist for assistance.

It is recommended that trend data should also be collected for the various types of data sets used. That is, in addition to collecting the most recent data available, any older data that are available should also be obtained and organized to show how the data on the community has changed over time.

Demographic data. Where worksheets call for population subgroup data to be collected, a health department should use a classification system that will permit subsequent comparison with population subgroup data at the state and national level.

A health department that wishes to limit the number of subgroups used may choose to use the minimum data set required by the U.S. Office of Management and Budget (OMB) for the collection of statistical information, which are:

- White, non-Hispanic
- Black, non-Hispanic
- Hispanic
- American Indian/Alaskan Native
- Asian

However, much more information is available for use. For example, all states and the District of Columbia currently report birth and death information to the National Center for Health Statistics (NCHS) by race for the following categories:

- White
- Black
- American Indian/Alaskan Native
- Chinese
- Japanese
- Hawaiian
- Filipino
- Other Asian or Pacific Islander
- Other

In addition, 49 states and the District of Columbia currently designate whether or not each individual identified is/was Hispanic and, if so, whether the national origin is/was:

- Mexican
- Puerto Rican
- Cuban
- Central or South American
- Other or Unknown Hispanic

Therefore a health department should be able to obtain birth and death information for the important population subgroups in its jurisdiction and is encouraged to do so.

All worksheets (whether for demographic or other data) that ask for population subgroup designations leave blanks for those designations, so that locally relevant categories can be used and so the same worksheet can be used for as many population subgroups as necessary.

Mortality data. These data provide the initial basis for assessing the health of the community. Mortality statistics are most readily available coded by the *International Classification of Diseases* (ICD) system. For the purposes of comparison with national rates, it is recommended that a health department use this methodology. On the "Leading Causes of Mortality" worksheets, record the ICD classification as well as the disease or condition that was the cause of death. A list of the ICD codes from the *Ninth Revision International Classification of Diseases* (ICD-9) is provided in Section II-B, page 108, with the code numbers grouped into categories that will be useful for examining "years of potential life lost," described in the next section.

The "Leading Causes of Mortality" worksheets call for listing the ten leading causes of death by age and population subgroup: that means the ten leading causes for ***each*** age group listed on the worksheet--different diseases will be listed for different age groups. Within each age group the deaths for the top ten diseases will be broken down into the number of deaths for the population subgroups chosen.

Optional Data. Worksheets for the following optional data are provided in Section II-B, pages 109—123: (1) estimated prevalence of disease by age and population subgroup, (2) leading causes of hospitalization by age and population subgroup, (3) perinatal indicators, (4) access to primary health care, (5) other health indices, which include occupational health and safety, substance abuse, mental health/mental retardation, and other risk factors, and (6) a profile of community environmental hazards. A health department may also wish to develop other data tables that will reflect significant local health problems that are not addressed by these optional worksheets. The information provided by all of this optional data would contribute substantially to the community health plan that will be developed. Health departments are strongly encouraged to collect as much data as possible.

Calculating "Years of Potential Life Lost"

The methodology used by APEX*PH* emphasizes premature mortality in identifying major causes of death in a community. Death before age 65 is considered "premature." The measure of premature mortality used is called *years of potential life lost* (YPLL) and is the number of years between the age at death and age 65, that is, the number of years which are "lost" by persons who die before age 65. (APEX*PH* considers causes of death of persons over the age of 65 in the next section.)

A worksheet for calculating YPLL is provided in Section II-B, page 107. A YPLL worksheet should be completed for each of the ICD-9 code groups in the list in Section II-B, page 108.

To calculate YPLL, do the following for each particular ICD-9 group:

(1) Record by age the number of deaths of females and of males in the major racial/ethnic groups in the county. (Use additional worksheets, as needed, to record data on all major racial/ethnic groups in the county.)

(2) Multiply the number of deaths recorded in an age range by the average number of YPLL's for that age range (given on the worksheet).

(3) Find the sum of the age-specific YPLL's to arrive at the YPLL for males and for females in each major racial/ethnic group in the county.

(4) Find the grand total of YPLL for a particular ICD code group by finding the sum of the YPLL's for both males and females in all racial/ethnic groups in the county.

Summarizing a Community's Health Problems

At this point, all data available to a health department is considered, and the principal causes of disease and death in the county are listed on the "Community Health Problems Summary Sheet." This worksheet is provided in Section II-B, page 124.

All problems on the Community Health Problems Summary Sheet should meet the definition of a health problem, i.e., a situation or condition of people which is considered undesirable, is likely to exist in the future, and is measured as death, disease, or disability. A health problem could be a leading cause of death or premature mortality, or a leading cause of hospitalization. The steps taken by the health department to summarize data on the community's health problems are described below. The Community Health Committee will complete the identification of health problems in Step 4.

First, the ICD disease groups that are the top ten contributors to premature mortality in the county are listed in the top section of the worksheet. These are the diseases or conditions with the 10 highest grand totals for YPLL on the "Years of Potential Life Lost" worksheets. Unusual contributions from race/ethnicity or gender to

a listed disease or condition should be noted in the Comments column of the summary sheet.

To ensure that causes of mortality principally affecting older persons are adequately represented, the mortality tables are reexamined for the leading causes of death among persons age 65 and over. Those that are major causes of death and which differ from the causes of premature mortality are added to the Community Health Problems Summary Sheet.

Next, any optional data that were collected are examined to determine whether there are major health problems in the community which occur at a higher rate in elderly, minority, or economically disadvantaged populations than in the community as a whole. Also, any significant environmental health problems should be noted at this time. Because these factors are likely to be important in developing intervention strategies, brainstorming about these relationships may identify additions to the health problem list and, ultimately, new interventions.

Finally, all available trend data are examined, and substantial changes in any of the diseases or other conditions, either increases or decreases, noted on the Community Health Problems Summary Sheet.

Once the collected data has been completely analyzed, the health department director and the senior management staff review the Community Health Problems Summary Sheet; they add other health problems occurring at a significant rate but not reflected in the mortality statistics or the other available data. These additional health problems should compensate for the potential biases inherent in the calculations of YPLL—for example, sexually transmitted diseases, mental health problems, or some of the chronic diseases. These additions to the list are substantiated, if possible, with statistics. If specific information is not available in an area, it is recommended that the general issue be kept in mind and brought up for discussion when the Community Health Problems Summary Sheet is presented to the Community Health Committee in Step 4.

ACTIONS (to be taken by those responsible for data collection and analysis):

1. Review the worksheets in Section II-B, pages 103—123, and plan what racial/ethnic categories to use and how and where the data will be collected.
2. Request data from the state, where appropriate. If some data appears to be unavailable, make every effort to find a way to obtain it—e.g., talk with a state epidemiologist, brainstorm in the local health department, approach other appropriate persons in the community and state.
3. Compile at least the minimum data described above (Worksheets in Section II-B, pages 103-108); collect data that will show trends as well as current status.
4. Complete the YPLL worksheet (Section II-B, page 107).
5. Prepare the "Community Health Problems Summary Sheet," adding comments and health problems other than those based on the top ten YPLL diseases, as described above.

Step 3.
Form a Community Health Committee

While those responsible for data collection and analysis are completing Step 2, above, the health department can also be taking action to form a Community Health Committee.

Deciding Whether a New Group is Necessary

The health department is often only one of many health-related organizations in a community. A representative advisory committee will allow the role of the health department and of these other health-related organizations, as well as the views of the public, to be focused on in a coordinated manner. Such coordinated efforts can improve the chances that limited community resources are utilized appropriately and that organizations with similar responsibilities are working together for community benefit.

A Community Health Committee is the essential mechanism by which consensus on health problems and priorities in the community health plan is achieved. A group which can serve this function may already exist. Many states and localities do have such ongoing groups to build on. For example, if the local board of health is representative of the community and is strictly an advisory, not a policy making body, then it may function as the Community Health Committee. Or some other group that can serve the function may exist. (Note that a board of health that is not representative or that sets policy should not act as the Community Health Committee.)

Defining the Relationship of the Committee to the Policy Board

The policy board, as well as the health department, bears responsibility for community assessment, policy development, and assurance. The Committee should play an advisory role to the policy board regarding the community assessment function. Community assessment requires participants with broad and diverse backgrounds. A policy board is limited by statute and may not be large or diverse enough to conduct community assessment alone. In return for a Committee's efforts to develop and recommend a health plan for the community, the policy board should provide the resources needed by the Committee.

A model set of bylaws that define the functions of a Community Health Committee is provided in Appendix D.

Identifying Potential Members

Representation. Choosing the right members is critical to the usefulness of a Community Health Committee. Ideally, to assure that the group is truly representative

geographic, professional, racial/ethnic, income, age, sex, and institutional factors. The following are some suggested membership categories:

- Citizens of different races and ethnic origins
- Medical community
- Mental health organizations
- Cooperative extension service
- Schools
- Social service organizations
- Substance abuse clinics
- Law enforcement agencies
- Voluntary agencies
- Clergy
- Chamber of commerce
- Unions
- Economic development agencies
- Senior citizens
- Other appropriate organized community groups

Size. In selecting members for the Committee, it is necessary to reach a balance between involving all persons interested in and knowledgeable about the issues, and maintaining a workable group that can function effectively. Given the need to have a representative group, in most cases the Committee will need to have at least 12 members, although in some small communities, Committees with as few as 8 members have been effective. It is recommended that the Committee have no more than 15 members. When the community cannot be fully represented by a 15-member Committee, it may be practical to use work groups composed of both Committee members and other persons from the community to deal with specific issues.

Depending on local circumstances, it may be advisable to consider using not just a single community health committee, but rather a multiple committee structure, establishing subcommittees or task forces to represent subpopulations during the assessment phase of The Community Process. Subcommittees of a full Community Health Committee might, by this method, each represent a single county within a multiple county health department jurisdiction. Or, in a large county or city, subcommittees might each represent a "community" that exists more or less distinctly within the larger jurisdiction of the health department. In these instances, specific portions of the committee work could be delegated to these special population subcommittees, which would then report back to the full Committee, on which they would have representation. The full Committee could then incorporate their report into information that was not tied to special populations.

Selecting and Orienting Committee Members

The health department director is responsible for assuring that Committee membership selection takes place. Selection should include advising potential members of the commitment necessary for membership. That commitment is defined in the set of model bylaws found in Appendix D and includes attendance at Committee meetings and an understanding of the overall process.

In an initial meeting of the Committee, the health department director and staff should orient the members to their responsibilities and to The Community Process. Copies of the bylaws may be handed out, and the Committee's charge and the support that can be expected from the health department explained. An overview of The Community Process and its expected benefits should be presented.

ACTIONS (to be taken by the director and senior staff in consultation with the policy board):

1. Decide whether it is necessary to form a new group for the Community Health Committee.
2. Review the model bylaws for a Community Health Committee, and modify them as appropriate, defining the structure of the Committee and its relationship to the policy board.
3. Decide how many members the Committee should have and what groups should be represented, and develop a list of potential members.
4. Select the Committee membership by approaching potential members, explaining the purpose of the Committee and commitment necessary for membership.
5. Orient the Community Health Committee to its responsibilities and to The Community Process.

Step 4.
Identify Community Health Problems

In this step, the Community Health Committee is given an opportunity to review and add to the health problems on the Community Health Problems Summary Sheet that was prepared by the health department staff. This is done to ensure that the community's perceptions of health problems are considered. When the Committee has added the problems they identify to the list, there should be no more than a total of 20 problems on the list: 10-15 that are based on data and up to 5 that are largely based on the community's perceptions.

The problems added by the Committee should meet the **definition of a health problem**: *a situation or condition of people which is considered undesirable, is likely to exist in the future, and is measured as death, disease, or disability.*

Opinions of the community at large can be collected by a number of methods, such as opinion surveys or talking with community leaders in business, industry, medicine, and hospital administration, as well as with the general public. At the very least, the views of the Committee members themselves should be collected by having each Committee member list what he or she perceives to be the community's most important health problem at the current time. Each perceived health problem suggested as an addition to the list should be discussed by the entire Committee to clarify its definition and its importance as a community health problem.

This step provides one of the principal benefits of a representative Community Health Committee: an opportunity for community representatives to engage in a dialogue with the health department director and staff about community health problems. This dialogue allows for learning about community health needs and priorities on both sides. Such dialogue is crucial to the development of an effective community health plan and to the leadership role of the local health department.

Although a match between perceived and data-based health problems is ideal, it may not always occur. Issues will probably surface that have not been identified as "problems" by the health department staff. Very likely, the Committee will perceive public health needs that are not correlated to mortality or morbidity data.

Some issues may be quite subtle and complex. For example, the Committee may believe that there is an unacceptably high incidence of child abuse and neglect in certain communities; this incidence may indicate or be correlated with the presence of other problems, such as infant mortality or child injury rates. However, these correlations may be very slight, and the Committee perception not be supported by the data. Health issues perceived as major problems by the Committee may in fact take away resources from problems that have more public health significance. Nevertheless, if, after discussion with the health department, the consensus of the Committee is that a situation or issue is a health problem, then it must be treated as one.

Also, at this time the Committee and the health department should identify potential obstacles to the effective use of the results of The Community Process. These obstacles may include a conflict between data on health problems and the community's perceptions, organizational problems (such as those that might be identified through the Organization Capacity Assessment), resistance to change, and pressures from specific interest groups. The Committee may wish to seek the assistance of the policy board in overcoming such barriers.

ACTIONS:

1. Present the "Community Health Problem Summary Sheet" to the Community Health Committee and explain the source and meaning of the data represented. (*Health Department action*)
2. Decide how the Committee wants to approach adding additional health problems to the "Community Health Problem Summary Sheet."
3. Gather information on what the community/Committee perceives the community's most important/serious health problems to be; make sure that they meet the definition of a health problem.
4. Discuss the health problems that are perceived by the community/Committee to be the most important for the community and add up to 5 of the most important to the summary sheet.
5. Identify potential obstacles to the effective use of the results of The Community Process and initiate action to overcome them.

Step 5.
Prioritize Community Health Problems

In this step the Community Health Committee ranks the problems on the "Community Health Problems Summary Sheet" in order of importance to the community and selects five to address further in a Community Health Plan.

Because resources may not be available to address all of a community's major health problems simultaneously, choices must be made on how the resources will be used. It is important that community opinion be reflected in how health problems are prioritized for the allotment of resources. A principal purpose of a Community Health Committee is to provide the community view on health priorities.

This participation by a Community Health Committee in priority setting is critical to the success of The Community Process and to the health of the community. It provides justification for both new and old health programs; it ensures that priorities are not dictated from outside the community; it allows a Community Health Committee to focus its energies on a limited number of highest priority health problems; and it gives the Committee a sense of ownership of the prioritized list of health problems. This sense of ownership is important in the next step of The Community Process. Therefore, a Committee should ensure that it achieves consensus both on the problems and on their order on the list. It is suggested that a Committee select and rank the five health problems that they believe should be given highest priority for community resources.

A fair, reasonable, and uncomplicated method to establish priorities is essential. Each Community Health Committee should select its own method. The Hanlon

Method[1] for setting priorities has been widely described and used for many years. A Community Health Committee may wish to use that method. Or a Committee may wish to use one of the two modifications of the Hanlon method that are described in this workbook (see Section I-A, page 23, and Appendix E). Another possible option is the Nominal Group Planning Method developed by A. L. Delbecq and A. H. Van de Ven.[2] This method is less numerical than the variations on the Hanlon method. It provides for getting the opinion of all members of a group, for orderly discussion of all issues, and for establishing priorities through a balloting process. Some other methods of setting priorities that are described in Spiegel and Hyman[3] are the Simplex Method, the Size of Need Gap method, the Criteria Weighting Method, and the Cluster Method. (These authors also describe the Nominal Group Planing and Hanlon methods.)

Whatever method is selected, all health problems must be assessed in the same way. A Community Health Committee is encouraged to take time to consider a number of approaches and select one that fits the style of the group.

ACTIONS (to be carried out by the Community Health Committee):

1. Select a method of setting priorities.
2. Use the selected method to rank the problems on the "Community Health Problems Summary Sheet" in order of importance for receiving community resources.
3. Select the health problems that the Committee will focus on as it develops a Community Health Plan. It is suggested that the Committee select the five problems that are highest in priority.

Step 6.
Analyze Community Health Problems

In this step, the Community Health Committee analyzes each of the health problems it has selected to address in a Community Health Plan: it develops a hypothesis about why a particular health problem exists. (In Step 8 it will use that

[1] J.J. Hanlon, "The design of public health programs for underdeveloped countries." Public Health Reports, Vol. 69 (Nov. 1954) p. 1028; and G. E. Pickett and J. J. Hanlon, Public Health Administration and Practice, 9th ed. (St. Louis: The C.V. Mosby Company, 1990), pp. 226—227.

[2] A.L. Delbecq, A.H. Van de Ven, and D.H. Gustafson, *Group Techniques for Program Planning*, Glenview, Ill.: Scott Foresman and Co., 1985.

