EZ/EC Project Packet

Tools and Resources from the Empowerment Zone/Enterprise Community (EZ/EC) Health Benchmarking Demonstration Project

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Please address all questions about the tools and resources in this packet to:

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Using This Packet

This packet is a compilation of 20 technical assistance tools and resources developed and used in the EZ/EC Health Benchmarking Demonstration Project. The packet is a supplement to the report, "Improving Health in Empowerment Zones and Enterprise Communities: Lessons Learned from the EZ/EC Health Benchmarking Demonstration Project."

These "real world" project materials are intended to provide practical guidance, examples, and ideas to EZ/ECs embarking upon health improvement initiatives. Duplication and adaptation of these resources to meet local needs are encouraged.

The materials in this packet are organized in five sections, according to types of EZ/EC health improvement activities. These sections are:

- Developing Health Improvement Objectives
- Conducting Needs and Assets Assessments
- Engaging Communities and Leaders in Health Improvement Efforts
- Communicating About the Process and Findings
- Organizing a Health Improvement Initiative

Please refer to the first page of each section for brief descriptions of the materials included within the section.

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Developing Health Improvement Objectives

This section includes the following EZ/EC Health Benchmarking Demonstration Project materials relevant to developing health improvement objectives.

IDENTIFYING GOALS, OBJECTIVES, STRATEGIES, & RESPONSIBLE PARTIES FOR PRIORITY AREAS

Goal ***Examples:*** *Increase regular exercise among older adults* *Ensure all children have access to health care* *Eliminate second hand smoke in public places*	***What do you want to happen?*** ***(Broad, lofty, indicates general purpose)*** Tips: • Begin with action words such as *reduce, increase, eliminate, ensure, establish, etc.* • Focus on the end result of the community's work. Consider whether the goal is community-wide or if it is important to specify a particular population (by age, race, gender, ability, socioeconomic status, or area).
Objective ***Examples:*** *By June 2001, reduce tobacco use among teens to 23% and young adults to 27% (target). (Baseline: teens, 26%; young adults, 30%)* *By December 1999, reduce by 75% the number of sales outlets where teens may purchase cigarettes. (Baseline: to be determined)* *By June 2000, increase physician use of smoking cessation advice to patients by 10%. (Baseline: CareFirst, 20%; Medical Society members, 20%; Westside Health Center, 40%)* *By December 2000, increase to 50% the proportion of estimated eligible City children who are enrolled in the State Healthy Children Program (CHIP). (Baseline: 13%).* *By March 2000, increase to 90% the proportion of City health care providers who have bilingual staff on-site or who use trained, on-call translators for non-English speaking patients.*	***How will we know if we reached the goal?*** ***(Offers specific and measurable milestones, or benchmarks; sets a deadline; narrows the goal by adding "who, what, when, and where;" clarifies by how much, how many, or how often)*** Tips: • Consider a wide range of things that could indicate community progress toward achieving health goals. Among these are individual behaviors, professional practices, service availability, community attitudes and intentions, insurance status, service enrollment, policy enactment, voluntary participation in employer programs, organizations that offer particular programs, policy compliance/ enforcement findings, results of population screening or environmental testing, or the occurrence of events that suggest breakdowns in the public health system. • Get ideas for your City from the state's Year 2000 objectives, other state objectives and the nation's draft Year 2010 objectives (Healthy People 2010). • Objectives need a **target** (the desired amount of change, reflected by a number or percentage) and a **baseline** figure (where the community is now) drawn from a specific data source. Exceptions include policy or organizational objectives that can be measured simply by being established. • Don't be afraid to consider non-traditional objectives that may resonate with citizens of EC neighborhoods (e.g., "increase by 50% the percentage of pizza outlets that deliver to neighborhoods after dark," as a proxy for violence).

IDENTIFYING GOALS, OBJECTIVES, STRATEGIES, & RESPONSIBLE PARTIES FOR PRIORITY AREAS

Strategy ***Examples:*** *Increase tax on cigarettes by at least 16 cents. (State legislative bill, advocate State Congressional delegation support federal cigarette tax.)* *Provide skills training to 60 physicians on effective smoking cessation counseling. Provide free self-help smoking cessation materials to health care providers.* *Enforce laws prohibiting tobacco sales to minors, using undercover teen customers to help monitor and enforce seller compliance. (SYNAR)* *Coordinate private sector job programs, linked to support services, for younger siblings of parenting young adults, gang involved youth, and other at-risk youth.* *Simplify CHIP eligibility application. Expand sites promoting CHIP and application assistance to employers, neighborhood agencies, parish nursing, YWCA, and others.* *Expand insurance coverage for parents of CHIP-eligible children. Tie to State initiative on insuring adults, partner with employers, and allow CHIP to contribute to employee-based health plan.* *Provide targeted community outreach to families not enrolled in CHIP. Use health ambassadors in door-to-door recruitment (Healthy Start), and apply for RWJ or other grants to expand program.*	***How will the objective be reached?*** ***(Specifies the type of activities that must be planned, by whom, and for whom)*** Tips: • Generate a list of strategies that gives various sectors a job to do (e.g., businesses, voluntary organizations, government, health care organizations, social services, faith organizations, and citizens). Consider strategies that require sectors to work together throughout the EC. • Consider the specific assets of your city and its Enterprise Community to choose strategies that are achievable. • Ask the Public Health Foundation for technical assistance if you need more information on strategies that have worked around the country to address objectives. Effective strategies may include: —targeted economic development —health education —social marketing —assessment & referral —policy (legislation, regulation, program policy) —enforcement —capacity building (new or improved programs) —coordination of services —changing the social or physical environment —employer programs • Consider strategies recommended in your state or local Healthy People plan and by other groups (such as PATCH, Planning Councils, HIV Prevention Community Planning Group, and the Tobacco Prevention Coalition).
Responsible Parties	***Who will coordinate and do most of the work?*** ***Who else will be involved?***

IDENTIFYING GOALS, OBJECTIVES, STRATEGIES, & RESPONSIBLE PARTIES FOR PRIORITY AREAS

WORKSHEET

Priority Area: _____

Goals	I.	II.
Potential Objectives	A.	A.
	B.	B.
	C.	C.
	D.	D.
Potential Strategies	Potential Responsible Parties ► ► ► ► ►	Potential Responsible Parties ► ► ► ► ►

EXAMPLE — PRELIMINARY HEALTH PRIORITIES FOR WILMINGTON, DE

Based upon Health Benchmark Project Findings
3/19/99

Note: Issues are listed in no particular order.

1) Create A Health Structure

There is a need for a unifying structure for health in Wilmington. Communities perceive that segmented and unclear responsibilities for all aspects of health do not adequately serve the City of Wilmington. A Board of Health, health office, or other structure can serve to unify City concerns, programs, and priorities.

2) Monitor Wilmington Health

There is no single, periodic report profiling Wilmington's health status that addresses issues of concern to the residents of the City. A regular report of various Wilmington health indicators would provide the community with information about important health areas, trends, and progress toward improving health, and also could lead to actions for improving health. Given the State-local relationship in health matters and the data resources of the Delaware Division of Public Health, the Division could produce a relevant health profile for Wilmington on a regular basis.

3) Improve Adolescent and Young Adult Health

Adolescents and young adults are the workforce of tomorrow. Wilmington teens are at risk for HIV/AIDS, sexually transmitted disease, violence, drug involvement, unintended pregnancy, unemployment, school dropout, arrest, and smoking. A strong initiative which supports the development of a mentally and physically healthy young adult population is consonant with the Enterprise Community's overall direction of improving economic opportunity in the City of Wilmington. To achieve healthier teens and young adults, Wilmington can build on assets that already exist in the community and the State—such as the Delaware Healthy Children's Program, the Governor's interest in teen pregnancy and families (Family Service Cabinet Council), Healthy Start, the Mayor's Health Planning Councils, the Federal and state funded health clinics, Planned Parenthood, parish nursing, and strong community interest and public safety support in addressing the drug problem.

