



**Ohio Department of Health (ODH)
Division of Family and Community Health Services (DFCHS)
Bureau of Child and Family Health Services (BCFHS)
Child and Family Health Services Program (CFHS)
Program Standards
2014**

Community Health Assessment and Program Planning Standards

Adapted from Community Health Assessment: A Practical Guide
By Ruth Shrock, Ohio Department of Health (1999)

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What is Community Health Assessment?

Community health assessment and program planning is the on-going process of identifying and analyzing a community's health problems, needs and assets, as well as its resources and capacity to address priority needs. Information obtained for the community health assessment is used to set priorities and to make decisions about program or organizational improvement and allocation of resources through the development of a community health action plan.

Community health assessment and program planning are an integral part of Child and Family Health Services (CFHS) programs. All applicants for CFHS funds are required to conduct and document Community Health Assessment activities.

Community health assessment and program planning is not an end product in itself, but is part of a process that provides information that is on-going and continuously monitored. There are many models for community health assessment. This model - Community Health Improvement Cycle, developed by ODH, (CHIC – Figure 1) uses the following nine steps:

1. Self-assessment (capacity assessment)
2. External assessment
3. Partnership building
4. Planning for data collection
5. Data collection and analysis
6. Priority setting
7. Intervention planning
8. Implementation
9. Evaluation

The community health assessment and program planning process can be used for a variety of purposes. Use the steps outlined above to select and address locally significant public health issues affecting targeted populations, such as access to care, disparities in health status, service gaps, specific health conditions and prevention activities.

There are four basic roles for public health agencies in the community assessment process:

- Leadership:
 - Establishing work groups
 - Cultivating partnerships
 - Setting work group agendas
 - Maintaining momentum throughout the process
- Collaborating partner:
 - Coordinate with other local organizations
 - Share data and other resources
- Source of technical assistance/consultation:
 - Share expertise in data collection/analysis

- Resource for data:
 - Health data
 - Program data

Community health assessment answers some important questions about the needs of people living in your community. These are:

- Who is in need?
- What are their needs?
- Where are the target populations in need?
- Why do the target populations have their needs? What contributes to or is related to these needs?
- How are the needs being addressed now? By whom, where, and how often?
- What are the unmet needs?

Community health assessment also answers questions about the strengths and assets of people living in your community:

- How have people or communities been meeting their own needs?
- What skills and talents can people bring to the table to meet identified needs and make a contribution to their community?
- And finally, after the program has been established - so what that we developed programs to address identified needs? What has changed and to what extent?

The benefits of community assessment are:

- Foundation for rational planning, action and evaluation.
- Promotes collaborative action.
- Avoids duplication of efforts.
- Guides appropriate use of scarce resources.
- Promotes community wide concerns about appropriate access and care.