[3] A.D. Spiegel, and H.H. Hyman, *Basic Health Planning Methods* (Germantown, Md.: Aspen Systems Corp., 1978), pp. 179—238.

hypothesis as a basis for recommendations on what should be done to reduce the problem, and when and where resources should be committed.)

The Committee may wish to break into smaller working groups for this analysis, with each working group analyzing one of the high priority health problems selected by the Committee. In addition to members of the Committee, others in the community with special expertise could be invited to participate. A health department staff member could facilitate each working group if health department resources permit.

Understanding the Terminology

The Committee must understand the following terms:

Risk factors: Scientifically established factors (determinants) that *relate directly to the level of a health problem.* A health problem may have any number of risk factors identified for it. For example, low birth weight is a risk factor for the health problem of infant mortality. It is a scientific fact that a higher percentage of babies that weigh less than 2500 grams at birth die in the first year than babies who weigh 2500 grams or more at birth.

Direct contributing factors: Scientifically established factors that *directly affect the level of a risk factor.* For example, teen pregnancy is one factor that contributes directly to the birth of low birth-weight babies.

Indirect contributing factors: Community-specific factors that *directly affect the level of the direct contributing factors.* For example, low self esteem may be one indirect contributing factor promoting teen pregnancy, thus generating low birth weight babies, and ultimately elevating infant mortality rates. These factors can vary considerably from community to community.

Obtaining Data on Risk Factors and Direct Contributing Factors

The state health department should be able to provide information developed by the Centers for Disease Control on risk factors and direct contributing factors for the health problems that the Community Health Committee is addressing. The local health department staff should be able to obtain this information and help the Committee understand how to use it.

Identifying Indirect Contributing Factors

Indirect contributing factors must be identified at the community level, because they are not the same everywhere. A Community Health Committee can bring a broad-based knowledge of the community to this task, and other appropriate persons from the community can provide still greater knowledge.

Group discussion should generate possible indirect contributing factors specific to the community. National studies can be useful in directing the Committee's

attention to possible factors. The same indirect contributing factor may be identified for more than one direct contributing factor, for different risk factors, or for different health problems.

It is common that a long chain of indirect contributing factors lead to a direct contributing factor. For example, poverty may be a factor which contributes to a second factor, social isolation, which may in turn contribute to a third factor, low self esteem, which promotes teen pregnancy, a direct contributing factor that generates the risk factor, low birth weight babies, that, in turn, increases the health problem of infant mortality. It is important that the group think through the complete sequence of interacting factors before leaving this step. More than one session may be required before the Committee is satisfied that all indirect contributing factors have been identified for a health problem.

A worksheet for use in this activity, the "Health Problem Analysis Worksheet," is provided in Section II-B, page 125.

ACTIONS:

1. Obtain information on risk factors and direct contributing factors for each of the health problems the Committee has selected to address; enter these on copies of the "Health Problem Analysis Worksheet" (located in Section II-B, page 125). Copy those worksheets in sufficient quantity to distribute to the Community Health Committee. (*Health department action*)
2. Review definitions of health problem, risk factor, and direct and indirect contributing factors; distribute the "Health Problem Analysis Worksheets" and discuss the Risk Factors and Direct Contributing Factors listed for some of the health problems to ensure that all members of the Committee have a common understanding of the terminology.
3. Review what the Committee members are to do in identifying Indirect Contributing Factors, and decide how the Committee will approach the task; break into working groups if that is what is decided.
4. Identify as many indirect contributing factors as possible for the health problem identified on each sheet, and enter them in the appropriate area of the "Health Problem Analysis Worksheet."
5. Summarize the analysis of each health problem to this point on the "Community Health Plan Worksheet" in Section II-B, page 126.

Step 7.
Inventory Community Health Resources

Health problems are corrected through actions that reduce the level of indirect contributing factors. In order to develop realistic plans for corrective actions, it is necessary to conduct an inventory of community health resources. Barriers to reducing the level of indirect contributing factors must also be identified in order to develop realistic plans.

The Community Health Committee, with the assistance of health department staff, should identify community assets that are potentially available to help reduce the indirect contributing factors of the problems the Committee has selected. Many of the community's health-related assets should be documented in health department files. The following are examples of possible community health resources:

- Child Abuse Prevention Council
- Substance abuse services
- Prenatal care services
- Corporate wellness programs
- Public transportation
- Waste recycling programs
- Sewage disposal regulatory process
- University training programs
- Cigarette tax/sales tax ordinance

It is also important to identify potential assets available at the local, state, and federal levels of government. All available resources should be recorded on the "Community Health Plan Worksheet" that was used in Step 6.

The Committee must also identify barriers in the community that may inhibit corrective actions. The following are examples of possible barriers:

- Inadequate tax base
- Lack of public transportation
- Lack of area-wide media interest
- Historical bias
- Conflict between special interest groups
- Turf guarding by public and private agencies

Barriers should be recorded on the "Community Health Plan Worksheet." provided in Section II-B, page 126.

ACTIONS:

1. Identify current and potential health-related assets that might be useful in reducing the level of the factors that indirectly contribute to the health problems being addressed by the Community Health Committee.
2. Identify barriers in the community that could hamper reducing the level of the factors that indirectly contribute to the problems being addressed by the Community Health Committee.
3. Summarize the information on resources and barriers on the "Community Health Plan Worksheet" in Section II-B, page 126. (The Committee has already been instructed to record some information on this worksheet.)

Step 8.
Develop a Community Health Plan

In the final step in The Community Process, the Community Health Committee develops recommendations to present to the health policy board for addressing the most critical health problems of the community. The "Community Health Plan Worksheet" will be completed in this step. A final form, the "Community Health Plan," provided in Section II-B, page 127, will also be completed.

Setting Objectives

Several levels of objectives are set for the Community Health Plan. To set these objectives, Committee members must understand the following terms:

Outcome Objective: A goal for the level to which a *health problem* should be reduced by some future date—i.e., what measurement of the health problem at some future date should reveal. An outcome objective is long term and measurable.

Impact Objective: A goal for the level to which a risk factor should be reduced by some future date—i.e., what measurement of the risk factor at some future date should reveal. An impact objective is intermediate in time (usually 3 to 5 years) and measurable.

Process objective: A goal for reducing the level of a direct or indirect contributing factor by some future date, or for the level at which a corrective action should occur between that date and the present time. A process objective is short term (usually 1 or 2 years) and measurable.

Examples of how to define objectives in these terms will be available in *Healthy Communities 2000: Model Standards*. Examples of these objectives are shown in the table on the next page.

Health Problem (present measure): *Infant mortality 12/1000 live births per year*	**Outcome Objective** (future measure): *By December 31, 1999, infant mortality to be no more than 8/1000 live births per year*
Risk Factor (present measure): *Low birth weight at 90/1000 live births per year*	**Impact Objective** (future measure): *By December 31, 1992, low birth weight at 70/1000 live births per year*
Direct/Indirect Contributing Factor • *Lack of early prenatal care (Only 60% of pregnant women receive prenatal care during the first trimester of pregnancy.)* • *Lack of access to prenatal clinics during non-working hours (Only 25% of prenatal clinics are open after 5:00 p.m. or during weekends.)*	**Process Objectives** (future measure): • *By December 31, 19_, 80% of pregnant women will have received prenatal care during the first trimester of pregnancy.* • *By December 31, 19_, all prenatal clinics will be open for at least 8 hours each week during non-working hours (after 5:00 p.m. weekdays or during weekends).*

Further examples of objectives defined in these terms for The Community Process are given in Section II-C.

ACTIONS:

1. For each health problem selected, enter Outcome and Impact objectives on a "Community Health Plan Worksheet." (*Health Department Action)*
2. For each health problem selected, develop process objectives for each indirect contributing factor identified in the health problem analysis and enter them on the appropriate "Community Health Plan Worksheet."

Identifying Corrective Actions

Actions which will reduce the indirect contributing factors should be identified. If, as there often is, there are a number of indirect contributing factors for a health problem, a number of corrective actions may be required to achieve any improvement in the level of the health problem.

For example, another chain of factors that contribute indirectly to teenage pregnancy might be the following:

Teenage pregnancies — *Why?* — Unprotected sex — *Why?* — Lack of knowledge of contraceptive methods — *Why?* — Inadequate/unavailable sex education — *Why?* — Lack of community interest or support

Corrective actions should be developed to address the lack of community interest and support for good educational programs and other activities such as family planning services that would provide information on contraceptive methods.

The completed community health plan should include a description of each health problem addressed by the Community Health Committee, including the high risk population and current and projected statistical trends, and factors which contribute to the level of the problem; what corrective activities are proposed; what community organizations are proposed to provide and coordinate the corrective activities; and how progress towards the outcome, process, and impact objectives will be measured. A form which can be used for this purpose, the "Community Health Plan," is provided in Section II-B, page 127.

Presenting the Proposed Community Health Plan

The Community Health Committee should present the proposed community health plan to the health policy board and review it with them at an official public board meeting. The policy board should be encouraged to adopt this health plan into formal policy. That process is described in Part III, Completing the Cycle.

ACTIONS:

1. For each health problem selected, identify corrective actions which will reduce the contributing factors identified on the "Community Health Plan Worksheet."
2. For each health problem selected, develop a "Community Health Plan" (form provided in Section II-B, page 127) which:
   a. Describes the health problem
   b. Describes corrective actions proposed to reduce the contributing factors
   c. Describes what organizations should provide and coordinate the activities
   d. Describes what data should be collected in an evaluation plan for measuring progress towards achieving the outcome, process, and impact objectives
3. Present the plan at an official public meeting of the health policy board.

Part II

The Community Process

Section B

Worksheets for

The Community Process

Read This Before Using the Worksheets

Do not write on the worksheets provided here.

Only one copy of each worksheet is provided and more than one copy will be needed. Use the worksheets in this workbook as originals for making the number of copies you need. Be sure to return the originals to the proper place in the workbook for future reference.

DEMOGRAPHIC PROFILE: AGE AND SEX

County: _____ Source and Date of Data: _____

Age Group	County						State		
	Number			Percentage			Percentage		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
< 1									
1 — 14									
15 — 24									
25 — 44									
45 — 64									
65 — 74									
75 & older									
Total									

Analysis of Data

Different age groups require different health services. For example, young children may need immunization and WIC programs; females between 15 and 24 may need programs related to teenage pregnancies; the elderly may need programs for chronic diseases. Compare the distributions of age and sex in the county with their distributions in the state and describe below age groups for which the percentage of the county population is considerably different than that of the state.

DEMOGRAPHIC PROFILE: RACE/ETHNIC DISTRIBUTION

County: _____ **Source and Date of Data:** _____

Population Subgroup	County		State
	Number	Percentage	Percentage

Analysis of Data

Some racial and ethnic groups have higher rates of certain diseases than other groups; for example, Native Americans are at increased risk of diabetes,; hypertension appears to be more prevalent in black populations. Compare the distribution of the county population among the different racial and ethnic groups with how the state population is distributed; does the county have an unusually large percentage of a particular racial or ethnic group? Describe below how the county distribution is different from that of the state.

SOCIOECONOMIC PROFILE

County: _____ **Source and Date of Data:** _____

Socioeconomic Measure	County	State
Percent of population below poverty level		
Percent of population unemployed		
Number of Food Stamp recipients		
Number of persons in the WIC program		
Number of Medicaid recipients		
Estimated number of homeless persons		
Percent with less than a high school education		
Percent with less than a college education		
Percent with a college or higher level of education		

Analysis of Data

The county's socioeconomic profile can indicate special health service needs. For example, an area with a concentration of homeless persons needs indigent health care facilities. Compare the county and state for each of the socioeconomic measures above. Describe below how the county's profile differs from the state's, especially where the county data indicates a need to target health services.

YEARS OF POTENTIAL LIFE LOST (YPLL) Worksheet

Complete a copy of this worksheet for each ICD-9 code group on which you have mortality data for your community. ICD-9 code groups are given on the back of the worksheet.

Disease: _____ **ICD Code Group:** _____

Population Subgroup _____

Age Category	Female				Male			
	Number of Deaths		Average YPLL	Age-specific YPLL	Number of Deaths		Average YPLL	Age-specific YPLL
< 1		*	64.5			*	64.5	
1 — 14		*	57			*	57	
15 — 24		*	45			*	45	
25 — 44		*	30			*	30	
45 — 64		*	10			*	10	
65+		*	0			*	0	
Total YPLL					Total YPLL			

Population Subgroup _____

Age Category	Female				Male			
	Number of Deaths		Average YPLL	Age-specific YPLL	Number of Deaths		Average YPLL	Age-specific YPLL
< 1		*	64.5			*	64.5	
1 — 14		*	57			*	57	
15 — 24		*	45			*	45	
25 — 44		*	30			*	30	
45 — 64		*	10			*	10	
65 +		*	0			*	0	
Total YPLL					Total YPLL			

Population Subgroup _____

Age Category	Female				Male			
	Number of Deaths		Average YPLL	Age-specific YPLL	Number of Deaths		Average YPLL	Age-specific YPLL
< 1		*	64.5			*	64.5	
1 —14		*	57			*	57	
15 — 24		*	45			*	45	
25 — 44		*	30			*	30	
45 — 64		*	10			*	10	
65 +		*	0			*	0	
Total YPLL					Total YPLL			

Grand Total YPLL _____

GROUPINGS OF ICD-9 CODES

ICD-9 Code Group	Category
(001-041, 045-139)	Infectious and parasitic diseases
(042-044)	AIDS, HIV infection
(140-208)	Cancer
(210-239)	Neoplasms, uncertain
(240-246, 251-279)	Nondiabetic endocrine diseases
(250)	Diabetes
(280-289)	Blood-related diseases
(290-319)	Mental disorders
(320-389)	Neurologic diseases
(410-414)	Ischemic heart disease
(401-405)	Hypertensive disease
(390-398, 415-429)	Other heart diseases
(430-438)	Cerebrovascular disease
(440-459)	Other vessel diseases
(460-478)	Upper respiratory-tract conditions
(480-487)	Pneumonia/influenza
(490-496)	Chronic obstructive pulmonary disease
(500-508, 510-519)	Other pulmonary disease
(520-569)	Conditions related to the digestive tract
(571)	Chronic liver disease
(570, 572-579)	Other liver - pancreas
(580-629)	Genitourinary diseases
(630-676)	Complications of pregnancy & childbirth
(680-709)	Skin diseases
(710-739)	Musculoskeletal and connective tissue diseases
(740-759)	Congenital anomalies
(761-763, 767-768)	Complications - newborn
(764. 765, 769)	Prematurity/respiratory distress
(770)	Other perinatal respiratory conditions
(760, 766)	Other perinatal conditions
(771)	Perinatal infections
(772-779)	Miscellaneous perinatal conditions
(798.0)	Sudden Infant Death Syndrome
(E810-E825)	Motor vehicle injury
(E800-E807, E826-E949)	Other injuries
(E950-E959)	Suicide
(E960-E969)	Homicide
(E980-E989)	Undetermined injury
(780-797, 799)	Ill-defined
(list all remaining)	All others

Access to Primary Health Care Profile

(Optional)

The following is a profile of the primary health care services available to the underserved in the community. It does not address quality issues, only percent of the population that uses each source.

County: _____ **Source and Date of Data:** _____

Primary Care Source	Percent of Population Served
Private Providers	
Community and Migrant Health Care Centers	
Local Health Department	
Other Sources	
Other Health Care Measures	**Number in County**
Uninsured/Underinsured	
Total Primary Care Providers/Population	

Analysis of Data

Compare state and county primary source percentage distributions and describe how the county distribution is different from the state. Does the county data indicate that substantial numbers of persons are underserved? For example, does the county have a high number of uninsured persons?

OTHER HEALTH INDICES

(Optional)

Several health areas of specific importance in a community health assessment are listed in the table below. This is not intended to be a comprehensive list. These indices may be seen either as risk factors or as health problems themselves.

County: _____ **Date and Source of Data:** _____

Area/Health Indices	National Average[1]	In Jurisdiction
OCCUPATIONAL HEALTH AND SAFETY		
Work-related Injuries — Deaths	6/100,000	
Work-related Injuries — Nonfatal	7.7/100	
Cumulative Trauma Disorders	100/100,000	
Occupational Skin Disorders	64/100,000	
Occupational Disease (e.g., Hepatitis B)	6,200 in 1987	
SUBSTANCE ABUSE		
Alcohol-related Accidents — Deaths	9.7/100,000	
Alcohol-related Accidents — Nonfatal	not available	
Cirrhosis Deaths	9.1/100,000	
Drug-related Deaths	3.8/100,000	
Drug Abuse Emergency Room Visits	not available	
Lung Cancer Deaths	37.9/100,000	
Current Smokers	29% (≥ 20 yrs. old)	

[1] Public Health Service, U.S. Department of Health and Human Services, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.* Washington, D.C.:U.S. Department of Health, Education, and Welfare, 1991.