4) Maximize Access and Use of Health Care

Accessible ambulatory care can improve outcomes in several chronic disease areas, such as diabetes and cancer. Early screening and effective management of chronic diseases, as well as early and regular prenatal care, are critical. Some opportunities which exist in Wilmington are: (1) maximizing enrollment in the Delaware Healthy Children's Program; (2) supporting the Governor's intent to use tobacco settlement dollars for adult health insurance; (3) providing more information about health care availability, perhaps extending the outreach efforts of Healthy Start, Delaware Healthy Children's Program, Managed Care Organizations, the State Division of Public Health, churches, and other community organizations; (4) maximizing Medicaid enrollment and use; and (5) developing a network of ancillary service providers using existing networks, e.g., the AIDS Interfaith Network, parish nursing program, and the OA Herring Center models

5) Support Healthy Behaviors

The majority of preventable adverse health conditions experienced by Wilmington residents are attributable to unhealthy behaviors, such as cigarette smoking, sharing of drug needles, unprotected sex, and lack of exercise. There is strong interest among community leaders to develop programs that promote and support mentally and physically healthier lifestyles. Building on business and recreational development programs, the Mayor's Health Planning Councils activities, church-based HIV/AIDS prevention activities, health fairs, PATCH activities, and the multitude of other community development programs can lay the groundwork for the development of coordinated and concerted efforts to promote behaviors that will lead to a healthier Wilmington.

6) Environmental Health

Wilmington needs a coordinated approach to assess, communicate, and address environmental risks that potentially impact the health and quality of life of City residents. Leaders and residents are concerned about a broad range of environmental issues, including lead exposure, air quality, water quality, toxic waste sites, and environmental inequities. A focused effort to assess available data on issues that concern the community, and for which there also are data to support the issue's relationship to health status, can clarify Wilmington's most promising opportunities to improve environmental health. Public and private sector assets to help Wilmington assess and address environmental risks include the City of Wilmington, Delaware Department of Natural Resources and Environmental Control, Delaware Division of Public Health, Environmental Protection Agency, Riverfront Development Corporation, the Governor's office, and Wilmington industries.

7) Improve Older Adult Health

Approximately 13,000 Wilmington residents are age 60 or older. Although the total senior citizen population is projected to remain stable between 1990 and 2010, the population of persons 80 years and over is expected to increase over 30% during the same period. Wilmington needs to identify and address the current and emerging health issues facing the City's culturally diverse older adult population, particularly anticipating needs of its oldest residents and aging "baby boomers." Older adult health issues identified in State and national plans [e.g. Healthy Delaware 2000, Healthy People 2010 (draft)] could guide Wilmington in exploring local opportunities to improve older adult health. Opportunities in the EC include development of exercise and entertainment at the Riverfront, home sharing opportunities between homeowners and college students, and building upon the existing spectrum of traditional older adult health services such as senior housing options, medical care, parish nursing, and neighborhood programs for the elderly.

Wilmington Health Benchmarking Project
'Supporting Healthy Behaviors' Work Group

DRAFT

Goal: Expand physical activity opportunities within the Enterprise Community neighborhoods.

Objectives:

1. Improve the existing physical environment in each Enterprise Community neighborhood to support walking and other physical activities.

I. By April, 2000* complete an environmental assessment of each EC neighborhood.
   A. Create a task force of community members within each neighborhood.
   B. Use National Safety Council's "How Walkable is Your Community" checklist for assessment.
   C. Summarize assessment results and prioritize neighborhoods based on score.

II. By October, 2000* develop plan to improve priority neighborhoods (Goal = 26 points).
   A. Expand community task force.
   B. Develop partnership with State & Local Transportation Dept., neighborhood planning councils, local construction companies, business leaders and other community groups.
   C. Develop partnership with Public Safety
   D. Identify and secure funding

III. By July, 2002* complete improvement plan

IV. By April, 2000* complete playground safety assessment of all playgrounds in each of the EC neighborhoods.
   A. Create Playground Safety task force of community members in each EC neighborhood.
   B. Train 1 member of each task force as a Playground Safety Inspector OR partner each task force with an existing PSI from outside the community.
   C. Use American Society for Testing and Materials "Standard Consumer Safety Performance For Playground Equipment for Public Use" for playground assessment.

V. By October, 2000* develop plan to improve priority playgrounds. (Goal = 100% compliance w/standards)
   A. Expand Playground Safety task force
   B. Develop partnership with City Parks & Rec. Dept, YMCA's, Community Centers and other community groups
   C. Identify and secure funding

VI. By January, 2003* complete improvement plan.

2. Create additional physical activity opportunities in EC neighborhoods.

I. By January 1, 2000* complete park acreage assessment within each of the EC neighborhoods.
   A. Partner with State & City Parks and Recreation and Planning/Zoning Departments.

II. By January, 2001* develop plan for increasing park acreage per 1,000 population. (Goal = 100% EC neighborhoods at or above national average)
   A. Identify existing open spaces suitable for park
   B. Development.
   C. Identify public and private landholders
   D. Partner with Wilmington Development initiative, City
   E. Planning Dept. and local businesses
   F. Work to create uniformity of physical activity opportunities between EC neighborhoods.
   G. Identify and secure funding

III. By January. 2005* complete expansion plan

*ALL DATES BASED ON JULY, 1999 PROJECT START DATE

Wilmington Health Benchmarking Project
'Supporting Healthy Behaviors' Work Group

DRAFT

Goal: Expand healthful nutrition opportunities within Enterprise Community neighborhoods.

Objectives:

1. Increase availability of healthful foods to EC residents through existing food distribution channels.

I. By January, 2000* complete assessment of availability and cost of healthful foods within each EC neighborhood.
   A. Partner with U of D Coop Extension, New Castle County Chamber of Commerce, and appropriate state and community agencies.
   B. Create task force of community members within each neighborhood.
   C. Partner with local food merchants, food banks, and other food distribution centers.

II. By October, 1999* develop plan to significantly increase availability of healthful foods and/or eliminate cost barriers.
   A. Partner with Dept of Agriculture and other wholesale food merchants.
   B. Coordinate local Food Bank efforts within EC communities.
   C. Identify and secure funding.
   D. Develop marketing plan to promote sale and distribution of healthful foods
   E. Work with merchants to improve placement of healthful foods within stores.

III. By December, 2001* complete development plan.

2. Create additional nutritional food opportunities within EC neighborhoods.

I. By January, 2001* develop two (2) community gardens within the Enterprise Community.
   A. Conduct environmental and needs assessment within each EC neighborhood in order to prioritize neighborhoods.
   B. Secure funding for project with U of D Cooperative Extension program
   C. Approach neighborhoods with idea/solicit involvement
   D. Develop task force of community members.
   E. Coordinate efforts of task force, U of D Cooperative Extension, and other appropriate agencies.

II. By January, 2001* develop one (1) food coop within the Enterprise Community.
   A. Secure funding for project with U of D Cooperative Extension program.
   B. Develop task force of community members from the Enterprise Community.
   C. Identify and secure location from City of Wilmington (preferably uninhabited property)
   D. Partner with DE Dept of Agriculture, and appropriate city, state, and community agencies.

III. By January 2001* develop a marketing campaign to promote nutritional food opportunities and health benefits of proper nutrition.
   A. Partner with existing health promotion efforts within the Enterprise Community, DE Div of Public Health Healthy Lifestyles team, and appropriate city and community agencies.
   B. Develop community wide event celebrating successes and healthy living.

* ALL DATES BASED ON JULY 1999 PROJECT START DATE

This section includes the following EZ/EC Health Benchmarking Demonstration Project materials relevant to conducting needs and assets assessments.

LIST OF POTENTIAL HEALTH MEASURES

BUSINESS HEALTH
Bankruptcy rate
Foreclosure rate
New businesses trend
Workmen's compensation claims

COMMUNITY MANAGEMENT
Interagency networks (Y/N)
Open city council meetings (Y/N)
Planning – economic development, social planning council (Y/N)
Policy environment (Favorable/ Not)
Readiness- fire escape plans, CPR training, retirement preparation (Y/N)
Representation in community groups (Y/N)
Responsiveness- emergencies (Y/N)
Volunteerism level
Voter turnout

DEMOGRAPHICS
Age distribution
Education levels
Income- median
Occupations
Population growth trends
Population stability
Poverty levels
Unemployment rates

GROWTH AND NUTRITION
Developmentally delayed children
Disability prevalence
Enrollment in entitlement programs
Elders who participate in fitness programs
Life expectancy
Self-reported health status
WIC

HEALTH BEHAVIORS
Alcohol use/ abuse prevalence
Exercise levels
Fruit and vegetable consumption
Overweight prevalence
Smoking prevalence
Substance abuse treatment need

HEALTH CARE RESOURCES
Insurance status prevalence
MA providers
Managed care penetration

HEALTH CARE UTILIZATION
Hospital use rate
Preventable hospitalizations rate

HEALTH OF MOTHERS AND CHILDREN
Contraceptive services and need
Low birth weight babies percent
Prematurity prevalence
Prenatal care percent
Teen parenting prevalence

