PLANNED APPROACH TO COMMUNITY HEALTH

GUIDE FOR THE LOCAL COORDINATOR

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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National Center for Chronic Disease Prevention and Health Promotion

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CENTERS FOR DISEASE CONTROL AND PREVENTION

Planned Approach to Community Health

Guide for the Local Coordinator

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We would like to thank the thousands of community people who have used PATCH and other community planning models to assess and improve the health and quality of life in their communities. These materials were updated and designed to provide you with information on the process and on things to consider when adapting the process for your community. Even if you are not undertaking a community planning process, you will find information concerning such things as data use, partnering within and beyond the community, and appropriate levels of evaluation that may help you enrich any community program.

For further information on health education, health promotion, and community health planning contact the National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Mailstop K–46, 4770 Buford Highway, N.E., Atlanta, Georgia, 30341; 770/488-5426; FAX 770/488-5964.

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Planned Approach to Community Health

Concept Guide

Planned Approach to Community Health: Guide for the Local Coordinator

How the PATCH materials are organized

The **PATCH: Guide for the Local Coordinator** is a three-part package of materials designed to help communities undertake the PATCH process. It provides "how-to" information on the process and on things to consider when adapting the process for your community. PATCH materials include the Concept Guide, which contains information and tools for carrying out the PATCH process; the Meeting Guide, which is designed to assist the local coordinator with planning and conducting the community group meeting(s) related to each phase of the PATCH process; and the Visual Aids packet, which includes camera-ready copy of overheads and handouts.

Because you will want to adapt these materials and pull items from them to meet your needs and circumstances, detailed listings of contents appear in each of the three components. Page codes are included to help with the location and collation of the materials. For example, a page coded CG1-5 would be from the Concept Guide, chapter 1, page 5. A page coded II-H-2 would be from phase II, handout number 2.

Components — Page code

Concept Guide

Meeting Guide

Visual Aids

Other PATCH tools:

Behavioral Data Packet	To be developed by the community; Described on page CG3-27
Checklist for Designing a Successful Intervention (Checklist)	Phase IV handout, IV-H-1; Described on page CG5-15; Components of the Checklist are in other handouts and overheads
Community Leader Opinion Survey	Phase I handout, I-H-4; Described on page CG3-28
Community Profile	Section PD-I of the Program Documentation of Appendix 3; Described on page CG2-2
Community Resource Inventory	Phase IV handout, IV-H-5; Part of the Checklist, handout for phase IV, IV-H-1; Described on page CG5-15
Contributors to Leading Causes of Death	Phase III handout, III-H-1; Described on page CG3-5
Evaluation Worksheet	Phase V handouts, V-H-1 and V-H-2 (example); Part of the Checklist, handout for phase IV, IV-H-1; Described on page CG5-19
Existing Community Programs/ Policies Matrix	Phase III handout, III-H-2; Phase III overhead, III-O-11; Phase IV overhead, IV-O-8 (example); Described on pages CG4-6 and CG5-14
Five Phases of PATCH	Phase I overheads, I-O-2 and I-O-3; Described on page CG1-4

Five Steps to Planning an Evaluation	Phase V handout, CG6-13; Described on page CG6-11
Inventory of Collaborating Groups	Phase I handout, I-H-2; Described on pages CG2-9 and CG5-3
List of Health Problems	Phase II handout, II-H-1; Phase II overhead, II-O-2; Described on page CG4-2
Meeting Evaluation Form	To be developed by the community; Described on page MGO-3
Mortality and Morbidity Data Packets	To be developed by the community; Described on page CG3-20
Opinion Data Packet	To be developed by the community; Described on page CG3-35
Program Documentation (PD)	Appendix 3, contains sections PD-I through PD-XII; Described on pages CG2-2, CG3-13, CG3-25, and CG3-34
Stages of Change	Phase IV handout, IV-H-6; Described on page CG5-20
Timetable	Phase IV overheads, IV-O-11 and IV-O-12; Part of the Checklist, handout for phase IV, IV-H-1; Described on page CG5-15
Work Plan	Phase IV handouts, IV-H-7 (example) and IV-H-8; Part of the Checklist, handout for phase IV, IV-H-1; Described on page CG5-17

Chapter 1

Overview of PATCH

Contents

Chapter 1
Overview of PATCH

Introduction

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. This concept guide is part of a variety of materials designed to help a local coordinator facilitate the PATCH process within a community. These materials provide "how-to" information on the process and on things to consider when adapting the process for your community.

Definition and goal of PATCH

PATCH is a process that many communities use to plan, conduct, and evaluate health promotion and disease prevention programs. The PATCH process helps a community establish a health promotion team, collect and use local data, set health priorities, and design and evaluate interventions. Adaptable to a variety of situations, it can be used when a community wants to identify and address priority health problems or when the health priority or special population to be addressed has already been selected. It can also be adapted and used by existing organizational and planning structures in the community.

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. CDC promotes the use of PATCH in helping achieve the year 2000 national health objectives.[1] These objectives aim to reduce the prevalence of modifiable risk factors for the leading causes of preventable disease, death, disability, and injury. Although these objectives are national in scope, achieving them depends on efforts to promote health and provide prevention services at the local level.

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[1] *U.S. Department of Health and Human Services. Healthy People 2000: National Health Promotion and Disease Prevention Objectives. Washington, D.C.: U.S. Department of Health and Human Services, Public Health Service, 1991; DHHS publication no. (PHS) 91-50212.*

Background of PATCH

PATCH was developed in the mid-1980s by the CDC in partnership with state and local health departments and community groups. The purpose was to offer a practical, community-based process that was built upon the latest health education, health promotion, and community development knowledge and theories and organized within the context of the PRECEDE (predisposing, reinforcing, and enabling constructs in educational/environmental diagnosis and evaluation) model.

PATCH was built on the same philosophy as the World Health Organization's Health for All and the Ottawa Charter for Health Promotion,[2] which specifies that health promotion is the process of enabling people to increase control over their health and to improve their health. To plan effective strategies, each community must go through its own process of assessing needs, setting priorities, formulating solutions, and owning programs. A key strategy in PATCH is to encourage linkages within the community and between the community and the state health department, universities, and other regional and national levels of organizations that can provide data, resources, and consultation.

In 1984–1985, PATCH was piloted in six states and communities by CDC staff, working in partnership with the state health departments and the communities. Subsequently, PATCH was revised by CDC staff, and additional tools and materials for carrying out PATCH in a community were developed. CDC staff expanded the delivery of PATCH to include 11 more states and communities. Beginning in 1988, three evaluation studies were performed by the University of North Carolina, the Research Triangle Institute, and the PATCH National Working Group to assess the effects of PATCH and to recommend refinements on future directions. Since 1991, CDC no longer delivers PATCH directly in communities. Instead, CDC provides limited training and consultation to state health departments and the public and private sectors on the application of PATCH. Currently, most state health departments have staff trained in PATCH and a state coordinator who serves as the state contact for PATCH.

PATCH is widely recognized as an effective community health planning model and is used by many states, communities, and several nations. It is used by diverse communities and populations to address many health concerns, including cardiovascular disease,

[2] *World Health Organization, Ottawa Charter for Health Promotion, International Conference on Health Promotion, November 17-21, 1986, Ottawa, Ontario, Canada.*

HIV, injuries, teenage pregnancy, and access to health care. It is used in states with and without a local health department infrastructure. Its community development approach is largely consistent with those of many community agencies, such as the agricultural extension services, hospitals, universities, and voluntary health agencies. Many state health departments work with agencies such as these to carry out PATCH. Universities, hospitals, worksites, military communities, area agencies on aging, voluntary health organizations, and other such groups have also adopted and used the PATCH process. Although many of the references and examples in these materials may describe its use by local health departments in conjunction with their state health department, we encourage any group or organization to use PATCH.

Elements critical to PATCH

Five elements are considered critical to the success of any community health promotion process.

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- *Community members participate in the process.* Fundamental to PATCH is active participation by a wide range of community members. These people analyze community data, set priorities, plan intervention activities, and make decisions on the health priorities of their community.
- *Data guide the development of programs.* Many types of data can be used to describe a community's health status and needs. These data help community members.
- *Participants develop a comprehensive health promotion strategy.* Community members analyze the factors that contribute to an identified health problem. They review community policies, services, and resources and design an overall community health promotion strategy. Interventions, which may include educational programs, mass media campaigns, policy advocacy, and environmental measures, are conducted in various settings, such as schools, health care facilities, community sites, and the workplace. Participants are encouraged to relate intervention goals to the appropriate year 2000 national health objectives.
- *Evaluation emphasizes feedback and program improvement.* Timely feedback is essential to the people involved in the program. Evaluation can also lead to improvements in the program.
- *The community capacity for health promotion is increased.* The PATCH process can be repeated to address various health priorities. PATCH aims to increase the capacity of community members to address health issues by strengthening their community health planning and health promotion skills.

The first and last critical elements, related to community participation and capacity building, are essential to ensure community ownership. Although the local coordinator facilitates the program, the community directs the program, and the program belongs to community members. Their decisions determine how the program progresses. All participants in the PATCH process share in its success.

The PATCH process

Although PATCH can be adapted to various health problems and communities, the phases of the process remain the same. Thus, once the mechanisms of the PATCH process are in place, only a few modifications are needed to address additional health issues. Phases can be repeated as new health priorities are identified, new target groups are selected, or new interventions are developed. The activities within phases may overlap as the process is carried out. Each of the five phases that constitute PATCH is described hereafter. The PATCH Assessment and Tracking (PAT) tool, included as Appendix 1, also summarizes each phase.

Phase I: Mobilizing the community

Mobilizing the community is an ongoing process that starts in phase I as a community organizes to begin PATCH and continues throughout the PATCH process. In phase I, the community to be addressed is defined, participants are recruited from the community, partnerships are formed, and a demographic profile of the community is completed. By collecting this information, participants learn about the makeup of the community for which health interventions will be planned. Knowing the makeup of the community also helps ensure that the PATCH community group is representative of the community. The community group and steering committee are then organized, and working groups are created. During this phase, the community is informed about PATCH so that support is gained, particularly from community leaders.

Phase II: Collecting and organizing data

Phase II begins when the community members form working groups to obtain and analyze data on mortality, morbidity, community opinion, and behaviors. These data, obtained from various sources, include quantitative data (e.g., vital statistics and survey) and qualitative data (e.g., opinions of community leaders). Com-

munity members may identify other sources of local data that should be collected as well. They analyze the data and determine the leading health problems in the community. The behavioral data are used during phase III to look at effects of behavior on health problems. During phase II, PATCH participants also identify ways to share the results of data analysis with the community.