OTHER HEALTH INDICES *continued*

(Optional)

Area/Health Indices	National Average	In Jurisdiction
MENTAL HEALTH/MENTAL RETARDATION		
Suicides	11.7/100,000	
Teenage Suicides	10.3%	
Child and Adolescent Mental Disorders	12%	
Adult Mental Disorders	12.6%	
Stress-related Health Effects	42.6%	
Serious Mental Retardation—School-aged Children	2.7/1,000	
Serious Mental Retardation—Noninstitutionalized Population	4.7/1,000	
OTHER RISK FACTORS		
Not Using Seat Belt	47%	
Overweight	23.8%	
Sedentary Lifestyle	60.9%	
Ever Had Cholesterol Checked	44.4%	
Diagnosed with Diabetes	28/1,000	
Being Treated for Hypertension	not available	
Current Smokers	29% (≥ 20 yrs. old)	

PERINATAL INDICATORS

(Optional)

County: _____ **Source and Date of Data:** _____

Perinatal Indicator	County Total by Population Subgroup						State Total by Population Subgroup					
	Number			Rate			Number			Rate		
Live Births												
All ages												
Maternal age <18 years												
Prenatal Care of Women												
First care in 3rd trimester												
Fewer than 7 prenatal visits												
Low Body Weight Live Births												
<2500 grams												
<1500 grams												
Live Births with Mortality or Birth Defects												
Perinatal mortality												
Fetal mortality												
Neonatal mortality												
Congenital anomalies												

LEADING CAUSES OF MORTALITY BY AGE AND POPULATION SUBGROUPS

(Optional)

County: _____ **Source and Date of Data:** _____

Disease/Condition by Age Group	Total Cases by Subgroup			County Rate by Subgroup			State Rate by Subgroup		
Age < 1									
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
All causes									
Age 1 — 14									
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
All Causes									

LEADING CAUSES OF MORTALITY
BY AGE AND POPULATION SUBGROUPS continued

Disease/Condition by Age Group	Total Cases by Subgroup			County Rate by Subgroup			State Rate by Subgroup		
Age 15 — 24									
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
All causes									
Age 25 — 44									
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
All Causes									

LEADING CAUSES OF MORTALITY BY AGE AND POPULATION SUBGROUPS continued

Disease/Condition by Age Group	Total Cases by Subgroup			County Rate by Subgroup			State Rate by Subgroup		
Age 45 — 64									
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
All causes									
Age 65 & older									
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
All Causes									

ESTIMATED PREVALENCE OF DISEASE BY AGE AND POPULATION SUBGROUPS

(Optional)

Identify the ten most prevalent diseases or conditions in the county based on the most recent data available.

County: _____ Source and Date of Data: _____

Disease/Condition by Age Group	Total Cases by Subgroup			County Rate by Subgroup			State Rate by Subgroup		
Age < 1									
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
All causes									
Age 1 — 14									
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
All Causes									

ESTIMATED PREVALENCE OF DISEASE BY AGE AND POPULATION SUBGROUPS continued

Disease/Condition by Age Group	Total Cases by Subgoup			County Rate by Subgroup			State Rate by Subgroup		
Age 15 — 24									
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
All causes									
Age 25 — 44									
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
All Causes									

ESTIMATED PREVALENCE OF DISEASE BY AGE AND POPULATION SUBGROUPS continued

Disease/Condition by Age Group	Total Cases by Subgroup			County Rate by Subgroup			State Rate by Subgroup		
Age 45 — 64									
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
All causes									
Age 65 & older									
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
All Causes									

Estimated Prevalence of Disease, All Ages/Population Subgroups

Disease/Condition	Total Cases by Subgroups			County Rate by Subgroups			State Rate by Subgroups		
(1)									
(2)									
(3)									
(4)									
(5)									
(6)									
(7)									
(8)									
(9)									
(10)									
All causes									

LEADING CAUSES OF HOSPITALIZATION BY AGE AND POPULATION SUBGROUPS

(Optional)

Identify the ten leading causes of hospitalization in the county. Record the description and number in each age group for each problem. Hospitalization data may be available from the state health authority. Use 3 to 5 year totals to reduce the problems associated with small numbers.

County: _____ **Source and Date of Data:** _____

Disease/Condition by Age Group	Total Cases by Subgroup			Length of Stay (Days)
Age < 1				
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				
All causes				
Age 1 — 14				
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				
All Causes				

LEADING CAUSES OF HOSPITALIZATION BY AGE AND POPULATION SUBGROUPS continued

Disease/Condition by Age Group	Total Cases by Subgroup			Length of Stay (Days)
Age 15 — 24				
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				
All causes				
Age 25 — 44				
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				
All Causes				

LEADING CAUSES OF HOSPITALIZATION BY AGE AND POPULATION SUBGROUPS continued

Disease/Condition by Age Group	Total Cases by Subgroup			Length of Stay (Days)
Age 45 — 64				
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				
All causes				
Age 65 & older				
(1)				
(2)				
(3)				
(4)				
(5)				
(6)				
(7)				
(8)				
(9)				
(10)				
All Causes				

ENVIRONMENTAL PROFILE (optional)

Analyze the physical and social components in the county to identify the environmental health hazards that may increase the risk of particular health problems. For each of the major types of environmental hazards listed below, record the specific health hazard (pollutant, agent, or source) that is present in the county and its potential or actual health effects.

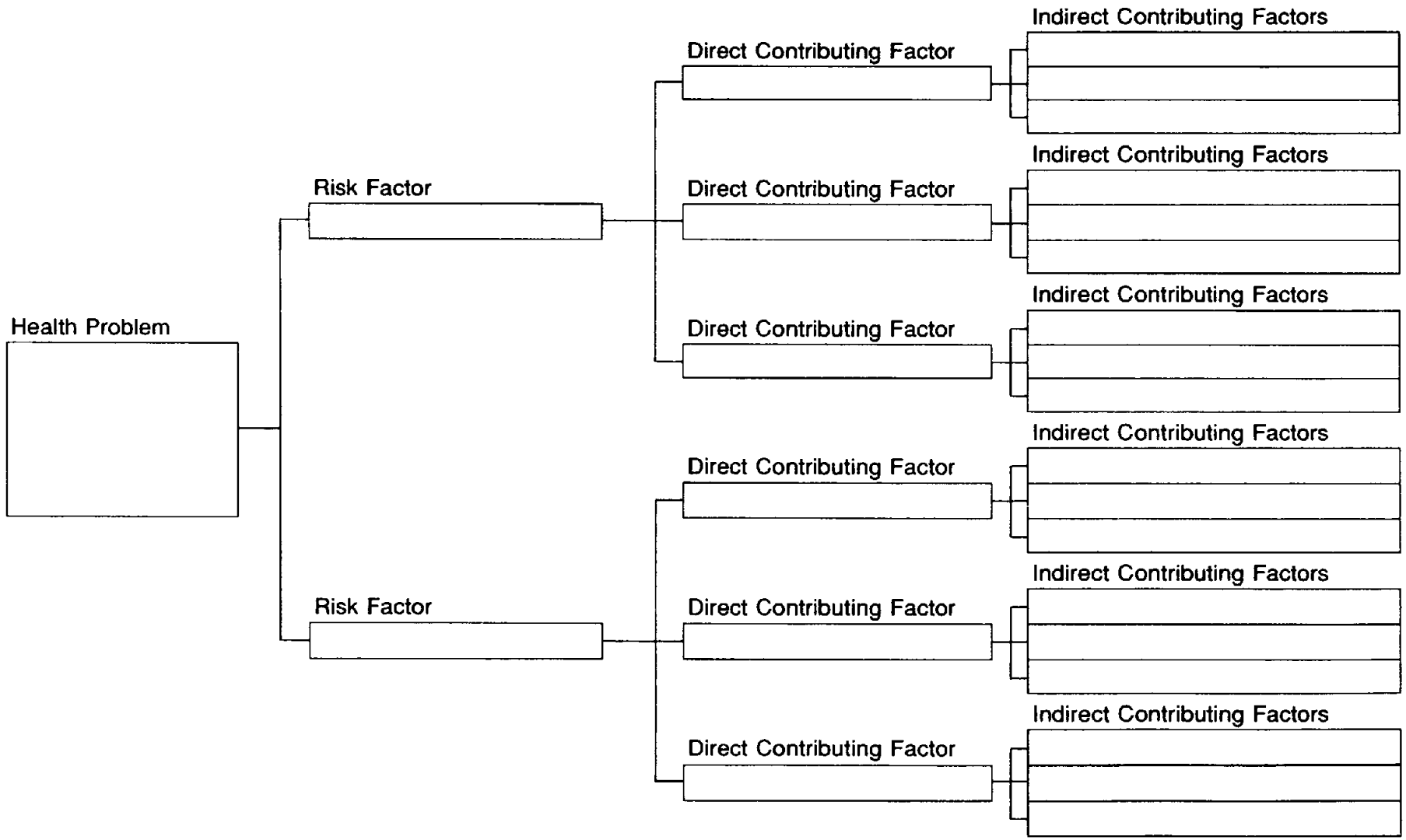
County: _____ **Source and Date of Data:** _____

Community Environmental Hazard	Pollutant, Agent, or Source	Potential or Actual Health Effects
Air Pollutants		
Water Contaminants		
Food Contaminants		
Land Pollution [human and industrial waste, pesticides, etc.]		
Other environmental hazards including work environment or conditions, radiation, climate, etc.		

COMMUNITY HEALTH PROBLEMS
Summary Sheet

Disease/Condition	Comments
Top ten (10) ranked contributers of YPLL	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
Additional health problems/issues determined by the health department	
1	
2	
3	
4	
5	
Additional health problems/issues determined by the Community Health Committee	
1	
2	
3	
4	
5	

HEALTH PROBLEM ANALYSIS WORKSHEET



COMMUNITY HEALTH PLAN: Worksheet

HEALTH PROBLEM:	**OUTCOME OBJECTIVE:**
RISK FACTOR(S) (may be many):	**IMPACT OBJECTIVE(S):**
CONTRIBUTING FACTORS (Direct/Indirect; may be many):	**PROCESS OBJECTIVE(S):**
RESOURCES AVAILABLE (governmental and nongovernmental):	**BARRIERS:**

COMMUNITY HEALTH PLAN

DESCRIPTION OF THE HEALTH PROBLEM, RISK FACTORS AND CONTRIBUTING FACTORS (including high risk populations, and current and projected statistical trends:

CORRECTIVE ACTIONS to reduce the level of the indirect contributing factors:

PROPOSED COMMUNITY ORGANIZATION(S)to provide and coordinate the activities:

EVALUATION PLAN to measure progress towards reaching objectives:

Part II

The Community Process

Section C

Examples from Test-Sites

EXAMPLES: TEST-SITE WORKSHEETS AND PLANS

This section contains sample worksheets and Community Health Plans based on documents from three of the test sites that applied The Community Process. These were selected to show how the process has been adapted to fit different local conditions. They show only a portion of the work carried out by the health departments concerned. Please note also that the health departments represented by these sample worksheets are not the health departments described in Appendix A.

Outline of Examples (with page references)

Example Three

A. Community Health Problem Summary Sheet (page 147)

B. Development of Plan To Address Infant Mortality

- Health Problem Analysis Worksheet - Infant Mortality (page 148)
- Community Health Plan - Infant Mortality (page 149)

C. Development of Plan To Address Motor Vehicle Accident Fatalities

- Health Problem Analysis Worksheet - Motor Vehicle Accident Fatalities (page 150)
- Community Health Plan - Motor Vehicle Accident Fatalities (page 151)

D. Development of Plan To Address Cerebrovascular Disease (Stroke)

- Health Problem Analysis Worksheet - Stroke (pages 152-153)
- Community Health Plan - Stroke (page 154)

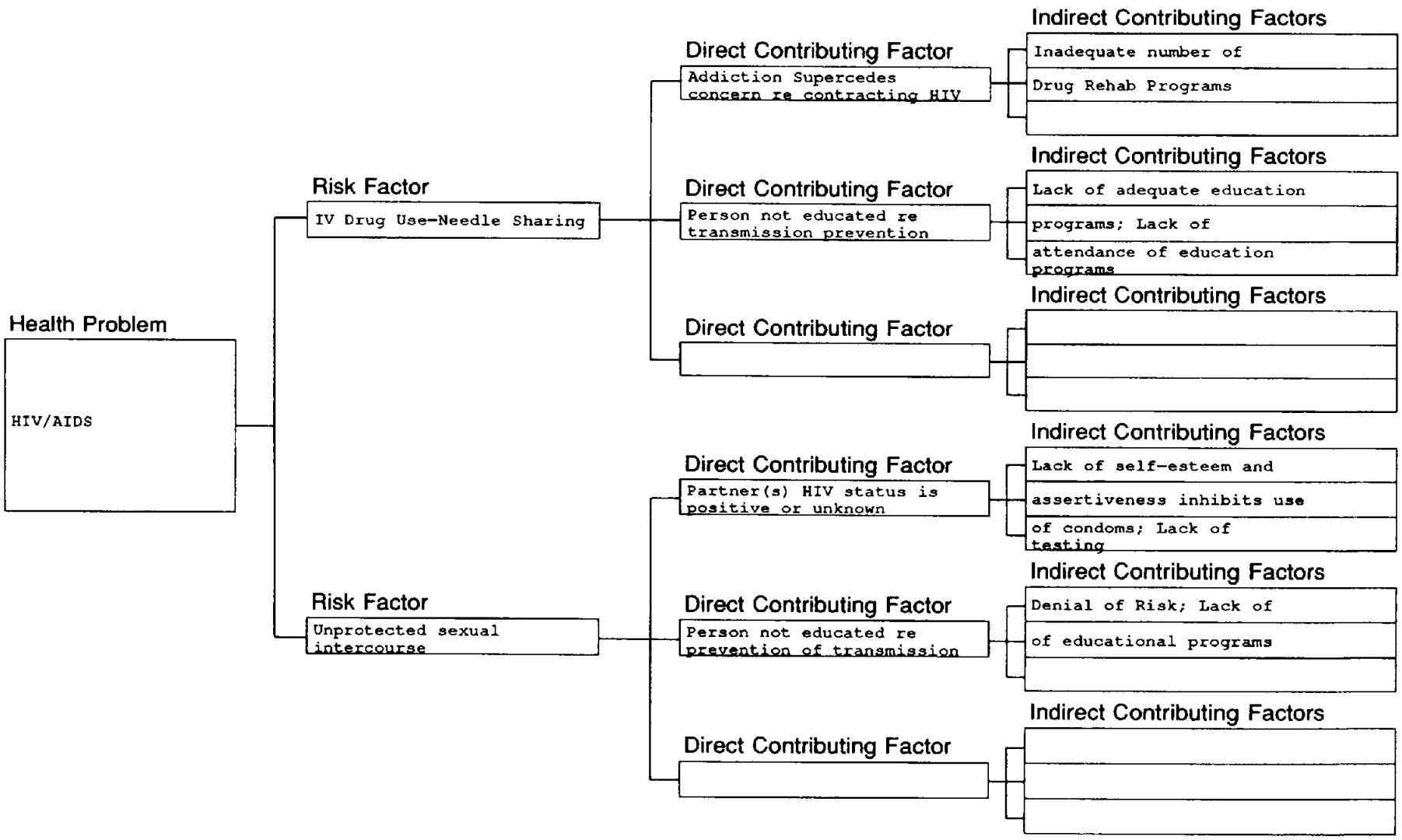
COMMUNITY HEALTH PROBLEMS

Summary Sheet

Disease/Condition		Comments
Top ten (10) ranked contributors of YPLL		
1 Cancer	(481)	
2 Motor Vehicle Accidents	(421)	
3 Heart	(343)	
4 Neoplasm	(329)	
5 Congenital Anomalies	(288)	
6 Complications-Newborn	(125)	
7 AIDS	(61)	
8 Other Injury	(54)	
9 Cerebral Vascular Disease	(48)	
10 Suicide	(46)	
Additional health problems/issues determined by the health department		
1 Maternal & Child Health		Battering, prevention, immunizations Target southwest, central & southeast
2 Services to the Elderly		Availability & accessibility, respite, nutrition, in-home care, immunizations
3 Substance Abuse		All age categories, outpatient services
4 Prevention Services		Worksite Wellness, injury control
5 Chronic Disease		To include Alzheimers
Additional health problems/issues determined by the Community Health Committee		
1 Medical care for 60+		
2 Fetal Alcohol Syndrome		
3 Health care advocacy for mentally disabled		
4 Parenting skills (single and young)		
5 Nutrition / 6. Fitness / 7. Uncompensated care		

EXAMPLE ONE

HEALTH PROBLEM ANALYSIS WORKSHEET



COMMUNITY HEALTH PLAN: Worksheet

HEALTH PROBLEM:

HIV/AIDS

OUTCOME OBJECTIVE:

After 1995, there will be less than one new case of HIV infection per year.