MORBIDITY
Caries immune children
Communicable diseases rates
Vaccine preventable diseases/ deaths
Mental illness prevalence

MORTALITY
Infant mortality –neonatal, postneonatal
Major killers – CHD, cancer, stroke, homicide, suicide, motor vehicle injuries, unintentional injuries, diabetes, COPD
Overall and age-level

PHYSICAL ENVIRONMENT
Environmental conditions –air, water, recreational water sites quality
Environmental hazards
Epidemics
Household smoke detectors prevalence
Households on water and sewage treatment systems, septic systems
Household fuel efficiency
Household recycling
Industrial waste recycling
Lead paint housing vulnerability, soil
Local industries
Natural disasters
Nuisance Index – noise, dirt, odors
Wildlife diversity

Example materials from the **EZ/EC Health Benchmarking Demonstration Project**, a joint project of the Public Health Foundation (www.phf.org) and the Assistant Secretary for Planning and Evaluation and Office of Disease Prevention and Health Promotion, Department of Health and Human Services (www.dhhs.gov) 9/99

LIST OF POTENTIAL HEALTH MEASURES

PREVENTIVE MEASURES

Blood pressure checks
Childhood immunization use
Cholesterol checks
Colon cancer screening prevalence
Diabetic eye and foot exams
Flu vaccine use among the elderly
Mammography prevalence
Pap prevalence
Recreation center use
Religious center use

SOCIAL SUPPORT MEASURES

Bike path mileage
Child abuse investigations
Domestic violence services
Family and friend support networks
Law enforcement
Neighborhood Watch Programs
Self help group participation
Suicide prevention services
Transportation services

INTRODUCTORY REMARKS: STAKEHOLDER INTERVIEWS

(Information for the project interviewer to cover with participants before beginning stakeholder interviews.)

- **Introduction by name and organization**.

- **Background of EZ/EC Health Benchmarking Project**
  - DHHS effort to assure that growth and revitalization of EZ/ECs include strategies for improving and measuring health
  - Economic growth byproduct of healthy community
  - Three demonstration sites (Enterprise Communities) – name other two
  - Goal of project is health benchmarks that reflect community needs and appropriate public health standards
  - PHF selected for TA role - to assist sites with assessing needs and assets of the community and establishing benchmarks
  - PHF will document processes to assist communities – apply lessons learned to other EZ/ECs

- **Benchmarking has five components**
  - Engaging community partners
  - Assessing community health needs and assets
  - Setting priorities
  - Establishing benchmarks
  - Communicating conclusions

- **Interviews today**
  - Part of engaging community partners
  - You have been identified as one of many stakeholders
  - Should take approx. 45 minutes
  - Objectives of these interviews:
    - ✓ Get input on what community thinks are important issues – ideas for change
    - ✓ Help us define community needs and resources – shape parameters of our effort
    - ✓ Ascertain what will drive your continued participation in the process

- **Next step: Will be summarized for the first Advisory Group meeting**.

- **Give the stakeholder an interview guide**.

HEALTH NEEDS OF THE ENTERPRISE COMMUNITY

- What are the priority health needs of the EZ/EC?
- What should the needs assessment address?
- Recent and projected changes?
- Problem areas? Barriers to provision of services?
- Contributors to problems?
- Special populations (AIDS, uninsured, Medicaid, prenatal care, …)

HEALTH RESOURCES OF THE ENTERPRISE COMMUNITY

- Adequacy/sufficiency of current resources?
- Is there coordination of current resources?
- Recent changes in access to health resources? Projected changes?
- Recent changes in utilization of health resources? Projected changes?

PROJECTED NEEDS AND RESOURCES

- What will the county look like in 5 years?
- What changes are necessary?
- What changes are likely?

PUBLIC/PRIVATE RELATIONSHIP

- Duplication of services?
- Gaps in services?
- Other than health department, who meets public health needs?

ROLE OF STATE AND CITY GOVERNMENT

- Assessment of needs?
- Provision of services? Assurance that services are provided?
- Integration of eligibility for all programs?

ENVIRONMENTAL ISSUES

- Major concerns?
- EZ/EC role/ health department role? State role?
- Adequacy of environmental protection?

KEY PLAYERS

- Who influences the delivery of public health services?
- Who influences health department programs and policies?

ECONOMIC ISSUES

- How is health linked with economic prosperity in the EZ/EC?
- Are any of the economic efforts of the EZ/EC tied to health? Can they be?
- What is the major economic development issue?
- What is the main health issue affecting economic success?

WISH LIST

POLICY MAKER INTERVIEW GUIDE

HEALTH NEEDS OF THE ENTERPRISE COMMUNITY
- What are they?
- Recent and projected changes?
- Problem areas? Barriers to provision of services?
- Contributors to problems?
- Special populations (AIDS, uninsured, Medicaid, prenatal care, …)

HEALTH RESOURCES OF THE ENTERPRISE COMMUNITY
- Adequacy/sufficiency of current resources?
- Recent changes in access? Projected changes?
- Recent changes in utilization? Projected changes?

LOCAL HEALTH DEPARTMENT
- Image of the health department?
- Effectiveness of the health department?
- Most important health department programs/roles?

PROJECTED NEEDS AND RESOURCES
- What will the county look like in 5 years?
- What changes are necessary?
- What changes are likely?

PUBLIC/PRIVATE RELATIONSHIP
- Duplication of services?
- Gaps in services?
- Other than health department, who meets public health needs?

ROLE OF CITY GOVERNMENT
- Assessment of needs?
- Provision of services? Assurance that services are provided?
- Integration of eligibility for all programs?

ENVIRONMENTAL ISSUES
- Major concerns?
- EZ/EC role/ health department role? State role?
- Adequacy of environmental protection?

KEY PLAYERS
- Who influences the delivery of public health services?
- Who influences health department programs and policies?

ECONOMIC ISSUES
- How is health linked with economic prosperity in the EZ/EC?
- What is the major economic development issue?
- What is the main health issue affecting economic success?

WISH LIST

EXAMPLE — HEALTH NEEDS AND ASSETS ASSESSMENT CHECKLIST (WILMINGTON, DE)

Wilmington Enterprise Community

Needs and Assets Assessment Activity		Primary Person	Date Due/Done
Engaging Community Partners for EZ/EC Assessment			
	Advisory group recruitment Develop list of prospective Advisory Group members. Finalize list with EC Director. Determine the Advisory Group Chair. ***Advisory group appointment*** Send letter of invitation to prospective Advisory Group members. Create Advisory Group membership list. ***Advisory group has a mission*** Write a mission statement for Advisory Group; incorporate the EC mission statement. Share with Advisory Group. ***Advisory group is informed*** Assemble material for first Advisory Group meeting- draft mission statement, written plan, and summary of findings. **Advisory group has a written plan** Write plan for needs assessment. **Advisory group has an administrative structure for accomplishing work** Develop a structure within which the Advisory Group will work. Write up structure. ***Advisory group staffing identified*** Develop resource people available to the Health Benchmarking Project activities. ***Resources for assessment activities identified*** Delaware Division of Public Health is assembling data; EC has allocated staff time; administrative support from ???		

EXAMPLE — HEALTH NEEDS AND ASSETS ASSESSMENT CHECKLIST (WILMINGTON, DE)

Wilmington Enterprise Community

Needs and Assets Assessment Activity		Primary Person	Date Due/Done
Engaging Community Partners for EZ/EC Assessment			
	Provide PHF with HUD software for exploration of utility in the Benchmarking Project. Provide a map of the EC Boundaries. ***Expertise identified*** *Locate and authorize access to statisticians, data manipulators, surveyors, policy writers, program personnel, etc.* ***Advisory Group Meets*** *Regional Health Director is invited to first Advisory Group meeting.* *Advisory Group meets for first time.* *Advisory Group meets for second time.* *Advisory Group meets for third time.*		
Identifying Community Health Needs and Assets			
	Ascertain key player perspectives (List of specific health issues and contributing factors) Develop list of key players and stakeholders. Invite key players and stakeholders to participate in interviews *Develop Interview Guide. Interviews with key players, Advisory Group, Delaware DH representatives.* *Develop a list of potential interviewees* *Conduct phone interviews where in-person interviews not possible. Develop a list of health issues from the interviews.* Interview key players and stakeholders. Summarize issues—policy, health issues, key players, prior assessments.		