Phase III: Choosing health priorities

During this phase, behavioral and any additional data collected are presented to the community group. This group analyzes the behavioral, social, economic, political, and environmental factors that affect the behaviors that put people at risk for disease, death, disability, and injury. Health priorities are identified. Community objectives related to the health priorities are set. The health priorities to be addressed initially are selected.

Phase IV: Developing a comprehensive intervention plan

Using information generated during phases II and III, the community group chooses, designs, and conducts interventions during phase IV. To prevent duplication and to build on existing services, the community group identifies and assesses resources, policies, environmental measures, and programs already focused on the risk behavior and to the target group. This group devises a comprehensive health promotion strategy, sets intervention objectives, and develops an intervention plan. This intervention plan includes strategies, a timetable, and a work plan for completing such tasks as recruiting and training volunteers, publicizing and conducting activities, evaluating the activities, and informing the community about results. Throughout, members of the target groups are involved in the process of planning interventions.

Phase V: Evaluating PATCH

Evaluation is an integral part of the PATCH process. It is ongoing and serves two purposes: to monitor and assess progress during the five phases of PATCH and to evaluate interventions. The community sets criteria for determining success and identifies data to be collected. Feedback is provided to the community to encourage future participation and to planners for use in program improvement.

Using PATCH to address a specific health issue or population

The phases just described outline the steps to identifying and reducing community health problems. When you use the PATCH process to address a particular health issue of high priority, modify the steps in phases I-III accordingly. For example, make it clear to the community that you are mobilizing members to address a specific health issue. Continue to recruit broad-based membership for your community group while identifying and including community members or agencies that have a special interest in the specific health issue. Modify the forms provided in the PATCH materials, and collect data for the specific health issue. Once the risk factors and target groups are selected, the PATCH process is the same for phases III-V when the health priority is not preselected. Similarly, when using PATCH to address the health needs of a specific population, such as older adults, you should modify phases I-III as needed.

How to use the PATCH materials

This Concept Guide is part of a three-part package of materials designed for the local coordinator, the person who initiates the PATCH process within a community. This local coordinator

- will have major coursework and experience in health education and community health promotion.
- will be able to adapt the PATCH process to meet the needs of the community.
- will serve as facilitator of this community-based process by working with a broad-based community group and ensuring community ownership.
- will use expertise and resources at the community, state, and federal levels.

PATCH materials include the concept guide, meeting guide, and visual aids.

These PATCH Guides are an updated version of the PATCH Books, first developed in 1986-1987 and widely used today. Current PATCH users are encouraged to use these revised materials. They provide additional “how-to” information on the process and on things to consider when adapting the process for your community.

On the basis of suggestions from PATCH users and the PATCH National Working Group, we have changed the terms used to describe PATCH participants. What was called a *core group* in the

original PATCH documents is now called a *steering committee,* and a *subcommittee* is now called a *working group*. *Workshop I* is now the *meeting* for phase I. The revised materials are packaged differently: the background information from previous books has been updated and combined to make up the *Concept Guide*, and the five scripts and information to help you conduct meetings for each phase of PATCH are together in the *Meeting Guide*. Each part of the package is described subsequently.

Concept guide

This Concept Guide presents an overview of PATCH, followed by separate chapters on each phase of the PATCH process. The guide includes tools, or forms, for planning and conducting various activities. It also provides background information on topics important to managing PATCH, such as group dynamics and statistical analysis, as well as practical information and suggestions for tailoring the process to the needs of your community. We recommend that you read the material in this guide thoroughly and review the section that corresponds to each phase of PATCH before you begin the phase.

The Concept Guide has as appendixes the PAT tool, the Program Documentation, a glossary, and a bibliography. The appendixes also include a variety of one-page tipsheets, referred to as Nutshells in earlier versions, that relate to the management of PATCH and group dynamics. You are encouraged to copy and share the tipsheets with group facilitators and working group chairpersons.

Meeting guide

The Meeting Guide is intended for use when planning and conducting meetings. It contains an introduction, followed by a separate section for each phase of the PATCH process. For each phase, it includes meeting objectives, recommends an agenda, and suggests specific activities that can be incorporated with your own ideas. The Meeting Guide is not intended to be exhaustive; rather, it helps ensure that key points are incorporated at the appropriate times, and it reduces the amount of time you need to prepare for each group meeting. The Meeting Guide is written for one meeting per phase; however, you may find that two or more short meetings per phase are more appropriate for accomplishing tasks in your community.

Visual aids

The packet of Visual Aids includes camera-ready copy for overheads and reproducible text for handouts. These materials are used at meetings throughout the PATCH process. The Meeting Guide indicates when to use each item, and the materials are arranged in the packet in order of use. Again, these sets of materials are by no means exhaustive. You may want to alter the suggested overheads so that they are more suited to your presentation style. You may want to modify or include other materials with the handouts so that the participants receive information more directly related to their specific community. Some of these materials are intended to serve as models for overheads and handouts you will need to develop to present data and other information for your own community.

Chapter 2

Mobilizing the Community

Contents

Chapter 2
Mobilizing the Community

Introduction

Mobilizing the community is an ongoing process that starts in phase I as a community organizes to begin PATCH and continues throughout the PATCH process. It involves defining the community and gaining commitment and support from its citizens. It also involves identifying or developing the organizational structure capable of carrying out the process and managing the long-term efforts to keep members and the community informed and energized. To gain the level of involvement necessary for a successful program, you must work with community members to

- define and describe your community.
- gain and maintain commitments from key organizations and individuals within and beyond the community.
- identify and coordinate community resources.
- communicate with the community often and through multiple channels.
- form partnerships for resources and support within and beyond the community.
- establish the structures and procedures needed to manage PATCH effectively.

In this chapter, we discuss some aspects of accomplishing these activities. Although we discuss these tasks independently, many overlap and the process of accomplishing them is rarely sequential. Defining the community, for example, requires communication with many community members. Membership and partners may change over time. For example, when the community identifies its priority health problems, behaviors, and target groups, you may want to reexamine your membership, resources, and partnerships and recruit others to meet changing or special needs.

As a process for planning community health, PATCH provides a vehicle for mutual and productive collaboration in which all parties benefit. It can be used to mobilize a community to address its health issues or, in communities that have many programs but lack collaboration between those programs, PATCH can serve a coordinating role in mobilizing existing community services and resources that can contribute to a healthier community.

Defining the community

A community may be defined by geographic boundaries, political boundaries, or demographic characteristics. Because data are often available for geographic or political units, defining a community by geography makes data collection easier. Also, selection of a political unit may increase the ability of the community to influence the use of government resources and policies to address priority health problems. Thus a PATCH community can be a neighborhood, a township, a city, a county, or a district. Special settings, such as public housing complexes, can also be PATCH communities. Whatever the definition of the community may be, residents must have public health needs in common and the resources within the community to respond effectively to those needs. To ensure that these internal resources are present, the community unit may need to be larger than a high-risk population that may become a target of future interventions. Members of a community should also have a "sense of community." They should have a sense of identity, shared values, norms, communications and helping patterns and identify themselves as members of the same community.

As you work to unite the community, one task may be to help community members increase their sense of the larger community. You will need to establish a general definition of community before you begin working to mobilize community members and form partnerships, adjusting the definition as appropriate. In essence, the community defines itself. The community begins to be defined when a group of citizens comes together to improve community health by using the PATCH process. During the process of defining your community, we recommend that you develop a profile of your community to understand its makeup.

Profile of the community

To help you complete a community profile, we have included a suggested format. Basic demographic information may help you ensure that the makeup of the PATCH community group reflects the makeup of the community. It may also help you decide how best to approach the community and its health problems as well as what some obstacles to communication may be.

For example, information about the average household income and size may help you determine the economic status of the community and thus what its resources may be. Knowing the average educational level of residents may help you gauge the level of your presentations and materials. Learning that the community has a large ethnic population may indicate the need to use non-English-language communication channels, such as foreign-language newspapers and radio stations.

You may want to add other items to the profile as well. Some communities identify the main employers in their community and then ensure that those organizations are represented in the PATCH community group or at least kept informed about PATCH.

Most of the information for the community profile can be obtained from data collected by the Bureau of the Census. Consult with your state coordinator and refer to the following publications:

U.S. Bureau of the Census. *Statistical Abstract of the United States, 1992.* 112th ed. Washington, D.C.: U.S. Bureau of the Census, 1992.

U.S. Department of Commerce. *1990 Census of Population and Housing Summary of Social, Economic, and Housing Characteristics.* Washington, D.C.: U.S. Department of Commerce, 1990.

Census data are generally available by region, state, metropolitan areas, and smaller geographical areas. Collect data so that you can make comparisons between your community and other areas such as the state or nation and thereby determine the relative status of your community.

The following suggested format for completing your community profile is the first section of the Program Documentation tool, included as Appendix 3. The purpose of the Program Documentation is to provide for the collection of basic information on the community and the PATCH process. The community group should review the forms and adapt them to meet its needs.

PD-I. Community Profile

Community: _____

Lead agency: _____

Contact person: _____

Address: _____

_____

Telephone number: _____ Fax number: _____

Source of data: _____ Year: _____

Community type: Urban___ Rural___ Suburban___ Other___

Geographic size or description: _____

_____

Total population:

Unemployment rate: Community _____ State _____

Per capita income: Community _____ State _____

Families below poverty level (%): Community _____ State _____

Age distribution in years:

Community

Age	%	No.
<1:		
1-14:		
15-24:		
25-64:		
≥65:		
total population:		

State

Age	%	No.
<1:		
1-14:		
15-24:		
25-64:		
≥65:		
total population:		

Number of households, by household size:

Number of persons in household

Community	**State**
1:	1:
2:	2:
3:	3:
4-5:	4-5:
6+:	6+:

Total number of households:

Annual household income:

	Community		**State**	
Amount	%	No.	%	No.
<$15,000:				
$15,000 to $24,999:				
$25,000 to $49,999:				
$50,000+:				

Marital status:*

			No. by sex	
	%	No.	Male	Female
Single:				
Married:				
Separated:				
Widowed:				
Divorced:				
Total:				

*Generally includes person 18 years of age and older.

Racial/ethnic composition:

	No.	%	% by sex Male	% by sex Female
White:				
Black:				
Hispanic*:				
American Indian+:				
Asian#:				
Other:				

*Includes both blacks and whites. +Or Alaska Native. #Or Pacific Islander.

Education:

Number of persons currently enrolled:

	Community
Elementary school	_____
High school	_____
Technical school	_____
College	_____

Educational achievement (% of adults who completed):

	Community	**State**
Elementary school plus 3 years of high school	_____	_____
High school	_____	_____
Technical school	_____	_____
College:		
1-3 years	_____	_____
4 years	_____	_____
≥5 years	_____	_____

Gaining commitments

The origin of the stimulus to undertake the PATCH process has varied in communities. In some communities, citizens have voiced concerns about potential health problems and requested that their public health department help them assess community health status and identify and address health problems. In other communities, the local health department, community hospital, university, chamber of commerce, community leader or another community agency has taken the initiative.