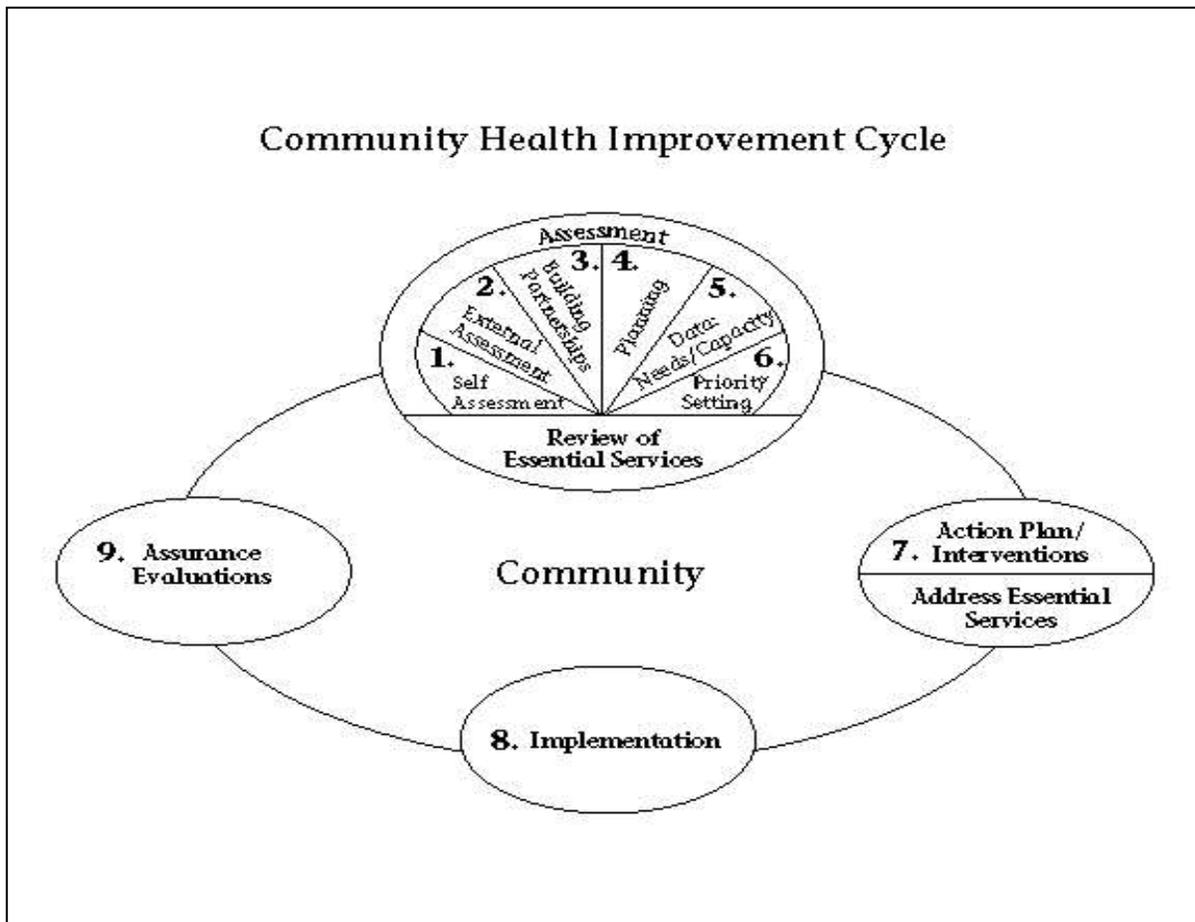


Figure 1

Community Health Assessment and Planning Component

Community Health Assessment (CHA) is the ongoing process of identifying and analyzing community’s health problems, needs and assets, as well as its resources and capacity to address priority needs. The purpose of the CFHS CHA is to identify these health problems, needs and assets in order to better the MCH related programs in the community. There are many recognized models for CHA, including the nine-step Community Health Improvement Cycle (CHIC) model, developed by ODH. All CFHS agencies are required to conduct a Community Health Assessment and report on its progress, but are not required to apply for CHA funding.

Eligibility and Justification: All applicants are eligible to apply for Community Health Assessment dollars. Applicants must describe the results of internal and external assessments regarding their capacity to take part in the Community Health Assessment process. If the applicant agency does not have primary responsibility for the Community Health Assessment in the community, applicants must describe the agency’s role in the health assessment process and how the applicant will collaborate with the lead agency during the assessment.

Measures: Measures are set by ODH. Applicants must use only those *measures* identified by ODH and their corresponding *benchmarks* for each *strategy*. *Measures* and *strategies*, along with their corresponding *eligibility criteria* and *benchmarks*, are listed on the CFHS Components Grid. Each *strategy* listed reflects an evidence-based community health assessment process. *Benchmarks* have been developed for all CFHS components and are used to measure progress toward achieving CFHS goals. Please note that proposed *benchmarks* cannot be altered.

Reporting

Successful applicants are required to report on progress towards completing activities and reaching benchmarks in ***mid-year*** and ***annual progress reports***. In addition to reporting in the program plan, applicants will be required to submit a more detailed narrative explanation of progress related to each activity and benchmark on strategy-specific worksheets.

Step One

Self Assessment (Organizational Capacity and Readiness)

Self-Assessment is an appraisal of the capacity and/or readiness of a health department or other organization to initiate and participate in a Community Health Improvement Cycle (CHIC). The value of a capacity assessment is that it provides the organization the opportunity to: 1) recognize the need to build capacity; 2) examine strengths and weaknesses; and 3) initiate long-term planning to bridge gaps. Self-assessment tells the organization whether technical, financial and/or staff support are available; whether the governing or other executive body is supportive; and whether capacity needs are completely understood.

Self-assessment should be done by all organizations considering some type of involvement in a CHIC. ***Health departments, both state and local, have a responsibility to play a central role in the CHIC.*** Do a capacity assessment at least every five years to monitor your capacity for CHIC.

Before starting any data collection process or analyzing existing data, it is important to determine the purpose(s) of the needs assessment. With the help of community partners, consider the reasons for and expected benefits of the needs assessment.

Will the needs assessment:

- Fulfill the requirements of an existing grant?
- Build a constituency for public health issues?
- Coordinate private, managed care and public sectors?
- Establish a “baseline” community health status?
- Update existing health related data?
- Prioritize and/or establish programs?
- Fulfill requirements of a proposal for additional funding?