EXAMPLE — HEALTH NEEDS AND ASSETS ASSESSMENT CHECKLIST (WILMINGTON, DE)

Needs and Assets Assessment Activity	Primary Person	Date Due/Done
Engaging Community Partners for EZ/EC Assessment		
Collect previous assessments and reports of health *Assemble previous needs assessments, data reports, assets assessments.* *Provide EC with health profile gleaned from sources outside Delaware.* *Obtain assessments identified during the interviews of stakeholders.* ***Inventory of data sources*** *List of available data and sources.* *Obtain community data source information.* *Assemble list from interviews.* List measures desired from each data source *Develop a request for data items from needs identified.* Assemble a list of data desired from the interviews of key players. ***Gaps in available data identified*** *Develop a list of health issues and the data needed.* ***Access to needed data*** *Submit requests for existing or new analysis of data.* ***Data collection to fill gaps*** *Identify data needed. Consult with EC.* *Assist in data collection instrument design.* *Conduct data collection.* ***Health status assessment*** *Assemble data about health issues.*		

EXAMPLE — HEALTH NEEDS AND ASSETS ASSESSMENT CHECKLIST (WILMINGTON, DE)

Needs and Assets Assessment Activity		Primary Person	Date Due/Done
Engaging Community Partners for EZ/EC Assessment			
	Identify findings, gaps, trends, effects in special populations. ***Synthesis of data around issue areas- target population, disease, outcomes*** *Synthesize findings.* ***Assets inventoried*** *List assets, map, strategize.* ***Examine the policy environment*** *Incorporate policy makers and policy questions into structured interview.* **Written conclusions including areas which need attention** *Needs and Assets |Assessment Report.*		
Determining Priorities			
	Criteria for priority setting (feasibility, importance, etc.) **List of recommendations based on need conclusions** **Ascertainment of intervention partners and assets mapping** **Assessment of intervention partner involvement** **Specification of intervention points and expected outcomes**		

EXAMPLE — HEALTH NEEDS AND ASSETS ASSESSMENT CHECKLIST (WILMINGTON, DE)

Needs and Assets Assessment Activity		Primary Person	Date Due/Done
Engaging Community Partners for EZ/EC Assessment			
	Prioritize recommendations		
Setting Benchmarks			
	Determine who will select benchmark(s) **Review of possible measures** **Select measure(s)** **Compare status quo with ideal, "best," average, or neighbors** **Identify data source(s)** **Generate calculations of various implementation scenarios** **Select benchmark for community**		
Communicating Conclusions			
	Communication plan for dissemination of conclusions **Written assessment report**		

EXAMPLE — HEALTH NEEDS AND ASSETS ASSESSMENT CHECKLIST (WILMINGTON, DE)

Needs and Assets Assessment Activity		Primary Person	Date Due/Done
Engaging Community Partners for EZ/EC Assessment			
	Short report of conclusions **Presentation to community, intervention partners, policy makers** **Create opportunities to be part of the health improvement process**		

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This section includes the following EZ/EC Health Benchmarking Demonstration Project materials relevant to engaging communities and leaders in health improvement efforts.

POTENTIAL PARTNERS

HEALTH
Coroner – city, county, state
Emergency Medical System
Home health agencies
Health departments – city, county, state
Health Professionals (individuals and societies)
Local hospitals
Nursing homes
Nutrition Centers
Mental health organizations
Red Cross chapters-local, state

EDUCATION
Colleges and universities
Schools- elementary, secondary
University extension service

VULNERABLE POPULATIONS
Area Council on Aging
Corrections
Day care facilities
Disabled citizen's alliance
Health department clients
Human resources council
Shelters
Soup kitchens
Youth coalitions

PLANNING/ REGULATORY AGENCIES
Area Health Education Center
Army Corps of Engineers
City managers/ county commissioners/ boards
Mayor's Office
Regional planning councils
State Legislators

SOCIAL FUNCTIONING
Churches
Civic Groups
County and city programs – recreation, parks, etc.
Fire fighters
Interagency coalitions and councils
Law enforcement
Special county or city programs
Water Patrol

BUSINESS
Businesses
Chamber of Commerce
Community economic development directors
Industry
Military installations

FUNDING SOURCES
Local philanthropic institutions
United Way

COMMUNICATION
Community newsletters
Health media advocates
Newspapers
Radio stations
Television

LITERATURE SEARCH SUMMARY: LOCAL HEALTH STRUCTURE MODELS

The Public Health Foundation searched published literature to identify models and lessons learned from various health structures. While the literature is not extensive in this area, we identified several articles that may provide guidance to Wilmington. Abstracts for referenced articles are attached.

Local Health Structures

"Models that work" to improve local community health include local boards of health, academic–community partnerships, and broad-based coalitions. Regardless of the type of structure, staffing is critical to their effective functioning (Goodman).

Local boards of health "provide assistance and leadership in systemization and improvement of the healthcare in communities." These boards represent well the views of their communities (Conway). Representation is sought from a variety of health and community sectors (usually physicians, office holders, and community members).

Academic-community partnerships have been useful ways of uniting some communities. As an example, the Center for Healthy Communities in Milwaukee, Wisconsin has used principles of partnership to build a foundation for community health development (Maurana).

Legislatively mandated broad-based coalitions often provide a forum and a mission for individuals representing sectors of the business, service, and neighborhoods. An example from San Diego describes Community Health Improvement Partners (CHIP), a 25-member coalition which conducts a triennial needs assessment, a community benefit plan, and an annual report. The main benefit is derived from the 12 work teams with specific areas of concern (JCJQI1998).

Benefits of Local Community Health Structures

In the literature, there are clear indications that a focal point for health is important to the overall health of the community. There are four areas where enhanced participation in health benefits citizens and complements the political agenda of those in office.

1) Joint, state and local, development of health policies and program implementation creates efficiency, effectiveness, and achievement of objectives. Paul-Shaheen presents phases of working together in a case study format. He also suggests a model for policy and program development that entails interaction between state and local staff. Having a strong, informed, prepared health response in the City makes for a more balanced partnership with the State.

2) When communities assess and prioritize their own health, support for health-related political action is generated (Keck). "Constituent demand for improved health status could provide the support politicians need."

3) The top local official is apt to be more involved in health when politically salient issues are linked to health (Marando).

4) Bender offers a stepped approach to handling public concerns over clusters of disease in schools, neighborhoods, and worksites. Success requires that "officials develop effective communication, maintain objectivity, and provide leadership for controversial and difficult issues." Scutchfield and colleagues describe one program for developing public health leadership among senior staff.

Guidance for Establishing a Health Focus in Wilmington

I. Creating a Local Health Office

A. Purpose

The primary purpose of a health office should be to help assure a functioning local health system that serves the needs of Wilmington residents. We recommend that the responsibilities of the office be guided by the ten essential public health services (below) developed by the U.S. Public Health Functions Steering Committee. The qualifications of office personnel should support their ability to assess Wilmington's public health system, coordinate with a wide range of constituencies, and assure that the essential public health services are available.

Using the framework of the ten essential public health services, the health office could:

- Assess the extent to which essential public health services are provided in Wilmington by state, federal, and local agencies, including the Delaware Division of Public Health, Department of Natural Resources and Environmental Control, Wilmington Licensing and Inspection Office, U.S. Environmental Protection Agency Region 3, federally qualified health centers, hospitals, and other community agencies
- Assess how well the essential services meet local needs, in partnership with the providers of services, community members, local officials, and consumers of services
- Serve as Wilmington's advocate and liaison to state and federal agencies, particularly to maximize the benefit of services already provided by these entities and to address gaps in the public health system
- Monitor progress toward achieving Wilmington public health objectives set by the community and public health agencies that serve the City
- Identify resources to address unmet needs in the local public health system
- Provide local leadership and coordination in Wilmington's response to public health needs not addressed by other entities

Essential Public Health Services

1. Monitor health status to identify community health problems.
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure a competent public health and personal health care workforce
9. Evaluate effectiveness, accessibility and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

B. Assessing Performance of Wilmington's Local Public Health System

A tool to assess the performance of local health systems is currently under development by the Centers for Disease Control and Prevention (CDC). The City of Wilmington, Delaware, would be considered a local public health system for the purposes of these performance standards. This tool is based on the essential public health services and includes model community standards and straightforward questions to guide community assessments, such as:

> "Do entities within the local public health system (LPHS) provide or assure culturally and linguistically appropriate promotional and educational material for special population groups?"
>
> "Do entities within the LPHS provide or assure adequate transportation services for those with special needs?"
>
> "Does the LPHS evaluate the population-based preventative health services for the entire community at least every two years?"
>
> "Have entities within the LPHS been granted authority to enforce any public health laws or regulations?" "Do the authorized entities exercise that authority?"
>
> "Do referral mechanisms exist in the community between the personal heath and mental/behavioral health systems?"
>
> "Does the LPHS use surveillance data to monitor sudden change in incidence, prevalence, and distribution of disease, injury, and health compromising and toxic events?"
>
> "Are surveillance data communicated at least quarterly to community health professionals?"