Seroprevalence of newborns will be 0.0% by 1993.

RISK FACTOR(S) (may be many):

1. IV drug use - needle sharing
2. Unprotected sexual intercourse

IMPACT OBJECTIVE(S):

1. Reporting of HIV+ status will become required so that prevalence can be monitored and preventive measures taken.
2. Reduced incidence of drug abuse; needles will not be shared by drug abusers.

CONTRIBUTING FACTORS (Direct/Indirect; may be many):

1. Substance abuse - altered judgement - lack of knowledge regarding transmission
2. Partner's HIV status unknown

PROCESS OBJECTIVE(S):

1. Education, especially in schools will be done to increase awareness.
2. Education regarding transmission and need for HIV testing; techniques to increase self esteem; assertiveness and decision making skills to be taught in schools, domestic violence programs, developmentally disabled persons, etc.

RESOURCES AVAILABLE (governmental and nongovernmental):

- County A Health Department, including Family Planning and WIC
- Council on Alcoholism
- State A Department of Health
- Schools, including universities
- Churches
- Correctional staff
- County A Probation Dept.
- County A Community Services
- AIDS Task Force

BARRIERS:

Resources (cont.):

- American Red Cross
- Cooperative Extension
- Private counselors

EXAMPLE ONE

COMMUNITY HEALTH PLAN

DESCRIPTION OF THE HEALTH PROBLEM, RISK FACTORS AND CONTRIBUTING FACTORS (including high risk populations, and current and projected statistical trends:

Number of cases of AIDS as of January, 1990 - 8; prison population - 15;
Estimated number of HIV+ persons - 80-800; 30-70% of prison population;
Seroprevalence rate of HIV+ newborns ranges from 0.00 to 0.23 in hospitals where County A residents give birth;
High risk population: IV drug users, teens, college students, prison inmates

Determinants and contributing factors:

- Denial of risk of contracting HIV exists due to: a) perception of low risk in a rural area, b) teen mentality, i.e., "It can't happen to me"
- Regarding HIV testing - it is not frequently done due to: a) need for testing not perceived; b) fear of discrimination/stigma associated with HIV; c) testing sites not readily available/accessible.
- Present law does not require reporting of HIV+ status.

CORRECTIVE ACTIONS to reduce the level of the indirect contributing factors:

- Contact with private practitioners
- Education regarding HIV risks and prevention of transmission
- Education regarding effect of ETOH and substance abuse on judgment with sexual practices
- Measures to enhance self esteem and assertiveness behavior
- Education to encourage HIV testing
- Education to prevent substance abuse
- Lobbying for legislation (especially pregnant women)
- Active case finding

PROPOSED COMMUNITY ORGANIZATION(S) to provide and coordinate the activities:

Schools
AIDS Task Force
Public Health
Family Planning
WIC
Domestic Violence program
Council on Alcoholism

EVALUATION PLAN to measure progress towards reaching objectives:

Monitor statistics

Survey students and general public regarding knowledge, attitudes

EXAMPLE ONE

RISK FACTORS

Determine the prevalence of the indicated risk factors for State B. These behavioral risk factors can be targeted for lifestyle interventions. In most if not all states or communities, the data will be based on sample sizes that are too small to provide reliable estimates for specific age groups. Therefore, only total for all persons 18 years and older can be determined. If possible, obtain risk factor prevalence by racial/ethnic groups as well.

	Risk Factor	Average Prevalence for State B, 1988
(1)	Not using seat belt (Def. 2)	38.8%
(2)	Drinking and driving	2.6%
(3)	Acute drinking	15.2%
(4)	Chronic drinking	5.4%
(5)	Overweight (Def. 1)	23.2%
(6)	Current smoker	22.5%
(7)	Sedentary lifestyle	53.1%
(8)	Hypertensive medication (Def. 3)	17.1%
(9)	Smokeless tobacco	4.5%
(10)	Dieting practices	NA
(11)	Ever had cholesterol checked (1988)	49.8%

Source: State B Health Division Vital Statistics, 1988.

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LEADING CAUSES OF MORTALITY
1988

	County B		State B	
Age: Less than one year	33 Deaths	Rank	339 Deaths	Rank
SIDS	13	(1)	99	(1)
Congenital anomalies	7	(3)	74	(2)
Respiratory distress synd.	10	(2)	29	(3)
Immaturity	1	(5)	25	(4)
Other respiratory	2	(4)	19	(5)
Age: 1 to 4 years	4 Deaths	Rank	86 Deaths	Rank
Unintentional injury	2	(1)	37	(1)
Congenital anomalies			12	(2)
Malignant neoplasms	1	(2)	9	(3)
Homicides	1	(2)	4	(4)
Disease of heart			4	(5)
Age: 5 to 14 years	7 Deaths	Rank	101 Deaths	Rank
Motor vehicle	4	(1)	43	(1)
Malignant neoplasms	1	(1)	11	(2)
Congenital anomalies			4	(3)
Suicide			3	(4)
Influenza/Pneumonia			3	(4)
Endocrine	1	(2)		
Unintentional injury	1	(2)		
Age: 15 to 24 years	35 Deaths	Rank	409 Deaths	Rank
Motor vehicle	20	(1)	245	(1)
Suicides	7	(2)	66	(2)
Homicides	3	(3)	30	(3)
Malignant neoplasms	1	(4)	22	(4)
Diseases of heart			7	(5)
Vascular	1	(4)		
Mental disorders	1	(4)		
Brain disease	1	(4)		
Unintentional injury	1	(4)		
Age: 25 to 44 years	102 Deaths	Rank	1,305 Deaths	Rank
Motor vehicle	21	(1)	361	(1)
Malignant neoplasms	8	(5)	209	(2)
Suicides	18	(2)	181	(3)
Diseases of heart	12	(4)	127	(4)
AIDS			84	(5)
Unintentional injury	13	(3)		

EXAMPLE TWO

(Continued)

	County B		State B	
Age: 45 to 64 years	209 Deaths	Rank	3,814 Deaths	Rank
Malignant neoplasms	106	(1)	1,432	(1)
Diseases of heart	95	(2)	1,082	(2)
Bronchitis, emphysema, asthma, COPD	22	(3)	164	(3)
Alcoholic diseases	8	(5)	151	(4)
Chronic lung disease			149	(5)
Cerebrovascular and other vascular	17	(4)		
Age: 65+ years	1,499 Deaths	Rank	18,501 Deaths	Rank
Diseases of heart	585	(1)	6,437	(1)
Malignant neoplasms	306	(2)	4,117	(2)
Cerebrovascular/vascular	210	(3)	1,855	(3)
Bronchitis, emphysema asthma, COPD	68	(4)	1,032	(4)
Influenza/pneumonia	53	(5)	838	(5)

EXAMPLE TWO

COMMUNITY HEALTH PROBLEM SUMMARY SHEET
COUNTY B, 1988

Disease/Condition	Risk Factors
Top Ten (10) ranked contributors of YPLL*	
1. Major cardiovascular diseases.	Overweight; smoker, sedentary lifestyle diet.
2. Malignant neoplasms.	Smoker; diet; smokeless tobacco; air pollution.
3. Motor vehicle accidents.	Not use seat belt; drinking; speeding.
4. Suicides.	Depression; poor self-image.
5. SIDS.	Low birth weight; prematurity; drug abuse/smoking/poor nutrition during pregnancy.
6. Accidents.	Drinking: unsafe environment/ACTS.
7. All other natural causes.	Unknown.
8. Certain causes in early infancy.	Unknown.
9. Congenital anomalies.	Drinking; pesticide poisoning.
10. Homicides.	Increase crime: availability of lethal weapons; poor conflict resolution.
Additional health problems/issues determined by health department	
1. Alcohol and drug abuse (perinatal)	Drinking; drugs; physical/psychological dependency.
2. Homeless families.	Chronic/acute unemployment: decreased employable skills; inadequate income.
3. Teen pregnancy.	Social pressure; inadequate sex education information; decreasing knowledge of community resources.
4. Availability of OB care.	No or inadequate health insurance; inadequate income.
5. Primary care for indigent.	No or inadequate health insurance; decreasing income.
6. Child abuse/neglect.	Inadequate parenting skills; chronic health problems; no respite services; decreasing family support services.

PUBLIC HEALTH ADVISORY BOARD
HEALTH PROBLEMS/ISSUES

*In Home Care (Home Health; Terminal Care)

*Lack of Affordable Health Care

*Drug and Alcohol Abuse Impact on Prenatal and Accidents

*Hazardous Substances and Toxic Waste; Awareness and Education

*Child Abuse and Neglect

*Teen Parents

*Homeless Families

*Communicable Diseases

*Substandard Housing

*Lack of Understanding Cultural Differences Resulting in Communication Problems

*Inadequate Housing

EXAMPLE TWO

MOST IMPORTANT COMMUNITY HEALTH PROBLEMS AND ISSUES
Prioritized by the Public Health Advisory Board

1. Child Abuse and Neglect
2. Lack of Affordable Health Care
2. Teen Pregnancy
2. Availability of Obstetrical Care
5. Alcohol and Drug Abuse including the impact on pregnant women and their unborn child and influence on motor vehicle accidents

Note: The three number 2's had the same number of total votes.

EXAMPLE TWO

COMMUNITY HEALTH PLAN

Need: Advocacy for Health Care Needs for Women and Children

Objectives	Activity	Person Responsible	Evaluation of Activity	Target Date
To promote the identification and promotion of services to meet the health needs of women and children	Lack of affordable health care: Exploring impact of SB-27 and managed care on service delivery of health care including primary care Meeting with primary care groups, e.g. S. and W. clinics regarding needs of low income individuals	Public Health Manager	Results of meeting program Program developments	January 1991
	A/D Abuse Impact on Prenatal and Accidents: Purchasing A/D staff time to work in prenatal program to assist with early identification and intervention	Various supervisors	Impact on numbers of individuals identified	December 1990
	Active in State HMHB committee on prenatal substance abuse	Public Health Manager	Outcome and activities of committee	January 1991
	Working with A/D task force look at expansion of and provision of comprehensive services to drug-involved child-bearing women		Outcome of task force activities	March 1991

EXAMPLE TWO

EXAMPLE TWO

Need: Prenatal Services to Low Income Women

Objectives	Activity	Person Responsible	Evaluation of Activity	Target Date
To provide prenatal care services to low income women and children	Available OB Care: Working with local Healthy Mothers/Healthy Babies coalition to develop a community forum focusing on need for OB care in County B involving Key Players	Public Health Manager	HMHB meeting progress with this issue Completion of community meeting	Ongoing October, 1990
	Health Department meeting with Local physicians, hospitals and related OB care providers to plan the most effective solution for County B	Public Health Manager	Review of minutes of meeting Progress reports	Ongoing and June, 1991

Need: Payment for Health Care for Low Income People

Objectives	Activity	Person Responsible	Evaluation of Activity	Target Date
To develop community resources for low income people in need of payment for health care	Adult Health/Teen Pregnancy: Actively explore development of adolescent Health Care Service in a school	Public Health Manager	Minutes of meeting results	June, 1991
	Exploring expansion of Family Planning Clinics at YWCA Exploring expansion of services through grant funds	Public Health Manager	Development of extra clinics	October, 1990
	Working with YWCA Teen/Parent program on potential grants	Public Health Manager	Receiving of funds	October, 1990

EXAMPLE TWO

EXAMPLE TWO

Need: Positive Parenting Resources for Those at Possible Risk for Child Abuse/Neglect

Objectives	Activity	Person Responsible	Evaluation of Activity	Target Date
To identify and develop positive parenting/ early intervention community resources for families at risk of child abuse.	Actively participate in the children and youth services commission looking at needs of children and youth.	Program Supervisor	Outcome of committee work	January, 1991
	Actively work with state committee looking at child abuse and how to use an integrated approach for early and ongoing intervention	Maternal Child Supervisor	Outcomes of committee work and implication at local level	September, 1990
	Coordinate with other agencies and groups in ongoing development of services to meet this need.	Public Health Manager	Types and numbers of activities entered into with child abuse prevention as focus Progress in child abuse prevention activities	Ongoing

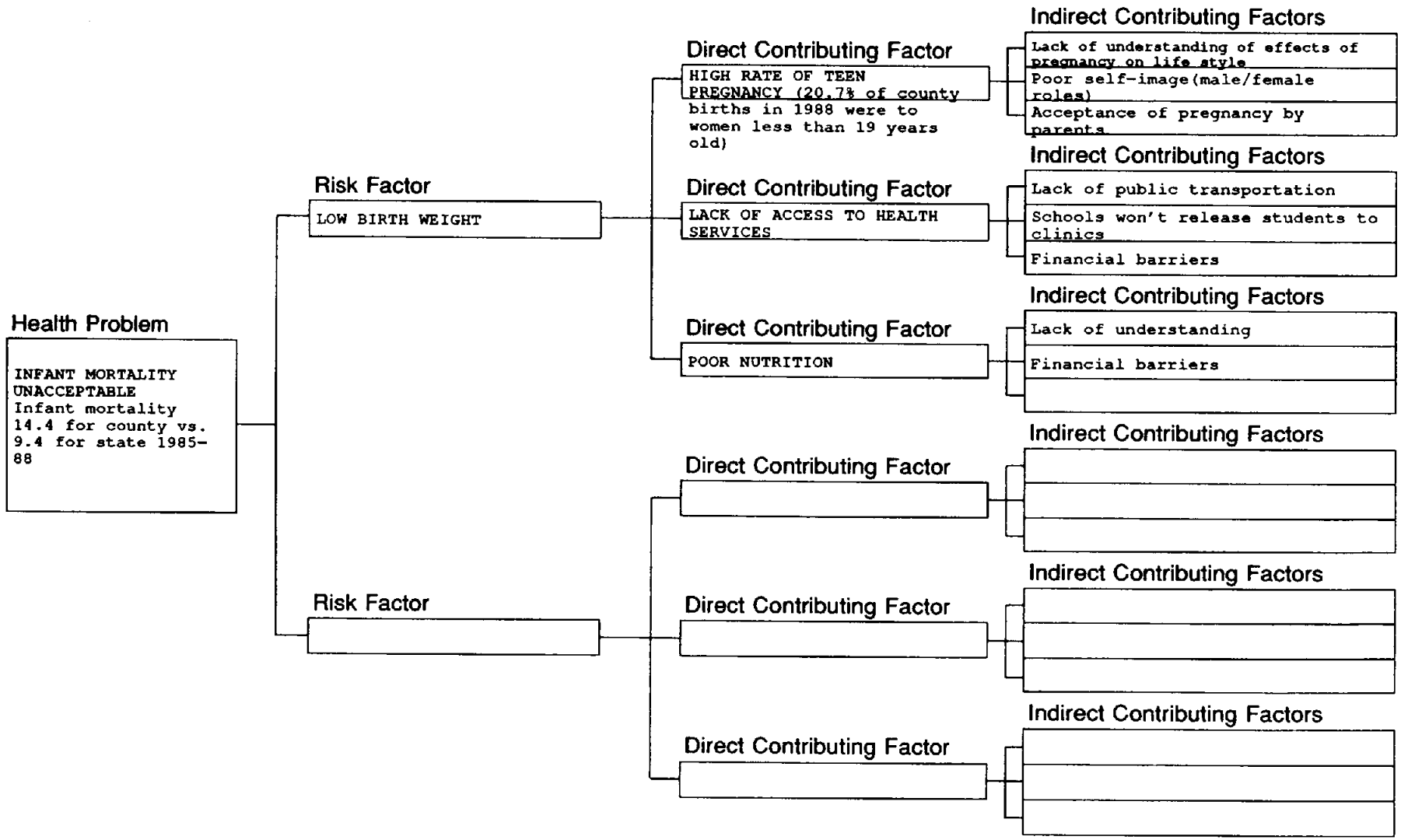
COMMUNITY HEALTH PROBLEMS

Summary Sheet

Disease/Condition	Comments
Top ten (10) ranked contributors of YPLL	
1 Malignant Neoplasms	County C: 1,223 State C: 76,190
2 Motor Vehicle Accidents	" " 1,036 " " 68,919
3 Diseases of the heart	" " 817 " " 78,437
4 Certain Conditions in Perinatal	" " 580 " " 38,232
5 Congenital Anomalies	" " 425 " " 24,832
6 Suicide	" " 240 " " 25,349
7 Diseases of Nervous System	" " 196 " " 10,465
8 Infectious/Parasitic Diseases	" " 178 NOT IN TOP 10
9 Metabolic & Immunity Diseases	" " 157 NOT IN TOP 10
10 CVD	" " 137 " " 9,586
Additional health problems/issues determined by the health department	
1 IN PROCESS	
2	
3	
4	
5	
Additional health problems/issues determined by the Community Health Committee	
1 IN PROCESS	
2	
3	
4	
5	

EXAMPLE THREE

HEALTH PROBLEM ANALYSIS WORKSHEET



COMMUNITY HEALTH PLAN

DESCRIPTION OF THE HEALTH PROBLEM, RISK FACTORS AND CONTRIBUTING FACTORS (including high risk populations, and current and projected statistical trends:

There is an unacceptable number of high risk (Myerburg score over 575) births to County C women. (Infant mortality is 14.4 for County C vs. 9.4 for State C.)