- Full expectations of administration/legislation?
- Collect valid/reliable data?
- Monitor/evaluate existing programs?
- Justify budget (maintenance/expansion/reallocation)?

The self-assessment involves a dialogue among staff concerning the internal strengths and limitations of the department. The degree to which the department possesses key attributes can influence its level of involvement in a community health assessment process.

So that you can evaluate this step in the process later, you should document:

- How you did your self assessment (process)
- What went well?
- What would you improve when you do it again?
- How did you address any concerns or deficiencies your agency identified?
- What were the challenges and how did you deal with them?

Step Two

External Assessment

External assessment determines to what degree adequate organizational and individual commitments and resources are available and if your community is ready to undertake a community assessment.

The goals of external assessment are: 1) to identify other organizations in the community that may already be involved in a CHIC process or who have access to key health-related data; 2) to form a steering committee that will identify the formal coalition/partnership to implement the CHIC; and 3) to assess the competencies and capacities of the local public health system.

Some important factors to consider:

- Support from key leaders, local champions and political stewards is key.
- Collaborations and partnerships within the community are critical.
- Involve key stakeholders early.
- Appointing a local coordinator to facilitate the process is crucial.
- Continued commitment to implement community based programs which respond to the assessment's findings is necessary.

The role of the health department is to:

- Convene/initiate the process.
- Assess interest among partners in working together.

- Explain the concept and process of community health assessment. Know why you are acting to that you can encourage others. You are the advocate for the process at this point.
- Identify members of a partnership or coalition to carry out the process and tasks of a community health assessment.

The process of external assessment includes the following steps:

- Identify at least three or more organizations to provide support and resources.
- Meet together to identify the following:
 - Members of a planning group/steering committee.
 - A refined definition of what you want to do.
 - A temporary lead agency to sponsor the first few meetings of the coalition and a temporary chair of an ad hoc steering committee to begin the process.
 - Champions and advocates.
 - Community/consumer partners for the coalition.
- Develop letters that specify the nature of the support needed and the length of the commitment.
- Have the person on your team with the most rapport with the potential partner make the first contact.

Step Three Partnership Building

A partnership, often better known as a coalition or a consortium, is a group of organizations and individuals working together in a common effort for a common purpose to make more effective and efficient use of resources.

A partnership is essential to ensuring community ownership in the Community Health Improvement Cycle (CHIC) process. It is or should become the community structure for planning and carrying out the CHIC.

Coalitions offer potential advantages over working independently – they can:

- Conserve resources.
- Reach more people within a community than a single organization.
- Accomplish objectives beyond the scope of any single organization.
- Have greater credibility than individual organizations.
- Provide a forum for sharing information.
- Foster personal satisfaction and help members to understand their jobs in a broader perspective.
- Foster cooperation among grassroots organizations, community members and large health organizations.

Choose partners in the community based on needed resources and political realities. The appropriate mix of participants must be assembled to engage in planning. This partnership group/coalition is essential to ensuring community ownership in the process. The following is a list of potential partners:

- Agricultural extension services.
- Businesses, Chamber of Commerce.
- Charitable organizations.
- Civic/service groups.
- Government officials (mayor, commissioner).
- Health agencies.
- Health councils/coalitions.
- Human service organizations.
- Labor unions.
- Medical facilities.
- Medical societies.
- Mental health services.
- Neighborhood associations and leaders.
- Older adult groups.
- Faith organizations.
- Professional associations.
- Public safety agencies (police, fire).
- Schools, colleges and universities.
- Social service agencies

Key steps in building effective coalitions

1. Analyze the purpose.
 - Make sure it is clearly articulated.
 - Purpose may change over time in response to member needs.
2. Recruit the right people
 - Consider people who can:
 - Move through community channels.
 - Speak on behalf of their organization.
 - Shape community attitudes and opinions.
 - Identify what the community needs.
 - Bring energy and commitment to the process.
 - Bring resources (e.g., funds, expertise, data).
3. Devise a set of preliminary objectives and activities.
4. Convene the coalition.
5. Anticipate the necessary resources:
 - Time commitment.
 - Support (financial, staff).

6. Define elements of a successful coalition structure:

- Coalition life expectancy.
- Meeting location, frequency and length.
- Membership parameters.
- Decision making process.
- Meeting structure/agendas.
- Participation between meetings.

7. Choose the leadership.

8. Make improvements through evaluation.

Before beginning a new coalition, it is important to determine whether a coalition already exists that is dealing with the problem. There can be serious negative consequences if a new coalition is viewed as attempting to preempt, replace or duplicate an existing situation. Given the energy and time it takes to create and maintain a coalition, new efforts need to take pre-existing interactions into consideration.