We believe this tool could be highly useful in Wilmington and are aware of no current plans to pilot the tool in a city without a local health department. The Public Health Foundation, as part of the tool's development team, may be able to facilitate Wilmington's involvement as a pilot site, if desired.

II. Common Local Health Models

The two most common models of local health structures are **local health departments** (service and administrative units of local government) and **local boards of health**, which vary in composition, responsibilities, and policy-making authority. Most municipalities in the U.S. are served by local health departments (mainly county, multi-county, city, or city/county health departments). Local boards of health are used in approximately three-fourths of states to provide local input into or control of the operation of local public health agencies. We previously sent to Zachariah Lingham some draft materials on establishing a local board of health from the National Association of Local Boards of Health (NALBOH). We would be pleased to offer additional information on these two models at your request.

III. Wilmington, Delaware, in a National Context

Delaware is one of few states (e.g. Vermont, Rhode Island, New Mexico, and Hawaii) that do not have local health departments. In these states, centralized public health services are provided by or under the authority of the state health agency. In centralized states, regional or district health officers are typically employees of the state.

Although **Vermont** has no local health departments, each town has its own local board of health, which is usually the town Board of Selectpersons. The board of health is responsible for appointing the town health officer. Vermont local health officers are agents of the State health department and have the authority to enforce State regulations in local jurisdictions.

Rhode Island has no local health departments, local health officers, or local boards of health. All public health services are carried out by the State. Rhode Island public health officials told us that they saw a need for a point person in many municipalities, yet no communities have appointed a staff person or created a health office.

In **New Mexico**, district health officers are appointed and employed by the State and are responsible for providing information on public health issues to local elected officials, local quality assurance functions, planning, evaluation, and serving as a liaison to community agencies and medical providers.

This section includes the following EZ/EC Health Benchmarking Demonstration Project materials relevant to communicating about the process and findings.

GLOSSARY

Assets inventory: Listing of previous assessments, planning documents, objectives, benchmarks and progress reports.

Assets mapping: Enumeration of community-based and -accessible programs, activities, expertise, resources, institutions, or individuals. Whether these assets lie physically inside or outside the community and within or beyond the influence of the community is determined (US DHHS (CDC), 1997, page 7.)

Benchmarks: "A standard established for anticipated results, often reflecting an aim to improve over current levels" (IOM, 1997, Page 93.) The standard is objective, measurable, and time limited.

Benchmarking: The process of establishing goals through attaining consensus of strategic players about priorities, interventions, roles and responsibilities based on knowledge of "best practice" and tracking progress toward these goals.

Community: An aggregation defined by its:

People - socioeconomics and demographics, health status and risk profiles, or cultural and ethnic characteristics

Location - geographic boundaries

Connectors – shared values, interests, motivating forces

Power relationships – communication patterns, formal and informal lines of authority and influence, stakeholder relationships, resource flows.

Community engagement: the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. (DHHS (CDC) 1997, Page 9)

Community health improvement process: "…a systematic approach to health improvement that makes use of performance monitoring tools …(that) will help them (communities) achieve their goals." (IOM 1997, Page 78)

Community health profile: "A set of …indicators of sociodemographic characteristics, health status and quality of life, health risk factors, and health resources that are relevant for most communities; these indicators provide basic descriptive information that can inform priority setting and interpretation of data…." (IOM 1997, Page 126-7)

Conceptual model: A theoretical description, and sometimes a schematic, delineating broad factors and direction of influence on outcomes. Details, especially definition and measurement, are operationalized in individual research studies and analyses. For instance, "disease" as a concept may be measured using deaths, new cases, disability, etc.

Essential public health services: (1) Monitor health status to identify community health problems; (2) Diagnose and investigate health problems and health hazards in the community; (3) Inform, educate, and empower people about health issues; (4) Mobilize community partnerships to identify and solve health problems; (5) Develop policies and plans that support individual and community health efforts; (6) Enforce laws and regulations that protect health and ensure safety; (7) Link people to needed personal health services and assure the provision of health care when otherwise unavailable; (8)Assure a competent public health and personal health care workforce; (9)Evaluate effectiveness, accessibility, and quality of personal and

population-based health services; and (10) Research for new insights and innovative solutions to health problems. (PHFSC 1994)

Health: "…the state of complete, mental, and social well-being and not merely the absence of disease or infirmity." (WHO Constitution, cited in Hanlon, 1969, page 5)

Leading health indicators: Subset of all possible indicators that can be thought of as hallmarks of health as its various dimensions (health status, premature death, disability, healthy lifestyle, risk factors, access to care.) (US DHHS, 1998; CDC, 1991)

Needs analysis/ assessment: The identification and evaluation of needs and strengths. It's main components are to: engage the community; identify health problems and community needs; determine priorities; set benchmarks; and communicate conclusions. (Adapted from, McKillip, 1987, Page 9.)

Public health: "… the Science and Art of (1) preventing disease, (2) prolonging life, and (3) promoting health and efficiency though organized community effort…" (Winslow, cited in Hanlon, 1969, Page 4)

Public health functions: "…the core functions of public health agencies at all levels of government are assessment, policy development, and assurance." (IOM. 1988, Page 140)

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EXAMPLE — EZ/EC HEALTH REPORT OUTLINE

New Haven Empowerment Zone Health Benchmarking Demonstration Project Report

EXAMPLE — EC NEWSLETTER ARTICLE: HEALTHY COMMUNITY, HEALTHY ECONOMY

Healthy Community, Healthy Economy
A healthy community makes economic sense to the EC and employers.

Wilmington EC Health Project to Set Benchmarks for Better Health
A new project brings together EC leaders, employers, and residents to set benchmarks to measure Wilmington health. Wilmington is one of three U.S. cities selected to participate in an EC/EZ Health Benchmarking Demonstration Project.

Few Enterprise Communities (ECs) or Empowerment Zones (EZs) are ready to address health issues in their coordinated economic development plans, according to federal officials. By funding this project, the U.S. Department of Health and Human Services hopes the Wilmington EC will serve as a model for other ECs across the nation. The project entitles the EC to technical assistance from the Public Health Foundation (PHF), a national non-profit group.

Since November 1998, PHF staff have interviewed dozens of Wilmington EC stakeholders to learn what people perceive are the EC's greatest health needs and assets. (See "top health issues," back page.) Using state health department data, PHF also created a profile of Wilmington health.

How Wilmington Mortality Measures Up

Wilmington Rates <u>Better</u> than the U.S. on:
Child mortality
Unintentional and motor vehicle injury-related deaths

Race-specific stroke deaths
Homicide

City is <u>Worse</u> than the U.S. & the State on:
AIDS/HIV
Nephritis (a kidney disease)
Septicemia (blood poisoning)
Drug-induced deaths

City & the State are <u>Worse</u> than the U.S. on:
Cancer
Diseases of the Heart
Diabetes

Better Employee Health Pays Off
By improving the health and behaviors of their labor force, many employers have gained financial returns. As examples:

- DuPont reduced disability days by 14% in sites using health promotion, compared to 6% in sites with no interventions.
- Pacific Bell found that employee fitness program participants claimed $300 less per case, with $722 per case savings for conditions related to lack of exercise.
- Prudential Insurance Company reports that the company's major medical costs dropped from $574 to $312 for participants in its wellness program.
- Employee illness days dropped 12.2% after a national manufacturing company targeted health promotion efforts to high-risk employees.

New research demonstrates that employers can save money in the long run for their health promotion efforts—even when they estimate that a proportion of employees will leave the company.

How much do behavioral health needs cost your company?