Whether interest in undertaking PATCH originates in the community or an agency, you will want to ensure that organizational and individual commitments and resources are available and that your community is ready to undertake the process. Identify existing community groups and consider whether an existing group could undertake the PATCH process or provide a foundation for building a structure for carrying out PATCH. If existing community groups are not appropriate, a new community group will need to be formed. Before you schedule the first community group meeting in phase I, you should secure commitments that include the following:

- a lead agency or existing community group to sponsor the process
- time for you as the local coordinator to facilitate the process
- three or more agencies or organizations to provide support and resources
- support from key leaders, local champions, and political stewards
- broad-based membership on the community group and steering committee
- collaborations and partnerships within the community
- collaborations and partnerships beyond the community
- time to develop a community-based program

Identify a lead agency to sponsor the process in the community. The lead agency could be the local health department, a community hospital, a university, an agricultural extension service, or other agency. If there is a local health department and it is not the lead agency, you should encourage its participation because of its key role in the health and well-being of the community.

The lead agency should clarify what resources it brings to PATCH. We recommend that the lead agency fund your position as local coordinator of the process. The time you need to manage the process will vary. You may find it a full-time job at first but need to devote less time as the process unfolds. Over a year, expect to spend 50

percent of your time if the process runs smoothly. The amount of your time required to manage PATCH depends on the help and resources available, community traditions with regard to volunteerism, and the partnerships that are established. Most of the information in this chapter will assist you in gaining commitments and establishing the structure needed to manage PATCH effectively.

To complement your role as advocate, many local coordinators have found that identifying and recruiting "program champions" prove invaluable. Those individuals can serve as "ambassadors" for the program to get things done. These program champions may serve two different roles: local champion and political steward. The local champion consistently advocates for the program. Although you also help perform this function, ideally the local champion takes the lead thus freeing you to manage day-to-day activities. The political steward steers the program through the political red tape, adds credibility to the program, and helps obtain resources. You may find it helpful to recruit program champions within the lead agency and within other community organizations, including local government, as appropriate.

The lead agency, program champions, and local coordinator should hold orientation meetings and one-on-one discussions with key people to gain commitments from at least three other agencies or groups in the community. These commitments should include letters that specify the nature of the support, such as participation in meetings, assistance with training and skill-building activities, staff time, meeting space, clerical support, copying services, mailing services, supplies, funds, or other resources. The letters should also indicate a willingness to participate in all five phases of PATCH, to maintain community ownership of the process, and to assist with recruiting a broad-based membership on the community group and steering committee (discussed later in this chapter).

In many communities, PATCH has increased networking between agencies and coordination of scarce resources.

As you inform groups, organizations, and residents about PATCH and gain their support for the PATCH concept, recruit participants representative of your community. These people should be citizens who are lay leaders or who represent local agencies or organizations from public and private sectors. Their contributions include knowledge of the community, voluntary and paid staff time, space for meetings and activities, funds, administrative services, and other resources, such as access to informal and public communication channels. Work with participants to clarify expectations and roles, and to reach agreement on the definition of the community and commitment to the PATCH process. Continue your efforts until you feel comfortable that the level of interest and resources is sufficient to sustain the program.

Commitments within the community

Gaining community-level commitments often involves coordinating resources with various community groups. PATCH provides a vehicle for productive collaboration in which all parties can benefit. In many communities, various groups are already committed to improving community health and may be sponsoring health promotion activities and services. Government agencies, including public health, schools, public safety, and social services agencies, have a mandate for protecting and improving the quality of life of the citizens and may be encouraged to use their resources and policies to address priority health issues. Invite those groups to join the PATCH community group, or at least build relationships with those groups to avoid duplication. Combined efforts may lead to more rapid and satisfactory results. In many communities, PATCH has increased networking between agencies and coordination of scarce resources. PATCH meetings and newsletters can be valuable to agencies that want to inform the community about their programs and activities.

Forge partnerships and encourage groups with different interests to work together. Sometimes, the PATCH community group may compete with other groups for scarce resources and volunteers. Further, some groups may be responsible primarily for promoting the goals of a national authority. However, by finding areas of mutual benefit, groups have shown that they are able to work together with much success.

To identify the groups in your community with which you might collaborate, use the Inventory of Collaborating Groups.

As you work to foster collaboration, be consistent in your messages from group to group. State the goals and objectives of the PATCH program so that they are easily understood by others. When you present them to representatives of other groups, indicate how this focus complements theirs. Invite them to participate in PATCH by identifying shared goals, and ask whether they can contribute financial resources, services, staff, and information. Ask for their involvement in planning, implementing, and evaluating PATCH.

When building a relationship with another group, be sure to agree on the division of labor. Decide who will coordinate the combined efforts, which joint objectives you want to accomplish, and what specific steps you can both take to accomplish those objectives.

To identify the groups in your community with which you might collaborate, use the Inventory of Collaborating Groups on the following pages. In the left-hand column, we list in alphabetical order the various types of organizations with which you might collaborate. In the space provided, write in the names of specific

groups of each type. To collect information about community organizations, contact the chamber of commerce, public libraries, United Way, city and county planning agencies, local media, and community leaders. Across the top of the page, we have suggested some types of collaboration you might seek with a group. Check each column that applies to each group. Refer to this inventory as you plan your contact with the many groups in your community. Not all groups will want to be involved in PATCH activities; however, keep them informed and they may become involved later. Some groups may want to see how PATCH works and what is accomplished before they agree to collaborate.

Inventory of Collaborating Groups

	Recruit for community group	Request mailing list	Ask for letter of endorsement	Request newsletter	Request data	Collaborate on intervention	Recruit volunteers
Agricultural extension services							
Businesses, chamber of commerce							
Charitable organizations							
Civic groups							
Government officials (e.g., mayor, commissioner)							
Health agencies (e.g., health department, voluntaries)							
Health councils/coalitions							
Labor unions							
Medical facilities (e.g., hospitals clinics)							
Medical societies							

Inventory of Collaborating Groups (Continued)

	Recruit for community group	Request mailing list	Ask for letter of endorsement	Request newsletter	Request data	Collaborate on intervention	Recruit volunteers
Mental health services							
Neighborhood associations and leaders							
Older-adult groups							
Organizations of faith							
Professional associations							
Public safety agencies (e.g., departments of police and fire)							
Schools, colleges, and universities							
Service groups							
Social service agencies							
Others							

Commitments beyond the community

Because many communities do not have abundant resources to conduct health interventions, a key strategy in PATCH is to encourage linkages both within and beyond the community. On the basis of its needs, a community may seek to develop partnerships with public and private sector organizations at the regional, state, or national levels. Some of the key resources to explore include the state departments of health and education, hospitals, universities, agricultural extension services, voluntary health agencies, businesses with health promotion policies and programs, and other communities undertaking the PATCH process.

For example, you might request that your state health department provide consultation and resources for such tasks as training, problem solving, and data analysis. You might ask the PATCH state coordinator with your state health department to participate in one or more community group meetings and to provide you with information from other PATCH communities that might be useful as you undertake the process and design interventions. The state health department may also be able to identify additional assistance and refer you to other state or national organizations, groups, or funding sources.

Partners outside the community can provide valuable technical assistance, consultation, data sources, model intervention programs, motivation, and moral support that can help enhance the viability and survival of your community's program. Also, with involvement of these partners, communities are better able to circumvent many of the turf battles that can develop when a single community-based group attempts to involve other local organizations in achieving a common objective. Most partners from outside the community will realize that fostering community empowerment and control are essential elements in building a long-term partnership with a community. You must ensure a healthy balance between outside assistance and community empowerment. In some cases, community participants may resent too much assistance from outsiders. The community group should maintain autonomy and be free to address problems that it considers appropriate for its community. Similarly, model intervention programs provided by state and national groups may be appropriate if adapted to meet the needs of your community. By having an active PATCH community, you will be in a better position to make use of these state and national programs and resources.

Partners outside the community can provide valuable technical assistance, consultation, data sources, model intervention programs, motivation, and moral support that can help enhance the viability and survival of your community's program.

Building commitments takes time

Defining and then mobilizing a community takes time and energy. Sometimes several months to a year or more are spent promoting PATCH and organizing citizens before a community is ready to begin the process. Factors that affect this process include whether the area of the community is urban or rural, whether the community is politically active, whether existing activities and groups can be tapped, what the level of resources is, what the average educational level of the citizens is, and whether potential participants recognize the need for improving the community's health status. However, as you inform the community about PATCH, hold meetings, and form groups, citizens work together to develop a collective identity, build relationships, and identify shared goals. Building trusting relationships, respect, and lasting community infrastructure for good health are necessary long-term objectives for any community-based program.

Similarly, it takes time to identify the types of technical assistance your community will need and to develop partnerships outside of the community to meet these needs. Taking time to establish the structures needed to manage the PATCH process within your community is important.

Structuring and managing PATCH

The PATCH program must have a clearly defined structure and function.

Like any organization, the PATCH program must have a clearly defined structure (e.g., committees) and function (e.g., operational procedures, meeting format, and communication networks). They should enhance the planning process by fostering a shared vision, mutual trust, willingness to work together, and a recognition and appreciation of differences among members.

Organizational structure

We recommend that the community's PATCH team consists of three partners: the community group, steering committee, and local coordinator.

Community group

This group makes all programmatic decisions and is responsible for many activities including these:

- analyzing community data
- selecting health priorities
- developing program objectives
- serving on working groups
- helping with program implementation and evaluation

Community group members are private citizens, political office holders, lay leaders, and representatives of service and social organizations, health organizations, private companies, and other groups. (See Inventory of Collaborating Groups). The community group may comprise from 12 to 100 people, but a group of 20 to 40 people has been shown in PATCH communities to be an effective size. PATCH communities have also found it valuable to have at least 20% of the comunity group be lay leaders.

The community group should reflect the makeup of the community and contain members with the skills and qualities needed to carry out the program. Some of the desired skills include ability to negotiate, solve problems, communicate, organize, analyze data, write, work with media, facilitate groups, and do long-term planning. Some of the desired qualities of the community group include people who are resourceful, credible, doers, visionary, and politically connected; know the community; and have a sincere interest in improving the health of the community.

Steering committee

This group's responsibilities include those of the community group as well as the following:

- helping the local coordinator with administrative functions
- chairing working groups for specific tasks
- helping to identify resources
- facilitating communication between working groups

A group of 6 to 12 people, drawn from the community group, has been shown to be an effective size.