To be addressed in proposed activities for this strategy in the CFHS Program Plan

- What is the purpose of your consortium/coalition? How will your coalition accomplish its purpose?
- Who are the stakeholders/partners that will be involved in the coalition? How will they be recruited?
- How do you plan to evaluate the effectiveness of the coalition (i.e., retention of members, attendance at meetings, and progress towards goals)?

To be addressed only in mid-year and annual reports:

- What were the key strengths and weaknesses of your consortium/coalition with regard to accomplishing goals and achieving its purpose?
- Were all key stakeholders (including consumers) actively participating in the CHA process? Please state their roles and those in the leadership role. Were any key stakeholders left out of the process? Why?
- What were the results of meetings held? Have any future meetings been planned?

Step Four Planning

Plan the needs assessment in order to know what information to gather. Planning is a prospective process that moves us into organized action. Planning doesn't guarantee success, but lack of planning can lead to failure. Planning is essential for each step of the community health assessment process.

This step involves the following questions:

- What do we want to know about our community's health?
- How will we find the information to answer these questions?
- How does our community's health compare to other communities, the state and the nation?
- What are the issues/problems we should analyze further?

There is no one right way to collect, analyze and interpret the data needed for a community health assessment. Methods for gathering the necessary information are almost unlimited.

The following are guidelines to assist in this process:

- Review the purpose.
- Develop a mission statement and goals.
- Agree on critical issues to be examined.
- Define the community.
- Determine the types of needs to be assessed.
 - Normative (compares health indicators to a desired standard).
 - Perceived (as indicated by community members).
 - Expressed (utilization – who seeks/uses services).
 - Relative (equity of services).
- Decide on what indicators will be used:
 - Demographic data (number and types of people in population).
 - Health profile (health status indicators).
 - Sociocultural profile (social conditions and cultural characteristics that influence and reflect the health and well-being of a community).
 - Lifestyle/health behaviors (risk reduction indicators).
 - Environmental hazards.
 - Resource profile (monetary, human, physical and social community resources):
 - Services/programs in other systems (e.g., government, schools).
 - Civic capacity (e.g., citizen participation, community leadership).
- Select approaches to assess data availability.
- Determine what data are available and acceptable for identified data needs:
 - Core data elements.
 - Optional data elements.
 - Secondary data (existing data collected for another purpose).
 - New data.
 - If you plan to collect primary data, e.g. conducting a survey, you will need to make sure you budget for this activity as well as include it in your timeline.
- Select data collection methods to use:
 - Quantitative data (measurable and objective – numbers/statistics).
 - Qualitative data (subjective – opinions, insights, views).

- Prepare a timeline.
- Collect information.
- Analyze data and summarize other information.
- Prepare a report.
- Estimate the cost/budget for the process.
 - Working with partners (e.g., hospitals, United Way, ADAMH Boards, Family and Children First Council) to share costs and/or conduct additional fund-raising can help support the financial demands of conducting a comprehensive community health needs assessment. CFHS funds may be used to support the work of an epidemiologist/researcher to assist with data-related processes.

To be addressed in proposed activities for this strategy in the CFHS Program Plan:

- What health assessment model will be used to implement community health assessment in your county?
- What role will your agency play in the community health assessment process in your county?
- Who will develop and oversee the CHA strategies in your work plan?

To be addressed only in mid-year and annual reports:

- What is the timeframe in which you plan to implement the various steps of community health assessment over the long term?

Step Five

Data: Needs/Capacity

Data are needed to document the community's health status, its needs and its resources and capacity for improving the health of all its citizens.

Data are collected to describe “what is” in a community and to compare this to “what ought to be”. Data do not “speak for themselves”. They must be analyzed and interpreted. A critical part of the assessment process is translating data about problems, risk factors, resources and costs into terms that facilitate decision making. An even more critical step is melding the “numbers” data with the perceived needs and wishes of the community into that decision making process.

Uses of data in the needs assessment process:

- Monitoring long term trends.
- Identification of differences in health status within racial or other subgroups of the population.
- Monitoring deaths that are generally considered preventable.
- Conducting health planning activities.

- Monitoring progress toward achieving improved health of the community's population.
- Developing ideas regarding possible causes or correlates of disease.
- Informing and advising managers, policy makers and the public.

There are many types of data; you will need to determine which types are most useful to you in your assessment activities.

Primary data is information collected first hand, e.g., surveys, focus groups and key informant interviews. Collecting primary data (quantitative or qualitative) may be expensive and time consuming, but may be a good choice if no other sources are available.

Secondary data refers to information gathered by another source which is then made available to you, e.g. epidemiologic surveys, vital statistics and US Census. Using secondary data is less expensive and generally requires less time than collecting primary data.