Troubled employees, many struggling with mental health and substance abuse problems, **cost U.S. employers over $100 billion annually**. This loss in revenues is due to:

- decreased productivity
- increased accidents
- replacement of workers
- disability payments
- deterioration of morale
- high absenteeism
- inefficiency
- early retirement
- retraining
- medical expenses

To compute your company's estimated annual loss, use the following formula:

<u>(annual payroll)</u> x 10% (employees affected) x 25% (lost efficiency) =
annual loss

Example materials from the **EZ/EC Health Benchmarking Demonstration Project**, a joint project of the Public Health Foundation (<u>www.phf.org</u>) and the Assistant Secretary for Planning and Evaluation and Office of Disease Prevention and Health Promotion, Department of Health and Human Services (<u>www.dhhs.gov</u>) 9/99

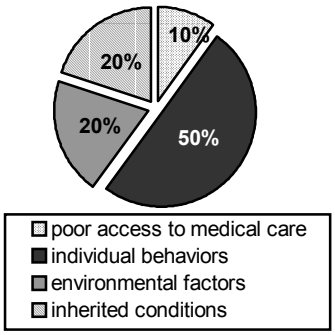
EXAMPLE — EC NEWSLETTER ARTICLE: HEALTHY COMMUNITY, HEALTHY ECONOMY

Prevention Saves Resources
All told, the U.S. spends one trillion dollars on health care each year—14% of the Gross National Product. Billions of health care dollars spent by private and public sectors could be saved if we invested in prevention.

Annual U.S. cost of preventable conditions:	
Alcohol and drug abuse	$110 billion
Smoking	$65 billion
Injuries	$100 billion
Cancer	$70 billion
Cardiovascular Disease	$135 billion

Most Premature Deaths Are Preventable Half of U.S. premature deaths can be prevented by changes in individual behaviors, such as tobacco use, poor diet, sedentary lifestyle, use of alcohol and drugs, and risk-taking that leads to injuries.

Causes of U.S. Premature Deaths
(Source: Institute of Medicine, 1982)



Tobacco use accounts for the largest proportion of preventable deaths (19%). **In New Castle County and Delaware,** smoking rates are higher than the U.S. average for every age group.

By capitalizing on EC assets and using strategies that work, the EC has many opportunities to reduce cancer, diabetes, heart disease, HIV/AIDS, infant mortality, and other conditions that take an economic and human toll on our City.

What are the top health issues to address in the EC?

A task force of EC leaders and residents determined in February seven priority areas to improve EC health. By summer, the task force will make action plans to address each area, including benchmarks to measure Wilmington's progress.
These seven priorities are based on the project's analysis of Wilmington health data, interviews with EC stakeholders, and the potential for the EC to make a difference in each area.
Listed in no particular order, these are:

1. **Create a Health Structure—**establish a health office to coordinate and track Wilmington health
2. **Monitor Wilmington Health—**create a regular, City-specific report to track and respond to health changes
3. **Improve Adolescent & Young Adult Health—**develop a mentally & physically healthy workforce of tomorrow
4. **Maximize Access & Use of Health Care—**coordinate and build on Wilmington's health care and behavioral health systems
5. **Support Healthy Behaviors—**make Wilmington a place that supports healthy behaviors through community development (e.g. recreational opportunities), health promotion, policies, etc.
6. **Environmental Health—**identify and address issues that affect human health
7. **Improve Older Adult Health—**meet the health needs of the City's elders and increase productivity in older years

Take a leading role in the EC and help make a healthier work force

The EC needs private sector leadership to achieve results in the seven priority areas above. The Wilmington EC Health Benchmarking Demonstration Project Task Force recently formed work groups for each area. These groups will set benchmarks to measure EC health progress and make action plans that can benefit employers in the EC community.

To join, call _____ at _ _ _-_ _ _-_ _ _ _.

Example materials from the **EZ/EC Health Benchmarking Demonstration Project**, a joint project of the Public Health Foundation (www.phf.org) and the Assistant Secretary for Planning and Evaluation and Office of Disease Prevention and Health Promotion, Department of Health and Human Services (www.dhhs.gov) 9/99

This section includes the following EZ/EC Health Benchmarking Demonstration Project materials relevant to organizing a health improvement initiative.

SELF-ASSESSMENT CHECKLIST

The Self-Assessment Checklist is designed to be a brief overview of community activities that comprise needs and assets assessment. Community assessment involves engaging the community, identifying community health needs and assets, determining priorities, setting benchmarks and communicating the assessment conclusions. Each component is viewed as essential to success in community benchmarking. Attached is a Self-Assessment Checklist designed to enable communities to gauge where they are in the process and where they need to start. Using a self-assessment tool early in the needs and assets assessment process assists with strategic decisions about where technical assistance resources will be most helpful.

Engaging communities implies the community is defined, that there is an interface between health care planners, policy makers, and providers with the community. The community is made up of several entities – people, organizations, locations, and formal and informal networks. An advisory group that will guide the needs and assets assessment is generally used. An advisory group promotes an early investment from the change agents, involves those whose health will be improved, and provides a structure for the assessment process.

Identifying community health needs and assets is the core community needs assessment activity. Quantifying, verifying, and documenting findings allow a systematic approach to the task of fact finding. Subjective and objective findings are compared. Findings from several sources are synthesized. Gaps are identified.

Determining priorities involves taking all the issues that the community could address and setting some rubrics for deciding where to begin. Community values, resources, and the state-of-knowledge are all applied to the ordering of potential activities. Factors such as importance, feasibility, asset characteristics, and doability are considered in the priority setting phase.

Setting benchmarks is critical to knowing where the community wishes to go. Benchmark measures are quantifiable, objective, and time limited. Benchmarks represent an end product of determining what is important to measure and what is the target amount of change desired. Benchmarks allow any audience to track progress. Community participants committed to changing health indicators are also encouraged to adopt a benchmark approach for their respective constituencies.

Communicating conclusions is useful in creating a broad sense that the entire community is in agreement on where it is going to focus attention and improve health. A planned communication strategy allows the thoughtful formation of a message, strategies to raise awareness and guides to participation.

This Self-Assessment Guide deals with the health improvement process only through the step of setting benchmarks. Implementation strategies and action plans are the next logical steps for communities to take. Without a solid implementation of efficacious and effective interventions, goals are not met.

SELF-ASSESSMENT CHECKLIST

Check, in the appropriate box, the level currently underway on each activity and indicate whether technical assistance may be desired.

Needs and Assets Assessment Activity		Current Activity Level			Assistance Requested (Yes/No/ Not Sure)
		None √	Low √	High √	
Engaging Community Partners for EZ/EC Assessment					
	Advisory group recruitment				
	Advisory group appointment				
	Advisory group has a mission				
	Advisory group is informed				
	Advisory group has a written plan				
	Advisory group has an administrative structure for accomplishing work				
	Advisory group staffing identified				
	Resources for assessment activities identified				
	Expertise identified				

SELF-ASSESSMENT CHECKLIST

Needs and Assets Assessment Activity		Current Activity Level			Assistance Requested (Yes/No/ Not Sure)
		None √	Low √	High √	
Identifying Health Problems and Community Needs					
	List of specific health issues and contributing factors				
	Collect previous assessment and reports of health				
	Inventory of data sources				
	Access to needed data				
	List measures desired from each data source				
	Gaps in available data identified				
	Data collection to fill gaps				
	Health status assessment				
	Synthesis of data around issue areas- target population, disease, outcomes				
	Assets inventoried				
	Examine the policy environment				
	Written conclusions including areas which need attention				

Needs and Assets Assessment Activity		Current Activity Level			Assistance Requested (Yes/No/ Not Sure)
		None √	Low √	High √	
Determining Priorities					
	Criteria for priority setting (feasibility, importance, etc.)				
	List of recommendations based on need conclusions				
	Ascertainment of intervention partners and assets mapping				
	Assessment of intervention partner involvement				
	Specification of intervention points and expected outcomes				
	Prioritize recommendations				

Needs and Assets Assessment Activity		Current Activity Level			Assistance Requested (Yes/No/ Not Sure)
		None	Low	High	
Setting Benchmarks					
	Determine who will select benchmark(s)				
	Review of possible measures				
	Select measure(s)				
	Compare status quo with ideal, "best," average, or neighbors				
	Identify data source(s)				
	Generate calculations of various implementation scenarios				
	Select benchmark for community				

Needs and Assets Assessment Activity		Current Activity Level			Assistance Requested (Yes/No/ Not Sure)
		None √	Low √	High √	
Communicating Conclusions					
	Communication plan for dissemination of conclusions				
	Written assessment report				
	Short report of conclusions				
	Presentation to community, intervention partners, policy makers				
	Create opportunities to be part of the health improvement process				

EXAMPLE — PROJECT ASSISTANT JOB DESCRIPTION (DENVER, CO)

Example Job Description – Project Assistant

The Project Assistant will be a detail-oriented self-starter who will assure the day-to-day operations of the EZ/EC Health Benchmarking Project in the Denver Enterprise Community. The Project assistant will interact with the Enterprise Community Coordinator, the Denver Health Director of Community Health Services, and the Denver Health Director of Government Relations.