Local coordinator

As the local coordinator, you facilitate the process and manage the day-to-day activities of PATCH. You will need to assume responsibility for tasks such as the following:

- advocating for PATCH and gaining commitments
- increasing awareness of PATCH and health issues within the community
- identifying training needs and mechanisms for training the community group, the steering committee, and working groups
- arranging for and facilitating meetings of these groups
- providing technical assistance to these groups
- nurturing partnerships within and beyond the community
- coordinating assistance from outside partners such as the state health department
- assuring that the process is managed and community ownership maintained
- helping to plan, carry out, and evaluate interventions

In this Concept Guide, we further describe the role of the local coordinator and recommend how the tasks might be accomplished

Functional structure

Partners outside the community can provide valuable technical assistance, consultation, data sources, model intervention programs, motivation, and moral support that can help enhance the viability and survival of your community's program. To work effectively, the PATCH group needs to establish structures including operational procedures to guide the group in decision making and other tasks; a forum for carrying out the process; mechanisms for carrying out tasks; and communication networks for sharing information. You may want to use the PD-X. Community Participant of the Program Documentation (see Appendix 3) or another mechanism to identify and evaluate participation.

Operational procedures

Operational procedures should be developed to monitor and guide the process. They should reinforce a group process that enhances a shared vision, sense of community, mutual trust, open discussion, appreciation of differences, and willingness to work together. They should include mechanisms for communicating within and between the PATCH groups, orienting new members, making decisions, and carrying out administrative tasks such as the development of work plans, timelines, and committees.

In most communities, the steering committee or the local coordinator drafts a set of operational procedures. Some communities assign the task to a working group. The operational procedures are then reviewed and approved by the community group.

Meeting format

PATCH is designed to be carried out through a series of community group meetings in which issues are discussed, tasks are assigned, and decisions are made. The *Meeting Guide* and *Visual Aids* provided with these materials are designed to help you plan and facilitate these meetings. The Meeting Guide also contains suggestions as to how you might vary the meetings to address local needs.

Your role is to facilitate the meetings and to encourage participation and ownership by the group. Encourage participants to contribute comments or ask questions and to debate issues. Enlist full participation and encourage members of the community group and working group chairpersons to present information and to facilitate sections of meetings. Use workshops and meetings to build a sense of vision and cohesiveness among participants. Provide training and skill-building activities as appropriate. The group decision-making processes used during meetings help develop consensus, commitment, and a sense of trust. To build and maintain trust, group members need to meet commitments, listen to and appreciate views of others, and be open about actions and intentions. Information should be shared openly and equally among members. Many local coordinators have found it extremely helpful to provide community group members with a PATCH notebook, usually a loose-leaf binder, that members can use to hold copies of community data, minutes of meetings, and other handouts.

The minutes of meetings should be recorded and then distributed to all community group members to confirm decisions made during the meetings and to inform members who could not attend. However, as priorities and objectives are being established during the first three phases of PATCH, you may also want to make personal

contact with members absent from key meetings to review the information discussed and the decisions made. You may wish to ask new members to arrive at the meeting early so you can provide an orientation. The importance of group dynamics and facilitation cannot be overstated. Review the Tipsheets (see Appendix 2) for hints on managing group process. Share these tipsheets, as appropriate, with chairpersons or other group members.

Working groups

Many of the activities carried out in PATCH are performed by working groups. The members of these working groups should be drawn from the community group, and chairpersons of the working groups should also serve on the steering committee. During the PATCH meetings, tasks are defined, working groups are established and participants are encouraged to join, and the group may meet at least long enough to select a chairperson.

During phase I, at least five working groups might be formed to focus on specific aspects of the PATCH process. Consider whether your community would benefit from creating any additional working groups or combining the working groups described later. If so, edit the working group task sheets in the handouts for phase I, and create new ones by outlining what the responsibilities of any additional groups should be. Form other groups as needed. For example, during phase IV, you may need one or more working groups to design and conduct interventions.

During the first community group meeting, schedule time for reviewing the tasks of the working groups; clarifying responsibilities; and establishing procedures, timelines, and meeting schedules. Not all work needs to be done by the group itself. The group can identify other persons within the community to help them. For example, in one community, the behavioral data working group trained members of the Homemakers Club of the county extension service to help with a community survey.

The chief responsibilities of each of the five suggested working groups are listed below. Use this information to begin thinking about the skills and qualities you will need in each group. Although many communities have participants volunteer to serve on working groups, you may want to identify some members and the chairpersons in advance to assure they have the skills you need. To help participants clearly understand which tasks the group is expected to perform, we have included in the handouts additional descriptions of the responsibilities of these groups for you to distribute at the community group meeting.

The five suggested working groups are listed below along with their main tasks.

Mortality and morbidity data

- Obtain and analyze mortality data, including trends in the data.
- Obtain and analyze morbidity data–primarily data for the main reasons for hospitalization.
- Collect and analyze any supporting data needed (e.g., motor vehicle collision reports and public health clinic records).
- Present the data to the community group.

Behavioral data

Behavioral data are either collected from the community or obtained from existing data. (See Chapter 3 for additional information.) When a community behavioral survey is not performed, working group members

- Examine existing state and national behavioral data.
- Develop synthetic estimates of behavioral data for the community.
- Examine data from community sources, such as lifestyle data collected by employers.

When collecting data using the CDC Behavioral Risk Factor Survey, you will want to inform your state health department. If the community wants to develop its own survey, you should contact your state health department for assistance and to ensure as much comparability with other data sets as possible. Working group members

- Determine the sample for the survey.
- Coordinate and conduct interviews.
- Arrange for analysis of data by the state health department.
- Report the results to the community group.

Community opinion data

- Develop the questions for the opinion survey.
- Determine the list of persons to be interviewed.
- Coordinate the logistics of conducting the survey, including training of interviewers.
- Coordinate and conduct interviews.
- Analyze results.
- Report the results to the community group.

Public relations

- Publicize the PATCH process and the health needs of the community.
- Work with representatives of local media by distributing press releases or making in-person visits.
- Coordinate the design of a PATCH logo and the production of a newsletter.
- Provide health education messages to the community through multiple media channels.

Evaluation

- Monitor the phases of PATCH to ensure a cohesive process for community health planning.
- Evaluate how the PATCH process has affected the community.
- Evaluate the success of PATCH interventions.
- Serve as a resource for the steering committee, the working groups, and the community group, as needed.
- Help improve programs by incorporating evaluation results.

Note that in some communities, an evaluation working group is not formed because the steering committee prefers to take responsibility for these tasks.

How long each working group is active depends on how long it takes to accomplish the specific tasks. Some groups, such as the public relations and evaluation groups, continue throughout the PATCH process, although the tasks they perform may change with each phase. Other groups, such as that for mortality and morbidity data, may disband when data collection and analysis are completed.

The number of members needed for each group depends on the number and complexity of the tasks, the skill level of the members, and the size of the community. Each working group should have at least three members. Expect some people to drop out, and try to plan for this by assigning additional members or identifying some people who could fill in at a later time. Members may want to rotate among groups or exchange roles within working groups to prevent burnout. If some community group members prefer not to serve on a working group, they can help in other ways by attending meetings, contributing to decisions, and identifying resources. Some people may be interested in joining future working groups for specific interventions.

Communication networks

Good communication is the key to mobilizing a community and keeping community members involved. The general public, specific groups and organizations, and selected individuals need to be informed and educated about the PATCH process. Once interventions are planned, the activities must also be promoted.

Your communication goals should include increasing community awareness about health issues, how the PATCH process can help the community, what decisions have been made by the community group, and how citizens can contribute to building a healthier community. To gain public support, try to appeal to potential participants in their own language. That is, avoid technical or bureaucratic language and a stiff communication style that could turn people away from rather than invite them to join PATCH. Further, the PATCH process generates substantial information about the community. Your task is to help communicate this information so that its significance is made clear.

Be sure that the language and style of your message are appropriate for the audience you are addressing. A message to the entire community, for example, should use language suited to the average educational level of the community. The message might be addressed to families or express concern for a given segment of the community, such as teenagers. In contrast, a message to health care workers should be expressed in the medical language that has special meaning for these professionals and might be supported by more complicated displays of data.

Thus, communicating effectively with persons of different groups requires knowing their educational level, background knowledge about a subject, goals, interests, and concerns. One way to learn how your audience communicates is to review some of the literature that people in that group read. You might also ask certain members of a group to review your messages and critique them before you deliver them to the group at large.

Reaching the many audiences within a community requires using multiple channels of communication, from mass media to word of mouth. By using several channels, you increase the likelihood that many diverse people will hear your message. You can communicate by using existing channels, or you can establish new ones. Many PATCH communities publish a newsletter to keep participants and the community abreast of planning and intervention activities.

The communication channel appropriate for your message depends on the audience. In the following sections, we discuss several channels of communication and when they may be most appropriately used.

In-person communication

Getting people to commit their time and energy to a project may require your showing personal interest in them. When you communicate in person, the listener tends to feel specially selected, and trust is encouraged. The listener can ask questions and contribute information that can influence decisions. Thus, in-person communication is a powerful way to promote acceptance of and gain support for new ideas.

Approach in person the individuals you would like to be involved in PATCH. Personal contact is also useful for informing influential members of the community about PATCH. Try to speak at meetings of many different groups, such as the League of Women Voters, Kiwanis International, Elks club, chamber of commerce, gardening clubs, parent-teachers associations, hospital grand rounds, town council, homeowners' associations, religious organizations, and so on. Be active in the various groups that can help you build a constituency for PATCH. Acceptance for PATCH is also gained as participants talk in person with neighbors, friends, coworkers, and acquaintances throughout the community. After an initial meeting, write personal letters and make telephone calls to follow up.

PATCH newsletter

A newsletter is one means that communities have found helpful for keeping community members informed about the PATCH process and activities. A newsletter sent to community group members and other groups and key individuals in the community can accomplish several purposes. It can

- encourage participation in PATCH.
- summarize past meetings and events.
- keep the community involved as decisions are made.
- announce interventions or coming events, including the next PATCH meeting.
- give the background information about issues or problems to be discussed.
- keep the community abreast of PATCH activities and accomplishments.

- recognize the achievements of the group and of individual members and the contribution of resources from the community.
- support the distinct identity of the program and its participants.

Some communities design a logo for their program that can be used on the newsletter and given high visibility throughout the community. These logos often become a source of community pride. The handouts for the community group meeting for phase I include examples of logos that you might want to share with participants. Some community groups design a logo themselves; other groups sponsor a contest or use another method to encourage suggestions from the community.

Public media

To reach the community at large and special segments of the community, use the established print and nonprint public media channels.

Small media include organizational newsletters and small-circulation publications that appeal to members of special groups, such as ethnic minorities and business people. Non-English-speaking persons, for example, may read a newspaper in their language but not the local, English-language paper. Members of the chamber of commerce may pay special attention to its bulletins and to professional publications. Other audiences can be reached through materials published by churches, civic groups, and voluntary agencies.