Population data describes characteristics (demographics, health status) of the group in which you are interested, e.g. state, county or city level.

Program data includes clinical and demographic information about individuals being served by health programs. These data describe only the group you are serving, which may differ significantly from the general population in your area.

When the data collection activities and surveys are done, the big question is – what to do next? After gathering data from various sources, you'll need to spend time reviewing the findings. The time needed is proportional to the amount of data gathered.

Steps in data analysis, interpretation and presentation:

- Organize the data.
- Review the pool of data with planning group members.
- Develop guidelines for analysis of quantitative (numbers, statistics):
 - Before developing your own guidelines, check with your state health agency or with funding sources to determine if standardized requirements, e.g. data on specific populations or health indicators, have already been developed.
- Develop guidelines for analysis of qualitative (opinions, focus groups) data.
- Consider data quality:
 - Verify reliability and validity.
 - Describe limitations and biases of data.
- Look at the data for overall patterns and trends.
- Look at the data for detailed information:
 - Descriptive statistics (mean, mode, median).
 - Inferential statistics (to make conclusions about a population based on information from a sample).
 - Use graphs to illustrate trends.
- Present data as meaningful information:

- Provide easy to understand descriptions and tables to demonstrate the most important data items.
- Tailor the presentation to the audience.
- Know what you would like to accomplish with your data and focus your discussion on these desired outcomes.

Putting it Together: Problem/Issue Identification

From a broad look at the data and information you have just collected, you can identify problems that can be further prioritized by the planning group as issues that need attention in your community. You will then further clarify and define this list of problems.

What problems exist for individuals?

Where do the problems exist?

Who seems to be the most affected?

How big is the problem (compared to the state or nation)?

How many are affected?

Is the community growing?

What is the economic profile of the community?

What health resources does the community have?

What strengths and assets do community members have to address some of the issues identified during the community health assessment process?

You should identify and address potential obstacles to the effective use of community health assessment results; for example, a conflict between the data and the community's perception of a health problem, organizational problems, resistance to change and pressures from specific interest groups. Your main interest should be on problems that can be impacted by the health community, though advocacy for other issues may be appropriate.

To be addressed in proposed activities for this strategy in the CFHS Program Plan

- What critical issues will be examined through the needs assessment process? How do these issues relate to your agency's mission statement and goals? What indicators will be used?
- What are the data gaps and/or barriers to data collection? How will they be addressed?
- Who will be responsible for overseeing the data collection process?
- How will your data be collected (e.g., primary data, secondary data, quantitative, qualitative)?

To be addressed only in mid-year and annual reports:

- What are the key findings/preliminary results of the data analysis?
- What are the key findings/preliminary results of the capacity assessment?

Community Health Assessment Data Indicators

The following are data indicators to be used as part of the Community Health Assessment and included in the CFHS grant application.

Provided in the CFHS and FP Health Status County Profile:

http://www.odh.ohio.gov/odhPrograms/cfhs/cf_hlth/cha/hsprofiles.aspx

Demographics

- Race
- Ethnicity
- Non-English spoken at home
- % Persons <100%FPL
- % Children <100%FPL
- % High School degree or higher
- % Bachelor's degree or higher
- % Children uninsured
- % Adults uninsured
- % Births paid by Medicaid
- % Children enrolled in Medicaid
- % Families female headed with children
- # Women 13-44
- # Women in need of publicly funded contraception
- # Physicians (MD, DO)
- Health Professional Shortage Area (yes/no)
- # Free clinics
- #FQHCs

MCH Data

- Total Births
- % Low birth weight
- % Very low birth weight
- % Preterm births
- % Very preterm births
- % Maternal smoking
- % Late prenatal care
- % Unmarried
- Teen birth rate (15-17 years old)
- Infant mortality rate
- Breast cancer rate
- Cervical cancer rate
- Uterine cancer rate

- Ovarian cancer rate
- Testicular cancer rate
- Lung cancer rate
- Chlamydia rate
- Gonorrhea rate
- # HIV infection diagnoses
- # Living with HIV/AIDS
- # Children screened for lead poisoning
- % Children with elevated blood lead level
- % Children ages 2-5 who are overweight

Additional Indicators Recommended for Inclusion in Community Health Assessment

- Description of racial and ethnic disparities in health indicators
- Alcohol use during pregnancy
- Unintended pregnancy rates
- Pre-pregnancy BMI of mothers
- Gestational weight gain of mothers
- Estimates of diagnosed diabetes in adults
- Percentage of mothers experiencing violence, abuse, or stress before or during pregnancy
- Breastfeeding rates (ever and at 6 months)
- Rate of untreated dental caries in children
- % Children with dental protective sealants
- Child Fatality Review data, e.g., # child deaths by manner and cause, age, race and gender, deaths from medical causes, deaths from external causes, preventability
- Child immunization rates
- Child asthma rates
- Access to hearing and vision specialty providers

Step Six Priority Setting

Priority setting allows a community to consider their most pressing problems, because resources are not likely to be available to address all problems identified.