Performance Objectives:

1. Develop a strong grasp of project and office policies, procedures, systems, and equipment in order to handle all aspects of the job effectively.
2. Provide assistance to the team, handling assigned tasks with attention to detail and consistently ensuring completeness and accuracy.*
3. Develop a general understanding of and be able to communicate to constituents, the EZ/EC Health Benchmarking Project's role, activities, and relationship within the Denver community. Begin to build a knowledge of group dynamics and group process, the community, economic development, and of the public health field in general.
4. Increase working knowledge of MS Word and Power Point and ability to integrate documents from these and other packages.
5. Develop and routinely practice strong communication skills and habits with the project team to help ensure effective coordination of project tasks, workload, and deadlines.

* Assigned activities will include: research (including web searches); developing and organizing briefing materials; handling meeting logistics; preparing and coordinating postal, fax, and electronic mailings; arranging and coordinating schedules for meetings, conference calls, and phone interviews; establishing group lists and mail merges; drafting routine memos and correspondence; data entry; assisting in designing and managing spreadsheets and data bases to track work status; taking notes; photocopying; and other project, research, and clerical tasks as assigned.

Mission Statement

To engage area partners in active pursuit of health improvements in the New Haven Enterprise Community

ANNOTATED LIST OF REFERENCES

The following is an annotated list of references related to the EZ/EC Health Benchmarking Project. It is intended to aid EZ/EC's in identifying resources to support community needs/assets assessment and benchmarking. The annotation includes abstracts, excerpts, or key findings from the source. The references—which include journal articles, published reports, organizations, and web sites—are organized according to the following categories: engaging community partners; identifying community health needs and assets; determining priorities; and setting benchmarks or targets that reflect the priorities, assets, and motivation of the community. The categories, and hence the references, should not be considered mutually exclusive, as each category is an integral, and interrelated component of community health assessment and benchmarking. For example, some references are excellent sources of information on the whole process of identifying needs, determining priorities, setting targets, and developing community action plans or strategies.

Engaging Community Partners

- American Cancer Society (National Advisory Group on Collaboration with Organizations). *A Collaboration Guidebook,* 1996.

  Common factors in successful collaborations:

  - Mutually agreed upon, clearly defined shared vision or guiding purpose
  - Competence
  - Mutual respect, tolerance, and trust
  - Skilled leadership
  - Active involvement of participants/attention to the process
  - Clearly defined roles, responsibilities, and operating procedures
  - Diversity and inclusion
  - Respect for differences
  - Good communications
  - Early success
  - Conflict resolution
  - Adequate resources

- Coalition for Healthier Cities and Communities. c/o Health Research, Education, and Trust, One North Franklin, Chicago, Illinois 60606 (312) 422-2635

  The coalition is a partnership of entities from the public, private and non-profit sectors collaborating to focus attention and resources on improving the health and quality of life of communities through community-based development.

- Goodman, R.M., Speers, M.A. et al. "Identifying and Defining the Dimensions of Community Capacity to Provide a Basis for Measurement." *Health Education and Behavior,* 25(3): 258-278, 1998.

  Dimensions of community capacity for program development, implementation and evaluation:
  - Citizen participation
  - Leadership
  - Skills
  - Resources
  - Social and inter-organizational networks
  - Sense of community
  - Understanding of community history
  - Community power
  - Community values
  - Critical reflection

- Kegler, M.C., Steckler, A. et al. "Factors that Contribute to Effective Community Health Promotion Coalitions: A Study of 10 Project ASSIST Coalitions in North Carolina." *Health Education and Behavior,* 25(3): 338-353, 1998.

  "The results suggest that coalitions with good communication and skilled members had higher levels of member participation. Coalitions with skilled staff, skilled leadership, good communication, and more of a task focus had higher levels of member satisfaction. Coalitions with more staff time devoted to them and more complex structures had greater resource mobilization, and coalitions with more staff time, good communication, greater cohesion, and more complex structures had higher levels of implementation."

- Milio, N. "Priorities and Strategies for Promoting Community-Based Prevention Policies." *Journal of Public Health Management and Practice,* 4(3): 14-28, 1998.

  "Policy making requires a grasp of the interplay among stakeholders, policy makers, the press, and the public. A framework for gathering relevant information and guiding strategic action is a useful tool for participation in community, state, and national arenas in the interests of population health."

- Norris T. "Healthy Communities." *National Civic Review,* 86(1):3-10, 1997.

  The author suggests that what works best to create and sustain positive community change can ultimately be defined in a local context. Six emerging common characteristics and qualities are described:

- Successful communities recognize that the health and sustainability of a community are products of the whole community working, not a result of isolated interventions in any single sector.
- Successful communities engage everybody and build ownership and civic engagement.
- Successful communities take a regional and a local approach…simultaneously.
- Successful communities know how they are performing.
- Successful communities start with a shared vision and follow with a specific action plan and implementation strategy.
- Successful communities build on existing resources and look at systemic change."

- Institute of Medicine (Committee on Public Health). *Healthy Communities: New Partnerships for the Future of Public Health*. National Academy Press, Washington, D.C., 1996.

  "The Committee's analysis…the public's health depends on the interaction of many factors; thus, the health of a community is a shared responsibility of many entities, organizations, and interests in the community, including health delivery organizations, public health agencies, other public and private entities, and the people of a community."

- U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC/ATSDR Committee on Community Engagement), *Principles of Community Engagement*, Atlanta, Georgia, 1997

  Principles of Community Engagement provides public health professionals and community leaders with a science base and practical guidelines for engaging the public in community decision-making and action for health promotion, health protection, and disease prevention. The document was prepared for public health professionals and community leaders within organizations, rather than a more grass-roots audience.

- Voluntary Hospitals of America, Inc. *VHA's Voluntary Community Benefits Standards: A Framework for Meeting Community Health Needs*, 1993.

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

Identifying Community Health Needs and Assets

- McGinnis JM and Foege WH. "Actual causes of death in the United States". Journal of the American Medical Association 270 (18): 2207-2212, 1993.

  Approximately half of all deaths could be attributed to various risk factors. Actual causes of death were determined to be, in order of importance:

  1- Tobacco
  2- Diet/inactivity
  3- Alcohol
  4- Infections
  5- Toxic agents
  6- Firearms
  7- Sexual behavior
  8- Motor vehicles
  9- Drug use

- McKnight JL and Kretzmann J. *Mapping community capacity.* Evanston, IL: Center for Urban Affairs and Policy Research, Northwestern University, 1990.

  A neighborhood assets map is made up of primary, secondary, and potential building blocks.

  Primary: Assets and capacities located inside the neighborhood, largely under neighborhood control.

  Secondary: Assets located within the community, but largely controlled by outsiders.

  Potential: Resources originating outside the neighborhood, controlled by outsiders.

- National Civic League web-site <www.ncl.org> Includes information on Healthy Communities Initiatives; Program for Community Problem Solving; a Healthy Communities Toolbox; and Healthy Communities publications.

  "Though all Healthy Communities initiatives look different, there are several key elements of successful initiatives: utilization of a broad definition of health; broad-based community involvement; development of a shared vision; and a real change in how systems in the community operate and relate to one another."

- Norris, T. "Creating the Building Blocks for Health." *Trustee,* April: 16-18, 1995.

  What creates health? (Based on a nationally representative survey of 1,000 Americans from all socioeconomic groups. DYG INC/Healthcare Forum, 1994)

Low crime	73%	High environmental quality	65%
Good place to bring up children	73%	Good jobs and healthy economy	64%
Low level of child abuse	72%	High-quality health care	61%
Not afraid to walk at night	71%	Affordable health care	60%
Good schools	71%	Good access to health care	60%
Strong family life	70%	Excellent race relations	54%

- Tong, DA. "Beyond Prevention: Healing the 'Sociomas'." Healthcare Forum Journal, May/June, 1996.

  "…patients show up every day at Greater SE Community Hospital with acute and chronic cases of what has been called the "sociomas" – social problems ranging from drug addiction to homelessness, and the despair that accompanies miserable life circumstances…. We have begun by building on past efforts, renewing and deepening our commitment to cost-effective primary-care and disease prevention programs in the inner city."

- US Conference of Mayors (HIV Program). Needs Assessment for HIV/AIDS Prevention and Service Programs: Gathering Information to Determine Needs, 1993.

  Three common methods of information collection:

  1. Social and Health Indicator Analysis

  Social and health indicators are aggregate statistical measures that depict significant aspects of a social situation and the health status of the population in the community. Examples of this type of data include incidence and prevalence data, census statistics on racial and ethnic household composition and size, income level, hospitalizations, and arrests.