County C has a higher number projected high birth scores (based on previous statistics) than "M" or "H" counties even though these counties have a higher population than County C.

20.7% of county births are to women less than 19 years of age.

Determinants and contributing factors:

1. Teen pregnancy is a major contributing factor to the county's high birth score number.
   - A. Although many qualify for a DHS card, health care is unavailable. (Only one physician currently accepting DHS insured O.B.'s.
   - B. Lack of access to health services. (No local transportation system).
   - C. Misconception regarding care for infants.
2. There is a need to improve education and nutrition services.

CORRECTIVE ACTIONS to reduce the level of the indirect contributing factors:

1. Encourage physicians to accept all O.B. patients as soon as possible after a positive pregnancy test.
2. Take health services to the clients. (F.P., STD, Screenings)
3. Include introduction to child care in the curriculum of the 6th and 7th graders.
4. Refer all of those eligible to YHS or to other related services.
5. All health/social service programs seeing O.B.'s need to be encouraged to include a drug prevention program.
6. Work with DHS and legislators to improve DHS reimbursement for OB services.
7. Encourage child day care programs in the schools.

PROPOSED COMMUNITY ORGANIZATION(S) to provide and coordinate the activities:

1. Community hospital - Board of Directors
2. County health department, YHS, Board of Education, Community Clinic
3. Board of Education, YHS, D & E Nursing Dept.
4. County health department, Private physicians, Birthright
5. Physicians seeing OB's, YHS, WIC
6. DHS, Community hospital, physicians seeing OB patients
7. YHS, DHS, Board of Education

EVALUATION PLAN to measure progress towards reaching objectives:

Review state/county statistics on an annual basis

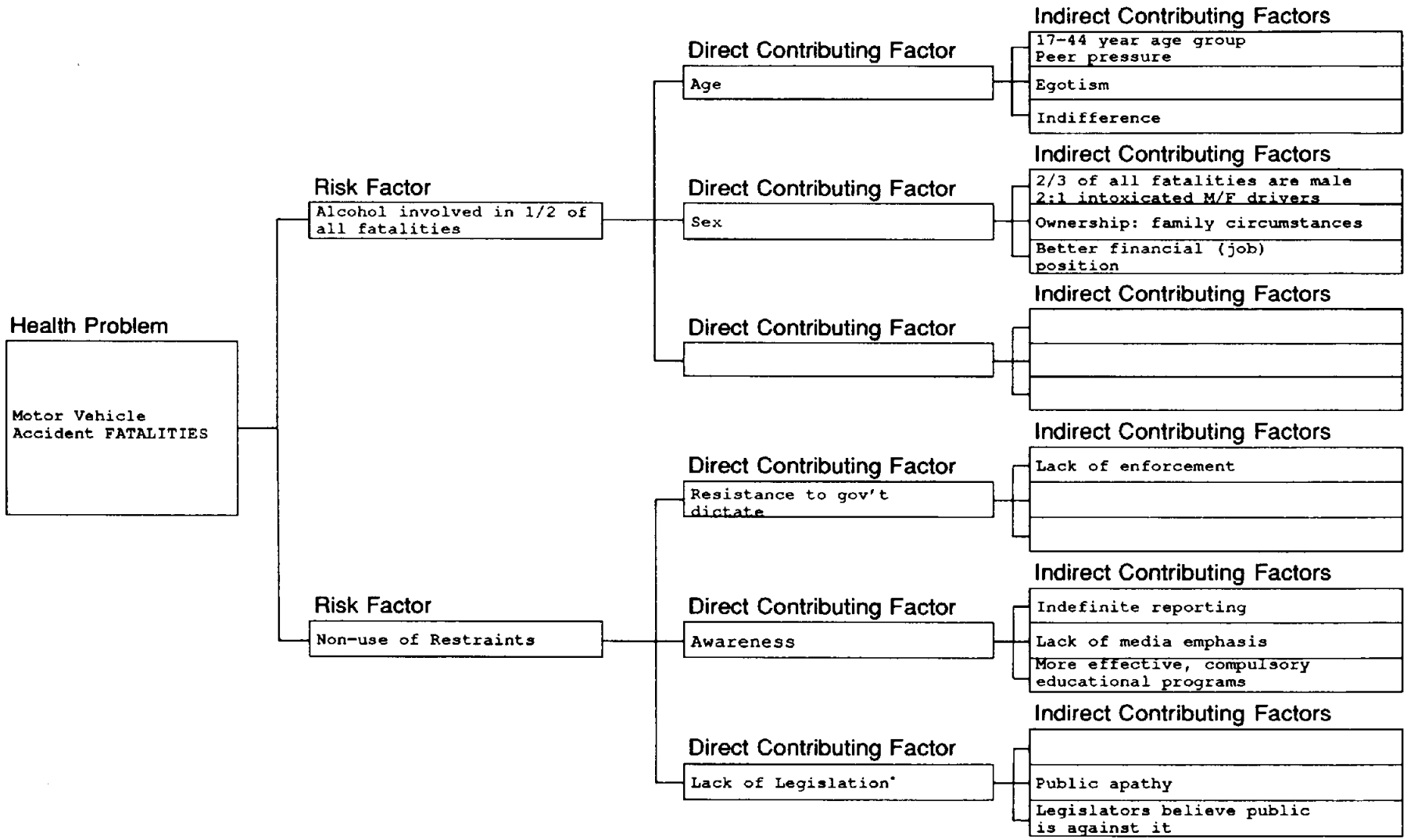
Establish a local reporting system

Monitor clinics that are implementing risk factor reduction program

Meet with Community Committee two times a year

EXAMPLE THREE

HEALTH PROBLEM ANALYSIS WORKSHEET



*No law for over nine years of age
0 - 3 requires child's seat
3 - 9 requires seat belt

COMMUNITY HEALTH PLAN

DESCRIPTION OF THE HEALTH PROBLEM, RISK FACTORS AND CONTRIBUTING FACTORS (including high risk populations, and current and projected statistical trends):

- The problem is the high death rate in motor vehicle accidents. The state, region, and county have higher rates as measured by 100 million miles of travel and by the crude rate. Accident fatalities are the leading cause of death in the state and the county for males between 15 - 40 years of age. Historically this is unchanged and would be expected naturally, socially, and economically. Longer, healthier, life spans would cause some modification.
- Major contributing factors are alcohol involvement and non-use of restraints arising from individual character and attitudes and affected by external conditions and circumstances.

CORRECTIVE ACTIONS to reduce the level of the indirect contributing factors:

- Encourage and support those groups and organizations now working for the reduction of the health problem.
- Enlist a greater participation by civic organizations, commerce, and industry for a concerted effort, toward the persistent exposure of the problems, establishing a pervading sense of awareness of total community concern and involvement.

PROPOSED COMMUNITY ORGANIZATION(S)to provide and coordinate the activities:

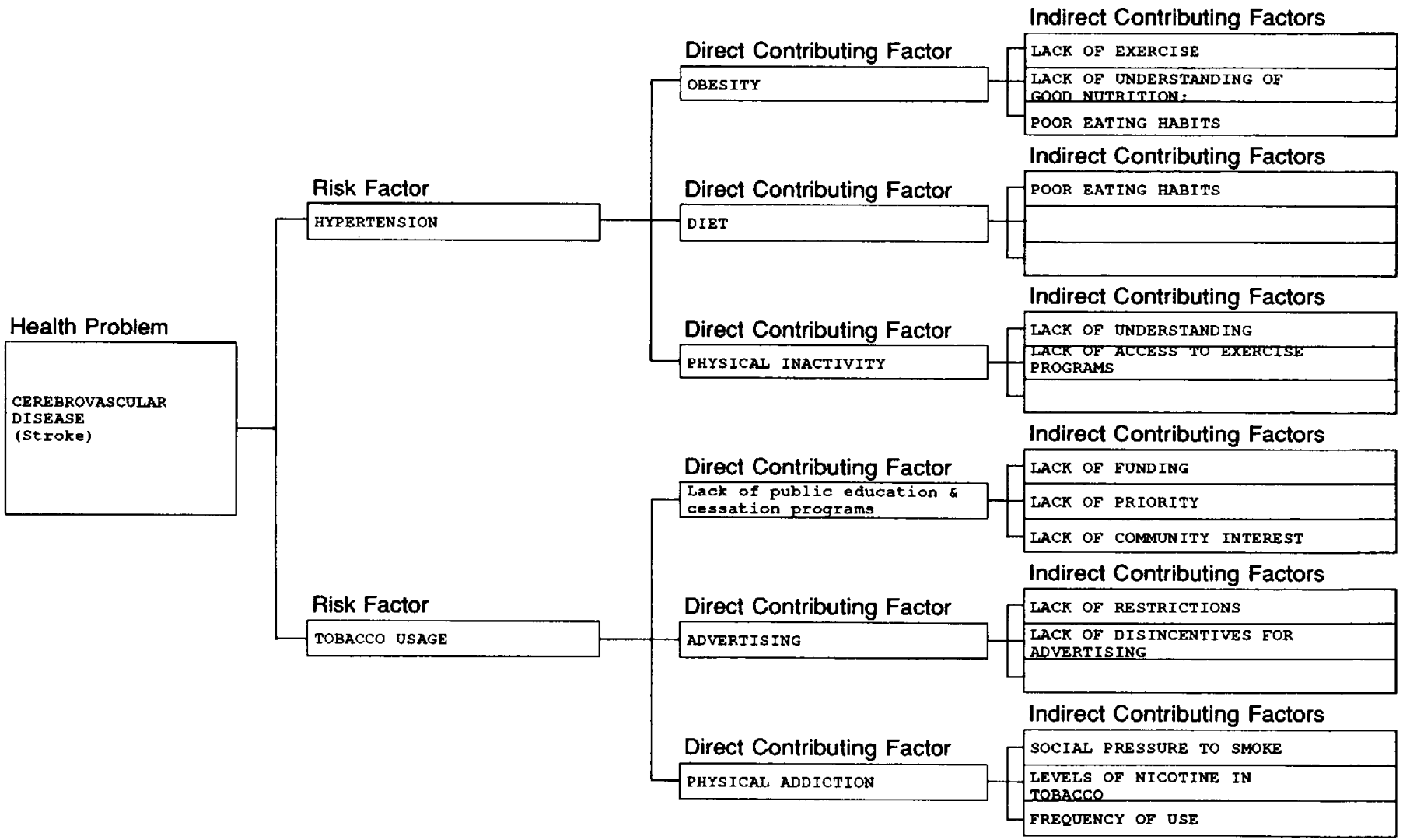
The formation of a consortium of groups and organizations would yield a sharing of ideas, broadening of activities, and establish a larger financial capability. Monies could be directed to pay for media exposure which would foster voluntary media contributions to the effort. A unified effort would create a greater influence of police enforcement, judicial decisions, and legislative perception of the will of the public.

EVALUATION PLAN to measure progress towards reaching objectives:

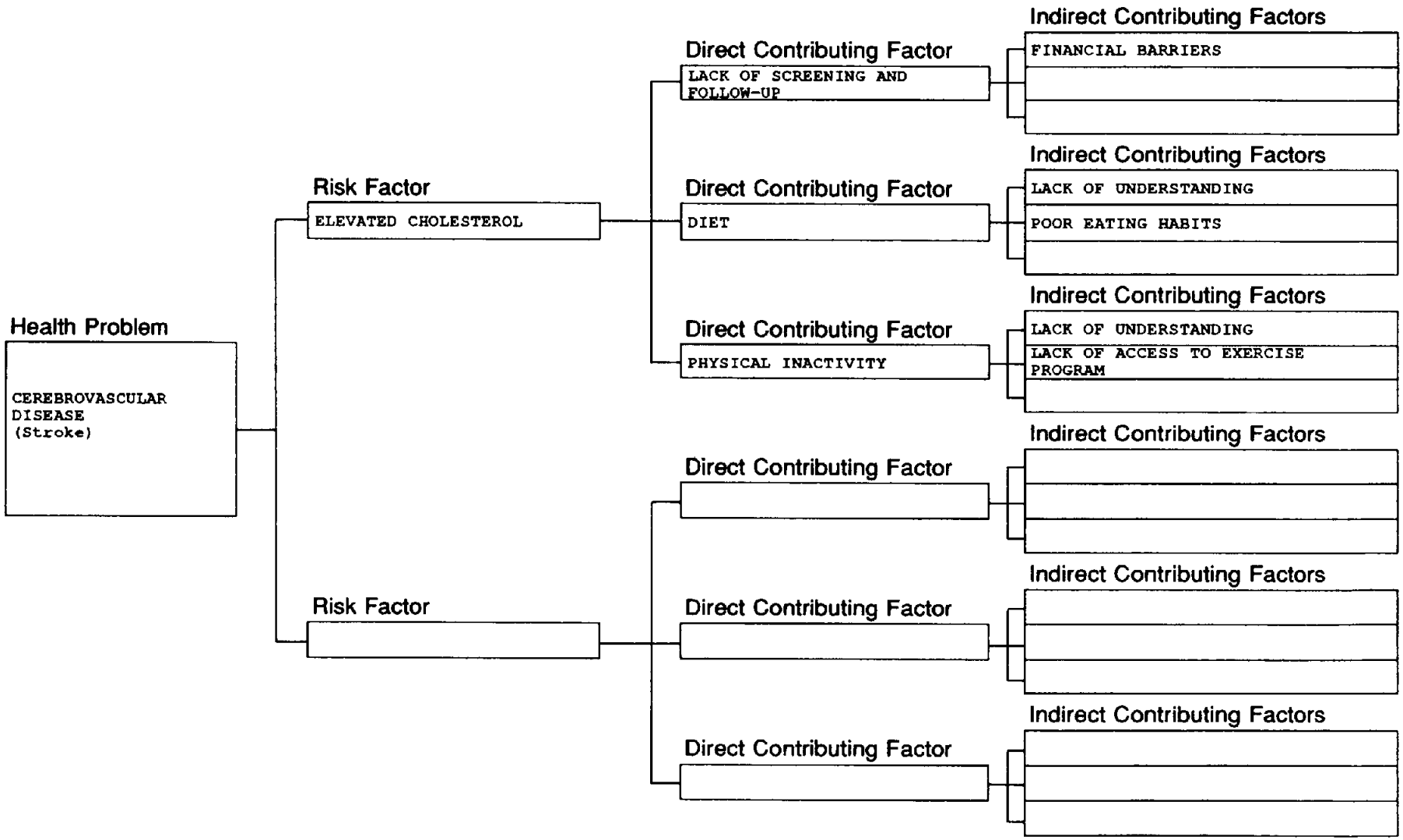
- Review state/county statistics on an annual basis
- Establish a local reporting system
- Meet with Community Committee two times a year

EXAMPLE THREE

HEALTH PROBLEM ANALYSIS WORKSHEET



HEALTH PROBLEM ANALYSIS WORKSHEET



COMMUNITY HEALTH PLAN

DESCRIPTION OF THE HEALTH PROBLEM, RISK FACTORS AND CONTRIBUTING FACTORS (including high risk populations, and current and projected statistical trends:

CVD: To reduce the Crude Death rate of 108.3 in County C to the United States level of 68.1 (per 100,000 population) in people over 65 years of age.

Risk factors Tobacco Usage, Elevated Cholesterol, Hypertension, and Level of Physical Activity

1. Thirty-one percent (31%) of U.S. population smoke
2. Lack of sustained physical activity
3. Poor dietary habits - poor food selection
4. Lack of appropriate medical screening/follow-up
5. Genetics
6. Stress

CORRECTIVE ACTIONS to reduce the level of the indirect contributing factors:

1. For all residents to become non-smokers
2. For serum cholesterol levels to be less than 200 mg per dl with a mean level of 160 mg per dl for the population and for the percentage of calories derived from fat to be less than 30%
3. For their blood pressure readings to be less than 140 MM Hg systolic and 90 MM hg diastolic
4. For people to exercise vigorously for a minimum of 20 minutes three or more times each week.
5. Encourage State of C to provide funding and technical assistance to communities to implement multiple risk factor reduction programs.