After health problems that seem important for a community are identified, an objective method to rank or prioritize those problems is needed so that the most important can be addressed first. A community's efforts will be more likely to be effective if they are focused on a limited number of concerns. Priorities are unique to the community that creates them. A priority for one community is not necessarily a priority for another.

Community leadership must be involved in the prioritization process. Their participation will foster active community ownership and commitment to the priority health problems. The entire partnership/planning group, including health care, human services and business sectors will need to work together to select and address priorities since many health problems are the result of multiple factors.

A formal prioritization process assures and documents a rational allocation of resources where most needed and creates a systematic, fair and inclusive process.

There is no one "right way" to set priorities, but it is important to apply the same selection criteria to all problems.

1. Define the problem in a way that all participants can understand.
2. Select criteria to assess the magnitude of the problem. Various criteria can be used, including:
 - Is the problem amenable to intervention proven effective by research?
 - Is there a high incidence or prevalence of the problem?
 - How many people are affected by the problem?
 - How severe are the consequences?
 - What is the community's perception of the problem?
 - What resources are available to deal with the problem?
 - How costly is the intervention?
 - Are trends with the problem increasing?
 - How much media coverage has the problem received?
 - What do focus group results tell us about the problem?
 - What is the economic burden to the community?
 - What is the amount of premature death associated with this problem?
 - How preventable is the problem?
 - How does our community compare regarding this problem to other communities/state/nation?

3. Rank the problems according to the assessment completed using your selected criteria. This can be done using a scoring mechanism or can be more subjective, with group members assigning priorities to each problem and then coming to consensus.

To be addressed in proposed activities for this strategy in the CFHS Program Plan

- What prioritization method/process will your coalition use? Who will be involved in the prioritization process? Who will facilitate the process?
- What criteria will be utilized to assess the importance of the problems being ranked?

To be addressed only in mid-year and annual reports:

- What are the results of the prioritization process?

Step Seven Intervention Plan

An intervention is a strategy, a usable plan of action, or program developed to achieve a preplanned purpose such as the improvement of health, knowledge, behavior, attitudes and practice.

Interventions are developed after the prioritization of health problems has been completed. It is important now to think through the entire sequence of interacting factors that contribute to the problem, to identify community resources to address the problem, and to identify barriers to reducing the problem. You are then ready to develop one or more specific interventions or corrective actions intended to reduce the problem.

The community health assessment should translate into a clear plan of action to improve the community's health. The following steps will lead to that plan of action:

- Identify and prioritize the top five (or so) health problems/concerns:
 - Priorities can be selected for various target populations of interest.
- Assign the problems to be addressed to community workgroups.
- For each problem to be addressed, the work group should identify:
 - Precursors and root causes (the "whys"):
 - Literature review.
 - Local expert opinion.
 - Target community (population) for intervention.
 - Appropriate interventions.
 - A priority for CFHS is to integrate evidence-based programs/interventions into the CFHS system(s) of care. The Association of Maternal and Child Health Programs (AMCHP) provides information about best practices as well as resources on the AMCHP web site. www.amchp.org

- <http://www.amchp.org/programsandtopics/BestPractices/Pages/default.aspx>
- <http://www.amchp.org/programsandtopics/BestPractices/Pages/BestPracticeTerms.aspx>
- <http://www.amchp.org/programsandtopics/BestPractices/Pages/Resources.aspx>
- Community resources.
- Timeline and work plan.

Steps to developing an intervention:

1. Decide what needs to happen.
 - What behavior needs to change in what population?
 - What environmental changes need to occur?
 - What are our resources?
2. Gather information about the level of the problem.
3. Decide who the intervention should help.
4. Involve potential clients or end users of the intervention.
5. With these potential clients, identify the issues or problems you will attempt to solve together.
6. Analyze these problems or the issue to be addressed in the intervention.
7. Set goals and objectives.
 - Process
 - Outcome
 - Objectives should be “SMART”
 - Specific (specify what they should achieve)
 - Measurable (must be able to assess if you are meeting the objective)
 - Achievable (are the objectives attainable?)
 - Realistic (can you achieve objective with available resources?)
 - Time (when should objective be met?)
8. Learn what others have done.
 - Literature review
 - Promising/best practices
9. Brainstorm ideas of your own.
10. Try to decide what interventions or parts of interventions have worked and how they may be applied to this problem.
11. Identify barriers and resistance you may encounter.
12. Identify core components and elements of the intervention.
 - Providing information and skills training
 - Enhancing support and resources
 - Modifying access and barriers
 - Monitoring and giving feedback
13. Develop an action plan to carry out the intervention.
 - Build in evaluation plan

- Timelines
 - Work plan
14. Pilot-test your intervention.
 15. Implement your intervention.
 16. Constantly monitor and evaluate your work.
 17. Formulate ways to continue the intervention plan's activities after sources of funding have terminated.