  2. Social Area Surveys

  Surveys provide a means for identifying information about a community or target population, service providers, and other groups. There are three types of survey methods generally used in needs assessments:
  - Mail questionnaires
  - Face-to-face interviews
  - Telephone interviews

  3. Structured Groups
  - Focus groups
  - Nominal groups
  - Delphi panels
  - Community forums and public hearings

- Greenberg M., Lee C., Powers C. "Public Health and Brownfields: Reviving the Past to Protect the Future." American Journal of Public Health. December 1998 Vol. 88 No. 12.

- Green, M. "Asset-Based Community Development – A Neighborhood Leaders Guide 6." Resource Journal. The Neighborhood Resource Center of Metropolitan Denver **http://www.nrc-neighbor.org/ (base link)** Note: Original link is retired.

- Mourad, M. Comprehensive Community Revitalization Community Based Neighborhood Planning & Strategies for Asset-Building—An Overview. "Building Individual and Community Assets." pp. 20-29. The Enterprise Foundation. 1998.

Determining Priorities

- Centers for Disease Control and Prevention. Health Status Indicator Reports: "State of the Art." Healthy People 2000: Statistics and Surveillance Report No 8: 1-4, 1996.

  Maryland developed consensus matrices to prioritize indicators based on comparisons for each county. Two comparisons were made for each indicator. The first compared the county's rates to the State's rates for the past five years. The second comparison was between the 5-year county trend compared to the State trend over the same period. Priorities were assigned based on the joint category. Highest priority was given to health indicators that had rates greater than the State and a worse trend when compared to the State.

- National Association of County and City Health Officials, Assessment Protocol for Excellence in Public Health, Washington, DC, March 1991.

  The Assessment Protocol for Excellence in Public Health (APEXPH) project, funded by a cooperative agreement from the Centers for Disease Control and Prevention (CDC) to NACCHO, was designed and tested through a collaborative effort of national public health organizations over a four-year period. A comprehensive public health assessment and planning process, APEXPH was developed to be used voluntarily by local health officials to assess the organization and management of the health department, provide a framework for working with community members and other organizations in assessing the health status of the community, and establish the leadership role of the health department in the community.

- Studnicki, J., Steverson, B., et al. "A Community Health Report Card: Comprehensive Assessment for Tracking Community Health (CATCH)." Best Practices and Benchmarking in Health Care, 2(5):196-207, 1997.

A systematic method for assessing the health status of communities has been under development at the University of South Florida since 1991. The system, known as CATCH, draws 226 indicators from multiple sources and uses an innovative comparative framework and weighted criteria to produce a rank-ordered community problem list. The CATCH results from 11 Floridian counties have focused attention on high priority health problems and provided a framework for measuring the impact of health expenditures on community health status outcomes.

- U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Planned Approach to Community Health: Guide for the Local Coordinator, Atlanta, Georgia.

  The Planned Approach to Community Health (PATCH) is a community health planning model that was developed in the mid-1980s by the Centers for Disease Control and Prevention (CDC) in partnership with state and local health departments and community groups. The goal of PATCH is to increase the capacity of communities to plan, implement, and evaluate comprehensive, community-based health promotion programs targeted toward priority health problems.

- Vilnius D. and Dandoy S. "A Priority Rating System for Public Health Programs." Public Health Reports, 105(5):463-470, 1990.

  When resources are limited, decisions must be made regarding which public health activities to undertake. A priority rating system, which incorporates various data sources, can be used to quantify disease problems or risk factors, or both. The model described in this paper ranks public health issues according to size, urgency, severity of the problem, economic loss, impact on others, effectiveness of interventions, propriety, economics, acceptability, legality of solutions, and availability of resources. Rankings have been applied to the following health issues: AIDS, coronary heart disease, injuries from motor vehicle accidents, and cigarette smoking as a risk factor.

Setting Benchmarks

- American Public Health Association. Healthy Communities 2000: Model Standards, 3rd Edition. Washington, D.C., 1991.

  Identifies guidelines for community attainment of the Year 2000 national health objectives. Includes chapters on special population age groups: children, adolescents and young adults, adults, and older adults.

- Healthy People 2010 Website, http://www.health.gov/healthypeople.

Provides up-to-date fact sheets, information on Healthy People Consortium activities, updated public comments on the draft objectives, staff contacts, and other information related to development of Healthy People 2010 objectives.

- Institute of Medicine (Committee on Using Performance Monitoring to Improve Community Health). Improving Health in the Community: A Role for Performance Monitoring. National Academy Press, Washington, D.C., 1997.

  Based on its review of the determinants of health, the community-level forces that can influence them, and community experience with performance monitoring, the committee finds that a community health improvement process (CHIP) that includes performance monitoring, as outlined in this report, can be an effective tool for developing a shared vision and supporting a planned and integrated approach to improve community health.

- National Research Council (Panel on Performance Measures and Data for Public Health Performance Partnership Grants, E.B. Perrin and J.J. Koshel eds.) Assessment of Performance Measures for Public Health, Substance Abuse and Public Health. National Academy Press, Washington, D.C., 1997.

  "There appears to be a growing consensus within public health, substance abuse, and mental health communities about the value of performance measurement. Indeed, many people believe the case for increasing, or even maintaining, public funding will depend on documented program performance."

- Oregon Progress Board. Oregon Benchmarks: Standards for Measuring Statewide Progress and Institutional Performance (Report to the 1995 Legislature). December, 1994.

  Oregon Benchmarks are the measurable indicators that Oregon uses at the statewide level to assess its progress toward broad strategic goals. In 1994, the program was one of 10 winners out of 1,350 applications of the annual Innovations in Government awards presented by the Ford Foundation and the Kennedy School of Government at Harvard University.

- U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Developing Objectives for Healthy People 2010, 1997, September. (Available at http://odphp.osophs.dhhs.gov/pubs/hp2000)

  A resource guide for individuals and groups to use in reviewing and modifying Year 2000 objectives, as well as developing new objectives. Includes updated tracking data.

- U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Improving the Nation's Health With Performance Measurement, Prevention Report Vol. 12(1):1-5, 1997.

Performance Measurement: Step by Step

Step1: Relate the performance measure to an important national, state, or local health priority area.

Step 2: Measure a result that can be achieved in 5 years or less.

Step 3: Ensure that the result is meaningful to a wide audience of stakeholders.

Step 4: Define the strategy that will be used to reach a result.

Step 5: Define the accountable entities.

Step 6: Draft measures that meet statistical requirements of validity and reliability and have an existing source of data.

- U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2000: Consortium Action, 1992. Washington D.C.: U.S. Government Printing Office.

  Describes activities that support the national health objectives arising from the more than 325 national membership organizations of the Healthy People 2000 Consortium.

Communicating Conclusions

- Brownson RC, Remington PL, and Davis JR. Chronic Disease Epidemiology and Control. American Public Health Association, Washington, D.C., 1993.

Step	Question	Action
1	What should be said?	Establish the message.
2	To whom should it be said?	Define the audience.
3	What communications medium should be used?	Select the channel.
4	How should the message be stated?	Market the message.
5	What effect did the message create?	Evaluate the impact.

"… the message must be framed as a simple, declarative statement. The term SOCO has been used to describe this Single Overriding Communication Objective."

- DiFranza JR, the Advocacy Institute, and the Center for Strategic Communications. Strategic Communications for Non-Profits: A Researcher's Guide to Effective Dissemination of Policy-Related Research, October 1996. Princeton, NJ: Robert Wood Johnson Foundation.

  Provides guidance on working with the mainstream press:
  - Who to call
  - What to say and how to say it
  - How to package your research for the press
  - When to call
  - After the story is sold
  - Sharing the spotlight
  - Getting help
  - Working with nonprofit organizations
  - Colleagues

- Lasker RD and the Committee on Medicine and Health. Medicine and Public Health: The Power of Collaboration. New York, NY: The New York Academy of Medicine, 1997.

  … collaborations around health promotion and health protection take five forms:
  - Community health assessments
  - Public education campaigns
  - Health-related laws and regulations
  - Community-wide campaigns to achieve health promotion objectives
  - "Healthy Community" initiatives

- Sutherland C. "Criteria for Rating Report Card Quality," 1998. Personal communication.

  (1) Organization of the report, (2) presentation of data, (3) use of graphics, (4) balanced interpretation (needs and assets are both portrayed), and (5) indicators are contextualized (narrative is provided on indicators) are the five criteria for rating report card quality. If all elements are present, then the rating is "Good"; if the elements are present and of outstanding quality, then the rating is "Excellent."