The mass media, including radio, television, and large-circulation newspapers, reach wider audiences. Attempt to use the mass media for broadcasting news, feature stories, and calendar events. Invite local journalists to participate in the community group, and ask media representatives to attend specific meetings. Keep members of the print and broadcast media informed through personal communication or by sending them the PATCH newsletter or news releases. A public relations working group, which can be established during the first community group meeting, can be made specifically responsible for keeping the media informed and involved.

Be sure to consider how the media for your community are organized. One PATCH community, for example, comprises three towns served by five newspapers. Instead of assigning a member of the public relations working group to work with each town, representatives were selected to hand carry news releases to the editor at each newspaper.

Finally, remember that nontraditional media channels are available as well. For example, distributing flyers in grocery stores or handing out brochures at athletic events may be ways to reach special audiences.

Adapting phase I to address a specific health issue or population

When a health issue of high priority is selected before beginning the PATCH process, some of the activities in phase I are modified accordingly. For example, if the health problem to be addressed is cardiovascular disease (CVD), make that point clear to the community as you are mobilizing members. Continue to recruit broad-based membership for your community group while identifying and including community members or agencies, such as the American Heart Association, that have a special interest in the specific health issue. As you develop partnerships and establish communication channels, look at all the possibilities as well as agencies and channels already committed to CVD. You may wish to use some basic data, such as mortality data, to help mobilize the community around the preselected issues. When using PATCH to address the health needs of a specific population, such as older adults, make similar modifications.

Chapter 3

Collecting and Organizing Data

Contents

Chapter 3
Collecting and Organizing Data

Introduction

Throughout PATCH, data are used to guide the process. Phase II begins when the community group forms working groups to assess community health status and needs. The community group uses data as it selects health priorities in phases II and III. In phases III and IV, the community group may want to obtain additional information on selected health priorities, target groups, and related community resources as it designs appropriate and effective interventions. In phase V and throughout the process, data are collected and examined to evaluate interventions and identify areas for program improvement.

PATCH communities have found data valuable to

- serve as a motivator, helping to develop within the community a sense of ownership; communities are more supportive of interventions when decisions are based on data.
- substantiate information presented to the community about health issues.
- greatly increase the ability of the community to form partnerships and to compete for grants, funding from foundations, and other resources.

The data obtained should be those that the community deems relevant to its PATCH activities. The community should use existing data when available and collect new information when necessary. All communities should compare their data with data for the state or nation; some communities may also want to compare their data with data for a region, district, or neighboring county.

The community should use existing data when available and collect new information when necessary.

The highest quality data are those that are precise enough for scientific validity and are representative of the community. Although the community should strive to use the most valid and reliable data, sources of data or information that are not representative of the community can prove valuable for use in health planning. Using multiple data sources may help compensate for lack of more precise data and can provide an overview of the community that is valid for program development.

In phase II of PATCH, participants need to obtain and analyze quantitative and qualitative data that help reveal the leading health problems in the community. The quantitative data include vital statistics, disease registry, and survey data, and the qualitative data derive from opinion surveys of community leaders and, as appropriate, the community at large. The community may identify other sources of data as well.

During this phase of PATCH you, as local coordinator, must work with community members to

- obtain and analyze mortality, morbidity, and behavioral data.
- obtain and analyze community opinion information.
- present and use data to identify health priorities.
- determine ways to share data with the community.

This chapter addresses data issues related to community needs assessment and identification of health priorities. It describes the types of data the community should collect; methods for compiling data; and ways to analyze, organize, and display data. It also includes some conceptual information that may help you guide participants in understanding the importance of using data, how to document and describe the community's health problems, and how to compare community data with data for other areas. For additional assistance related to data, identify expertise within your community, consult the Bibliography (see Appendix 5), or consult with your state health department or a college or university.

Causes of death and disability

In the year 1900, most people died from infectious diseases. Gradually, as living conditions improved and advances were made in sanitation, immunization, and medicine, deaths from infectious diseases decreased. Chronic diseases then became the leading causes of death. Here are the leading causes of death in 1900 and 1990; the causes of death with the highest rates are listed first.

Leading Causes of Death, United States, 1900 and 1990

1900	1990
Tuberculosis	Coronary heart disease
Pneumonia/influenza	Cancer
Diarrheal diseases	Stroke
Coronary heart disease	Injuries
Liver disease	Bronchitis/emphysema
Injuries	Pneumonia/influenza
Stroke	Diabetes
Cancer	Suicide
Bronchitis	Chronic liver disease
Diphtheria	Homicide

Accordingly, health officials have begun to turn their attention to preventing behavior-related diseases and to encouraging behavior and lifestyle changes at an individual and community level that can significantly influence whether a person develops a disease. Increasing attention has also been paid to intentional and unintentional injuries as causes of death. Elements of these events are believed to be controllable; many injuries can be prevented by changing related behaviors, policies, and developing a supportive environment.

Preventing premature death and disability

To prevent premature death and disability, we begin by asking why they occurred. Similarly, we look for "whys," or risk factors, for diseases. Factors that contribute to premature death include

- unhealthy behaviors.
- biologic or genetic conditions that predispose people to disease.
- inadequacies in the health care system.
- unsafe environmental conditions.

Unhealthy behaviors contribute the most to premature death and account for an estimated 54% of all diseases of the heart, 37% of cancers, and 69% of motor vehicle fatalities. In the United States, it is estimated that about 50% of all deaths before age 75 are caused by unhealthy behaviors, 20% by environmental factors, 20% by biologic factors, and 10% by inadequacies in the health care system.[1]

[1] *Dever GEA. Community Health Analysis: Global Awareness at the Local Level (2nd ed.). Gaithersburg, MD: Aspen Publications Inc., 1991;35.*

Risk factors can be either behavioral or nonbehavioral. Some risk factors–particularly those that are behavioral–may be amenable to change. Although we cannot change people's genetic makeup, we may be able to encourage them to engage in regular physical activity, eat healthy foods, take blood pressure medication, or stop smoking, and these behaviors may reduce the risk for certain diseases.

Environmental factors may also be changed to lower the risk for death or disability. For example, traffic lights might be installed at an intersection that is the site of many traffic fatalities or grocery stores might provide more low-fat food choices. Policy changes might also be possible–for example, laws prohibiting the sale of tobacco products to minors might be rigorously enforced, clean indoor air policies might be used to ensure smoke-free environments, and a worksite policy might allow flexible work schedules to encourage employees to engage in regular physical activity.

PATCH can be used to guide the community in analyzing causes of death and disability, identifying risk factors for these causes, and developing ways to reduce or change these risk factors, thereby reducing death and disability.

The following table, Table 1, summarizes risk factors that contribute to the leading causes of death.

Table 1. Contributors to the Leading Causes of Death

		Heart disease	Cancer	Stroke	Injuries (Nonvehicular)	Influenza/ Pneumonia	Injuries (Vehicular)	Diabetes	Cirrhosis	Suicide	Homicide
Behavioral risk factor	Tobacco use	•	•	•	•	•					
	Diet	•	•	P				•			
	Obesity	•	•					•			
	Lack of exercise	•	•	•				•			
	High blood pressure	•		•							
	High blood cholesterol	•		P							
	Stress	P		P	•		•			•	•
	Alcohol abuse	•	•	•	•		•			•	•
	Drug misuse	P	•	P	•		•			•	•
	Not using seatbelts						•				
	Handgun possession				•					•	•
Nonbehavioral risk factor	Biological factors	•	•	•		•		•	•	•	P
	Radiation		•								
	Workplace hazards		•		•		•				
	Environmental factors		•		•						
	Infectious agents	P	•			•			•		
	Auto/road design				•						
	Speed limits						•				
	Health care access	•	•	•	•	•	•	•	•	•	•

P = possible

Quantitative data

By analyzing mortality, morbidity, and behavioral data, we attempt to quantify health problems and the behavioral risk factors that contribute to them.

Mortality and morbidity data

Mortality data describe the deaths that occur in your community. These data are often analyzed by sex, race, age at death, and other variables about the deceased and compared with similar local, state, and national data. Such comparisons may indicate that certain health problems are more extensive in your community than in others or more severe among some groups than others.

Mortality data are collected in a standard format by all 50 states, the District of Columbia, Puerto Rico, and U.S. territories. The data are generally maintained by the state health department vital statistics units, from which they are available in computerized form for at least the last 10 years. These data are submitted to CDC's National Center for Health Statistics (NCHS) where they are combined with data from all the other states and territories in a national mortality data set.

Compiling information on all deaths that occur in a particular year and preparing a data set for public use takes a considerable amount of time. Consequently, complete files are usually not available from your state health department for several months after the end of a calendar year. Before then, preliminary files or advance data may be made available to health departments and other interested parties. For example, NCHS provides provisional mortality data in its Monthly Vital Statistics Report, which is available in many libraries, at most state vital records units, or through subscription. Summary mortality data are also available by state on CDC's computer network through WONDER (Wide-Ranging Online Data for Epidemiologic Research), which is designed by CDC to simplify online access data bases maintained by CDC. WONDER can be accessed from a modem-equipped personal computer.

For more information about WONDER, contact your state or local health department or CDC/Atlanta at (404) 332-4569.

Throughout the United States and most of the world, causes of death are standardized by translating the written diagnosis into a medical code contained in the *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, Ninth Revision* (ICD-9). To allow for comparison between community, state, and national data, the cause of death codes used by NCHS are taken from the ICD-9.

Mortality data are reported by place of residence or place of occurrence. The resident death rate reports the death rate for residents of an area, no matter where the deaths took place. The occurrence death rate reports the death rate for an area, regardless of where the decedents resided. The resident death rate is generally used for assessing the health risk of a community.

Morbidity data can be used to quantify the burden of disease in a population. These data help identify the leading causes of illness, injury, and disability and are useful in considering such outcomes as quality of life or the social and economic costs to society of certain health problems. Morbidity can be defined by looking at the incidence or prevalence of disease in the population. The incidence is the estimate measure of new cases of a disease or other events during a period of time. The prevalence is a measure of all cases, old and new, of disease or other health events that exist at a given time. The morbidity information provided by hospital discharge data and other data sources can assist your community in identifying the leading causes of disease and economic burden.

Although morbidity data are not always easily accessible and accurate, you are encouraged to look for existing sources. Morbidity data can be derived from medical records and population-based data sources. As with mortality data, these data can also be analyzed by subgroup or cause of morbidity and compared with data for other areas. The two main difficulties associated with collecting morbidity data are the following:

- Data are not reported in a consistent manner because there are no federal regulations for reporting morbidity data, reporting requirements vary between states and prevent comparability, and not all providers routinely maintain such data.
- In the case of hospital discharge data, the population served by local hospitals may not be the same as the community's population; local hospitals may serve people from outside the community; and residents may go outside the community for health care.