To be addressed in proposed activities for this strategy in the CFHS Program Plan

- How will the workgroup identify appropriate interventions/best practices and community resources?

To be addressed only in mid-year and annual reports:

- What public health interventions have been chosen and why were they chosen?

Step Eight Implementation Plan

Implementation includes all the ways your intervention/action plan/program plan will be executed, including financing, marketing and building coalitions of appropriate agencies/individuals to carry out your stated objectives and activities. If the steps to get community buy-in were undertaken in the development of the intervention plan, there is more likelihood of community ownership in the process. The community must own the plan if it is to be successfully carried out.

Successful program implementation depends on the following:

- Integrating education, policy and environmental strategies to provide effective interventions.
- Working within community or governmental systems to effectively and efficiently improve large segments of the community.
- Starting simple and building on successes.
- Using different channels, methods and sources to capture the attention of many types of people.
- Tracking the activities for the purposes of program management, evaluation, modifying program components and efficiency of resources.
- Strengthening the advisory group/coalition and supporting and training program volunteers to enhance their productivity, effectiveness and satisfaction.
- Reporting to the community/working with the media to inform stakeholders and the community; to promote program activities; to advocate for systems and environmental changes and to solicit support for the programs.

Executing the Intervention:

1. Prepare your community for any changes resulting from implementing your action plan.
2. Turn responsibility for implementing the action plan to organizations identified in the plan.
3. Develop an implementation work plan.
4. Develop a master budget or individual agency budgets to be integrated into the work plan.
5. Involve coalitions.
6. Evaluate as you go.
7. Realize that assessment is an on-going process. Meet at regular intervals to review progress and make changes as needed.

To be addressed in proposed activities for this strategy in the CFHS Program Plan

- Who is responsible for carrying out intervention implementation?
- How will the community be prepared for changes resulting from implementation?

To be addressed only in mid-year and annual reports:

- Have interventions been successfully implemented? Have there been any barriers to implementation?

Step Nine Evaluation

Evaluation is the process of collecting and examining information (quantitative and qualitative) to determine the accomplishments, strengths and weaknesses of an intervention, a plan or program. In the simplest terms, evaluation is a process or activity that involves assessing or measuring the value of something. Evaluation answers the questions: “Are we doing the right things?” and “Are we doing things right?”

Evaluation is a management tool to improve programs/strategies; to do this, evaluation should be integrated into program planning from the very beginning. Evaluation encourages critical up-front thinking about program goals and objectives and appropriate measures of success. Evaluation should be conducted at two levels: 1) process – looks at the tasks and procedures of the program and 2) outcome – looks at the results/changes in the target population from the program.

Different evaluation questions need to be asked at different phases of program development. The questions for new programs are different than for programs that are in mid-stages of implementation or that are more mature. Evaluation is an evolving, iterative process.

Why Evaluate?

- Determines whether and how well program objectives are met.
- Determines strengths and weaknesses of program for decision-making and program planning.
- Establishes a level of quality assurance and control.
- Meets the demand for public or fiscal accountability.
- Improves staff skill in program planning, implementation and evaluation.
- Promotes positive public relations and community awareness.
- Fulfills grant or contract requirements.

Levels of Evaluation

Formative:

- Takes place after a program is designed but before it is broadly implemented.
- Examples: readability tests, focus groups, individual in-depth reviews.

Process:

- Mechanism for checking on the progress of activities.
- Answers questions such as:
 - How well did we plan?
 - How are individual activities progressing?
 - Is the intended audience being reached?
 - Are people responding?
 - Are there any problems or issues that need to be worked out?

Outcome:

- Determines whether program/intervention is making a difference/has an effect.
- Results can justify need for additional or continued funding.
- Results can be used to improve and revise an on-going program

To be addressed in proposed activities for this strategy in the CFHS Program Plan

- How will evaluation methods be employed (differentiating between process and outcome evaluation efforts) for each intervention?
- Who will oversee evaluation efforts? What experience and skills does this person have related to evaluation?