PROPOSED COMMUNITY ORGANIZATION(S) to provide and coordinate the activities:

Health department staff/WIC
Hospital medical staff/Private physician offices
Youth Health service Staff/early intervention
School system
Local service clubs
More press and radio coverage of risk factors

EVALUATION PLAN to measure progress towards reaching objectives:

Review state/county statistics on an annual basis

Establish a local reporting system

Monitor clinics that are implementing risk factor reduction program

Meet with Community Committee two times a year

EXAMPLE THREE

Part III
Completing the Cycle

COMPLETING THE CYCLE

This final section of the workbook is different from the other two sections in that it is not a step-by-step process but a discussion of the policy development and assurance functions of a local health department. It also describes the basic monitoring and evaluation functions necessary to ensure that the Organizational Action Plan and Community Health Plan are effectively carried out and that they accomplish the desired results. By carrying out the tasks described below, the cycle of the local health department's assessment, policy development, and assurance functions is completed.

Policy Development

Public policy development includes resource allocation, program development, and regulation in both the public and the private sectors of the community. Public policy is developed as a part of a formal, representative, governmental process. At the same time, in order to achieve significant public health goals, the health department and its policy board must exercise leadership in facilitating sound health policy decisions by other public and private organizations. It may even be that this leadership role is the most important function of a local health authority. The Community Health Assessment and planning process, if successful, should have led to an understanding of this role in detail and in relation to agreed upon community health goals. The policy board and the health department will use the results of the Community Health Assessment for policy review and action.

The policy development process at the local level should not be an isolated activity. The policy board is a stakeholder in the policy development processes of both state and federal government. Being involved at these levels will not only give the policy board an active role in determining its own future, but this larger involvement will establish a context within which local issues can be seen realistically and be more effectively resolved.

In this process, the policy board will review the Community Health Plan and identify critical policy issues or unforeseen events and problems that arise out of the implementation of the Plan. The completed Plan will form the basis for policy development and administration.

The policy board analyzes public policy issues, including those that may not on their surface appear to be pure "public health" issues, for their impact on public health. Any policy issue that the board determines is related to the public's health should also be considered in the context of the current Community Health Plan. This will often

lead to the need to amend the Plan itself. Such an amendment should follow the same basic process that was used for the initial development of the Plan.

It is the responsibility of the policy board to formulate alternatives and set strategies for action on health policies. The decisions of the board should be based on staff analysis and thorough discussion by the Community Health Committee. Actual policy decisions, however, should be made by the board.

Another responsibility of the policy board is to advocate public policy issues and to set priorities conducive to better community health. The board and the department should become and remain proactive in the full implementation of the Community Health Plan. This will often mean advocating on behalf of organizations, public or private, that are entirely separate from the department itself. In this way, the total resources of the community, not just the budget of the department, are the subject of its public policy decisions and actions.

Because so much of the policy-oriented responsibilities of the local health authority go beyond the organizational structure and activities of the health department, it is essential that the Community Health Committee has a central role in policy development. The health director and the policy board will need to assess continuously the role and effectiveness of this Committee. The Community Health Committee is not just an "ad hoc" group for the preparation of a plan, but an active part of the policy analysis function of the health authority itself. Its members represent the basic resources that the local health authority has available for planning, implementation, and evaluation. They are also the formal and most effective link between the local health authority and the community for whose health it is responsible.

Assurance of Implementation of Organizational and Community Health Plans

The health department director must assure and facilitate the completion and continuity of the community health assessment process. The key element of this responsibility is the empowerment and support for the Community Health Committee. This responsibility also entails ensuring that the data-based surveillance activities that were central to the Community Assessment function continue as a part of the internal staff and management activities of the department.

Ultimately, it should be the policy board, not the director or the Community Health Committee, that is the primary impetus for development and implementation of a Community Health Plan. This requires that the policy board be fully aware of its leadership responsibilities through board development, continual updating on community health status and progress in implementing the Plan, and regular interaction with the community through the Community Health Committee.

During the community assessment process, on the advice of the Community Health Committee, the policy board should have identified and set priorities among the various health problems brought to its attention. This process should not end when the board formally adopts the Plan. Rather, the adoption of the Plan should be the beginning of a continual process of problem identification and priority setting.

The health department director should periodically meet with those assigned responsibility for implementing activities in the Organization Action Plan to assure that those activities are successfully carried out.

The health department director should periodically provide the policy board with opportunities to monitor and evaluate the impact of its policies on community health problems. Detailed reporting should be done for the Community Health Committee to assist in deciding which issues and information should be brought to the attention of the policy board.

The policy board must also be able to influence the local governmental unit to which it is accountable, as well as the units of government within the geographic area for which it is responsible. This will require the consideration of the policy interests of these units of government in the planning process and the activation of the constituencies represented on the Community Health Committee.

Assurance of Public Health Services

The local health authority, through its policy board, has the duty to assure that the public has the policy framework and services needed to meet the community's public health goals. In order to fulfill this duty, the policy board must assure that there is agreement on what these goals are and what are the most appropriate methods of reaching them, consistent with community values and resources. The basic "assurance" functions of the local health authority consist of several related activities, including:

- the promotion of cooperation and collaboration within the community
- the education of the general public and its elected representatives
- either the direct provision of needed services or facilitating the provision of services by other community resources
- appropriate and effective protection of the public health through regulation and enforcement
- continuous community development to identify or create resources needed to resolve health problems

To establish a basis for assurance, the policy board must assist the department in identifying resources in the community not under the direct control of the department itself. The board, through its policies and its leadership, should assure that these community resources are available and used in ways that contribute to the achievement of the goals agreed upon during the community assessment and planning

process. The policy board is responsible for fostering the development of the cooperation and collaboration needed to maintain this partnership.

When the community lacks resources to meet goals that have been identified as high priority, the policy board will need to assure that needed resources are found. This may entail increases in the health department's budget, or it may require the development of new resources within the community itself. The decision regarding whether an unmet need should be addressed by department staff or by other organizations in the community is a fundamental policy decision and should be dealt with according to the principles and process discussed above under Policy Development. Achieving success will require aggressive and effective public education efforts to assure that the political constituency exists to support the policy decisions that will need to be made.

The local health authority exists within the context of specific legal authority established at the federal, state, and local levels. It is the responsibility of the department director, working with the policy board, to assure and implement these legislative mandates and statutory responsibilities through enforcement activities or policy development. During the Community Assessment process, health problems may be identified that can best be resolved through the use of authorities not currently given to the policy board. In such cases, it may be the responsibility of the policy board to assure that this new authority is established, either through state legislation or local ordinances and regulation.

The local health authority should endeavor to develop and maintain a spirit of cooperation and collaboration with other local health authorities, the state health authority, and post secondary schools and schools of public health. This element of the assurance function will call upon the leadership ability of both the policy board and the department staff.

Through all its operations, it is a basic duty of the local health authority—both the policy board and the department—to assure that levels of public health protection and promotion agreed upon during the planning process or established through governmental action are maintained without interruption to avoid crises harmful to the health of the community. A continuous cycle of assessment, policy development, and assurance will provide a process by which the policy board and its community maintain agreement on problems, priorities, and programs. If the policy board has established a position of leadership in the community and enlisted all available resources in the cause of the public health, disruptions in funding or sudden changes in community need can be met within the context of the overall community health system.

It is the task of the health department director, working with the policy board and its community health committee, to monitor existing community health services to assure that they are appropriate and affordable. Because these services will not all be under the policy or management control of the department, this monitoring function will need to be developed with the cooperation of the community organizations that contribute toward the achievement of community health goals. Under some

circumstances, however, cooperation and collaboration may not be adequate to assure that needed services are available at a cost that makes them accessible to all in need. In such cases, the policy board may need to consider the use of or the creation of regulatory authority or of new departmental service programs.

The department should seek to establish community agreement upon minimum standards and service levels that will be available to all persons in the community, regardless of their ability to pay, and methods by which it will assure that these services are received. The Community Process is an ideal method for arriving at this agreement, and the Community Health Committee is a key resource in this process.

Although there are many organizations working to improve and maintain the environment, the local health department will be the only one that can assure that environmental activities are consistent with community health goals. As with service provision, the assurance of a clean, safe, healthy environment will require a combination of cooperation and collaboration, public education, enforcement, and community development.

The department should work to promote community values that are conducive to the setting and achievement of appropriate public health goals. This will often require working through the policy activities of other organizations. One example of this would be efforts to develop policies in community businesses and industries conducive to health risk assessment as risk management. The ultimate goal is the improvement and maintenance of the health of these organizations' employees; but the policies set, the resources used, and the leadership exercised will be the result of the decisions of business leaders, not public health officials.

Other areas of this kind of assurance activity would be the educational institutions within the community. The policy board and staff of the local health authority should participate in the development of health policy issues in colleges and schools to assure healthy environments for the general student body and for special populations using those institutions.

Throughout all its assurance efforts, the local health authority should rely upon and develop the capacities of its community's organizations to protect and promote the health of its citizens. Ultimately, this partnership in public health provides the policy board with its leadership authority, which is the basis of its effectiveness in assuring the community's health.

Monitoring and Evaluation

Once completed, the APEX*PH* process forms the basis for continual monitoring and evaluation of both organizational and community public health capacity and effectiveness. Part I suggests that a formal re-assessment of the local health department and its community occur at least every four years, and that less intense reviews of progress be conducted at two-year intervals.

The Organizational Action Plan and the Community Health Plan developed as a result of APEX*PH* should provide the basic performance indicators. In addition to the specific, measurable and time-specific objectives that are the heart of these plans, these processes should also have resulted in documented descriptions and analyses of organizational and community strengths and weaknesses (or problems). These should provide an excellent starting point for continued monitoring and evaluation of progress toward goals and objectives. Monitoring and evaluation, however, should not be a "closed loop." The health department and its community will continually be presented with new situations, new resources, and new technologies; these should be accounted for in the overall monitoring process.

In this discussion, *monitoring* refers to continuous formal or informal assessment of progress toward goals and objectives and of general effectiveness and relevance of activities. *Evaluation* refers to a formal, documented assessment of effectiveness in actually meeting stated goals and objectives with an analysis of the performance for the purpose of guiding future decisions about the health department and the community's health.

Monitoring progress toward objectives set in the Organizational Action Plan should be an internal management function. Evaluation of the organization, however, can be done, as it was initially, entirely within the department itself; or it can be broadened to allow policy board and community involvement in assessing the organization's capacity to serve as the lead public health agency. It might also be beneficial for a local health department to involve its state health authority in certain elements of its evaluation process, especially if local effectiveness is dependent on state technical, fiscal, or legal support. There are risks, and comparable potential benefits, to opening the Organizational Capacity Assessment process to the policy board and the community. Whether this evaluation process is a community or an internal affair, however, it should still follow the same basic principles.

The Introduction and the instructions in Part I both emphasize the value of adapting the indicators in Part I to the local health department's actual situation. In addition, they recommend that certain indicators are of particular importance to a policy board (for example, "Legal Authority"). Other indicators are of less relevance either to the community or to the policy board (for example, "Personnel Management"). If a decision is made to involve either the community, the state health authority, or the policy board—or all of these—in evaluating the Organizational Action Plan, it is advisable to select only those sections of the Plan that are relevant for use in this process. In Part I, it is recommended that only certain sections of the Organizational Capacity Assessment would be relevant to a policy board (see Appendix B); this same advice would apply to evaluation by either the policy board or the community health committee. It is important that the department avoid a situation in which its policy board or community advisory committee becomes involved in purely administrative decisions.

With all this in mind, then, the local health department should establish and conduct the following continuations of the APEX*PH* organizational capacity assessment process:

- The director should regularly review progress toward the objectives in the Organizational Action Plan with key management staff and with the Internal Assessment Team. This monitoring process will allow staff to refine objectives on the basis of experience, changes in resources, or changes in overall priorities. This relatively informal monitoring will also help the director and the management staff prepare for a more formal re-assessment (or evaluation) or organizational capacity two to four years following the initial assessment.
- At least every four years, and possibly every two years, the director of the department should formally evaluate the effectiveness of efforts to meet the goals and objectives in the Organizational Action Plan. In addition, the department should undergo a formal re-assessment following the same process outlined in Part I, to allow for a fresh look at overall organizational priorities and performance. This re-assessment should lead to the development of a revised Organizational Action Plan. To the degree feasible and appropriate, this re-assessment should involve the department's policy board and members of the community. It may also be appropriate to request involvement from the state health authority in assessing indicators related to authority, funding, and technical support in Part I.
- The director should regularly review progress towards the objectives in the Community Health Plan. The director should also monitor the extent to which the Community Health Committee remains involved in the implementation of the Community Health Plan. Some specific monitoring activities are as follows:
  - Review the degree to which the department meets the indicators in subsections II, III, and IV of Part I-B.
  - Monitor the degree to which the objectives and activities in the Community Health Plan are accomplished
  - Monitor the degree to which Committee members express interest in progress toward the achievement of Community Health objectives, independently of formal methods of Community Health Plan monitoring and evaluation noted in Part I and below
  - Observe the degree to which the Community Health Committee interacts with the board of health or its parent unit of government, especially the degree to which Committee members are seen and act as spokespersons for public health policy and the achievement of objectives in the Community Health Plan
  - Observe the degree to which department staff consider the Community Health Committee a resource (rather than a task)

- Review the Committee agendas to see the degree to which they are action oriented, rather than meetings at which community members passively receive opinion and information from staff
- Review the Committee attendance at meetings
- Review the Committee minutes to see if issues not brought up by staff are raised by Committee members
- Monitor the degree to which the department's Community Health Committee is used as a forum for major public health issues by non-Committee members of the community
- Monitor whether vacancies on the Committee are filled quickly and without recruitment

These relatively simple methods will give the director and the health department staff a good sense of whether it is necessary to revitalize the process. (See Appendix F for a "Community Health Committee Self-Assessment Form" that could be useful in monitoring the committee's own perceptions of its usefulness.)

If prepared as recommended in Part II, the Community Health Plan will contain its own monitoring and evaluation criteria. Monitoring should be a continuous process and should involve the Community Health Committee and any other community resource identified in the Plan.

Within two years following the adoption of the Community Health Plan by the policy board, the department should conduct a formal evaluation of the effectiveness of efforts undertaken to achieve its goals and objectives. This evaluation does not need to be elaborate, nor does it need to include a formal community assessment as outlined in Part II; but it must include the community Health Committee. New health status data should not be necessary, except as may be needed to measure progress on specific objectives in the Plan. Because the nature of the evaluation is entirely dependent on the Community Health Plan, it is not possible to go into detail about the process to be followed. It is important, however, that the evaluation be documented and that it lead to decisions about the Community Health Plan.

The purpose of this evaluation is to determine if progress is being made in the accomplishment of the community's health objectives and, if not, either to determine how to change methods or to reconsider the objective. The result of the evaluation would be an updated Community Health Plan, as well as a progress report for the policy board and the community at large.

In addition to monitoring and evaluating progress in accomplishing community health objectives, the local health department should maintain a continuous surveillance of the health status of its population. Depending on the resources of the department, this activity might require direct assistance from the state health authority or other local health departments. This activity is noted in several of the indicators in Part I-B, especially subsection III.

At least every four years, this surveillance activity should be integrated with The Community Process, and a formal re-assessment of the community health status should be undertaken. The same methods outlined in Part II should be used in this re-assessment process, except as may have been adapted by the department to fit local circumstances and resources.

Once a local health department and its community has completed this monitoring and evaluation cycle, it should find that the distinctions between the internal organizational assessment and the public community assessment processes begin to disappear. APEX*PH* is intended to stimulate local commitment to continuous progress toward excellence in public health. What is presented in this workbook is only a beginning of what every local health department, operating in partnership with its community and with its state health authority, can accomplish for itself and the people it serves.

Appendices

LIST OF APPENDICES

APPENDIX A

DESCRIPTION OF METHODOLOGIES USED AT THREE TEST SITES

DESCRIPTION OF METHODOLOGIES USED AT THREE TEST SITES

The health departments that served as test sites—both the pilot sites and the demonstrations sites—adapted the APEX*PH* process to fit their local situations. The following descriptions of how three test sites approached the process illustrate how The APEX*PH* Process has been applied in health departments and communities of different sizes.

Test-Site Example No. 1

Description of the Test Site

The health department selected for this example has a health officer and 2 other staff members. It serves a jurisdiction of 8,100 persons.

How the Test Site Carried Out Step 2 of Part I

The health officer, with assistance from the other two staff members, scored both the perceived status and current status of the indicators. They attempted to reach consensus on the ratings for each indicator through group discussion. When necessary, the health officer made the final decision on the rating for an indicator. Twenty indicators received a *not relevant* rating.

How the Test Site Carried Out Steps 3 and 4 of Part I

The health department defined strengths as indicators with scores of "HF." Eighty-one indicators had received scores of "HF." The health officer summarized these 81 indicators as strengths on an adaptation of the Analysis of Organization Strengths/Problems Worksheet provided with the workbook.

How the Test Site Carried Out Step 5 of Part I

The health officer listed the remaining indicators, except for those rated "0," *not relevant*, as problems on another copy of the same worksheet, grouping them by major sections of the Capacity Assessment Worksheet, and rated each group as I, II, or III in priority. Three groups were given priority ratings of I.

The three priority I groups were then addressed on the planning forms as suggested in the Workbook. Four to six specific goals were listed for each Priority I group.