Hospital discharge data, which are sometimes available through a state agency or from local hospitals, are a major source of morbidity data. These data, which generally include reason for hospitalization and length of stay, can contribute to measuring the burden and cost of illness and disability in the community. Statewide hospital discharge databases, currently maintained by 35 states, generally support health planning and cost containment. Many states also maintain registries for such health priorities as cancer and birth defects. Your state health department should know if these databases exist and where they are located within your state.

Measures of mortality and morbidity

Expressing deaths as rates allows for useful comparisons.

Sometimes a count of health events (number of deaths or hospitalizations) is inadequate for expressing the burden of mortality and morbidity. The number of health events has little meaning unless the size of the population is known, for a higher count is expected from a larger population. Knowing that a county had 248 deaths due to cardiovascular disease and that the state had 7,658 deaths does not allow for comparison. Expressing these deaths as rates, 231.2 deaths per 100,000 for the county and 213.4 deaths per 100,000 for the state, does allow for useful comparisons. Values for different areas, populations, or periods must be made comparable to allow for evaluation. Thus mortality and morbidity data are usually presented as rates.

Crude, specific, and adjusted rates

A rate is expressed as a fraction in which the numerator is the number of persons to whom an event occurred during a period of time, and the denominator is the total number of persons in the population at risk for the event during the same period of time. The fraction is usually given per 1,000 or 100,000 persons per year.

A crude death rate is the number of deaths for a given population during a given period, divided by the total population during the same period. The population can be that of a state, a county, or another geographic unit for which data are available. The crude death rate is a rough estimate because it reflects all the factors in a community that could affect the total death rate, such as the demographic, social, and economic makeup of the community. Thus, crude rates can be misleading if an event occurs disproportionately in a group that is overrepresented or underrepresented in the population. For example, a high crude death rate is generally expected for a community with a high proportion of older persons, such as a retirement community.

To more clearly identify priorities and target populations, your community should calculate rates for specific subgroups, by age, sex, race, or other characteristics. For example, you might calculate an age-specific rate for persons aged 18 to 24 years or an age-sex-race-specific rate for black women aged 18 to 24 years. For these rates, the number of events for the subgroup is divided by the total population of the subgroup.

To focus on specific diseases, you can calculate cause-specific rates for particular causes of death or disability. For example, you might calculate the mortality rate for all cardiovascular deaths in your community. You might also calculate cause-age-sex-race-

specific rates for subgroups in your community, for example, 45-to-64-year-old white men who die of cardiovascular disease.

An adjusted rate, or a standardized rate, helps control for demographic differences between populations being compared. Adjusted mortality rates, for example, estimate what the mortality rates for populations would be if their composition were similar to that of a comparison, or standard, population. The standard population could be the state or U.S. population, and adjustment can be made for age, race, sex, or other characteristics. Because the rates are standardized to the same population, however, they are comparable and thus allow for analyses between populations.

Choosing a rate

Whether to use crude, specific, or adjusted rates depends on the purpose of the analysis. Crude rates are easy to compute and understand. They represent the actual experience of the population and provide a rough measure that reflects many factors, such as the demographic, social, and economic makeup of the community. Crude rates are useful when determining the overall allocation of health resources. For public health planning, however, specific rates provide the most detailed information about the pattern of disease in a population. However, comparisons of specific rates can become cumbersome when data for many groups must be presented. Adjusted rates remove the effect of population differences to allow for comparisons between groups or over time. Bear in mind that the actual value of an adjusted rate has no inherent meaning because it is mathematically derived and can be based on one of many standard populations. Therefore, adjusted rates should be used only for comparison purposes.

For public health planning, specific rates provide the most detailed information about the pattern of disease in a population.

You may find that a combination of measures is needed to analyze the data collected to fully express the disease burden in your community. Also, examining the same rate over time, or trend analysis, would provide evidence of the increasing, decreasing, or stable trends in mortality or morbidity.

Years of potential life lost

Another way to examine the impact of disease is in years of potential life lost (YPLL) for each death that occurs before a selected age end point. Therefore, YPLL is a measure of premature mortality. The generally accepted end point is age 65; however, because the average life span in the United States is longer than in many countries, premature mortality is often defined nationally as deaths before age 75 or even 85. Alternatively, the end point can be based

YPLL is a measure of premature mortality.

on the life expectancy of persons in specific age groups. YPLL then is the difference between the age at death and the selected end point.

YPLL provides another way to assess the burden of deaths due to specific diseases. Because YPLL is greater for deaths among young persons than old persons, it emphasizes the causes of death that affect the young. It can be useful for expressing the impact of premature deaths from injuries or from chronic diseases, such as breast cancer and coronary heart disease. Calculating the number of years of life lost due to selected causes of death will help the community view these causes of death not only as life lost to individuals but to the community.

Additional measures for determining the impact of preventable disease, death, disability, and injury are currently being refined and may become available in the future. These include measures that indicate "quality of life" and "years of healthy life." Contact your state health department concerning progress made with additional measures.

Collecting mortality and morbidity data

As you proceed with your working group and with assistance from resources such as your state health department or university, obtain the data required to complete the appropriate pages in the Program Documentation (PD) tool (see Appendix 3). The sections to be completed while compiling mortality data are

- Unique Health Events (PD-II)
- Number of Deaths and Years of Potential Life Lost by Major Disease Categories (PD-III)
- Five Leading Causes of Death by Age Groups (PD-IV)
- Comparison of Mortality Rates for Leading Causes of Death by Race, Sex, and Age Groups (PD-V)

A unique health event is an event or activity that may have a short- or long-term effect on the health or health risk of a community. A devastating hurricane or passage of a seatbelt law might explain abrupt variations in mortality data that should be discussed with the community group. Provide trend data on at least the top five causes of death. When analyzing data for communities with small populations, it might be appropriate to use three to five years of aggregated data. Otherwise the community group might identify health priorities that reflect one-time events.

As you coordinate data working groups, consult with the working group collecting opinion data to find out what key problems have been identified. As appropriate, collect additional mortality data concerning these problems.

The disease categories in PD-III are based on the leading causes of death. Decide if these, or other, categories are appropriate for your community. When obtaining the number of deaths by disease categories and age group (PD-III and V), be consistent with how you define the cause of death when comparing local data with state and national data. The ICD-9 codes are used frequently by CDC to define the leading causes of death.

Frequently Used ICD-9 Codes	
Coronary heart disease (Heart disease)	ICD codes 390-398, 402, 404-429
Cancer	ICD codes 140-208
Stroke	ICD codes 430-438
COPD*	ICD codes 490-496
Unintentional injuries†	ICD codes E800-E949

When making a comparison of mortality rates by race, sex, and age groups (PD-V), you will need to aggregate three to five years of data unless your community is a large metropolitan area. If your community has data on additional populations within the community, such as Hispanics, Asian-Americans, and Native Americans, prepare similar PD pages to record those data.

The morbidity data a community is able to collect vary. Therefore, there are no forms in the PD for displaying morbidity data. Communities can generally obtain hospital discharge data and display them for their community group. When you are obtaining or presenting hospitalization data, you should distinguish what discharge diagnosis is used. Most forms of hospitalization data may be tabulated by primary discharge diagnosis, any listed discharge diagnosis, or both. Reporting only primary diagnosis will often underrepresent the actual prevalence of a particular disease condition, whereas reporting any listed diagnosis may more accurately represent the disease burden associated with a disease condition.

**Chronic obstructive pulmonary disease (COPD) includes such categories as bronchitis and emphysema.*

†Unintentional injuries include such categories as falls, drownings, fires and burns, poisonings, and motor vehicle injuries.

As you coordinate data working groups, consult with the working group collecting opinion data to find out key priorities identified. As appropriate, be able to provide additional morbidity data concerning major priorities.

Explore the availability of mortality and morbidity data within your community and state and from your various partners. Some of the resources for community data include

- State and local health departments–Census data on births, deaths, and social conditions such as divorces.
- State and local social service departments–Variety of data including percentages of population on welfare and unemployment.
- State and local departments of highway safety–Data on traffic injuries and seatbelt use.
- State and local police departments–Information on crime trends, high-crime areas, and driving under the influence of alcohol or drugs.
- Boards of education–Information on percentage of population who have secondary degrees and undergraduate degrees (also in census data).
- Voluntary agencies–Data on causes of death, disability, and their risk factors.
- Hospitals–Information on length of stays, major causes of hospitalization, and description of hospitalized populations.
- Major employers or chamber of commerce–Data on demographic information on workforce, illness, and disability information.
- Colleges and universities–Information on morbidity trends and forecasts on population trends.

The following pages are sections of the Program Documentation (see Appendix 3) that relate to mortality data. You will need to create additional pages for each age group listed in PD-V. The age groups listed in the year 2000 national health objectives should be used: <1, 1-14, 15-24, 25-44, 45-64, and 65+. Data should be prepared for at least “whites” and “blacks and others.” If you have sufficient data, prepare similar pages on additional populations such as Hispanics, Asian-Americans, and Native Americans.

PD-II. Unique Health Events

A unique health event is an event or activity that takes place in the community that may have a short-term or long-term effect on the health or health risks of its citizens.

Examples of unique health events include special community health promotion and health education activities, health legislation, and environmental or natural events. Events can have a negative or positive effect on health. For instance, positive events might include the addition of fluoride to the drinking water or passing a law requiring the use of seatbelts. Negative events might include a hurricane or flood or the repeal of the tax on tobacco products.

Do not report PATCH program results or activities in this section. Report PATCH activities in PD-XII.

Date	Description of the Event	Number of People Affected

PD-III. Number of Deaths and Years of Potential Life Lost by Major Disease Categories*

Community _____ Year _____

Disease Category	Rank	# of Deaths	YPLL† Before Age 75
Heart disease			
All cancers			
Lung cancer		‡	‡
Cerebrovascular disease			
Emphysema			
Influenza and pneumonia			
All fatal injuries			
Motor vehicle injuries		‡	‡
Liver disease			
Suicide			
Homicide			
Diabetes mellitus			
Other			
Total			

* Based on leading causes of death.

† YPLL = Years of potential life lost for deaths > 1 year of age.

‡ To calculate the "Total" number of deaths or YPLL, add all numbers in the column except for lung cancer and motor vehicle injuries.

Source: _____

PD-IV. Five Leading Causes of Death by Age Groups

Community _____ Year _____

Age < 1 Cause	Total*	Percent†
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
All other causes		

Age 1-14 Cause	Total*	Percent†
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
All other causes		

Age 15-24 Cause	Total*	Percent†
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
All other causes		

* Total number of deaths from this cause.

† Number of deaths from this cause divided by total of all deaths in this age group.