To be addressed only in mid-year and annual reports:

- What are the preliminary results of the evaluation? Have any challenges or barriers prevented adequate evaluation of interventions?

Evaluating the Community Health Assessment Process

An evaluation of the community health assessment process will yield useful insights for improving future assessment efforts or for up-dating prior efforts. To evaluate the community health assessment process, look at the nine step cycle and develop questions for each step. An example is provided below.

| The Nine Step Cycle | Sample Questions for Each Step |
|-----------------------------|------------------------------------------------------------------------------------------------------------------------------|
| Self-Assessment | What was our capacity to carry out the community assessment process? Did we have support of agency management/Board etc.? |
| External Assessment | What were the existing strengths of the community in regard to community assessment? |
| Partnership Building | What worked? Lessons learned? |
| Planning | Was a written plan developed? Was there ownership in the plan? Were community members involved in its development? |
| Data: Needs/Capacity | Were data available? What were the problems in collecting needed data? |
| Priority Setting | Was there consensus on priority problems? |
| Planning for Implementation | Was problem analysis done before deciding on interventions? |
| Implementation | Were written plans for implementation developed? Was funding available to implement the plan? |
| Evaluation | Did evaluation of the community health assessment process include a look at the process, the results and the outcome? |

Resources

http://www.odh.ohio.gov/odhprograms/cfhs/cf_hlth/cha/commhealth.aspx

<http://development.ohio.gov/files/research/C1001.pdf>

www.cdc.gov/nchs

www.healthypeople.gov

www.cdf.ohio.org

www.kidsohio.org

www.census.gov

<http://peristats.modimes.org>

www.cdcnpin.org

<http://www.thecommunityguide.org/default.htm>

www.naccho.org

<http://www.astdd.org/>

<http://ask.hrsa.gov/>

<http://www.citymatch.org/>

<http://www.amchp.org/Pages/default.aspx>



Appendix: CHA Planning and Reporting Guide

| | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|
| Review this checklist at mid-year and year end. Use it as a guide to ensure each strategy is addressed in the program plan and/or narrative. | Completed |
| Step 1: Internal Assessment | |
| <ul style="list-style-type: none"> Summary of internal assessment results submitted to ODH. | |
| Step 2: External Assessment | |
| <ul style="list-style-type: none"> Summary of external assessment results submitted to ODH. | |
| Step 3: Build Partnerships | |
| <ul style="list-style-type: none"> Summary of key strengths and weaknesses of the consortium/coalition in regards to accomplishing goals and achieving purpose submitted to ODH. | |
| <ul style="list-style-type: none"> Status of key stakeholder's involvement submitted to ODH. (i.e. did they all participate?) | |
| <ul style="list-style-type: none"> List of key stakeholder's roles submitted to ODH. | |
| <ul style="list-style-type: none"> List of key stakeholders left out of the process submitted to ODH. | |
| <ul style="list-style-type: none"> Summary of the results of consortium meetings submitted to ODH. | |
| <ul style="list-style-type: none"> Plan for future meetings submitted to ODH. | |
| Step 4: Planning | |
| <ul style="list-style-type: none"> Progress updates to CHA plan submitted to ODH. | |
| <ul style="list-style-type: none"> Plan for timeframe of implementation of CHA steps over time submitted to ODH. | |
| Step 5: Assess Data Needs/Capacity | |
| <ul style="list-style-type: none"> Overview of Data collection plan submitted to ODH | |
| <ul style="list-style-type: none"> Summary of key findings/preliminary results of data analysis submitted to ODH. | |
| <ul style="list-style-type: none"> Summary of key findings/preliminary results of capacity assessment submitted to ODH. | |
| Step 6: Conduct Prioritization | |
| <ul style="list-style-type: none"> Summary of the results of the prioritization process submitted to ODH. | |
| Step 7: Plan Interventions | |
| <ul style="list-style-type: none"> Overview of Intervention plan submitted to ODH | |
| <ul style="list-style-type: none"> Summary of public health interventions and reasons they were chosen submitted to ODH. | |
| Step 8: Plan Implementation | |
| <ul style="list-style-type: none"> Overview of Implementation plan submitted to ODH | |
| <ul style="list-style-type: none"> Summary of implementation results submitted to ODH. | |
| <ul style="list-style-type: none"> Summary of barriers to implementation submitted to ODH. | |
| Step 9: Conduct Evaluation | |
| <ul style="list-style-type: none"> Overview of Evaluation measure and results submitted to ODH | |
| <ul style="list-style-type: none"> Summary of preliminary evaluations results submitted to ODH. | |
| <ul style="list-style-type: none"> Summary of challenges and/or barriers of evaluation submitted to ODH. | |