How the Test Site Carried Out Step 2 of Part II

While Part I was in progress, the health department began collecting the community assessment data from the state health department; the data were already broken down by ICD code. Using these data, the health department set priorities among the causes of mortality based on the total number of deaths caused by each. The health department also added problems to the priority list that were not supported by data but which they felt were substantial.

How the Test Site Carried Out Steps 3—5 of Part II

The health department used an already existing committee to serve as their community health committee. They held briefing meetings with the committee before presenting the data collected in Step 2. The committee then added several problems/issues to the list of priority health problems. Then the health department and the committee worked together to select five top priority problems to address further. Some of the problems selected were data-driven, and some were concerns of the committee.

How the Test Site Carried Out Steps 6—8 of Part II

The health department and committee worked together to analyze the five top priority problems and develop an action plan for each. They used worksheets provided for this purpose in the APEX*PH* workbook.

Test-Site Example No. 2

Description of the Test Site

The health department selected for this example has 24 staff members in 3 divisions. It serves a jurisdiction of 28,834 persons.

How the Test Site Approached Part I

The health officer and the heads of the 3 divisions worked as a single team to complete Part I, using a consensus process. They completed Part I in 8 weeks, meeting for 2 hours each week.

How the Test Site Carried out Steps 2-5 of Part I

The entire team scored both the perceived importance and the current status of the indicators; nine indicators were scored as *not relevant*. The team defined strengths as scores of "HF" and "MF" on the indicators, and summarized strengths in language specific to that health department.

The team selected primarily indicators on which the health department scored "HP" or "HN" for its problem analysis. The team defined problems for related

indicators within each major section of the Capacity Analysis Worksheets. In all, 48 problems were defined, and their related factors well documented.

How the Test Site Carried out Steps 6 and 7 of Part I

The team selected the problems of highest priority and developed 17 goals, with measurable objectives and well documented responsibilities and methods for addressing those high priority problems. In developing action plans, the team sometimes combined problems from different major sections of the Capacity Analysis Worksheets.

How the Test Site Carried Out Step 2 of Part II

The team began collecting data for Part II while still working on Part I. It obtained mortality and behavioral risk data from the state health department; the YPLL's were already calculated for the mortality data. The team also obtained hospitalization, MCH, demographic, and environmental data.

How the Test Site Carried Out Steps 3—5 of Part II

A community health committee of 18 to 20 persons was organized through the APEX*PH* process. Members included the county commissioner, the mayor, and other community and professional people. The committee held introductory meetings, but waited to consider community health problems until it had all the required data. The committee used the priority setting process described in Appendix E to select issues to address. It developed a list of five health issues to address. Of the five issues selected, two problems were among the top ten causes of YPLL; the other three were issues raised either by the health department team or by the community health committee.

How the Test Site Carried Out Steps 6—8 of Part II

The community health committee used the process described in Step 6 to analyze the high priority problems it had selected and to develop detailed plans for addressing them.

Test-Site Example No. 3

Description of the Test Site

The health department selected for this example has 124 staff members in 3 divisions. It serves a jurisdiction of 206,000 persons.

How the Test Site Carried Out Step 2 of Part I

A group of 24 management staff from all divisions scored the indicators for their *perceived importance* to the health department. No indicator was rated "not relevant" ("0"). A second group of 23 line staff from all divisions scored the *current status* of the health department on the indicators. The version of the Capacity Assessment Worksheets used by this health department did not include a "Status Unknown" rating, but the health department added that rating to the worksheets. No attempt was made to reach consensus on these scores; instead, the number of staff members assigning a score was used as a criterion for the definition of strengths and weaknesses in Step 3.

How the Test Site Carried Out Steps 3—5 of Part I

The health department defined a strength as an indicator with a score of H or M (highly or moderately important) from all *perceived importance* raters combined with a score of F or P (fully or partially met) from all *current status* raters. Fifteen (15) indicators met these criteria. The health department used the wording of the indicators to define those 15 strengths.

The health department defined a weakness as any indicator that received a *current status* rating of "I don't know" from more than 15 of the 23 persons who rated current status. Twenty six (26) indicators met this criterion. Of the 26, the health department considered that 3 needed remedial action and that information needed to be collected for 6. The health department used wording of these 9 indicators to define 9 problems.

How the Test Site Carried Out Steps 6-7 of Part I

The 47 staff members who had rated the indicators for perceived importance and current status broke into small groups to address the 9 problems that they had identified. They developed detailed plans for the 3 problems that needed remedial action and prepared timelines for collecting information on the other 6.

How the Test Site Carried Out Step 2 of Part II

The health department began data collection for Part II simultaneously with undertaking Part I. It requested data from many sources, including the State Health Division, the State Employment Division, the State University, the State Shelter Network, the 1990 U.S. Census, the County Health Department, and other sources. It collected demographic, mortality, risk factor, and MCH data, and environmental information. From these data, it developed a list of 15 community health problems which included the top 10 causes of YPLL.

How the Test Site Carried Out Steps 3—5 of Part II

An already existing group, the Public Health Advisory Board established by the County Board, was used as the community health committee. This committee reviewed the health problem list developed by the health department and added 11 more issues. The committee then used a nominal group process to select five top priority problems

to address. None of the top ten causes of YPLL was among the five problems selected.

How the Test Site Carried Out Steps 6-8 of Part II

The community health committee compared its list of 5 top priority problems with the health department's current health plan. Subgroups of the committee reviewed the health plan to establish what, if any, additional actions were needed. They then wrote detailed community health plans to specify what actions were to be taken. It is expected that implementation of the plans will occur.

APPENDIX B

PROCEDURES FOR USE BY A POLICY BOARD IN SCORING INDICATORS

Instructions for the Policy Board:
How To Rate Selected Indicators of Organizational Capacity

The health department invites the Policy Board to participate in the current organizational assessment of the health department. The worksheets on the following pages list some of the indicators which staff are currently using to rate the department's organizational capacity. Policy Board members are asked to rate the importance of these indicators to the successful functioning of the health department.

Scoring the Perceived Importance of the Indicators

In the column headed "Perceived Importance," the Policy Board should enter one of the following *importance ratings* for each indicator:

H = High importance

M = Moderate importance

L = Low importance

0 = Not relevant

The rating should represent the consensus of the Board members on the importance of each indicator to the functioning of the health department. Some scores of 0, "Not relevant," are to be expected, because not every indicator will apply to every health department.

The *importance rating* of an indicator should be independent of its current status in the health department. Care should be taken to avoid rating an indicator as important simply because the health department currently performs the activity described by the indicator.

Capacity Assessment Worksheets

Indicators	Perceived Importance Codes: H M L 0*
I. Authority to Operate	
A. Legal Authority	
1. The health department has the authority to delegate public health duties to municipalities within its jurisdiction.	1._____
B. Intergovernmental Relations	
1. At least once every two years (biennially), the health department reviews its joint powers agreements, memoranda of understanding, and other agreements with units of government within its jurisdiction or in neighboring jurisdictions to identify problems, propose solutions, and look for areas for further development.	1._____
2. Units of government within the jurisdiction of the health department are represented on a committee, subcommittee, or other body advisory to the local department of health.	2._____
3. The health department is regularly consulted by the local elected officials about aspects of local policy relating to health issues.	3._____
4. The director or a representative communicates appropriately and regularly with state legislators who represent the district the health department serves.	4._____
5. The health department is regularly consulted by the local schools when setting health policy.	5._____
C. Legal Counsel	
1. The health department has legal counsel sufficient to provide advice as needed on administrative practices; department powers, duties, policies, and procedures; relevant laws and ordinances; contracts; and other legal matters.	1._____
2. Procedures for the enforcement of board authorities and responsibilities are documented and are reviewed at least biennially with legal counsel.	2. _____

*Perceived Importance Codes:
H = High importance
M = Moderate importance
L = Low importance
0 = Not relevant

Indicators	Perceived Importance Codes: H M L 0*
II. Community Relations	
A. Constituency Development	
1. At least every four years, the health department actively involves all key individuals and organizations within its jurisdiction that might be engaged in public-health- related activities to determine their goals and their perceptions of their roles, authorities, and needs, including:	A1. _____
a. Units of government with authority within the jurisdiction of the health department, including the governmental unit from which the department derives its basic authority.	1a._____
2. The health department has formed a citizens' or community committee or has established another formal method of involving the people it serves in the identification of community health problems and the development of a community health plan.	2. _____
B. Constituency Education	
1. Professional staff members of the health department participate in or serve on councils, boards, or committees of public- health-related organizations at the state and local level.	B1. _____
III. Community Health Assessment	
A. Mission and Role	
1. The health department has a clear and concrete mission statement that all staff are capable of stating and explaining in relation to their duties.	A1. _____
2. The health department has established a process for community health assessment and the development of a community health plan.	2. _____
3. At least every four years, the health department conducts a public review and discussion of its mission and role, its public health goals, its accomplishments, past activities, and plans in relation to community health.	3. _____
4. At least every two years, the health department formally requests all units of government within its jurisdiction to comment on the department's programs, plan, and budget.	4. _____
5. The health department maintains a current description (no older than two years) of the public health services, programs, and authorities of the municipalities in its jurisdiction.	5. _____

*Perceived Importance Codes:
H = High importance
M = Moderate importance
L = Low importance
0 = Not relevant

Indicators	Perceived Importance Codes: H M L 0 *
III. Community Health Assessment	
B. Data Collection and Analysis	
1. The health department conducts appropriate statistical analysis of birth and death records and reports these results to the policy board, staff, and community on a regular basis.	B1_____
C. Resource Assessment	
1. The health department has joint powers agreements with other units of government in neighboring jurisdictions or within its own jurisdiction for the shared funding and operation of enforcement and service delivery programs where economies of scale and efficiency are possible.	C1_____
IV. Public Policy Development	
A. Community Health Assessment and Planning	
1. The health department and the community identify and set priorities for addressing health problems based on the results of the community health assessment.	A1._____
2. The health department and the community develop a community health plan based on the results of the community health assessment and priority-setting processes.	2._____
3. The health department director and the community involve the policy board in the review and revision, if necessary, of the proposed community health plan.	3._____
4. The policy board monitors the implementation of the community health plan.	4._____
B. Community Health Policy	
1. The policy board obtains information from an established citizens' advisory group and from the health department regarding public policy issues affecting the public health.	B1._____
2. The policy board identifies any additional public policy issues affecting public health and analyzes those issues.	2._____
3. The policy board establishes priorities and formulates strategies for action on high priority health policy issues.	3._____

*Perceived Importance Codes:
H = High importance
M = Moderate importance
L = Low importance
0 = Not relevant

Indicators	Perceived Importance Codes: H M L 0*
B. Community Health Policy *continued*	
4. The health department facilitates the formulation of public health policy in the community.	4._____
5. The policy board advocates changes in public policy to correct the public health problems of the community.	5._____
C. Public Policy and Public Health Issues	
1. The local governmental unit uses the policy board and the health department director in developing public policy which may impact public health.	1._____
2. The elected officials at the local level actively solicit the opinions of the professional staff and/or health department director on scientific issues in policy development.	2._____
3. The health department director and policy board participate at both the state and local levels in governmental decision making which may have an impact on local health issues.	3._____
V. Assurance of Public Health Services	
A. Public Policy Implementation	
1. The policy board uses its authority to assure necessary services to reach agreed upon goals for its constituents.	1._____
2. The policy board assists the health department in utilizing all resources in the community to assure the desired services to all its citizens.	2._____
B. Involvement of Community in the Public Health Delivery System	
1. The policy board and senior management of the health department work with employee groups in assessing health risks of employees and in managing those risks.	1._____
2. The policy board and senior management participate in the development of health policy issues in colleges, schools, and industry to assure an optimum, healthy environment for special groups.	2._____
3. The policy board and the health department director assure health protection and health promotion services utilizing community-based organizations.	3._____

*Perceived Importance Codes:
H = High Importance
M = Moderate Importance
L = Low Importance
0 = Not relevant

APPENDIX C

MODEL JOB DESCRIPTION FOR COMMUNITY HEALTH COMMITTEE MEMBERS

MODEL JOB DESCRIPTION FOR COMMUNITY HEALTH COMMITTEE MEMBERS[1]

Length of Commitment:

Three years subject to reappointment

Estimated Time Required:

Monthly meeting of 1-2 hours

1-2 hours per month for preparation and follow up

Desired Attributes:

1. Commitment to improving the health of the county (or community or community health services area).
2. Knowledgeable about the county.
3. Willingness to maintain a county-wide perspective.
4. Ability to represent an important perspective, organization or sector of the county.
5. Willingness and ability to provide the required time.

Overall roles:

1. Advise, consult with, and make recommendations to the Community Health Board at the direction of the Board.
2. Present the perspective you represent in discussions, balancing those views with a county-wide perspective.

Specific Responsibilities:

These responsibilities should be determined by the charge developed by the community health policy board for the Committee.

Benefits:

Opportunity to improve the health of area residents; community service; personal and professional growth; opportunity to represent your organization or profession.

Source: Minnesota Department of Health, State Community Health Services Advisory Committee, *Community Health Services Work Group Interim Report,* August 1990

[1]This is a model job description only. A job description should be developed that specifically reflects the meeting schedule, roles, and responsibilities of your Community Health Committee.

APPENDIX D

MODEL BYLAWS FOR A COMMUNITY HEALTH COMMITTEE

MODEL BYLAWS FOR A COMMUNITY HEALTH COMMITTEE

ARTICLE I. NAME

The name of this committee shall be _____ County Community Health Committee.

ART. II. PURPOSE AND GOALS

The overall mission of the committee is to assist the Board of Health by advising the Board regarding the health problems of _____ County and thus assist the Board in its responsibility to undertake "community assessment." The Committee will promote the prevention of premature death, disability, and illness by developing a _____ County community health plan for recommendation to the Board. The role of the Board of Health is to support the Committee by providing the resources needed by the Committee to undertake the work, and by facilitating the planning process. The following is a proposed objectives statement.

The mission of the Committee is to assist the Board of Health by:

1. Developing a community health plan which includes health problems identification; problem analysis incorporating the identification of risk factors, direct contributing factors, and indirect contributing factors.
2. Proposing actions to remedy indirect contributing factors, remove associated barriers to such remedies, and obtain resources which can contribute to the remedies.
3. Establishing priorities for all identified health problems.
4. Identifying department/organization work teams which should coordinate efforts with respect to each health problem.
5. Drafting and presenting to the Board the recommended health plan.
6. Promoting and supporting the importance of reducing the health problems to the Board and the community.
7. Developing and maintaining good communications with the board via monthly reports to the Board by the Health Officer and periodic reports from the Executive Committee of the Health Committee.

ART. III. MEMBERS

SECTION 1. ***Number.*** The Committee shall consist of no less than 12 members and no more than 28. A vacancy shall not prevent the Committee from conducting business.

SEC. 2. ***Appointment and removal.*** Initial members of the committee shall be appointed by the Board of Health. Future members and/or members to fill vacancies of the Committee shall be appointed by the Committee. The Committee shall have the right to remove Committee members for good cause shown after notice and a hearing before the Committee as a whole. A two-thirds (2/3) majority is required for removal. Automatic removal results when a member misses three (3) consecutive meetings or six (6) meetings in a calendar year. Recommendations for membership will be accepted from any source.

SEC. 3. ***Term.*** Committee members shall serve for staggered three (3) year terms. This does not preclude any member from being reappointed.

SEC. 4. ***Compensation.*** All members of the Committee shall serve without compensation.

SEC. 5. ***Voting.*** Each member or his/her Committee-approved proxy shall be entitled to one vote on each matter submitted to a vote of the Committee. Members shall nominate proxies to the Committee for consideration and vote.

SEC. 6. ***Staff members.*** Staff and coordination will be provided by the health department.

SEC. 7. ***Volunteer status.*** Committee members and proxies serve on a volunteer basis to the Board of Health.

SEC. 8. ***Board of Health representative.*** The Health Officer or his/her designated representative shall act as representative of the Board of Health.

ART. IV. MEETINGS

SECTION 1. ***Regular Meetings.*** Regular meetings of the Committee shall be held on a monthly or as-needed basis.

SEC. 2. ***Special Meetings.*** Special meetings of the Committee may be held on call of the Board of Health, the Chairperson of the Committee, or by any three (3) members of the Committee.

SEC. 3. ***Notice of Meeting.*** Written notice stating the date and hour of each meeting shall be delivered or mailed to each member not less than five days before each meeting. Announcement of meetings will be made through the local media.

SEC. 4. ***Quorum.*** A quorum for the purpose of holding a meeting shall consist of not less than six (6) Committee members.

SEC. 5. ***Manner of Acting.*** A quorum present, the act of a majority of the members present shall constitute the action of the entire Committee, except as may be otherwise provided in these Bylaws.

SEC. 6. ***Parliamentary Procedure.*** *Robert's Rules of Order*[1] are adopted.