Source: _____

PD-IV. Five Leading Causes of Death, by Age Groups in

Community_____Year_____

Age 25-44 Cause	Total*	Percent†
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
All other causes		

Age 45-64 Cause	Total*	Percent†
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
All other causes		

Age 65+ Cause	Total*	Percent†
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
All other causes		

* Total number of deaths from this cause.

† Number of deaths from this cause divided by total of all deaths in this age group.

Source: _____

PD-V. Comparison of Mortality Rates for Leading Causes of Death by Race, Sex, and Age Groups

Mortality Rates (per 100,000) for Leading Causes of Death Among Males Aged _____

Community _____/_____ (Year) State _____/_____ (Year) United States /_____ (Year)

Rank	Cause	# of deaths	Rate	Rank in state	# of deaths	Rate	Rank in nation	# of deaths	Rate
1.									
2.									
3.									
4.									
5.									

Mortality Rates (per 100,000) for Leading Causes of Death Among Females Aged _____

Community _____/_____ (Year) State _____/_____ (Year) United States /_____ (Year)

Rank	Cause	# of deaths	Rate	Rank in state	# of deaths	Rate	Rank in nation	# of deaths	Rate
1.									
2.									
3.									
4.									
5.									

PD-V. Comparison of Mortality Rates for Leading Causes of Death by Race, Sex, and Age Groups

Mortality Rates (per 100,000) for Leading Causes of Death Among White Males Aged _____

Community _____/_____ State _____/_____ United States /_____
(Year) (Year) (Year)

Rank	Cause	# of deaths	Rate	Rank in state	# of deaths	Rate	Rank in nation	# of deaths	Rate
1.									
2.									
3.									
4.									
5.									

Mortality Rates (per 100,000) for Leading Causes of Death Among White Females Aged _____

Community _____/_____ State _____/_____ United States /_____
(Year) (Year) (Year)

Rank	Cause	# of deaths	Rate	Rank in state	# of deaths	Rate	Rank in nation	# of deaths	Rate
1.									
2.									
3.									
4.									
5.									

PD-V. Comparison of Mortality Rates for Leading Causes of Death by Race, Sex, and Age Groups

Mortality Rates (per 100,000) for Leading Causes of Death Among Black and Other Males Aged _____

Community _____/_____ State _____/_____ United States /_____
(Year) (Year) (Year)

Rank	Cause	# of deaths	Rate	Rank in state	# of deaths	Rate	Rank in nation	# of deaths	Rate
1.									
2.									
3.									
4.									
5.									

Mortality Rates (per 100,000) for Leading Causes of Death Among Black and Other Females Aged _____

Community _____/_____ State _____/_____ United States /_____
(Year) (Year) (Year)

Rank	Cause	# of deaths	Rate	Rank in state	# of deaths	Rate	Rank in nation	# of deaths	Rate
1.									
2.									
3.									
4.									
5.									

Preparing for community group meeting

As you and the working group analyze and organize the data for presentation to the community group, prepare to give an overview of the items listed in the Program Documentation and then spend time on the causes of death that are especially noteworthy. In particular, emphasize those causes of death that have a higher rate when compared with the state, nation, or other populations and those that are of special concern to the participants in the community group or respondents to the opinion survey. If the numbers in the data set are small, consult with a statistician or epidemiologist on how to interpret them. Three to five years of data may need to be combined to have numbers large enough to be of value in health planning. Also, looking at trends in the data for at least the top five causes of death might prove valuable.

Prepare a Mortality Data Packet containing a matching set of overheads and handouts.

Prepare a mortality data packet containing a matching set of overheads and handouts to display your community's data. Examples of overheads showing community data are located as handouts for the phase I meeting. Review the section on *Presenting Data* in this chapter. The packet might include completed pages copied from the Program Documentation. It should display summary information and highlights from the Program Documentation and should address at a minimum the following items:

- unique health events that might affect interpretation of the community's data (PD-II)
- five leading causes of death in the community (PD-III), compared with state and national data if possible
- five leading causes of death broken down in categories that show substantial differences: by race, sex, or age (PD-IV and V)
- display the five leading causes of YPLL (PD-III)
- trend data for five leading causes of death
- any comparison or group (race, sex, age) data (PD-V) that are outstanding or unique

Prepare a morbidity data packet containing a matching set of overheads and handouts to display your community's data. The packet should concentrate on the top five reasons for being hospitalized and any other data the group can identify.

Behavioral data

Because behavioral risk factors contribute to almost half of the leading causes of death and disability and have the potential to be changed, behavioral data are an important part of the PATCH process. Behavioral data should be used by the community to identify risk factors and target populations to address. Thus you will need to determine the prevalence or frequency of behavioral risk factors in your community. There are two approaches to obtaining these data: use existing data to estimate the prevalence of particular risk factors in your community or collect the information from the community.

Using existing behavioral data, including the BRFSS

All 50 state health departments have statewide behavioral data collected by using CDC's Behavioral Risk Factor Surveillance System (BRFSS). These data estimate the prevalence of behaviors related to the leading causes of death and disability and are available by such variables as age, race, sex, income, and education. In 1981, CDC began helping states and communities to survey adults, 18 years and older, by telephone about their health behaviors. In 1984, CDC initiated BRFSS to enable states to collect state-specific behavioral risk factor data. By 1994, all 50 states and the District of Columbia were participating in the BRFSS.

By 1994, all 50 states and the District of Columbia were participating in the BRFSS.

BRFSS is a telephone survey for which participating states use a standard protocol and standard interviewing methods to complete from 100 to more than 300 interviews each month. The interviewing instrument used for the BRFSS is in three parts: the core questionnaire, standard modules, and state-specific questions. The core questionnaire is a set of questions asked by all states; it deals primarily with recent or current behaviors that are risk factors for disease or injury and with quality of life indicators. Responses to certain core questions are used to define the risk factor variables that are used to classify respondents as either at risk or not at risk for adverse health events. (See Risk Factor Definitions provided with PD-VII in this chapter.) Each year, CDC supplies standard reports on the core data to states. These reports include the prevalence of risk factor variables by demographic characteristics and among participating states.

The standard modules are sets of questions developed by CDC on specific topics suggested by states. States decide which, if any, standard modules they will include each year. In addition, states develop and use state-specific questions. Over the years, topics covered by the standard modules and by state-specific questions

have included screening for cervical, breast, and colorectal cancer; health care visits; health insurance; smoke detector use; smoking cessation; perceived health problems; and sources of health information. For further information on questions, ask your state coordinator.

As you explore other sources of behavioral data within your community and state, look for data that also address risk behaviors in other populations not addressed in the BRFSS. For example, in 1993 the CDC's Youth Risk Behavior Survey was used by 43 states and territories and 13 large cities to determine behaviors among ninth to twelfth grade students. For more information, contact the health education coordinator in your state education department or the CDC, Division of Adolescent and School Health at 770/488-5330.

Community use of BRFSS data

Most state health departments can provide communities with state and national behavioral data. Many states also combine multiple years of BRFSS data to have a sample large enough to provide data for subsets of the state. For example, one state has four public health regions and provides BRFSS data for each region. Another state determined it was more appropriate for health planning to analyze its data for three subsets of the state: the one large metropolitan area, all other urban counties, and all rural counties.

Most states may find that sample sizes are inadequate for estimating risk factor prevalence for small geographic areas such as counties or your PATCH community. However, *synthetic estimates* of community data can be derived by extrapolating from the BRFSS data for the state or subset of the state. For example, you can calculate synthetic estimates by using the population estimates for the subgroup of interest and the state BRFSS risk factor prevalences for that subgroup. This approach assumes that the risk factor prevalences for specific subgroups in your community are the same as the statewide risk factor prevalences for the same subgroups. For example, it assumes that black women in your community have the same prevalence of smoking as black women throughout the state. The accuracy of the estimate depends on whether the residents in your community behave similarly to residents in the state as a whole.

Synthetic estimates derived from state and national sources are crude and can be misleading, particularly when individual communities differ demographically from the state as a whole. However, when used in conjunction with other data, synthetic estimates may be sufficient for health planning, for setting priorities, and for

targeting prevention strategies. In addition to BRFSS data, you can also use other national data sets, such as the National Health Interview Survey, to derive the synthetic estimates for communities.

Another caution in using synthetic estimates concerns dividing the state BRFSS sample by more than one demographic variable. Too many demographic divisions of the sample make the size of the individual cells too small for accurate data analysis. Making projections about your community on the basis of such small numbers may be inappropriate. A rule of thumb may be that fewer than 50 in a cell restricts the interpretation of these data. Synthetic estimates remain a quick and inexpensive way to use state, regional, or national data to estimate the prevalence of risk behaviors in your community.

Collecting behavioral information

If you do not wish to use state BRFSS data or synthetic estimates for your community or subset of the state, you can obtain behavioral data for your community. Some state health departments have used the states' BRFSS mechanisms to conduct a special survey of a PATCH community or to oversample in the community while performing their monthly BRFSS calls. Other PATCH communities have conducted their own behavioral survey with assistance from their state health department. If you wish to do a community survey, talk with your state coordinator about whether the state can provide assistance or whether there are other available resources, such as university polling centers.

If you choose to collect your own behavioral data, you may want to add additional questions about other risk factors. These questions will need to be reviewed by your state coordinator or another expert in questionnaire design to ensure they will provide the information you want. Because the established computer software cannot be used to analyze added questions, you will need to analyze separately any additions to the standard questionnaire.

A community behavioral survey may cost from $3,000 to $10,000. The cost primarily depends on whether interviewers are paid or are volunteers. Paying interviewers is strongly recommended. The collecting of behavioral data requires planning, training interviewers, and coordinating resources.

Conducting a community behavioral survey has advantages:

- The data are specific to the community and provide valuable information about its citizens.

- The behavioral survey is a major activity that can help mobilize the community early in the process. It also gives visibility to PATCH because many community members hear about PATCH as a result of the survey.

Disadvantages include

- Depending on whether you pay to have the survey done or rely on volunteers, the survey may use a significant amount of limited human and financial resources.
- The time it takes to collect and analyze the data can cause the community to lose interest.

Your community may wish to collect behavioral risk factor information by developing its own survey instrument and protocol. This may prove to be an even more difficult and time-consuming process. Before you proceed, contact your state health department or another resource for assistance with instrument and survey design to ensure that the data are usable and are as comparable with other data sets as possible.

Making the choice

As you make decisions on what behavioral data to obtain, it would be advisable to work with the state coordinator and the person in charge of the BRFSS to examine existing data. Some PATCH communities have chosen simply to use BRFSS data for their state or subset of their state. Other communities believe the subgroups in their community are similar to the same subgroups within the state and accept synthetic estimates based on state data. Still other communities believe that members of their community are different from the general population of the state and that conducting the survey locally is worth the effort because of the unique information they would get.