ART. V. OFFICERS

The officers of the Committee shall consist of the following and such other officers as the Committee may from time to time designate and appoint:

(a) Chairperson

(b) Vice-Chairperson

(c) Recording Secretary

(d) Executive Committee

The Chairperson shall preside at all meetings of the Committee. In the absence of the Chairperson, the Vice-Chairperson shall preside. The Recording Secretary shall supervise and present minutes at each meeting.

---

[1]Roberts, Henry N. *Robert's Rules of Order, Newly Revised* (Glenview, Ill.:Scott, Foresman & Co., 1981).

ART. VI. COMMITTEES

SECTION 1. Subcommittees may be appointed specializing in concerns relative to children, adolescents, adults, seniors, or subject matter.

SEC. 2. The Executive Committee shall report to/meet with the Board of Health periodically to report Committee efforts to the Board and to plan development/revision status.

ART. VII. TASK FORCE

Task forces may be appointed as needed to accomplish specific short-term objectives.

ART. VIII. BOOKS AND RECORDS

The Committee shall keep minutes of all proceedings of the Committee and such other books and records as may be required for the proper conduct of its business and affairs.

ART. IX. AMENDMENTS

These Bylaws may be amended at any regular or special meeting of the Committee. Written notice of the proposed Bylaw change shall be mailed or delivered to each member at least five (5) days prior to the date of the meeting. Changes in the Bylaws must be approved by the Board of Health. Bylaw changes require a two-thirds (2/3) majority vote of the Committee members present.

Source: Mid-Michigan District Health Department, Michigan, 1989

APPENDIX E

A METHOD FOR SETTING PRIORITIES AMONG HEALTH PROBLEMS

A METHOD FOR SETTING PRIORITIES AMONG HEALTH PROBLEMS

Local communities commonly face an increasing range of pressing health problems which they must meet with limited or decreasing resources. To direct these resources well, they must establish priorities among the multitude of problems confronting them. For this difficult, yet necessary, task they need a process which is fair, reasonable, and easy to use. The process should ensure that all health problems are addressed in the same way.

The most commonly used methods set priorities on the basis of the size and seriousness of the problem and the effectiveness of available interventions. Some methods also allow other factors to be considered. The method described below is a modification of a method developed by J. J. Hanlon[1]. A worksheet for use with this method is provided on page E-7. The instructions below are organized around the completion of the worksheet.

A. Rate the Size of the Health Problems

Give each health problem being considered a numerical rating on a scale of 0 through 10 that reflects the percentage of the local population affected by the particular problem--the higher the percentage affected, the larger the numerical rating. Enter the number in Column A of the worksheet.

The table below is an example of how the numerical rating might be established. The scale shown is for illustrative purposes only, and is not based on scientific or epidemiologic data; a community establishing priorities should establish a scale appropriate to the level of the health problems in that community.

Percent of population with the health problem	"Size of Problem" Rating
25% or more	9 or 10
10% through 24.9%	7 or 8
1% through 9.9%	5 or 6
.1% through .9%	3 or 4
.01% through .09%	1 or 2
less than .01% (1/10,000)	0

[1]J. J. Hanlon, "The design of public health programs for underdeveloped countries." *Public Health Reports*, Vol. 69 (Nov. 1954), p. 1028; and G. E. Pickett and J. J. Hanlon, *Public Health Administration and Practice*, 9th ed. (St. Louis: The C. V. Mosby Company, 1990), pp. 226—227.

Alternatively, the "Size of Problem" ratings could be established by giving the health problem with the highest frequency a rating of 10, the problems with the lowest frequency a rating of 0 or 1, and the other problems rated according to where they are relative to the most common or least common problems.

B. Rate the Seriousness of the Health Problems

To score the seriousness of a health problem, enter a number between 0 and 10 into Column B of the worksheet on page E-7; the more serious the problem, the higher the number. In the priority setting process being described here, the seriousness of a health problem is considered to have a greater impact than its size; for this reason, in the final calculation, the "Seriousness Rating" given will be multiplied by a factor of 2.

Every community must establish its own criteria for rating the seriousness of health problems. Once criteria for rating the seriousness of health problems have been decided on, the seriousness of every health problem must be judged against the same criteria.

The following questions may be helpful in setting criteria for rating the seriousness of health problems:

- What is the emergent nature of the health problem? Is there an urgency to intervene? Is there public concern? Is the problem a health problem?
- What is the severity of the problem? Does the problem have a high death rate or high hospitalization rate? Does the problem cause premature morbidity or mortality?
- Is there actual or potential economic loss associated with the health problem? Does the health problem cause long term illness? Will the community have to bear the economic burden?
- What is the potential or actual impact on others in the community (e.g., measles spread in susceptible population)?

An example of criteria for scoring for seriousness is shown in the table below.

How Serious a Health Problem is Considered	"Seriousness" Rating
Very Serious (e.g., very high death rate; premature mortality; great impact on others; etc.)	9 or 10
Serious	6, 7, or 8
Moderately Serious	3, 4, or 5
Not Serious	0, 1, or 2

C. Rate the Health Problems for the Effectiveness of Available Interventions

The effectiveness of interventions to reduce the health problem is an important component in priority setting. However, precise estimates are usually not available for specific health problems. It may be helpful to define upper and lower limits of effectiveness and assess each intervention relative to these limits. For example, vaccines are a highly effective intervention for many diseases; those diseases would receive a high "Effectiveness of Intervention Rating." At the other end of the scale are diseases such as arthritis, for which interventions now available are mainly ineffective. With this in mind, each health problem should be scored for the effectiveness of available interventions according to the table below, and the number entered in Column C of the worksheet.

Effectiveness of Available Interventions in Preventing the Health Problem	"Effectiveness Rating"
Very Effective 80% to 100% effective (e.g. vaccine)	9 or 10
Relatively Effective 60% to 80% effective	7 or 8
Effective 40% to 60% effective (e.g., laser treatment for diabetic retinopathy to prevent blindness)	5 or 6
Moderately Effective 20% to 40% effective	3 or 4
Relatively Ineffective 5% to 20% effective (e.g., smoking cessation interventions)	1 or 2
Almost Entirely Ineffective Less than 5% effective	0

D. Apply the "PEARL" Test

Once health problems have been rated for size, seriousness, and effectiveness of available interventions, they should be judged for the factors of propriety, economics, acceptability, resources, and legality. (The initial letters of these factors make up the acronym "PEARL," which can serve as a mnemonic for this aspect of priority-setting.) Questions to be answered for each factor are given below.

- **Propriety**—Is a program for the health problem suitable?
- **Economics**—Does it make economic sense to address the problem? Are there economic consequences if a program is not carried out?
- **Acceptability**—Will the community accept a program? Is it wanted? (For example, a smoking cessation program may not be accepted or wanted in a community whose livelihood depends on the tobacco industry.)
- **Resources**—Is funding available or potentially available for a program.
- **Legality**—Do current laws allow program activities to be implemented?

Any health problem which receives an answer of "No" on any question should either be dropped from consideration for the present or, alternatively, the reason for the "No" answer can be considered and, if it can be corrected, consideration of the health problem might continue.

Calculate Priority Scores for the Health Problems

Priority scores are calculated from the scores recorded in columns A, B, and C for each health problem, and are recorded in column D. The following formula is used for this calculation (letters represent the values in columns A, B, C, and D on the worksheet on page E-7).

$$D = [A + (2 \times B)] \times C$$

For example, suppose the following values appear in columns A, B, and C:

Column A = 6

Column B = 4

Column C = 2

The following calculation would be carried out for the priority rating to be recorded in column D:

$$D = [6 + (2 \times 4)] \times 2 = 28$$

Assign Ranks to the Health Problems

Once priority scores have been recorded for all health problems, assign a priority rank for each problem, based on the size of its priority scores, and record it in column E. For example, the health problem with the highest priority score should be given a rank of 1, the problem with the next highest priority score, a rank of 2, and so on. Health problems with the same priority score should be given the same priority rank.

Health Problem Priority Setting Worksheet

List the health problems as determined through data collection, community perceptions, or other means. Make additional copies of this worksheet, as necessary.

Health Problem	A Size	B Seriousness	C Effectiveness of Intervention	D Priority Score $(A+2B)\,C$	E Rank

APPENDIX F

A SELF-ASSESSMENT FORM FOR USE BY A COMMUNITY HEALTH COMMITTEE

A Self-Assessment Form
for Use by a Community Health Committee

The purpose of this self-assessment is to provide an opportunity for committee members to provide input to the process and the policies which govern their meetings. The results will be summarized by health department staff and distributed to the health policy board, health department staff, and the committee for consideration.

Directions:

Please indicate your agreement or disagreement with the statements below by circling the number on the scale that best represents your experience on the Community Health Committee. We prefer your responses to be anonymous, so please do *not* include your name.

	Completely Agree				Completely Disagree
1. The atmosphere is friendly, cooperative, and pleasant.	5	4	3	2	1
2. The purpose of each task or agenda item is defined and kept in mind.	5	4	3	2	1
3. Everyone participates in discussions, not just a few.	5	4	3	2	1
4. There is no fighting for status or hidden agendas.	5	4	3	2	1
5. The committee uses the resources of all, not just a few.	5	4	3	2	1
6. Members stay with the task.	5	4	3	2	1
7. The committee adjusts to changing needs and situations.	5	4	3	2	1
8. Committee members feel safe in speaking out.	5	4	3	2	1
9. Meetings have free discussion.	5	4	3	2	1
10. Interest is generally high.	5	4	3	2	1
11. Committee meetings run smoothly, without interruptions or blocking.	5	4	3	2	1
12. Meetings start and stop on time.	5	4	3	2	1

Source: Based on an adaptation from Harleigh Trecker by the Minnesota Department of Health, State Community Health Services Advisory Committee, *Community Health Services Administration Work Group Draft Interim Report,* August 1990

		Completely Agree				Completely Disagree
13.	Members seem well-informed and up-to-date and understand what is going on at all times.	5	4	3	2	1
14.	Technical terms and acronyms are clearly defined and understood by all.	5	4	3	2	1
15.	Routine matters are handled quickly.	5	4	3	2	1
16.	Sub-committee and/or other committee reports are routinely made to the entire committee.	5	4	3	2	1
17.	The committee advises and makes recommendations to the health policy board.	5	4	3	2	1
18.	The roles of health department staff in relation to the committee are clearly defined and followed.	5	4	3	2	1
19.	Materials for meetings are prepared adequately and in advance of meetings (agendas, minutes, study documents).	5	4	3	2	1
20.	Minutes accurately reflect the proceedings of the meeting.	5	4	3	2	1
21.	Members have a good record of attendance at meetings.	5	4	3	2	1
22.	I am usually clear about my role as a committee member.	5	4	3	2	1
23.	My assignments are manageable and not overburdening.	5	4	3	2	1
24.	Meeting times work well with my schedule.	5	4	3	2	1
25.	Notification of meetings is timely.	5	4	3	2	1
26.	Location of meetings is convenient.	5	4	3	2	1

27. Do you feel that your expertise or talents are being used well? If not, how could they be used more effectively?

28. What changes would make the committee more effective?

29. What changes would make serving on the committee more enjoyable?

30. Other comments and suggestions:

APPENDIX G

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APPENDIX H
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APPENDIX I

GLOSSARY

GLOSSARY

Administrative Core: The organizational infrastructure which ensures that the agency plans, organizes, manages and coordinates services within its jurisdiction to meet the collective health needs of the population in an effective and efficient manner (APHA, 1985).

APEX*PH*: Assessment Protocol for Excellence in Public Health.

Board of Health: The governing authority of a local health department, usually comprised of a chair and board members. The chair and board members can be either appointed or elected, and may or may not serve at the discretion of another elected official; for example, the mayor, or the voters in a particular jurisdiction.

Community: In general, all of the individuals within the jurisdictional area served by a local health department. In certain cases, this may cross city and county lines.

Community Health Committee: A committee, discussed in Part II, created to work with a health department for community health assessment and the generation of a community health plan.

Community Support: Actions undertaken by those who live in a community which demonstrate the need for and the value of the local health department. Community support often consists of, but is not limited to, participation in the services provided, active solicitation of elected and state officials for expanded services, participation at board meetings, support for services now being provided that are threatened to be curtailed or eliminated, and other activities which show that the community is pleased with the activities being performed by the local health department.

Contributing Factors (Direct and Indirect): "Those factors that, directly or indirectly, influence the level of a determinant" (CDC, Atlanta).

Determinants (or Risk Factors): "Direct causes and risk factors which, based on scientific evidence or theory, are thought to influence directly the level of a specific health problem" (CDC, Atlanta).

Director of Health: The person responsible for the total management of a local health department. This person may be appointed by the board of health or may have assumed the position by some other legal means. The director of health is usually responsible for the day-to-day operations of a local health department and its

component institutions, often sets policy or implements policies adopted by the Board of Health, and is responsible for fiscal and programmatic matters.

E.P.A.: The U.S. Environmental Protection Agency, an agency of the federal government charged with protecting the environment.

Epidemiology: "The study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to control of health problems." (Last, 1988[1]).

Executive Staff: The director of a health department, along with his/her assistants, finance officers, personnel directors, etc.

Health Care Provider: A person, agency, department, unit, subcontractor or other entity that delivers a health related service, either for payment or as an employee of a governmental or other entity. Examples include hospitals, clinics, free clinics, the local health department, etc.

Health Problem: A situation or condition of people or the environment measured in death, disease or disability which is believed will exist in the future and which is considered undesirable.

Local Control: The ability of a jurisdiction to adopt and enforce its own rules, policies, and procedures related to carrying out its functions. An example is a local health department that is not under the jurisdiction control of a state health department or state governmental unit.

Local Health Department: "...an official (governmental) public health agency which is in whole or in part responsible to a sub-state governmental entity or entities. The latter may be a city, county, city-county, federation of counties, borough, township, or any other type of sub-state governmental entity. In addition, a local health department must: have a staff of one or more full-time professional public health employees [e.g., public health nurse, sanitarian]; deliver public health services [e.g., immunization, food inspection]; serve a definable geographic area; and have identifiable expenditures and/or budget in the political subdivision(s) it services." (ASTHO, 1983)

Local Health Officer: See Director of Health.

Local Public Health Authority: The agency charged with responsibility for meeting the health needs of the community. Usually this is the Board of Health and its administrative arm, the local health department. This authority may rest with the

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[1]Last, John M. *A Dictionary of Epidemiology*, edited for the International Epidemiological Association, 2nd ed. New York: Oxford University Press, 1988.

Board of Health, may be a city/county/regional authority, or may consist of a legislative mandate from the state. Some local public health authorities have independence from all other governmental entities, while others do not.

Management Staff: Senior level officials, such as directors of component programs within a local health department.

Personal Health Services: Services provided to individuals, rather than the community as a whole. An example is the maternal and child health programs provided by many local health departments.

Professional Staff: Those personnel assigned to perform duties and execute the responsibilities as mandated by the board of health or other governmental entity. Examples of professional staff include: directors, doctors, nurses, public health educators, auditors, etc. They are distinguished from support staff [e.g., secretaries, clerks] by education and certifications.

Public Health: (many alternatives) ". . . the science and the art of preventing disease, prolonging life, and promoting physical health and mental health and efficiency through organized community efforts toward a sanitary environment; the control of community infections; the education of the individual in principles of personal hygiene; the organization of medical and nursing service for the early diagnosis and treatment of disease; and the development of the social machinery to ensure to every individual in the community a standard of living adequate for the maintenance of health." (C.-E.A. Winslow[1])

Public Health Services: The provision of services which are targeted to meet the health needs of the community.

Risk Factor: See Determinants

Self-Assessment: Evaluation without assistance from outside parties. In the case of APEX*PH*, self-assessment means that the local entity performs the work itself, and does not have any other entity, either governmental or otherwise, perform the assessment.

Self-Help: The idea of providing for oneself in the absence of other viable alternatives (political, economic, social).

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[1]Winslow, Charles-Edward Amory. *Man and Epidemics.* Princeton, N.J.: Princeton University Press, 1952.

Surveillance: The systematic collection, analysis, interpretation, and dissemination of health data to assist in the planning, implementation, and evaluation of public health interventions and programs.

APEX*PH* WORKBOOK ORDER FORM

The APEX*PH* Workbook can be xeroxed; however, if you would like additional copies, NACHO and USCLHO members may purchase APEX*PH* Workbooks at a cost of $15.00 per copy. All other organizations may obtain copies of APEX*PH* for $20.00 each.

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__USCLHO Member.

__Please send___ copies of APEX*PH* at $20.00 each; I represent another organization.

__I represent a local health department who has not received a complimentary copy of the workbook. Please send me my one free copy.

I will be__implementing the APEX*PH* Workbook;__using APEX*PH* as a reference book.

Return this form to:

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Washington, D.C. 20001

An invoice will accompany the Workbook; please pay upon receipt.

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