The choice of what method to use to gather risk-behavior information is not always easy. Individual states and communities must look carefully at their alternatives and make a choice, based on their needs and resources. It is, however, a decision that needs to be made early in the process. Whatever the decision, as you proceed with your working groups and with assistance from resources such

PD-VII. A Comparison of Behavioral Data (Percentage) Among Adults by Community, State, and Nation

	Community			State			Nation		
	M	F	Total	M	F	Total	M	F	Total
Seatbelt (1)									
Seatbelt (2)									
Hypertension (1)									
Hypertension (2)									
Overweight (1)									
Overweight (2))									
Current smoking									
Acute (binge) drinking									
Chronic drinking									
Drinking and driving									
Sedentary lifestyle									
No leisure-time activity									
Regular and sustained activity									
Regular and vigorous activity									
Cholesterol screening (1)									
Cholesterol screening (2)									
Cholesterol awareness									

Community data source: _____

State data source: _____

National data source: _____

as your state health department or university, obtain the data needed to complete the PD-VII form in the Program Documentation.

Behavioral Risk Factor Surveillance System

Risk Factor Definitions

Seatbelt (1)	Respondents who report that they "sometimes," "seldom," or "never" use safety belts.
Seatbelt (2)	Respondents who report that they "nearly always," "seldom," or "never" use safety belts (i.e., do not always use a safety belt).
Hypertension (1)	Respondents who report that they have had their blood pressure checked within the past two years.
Hypertension (2)	Respondents who report that they have ever been told they are hypertensive.
Overweight (1)	Respondents who report that they are at or above 120% of ideal weight. Ideal weight defined as the midvalue of a medium frame person, from the Metropolitan Life Insurance height-weight tables (1959).
Overweight (2)	Women with body mass index (weight in kilograms divided by height in meters squared (w/h**2) >=27.3 and men with body mass index >=27.8.
Current smoking	Current regular smoker (ever smoked 100 cigarettes and smoke regularly now).
Acute (binge) drinking	Respondents who report that they have had five or more drinks on an occasion, one or more times in the past month.
Chronic drinking	Respondents who report that they have had an average of 60 or more alcoholic drinks a month.
Drinking and driving	Respondents who report that they have driven after having had too much to drink, one or more times in the past month.
Sedentary lifestyle	Respondents who report that they have had no activity, or no physical activity, or pair of activities that were done for less than 20 minutes, or less than three times a week in the past month.

No leisure-time physical activity	Respondents who report that they have had no leisure-time physical activity during the past month. This measures Year 2000 Objective 1.5 - Target $\leq$ 15%.
Regular and sustained physical activity	Respondents who report that they have had physical activity 5 or more sessions per week, 30 minutes or more pre session, regardless of intensity. This measures Year 2000 Objective 1.3 - Target $\geq$ 30%.
Regular and vigorous physical activity	Respondents who report that they have had physical activity or a pair of activities for 3 or more sessions per week, 20 minutes or more per sessions, at 50% or more capacity. This measures Year 2000 Objective 1.4- Target $\geq$ 20%.
Cholesterol screening (1)	Respondents who report that they have ever had their blood cholesterol checked.
Cholesterol screening (2)	Respondents who report that they have had their blood cholesterol checked within the past five years.
Cholesterol awareness	Respondents who report that they have been told their cholesterol is high by health professional.

Preparing for community group meeting

As you analyze and organize your behavioral data, you will want to summarize the items listed in PD-VII and then spend time on behaviors that are especially noteworthy. Noteworthy behaviors include those with a higher prevalence in your community when compared with the state, nation, or those that have been expressed as a concern by the community group participants or the opinion survey respondents, or those that cause a high degree of death, disability, and illness.

Prepare a Behavioral Data Packet containing a matching set of overheads and handouts to display your community's data.

When you fill out PD-VII, a rule of thumb is to have at least 50 persons represented in any cell. If fewer than 50 persons responded, your sample size may be too small to quote but may be of some value in decision making. You can often correct this problem by combining variables such as age groups. Ask your state coordinator or statistician for help. When reporting the data, you should round off the prevalence figures to whole percents.

Prepare a Behavioral Data Packet containing a matching set of overheads and handouts to display your community's data. It might also include a copy of PD-VII. Review the section on *Presenting Data* in this chapter. The packet should display summary information of the behavioral data for community, state, and national levels and more detailed information when behavior varies by subgroups such as among men and women.

Qualitative information

By looking at opinion data from community leaders, we attempt to learn about the perceived health priorities and quality of life in the community. One of the key components of community-based health promotion is the active involvement of the community in the planning, implementation, and evaluation of health programs. The opinions or beliefs that come directly from community leaders can provide valuable information about the health needs of the community. We cannot emphasize enough the importance of this kind of information to the success of a community-based process. The opinions of the community must be heard and respected if there is to be community ownership.

Community opinion data

Opinion information provides viewpoints from the community about health awareness, needs, and perceived health problems. A combination of quantitative and opinion data will help the community define problems and develop meaningful community goals and objectives. A comparison of quantitative information (mortality, morbidity, and behavioral data) with the opinion data will either substantiate or disprove the opinions of the community.

For example:

One community perceived cancer to be a problem and requested assistance from its state health department. Members of the community believed that the drinking water was the culprit. As the community undertook the PATCH process, data were gathered and analyzed that showed lung cancer was the prominent type (site) of cancer, whereas digestive cancers were extremely rare. Thus, the community designed an intervention program to target lung cancer by reducing tobacco use.

Knowing what the community or specific populations perceive to be their health needs is extremely important in planning programs to address those needs. Opinion information also reveals the community's level of awareness of health issues and its health problems and can help direct the design of press releases and educational information. It reflects community values and other qualitative factors not provided by the quantitative data. Also, the process of collecting opinion data provides an opportunity to inform more community members about PATCH and helps build community support for planning and carrying out health programs. It also helps you identify sources of support and opposition within the community.

There are two types of surveys that can be done—one of community leaders and one of the community at large. The materials provided in this chapter emphasize the survey of community leaders. The Community Leader Opinion Survey questionnaire (see page CG3-29), working group materials, and a sample Communitywide Opinion Survey are included in the handouts.

Conducting a survey of the community at large can be a big task. To be representative, respondents should be randomly selected from the entire community. However, most community groups lack the time and resources to conduct this type of survey. Some communities collect communitywide data in malls, at health fairs, or by placing mail-in coupons in the newspaper. Although these data are not representative enough to weigh heavily in the decision-making process, they may be valuable by increasing the awareness of the community group and identifying issues that may need to be explored further when designing interventions later in the PATCH process. They should be analyzed separately from the leader survey.

Identifying opinion leaders

Every community has what it calls "opinion leaders." They are people in positions of power who have the reputation for getting things done, who made key decisions on previous issues, who actively volunteer their time to help the community, or who are formal or informal neighborhood or community leaders. Whereas some opinion leaders are easy to identify because they hold official positions in the community, there are many other leaders who are not in positions of authority, but are influential and knowledgeable about the community. Special efforts should be made to identify these informal leaders to obtain their opinions. To help community

groups identify key leaders to be interviewed, we have provided a list of some characteristics and affiliations on the Description of Respondent form page (see page CG3-30) with the Community Leader Opinion Survey materials. The final list of interviewees should represent the sex, age, race, and affiliation groups reflective of the demographic makeup of the community. Many PATCH communities generate 100 to 150 names and complete 60 to 125 surveys.

Community Leader Opinion Survey

1. What do you think the main health problems are in our community?

2. What do you think are the causes of these health problems?

3. How can these problems be reduced or eliminated in our community?

4. Which one of these problems do you consider to be the most important one in our community?

5. Can you suggest three other people with whom I might talk about the health problems in our community?

Thank you for your help. Right now I do not have any more questions, but may I contact you in the future if other issues come up.

Description of Respondent

Respondent's name_____

Record the following information for each respondent, without input from the respondent, if possible. To ensure confidentiality, separate this page from the rest of the survey before returning both to the working group chairperson or local coordinator.

1. Sex: ___Female ___Male
2. Race: ___White ___Black ___Hispanic
   ___American Indian __Asian __Other
3. Age: _<18 _18-24 _25-44 _45-64 _65+
4. Affiliation that resulted in respondent being selected:

___ A. Business person
___ B. Citizen activist
___ C. City/county official
___ D. Civic association member
___ E. Community outreach worker
___ F. Health professional (specify)
___ G. Law enforcement person
___ H. Leader of organization of faith
___ I. Local celebrity
___ J. Media/news person
___ K. Neighborhood formal/informal leader
___ L. School board member/administrator/teacher
___ M. Social services provider
___ N. Voluntary health agency representative
___ O. Youth peer leader
___ P. Other

5. Member of community: _____<3 _____3-9 _____10+ years
6. Geographical area:_____ urban _____ rural
   Neighborhood: _____

Collecting opinion data

Communities have found it best to do the opinion survey of community leaders using person-to-person interviews. Preparing your community group to do the Community Leader Opinion Survey is a major component of the community group meeting for phase I (see Meeting Guide for Phase I). Then the survey is completed and the data are reported to the community group during phase II meetings.

There are seven steps to completing an opinion survey:

1. Identifying opinion leaders to be interviewed.
2. Developing additional questions, if desired, for the survey instrument.
3. Identifying and training interviewers.
4. Interviewing opinion leaders.
5. Collating data from the interviews and preparing handouts and overheads to present to the community group.
6. Completing the PD-VI Community Leader Opinion Survey Data.
7. Writing a final report based on the group's consensus of high-priority problems.

The community group may need to be involved in steps 1 and 2, but major responsibility for completing the remaining steps rests with the Opinion Data Working Group. The form to be completed while compiling opinion data is the Community Leader Opinion Survey Data.

The most practical way to analyze community opinion data is to simply rank the problems according to the frequency of their being stated as problems. To rank these data, review the information from interviews and tabulate the number of times a problem was stated. Group responses consistently and only when they are similar. If more than one person tabulates responses, have them work together to ensure that responses are grouped similarly.

A sample Community Leader Opinion Survey questionnaire packet is included in the handouts. The questionnaire and introductory scripts should be adapted as appropriate for your community. The packet includes these elements

- script for making the appointment
- introductory script
- sample questionnaire
- description of the respondent
- handouts and task sheets for working group

If you add questions to the survey, begin with easy-to-answer questions to help the respondent to feel comfortable. Ask questions in a logical order, covering one point completely before going on to another. Each interview should take no longer than 20 to 30 minutes. Keep in mind these additional guidelines when developing questions.

- Language problems can arise from ethnic, racial, or regional differences. Make sure that the respondent will understand the meaning of questions without much explaining.
- Avoid professional jargon. Rather than saying “we are collecting community opinion survey data in our community,” you might want to say, “we are asking leaders their opinions regarding health problems in our community.”
- Avoid asking two questions in one sentence. For example, “do you believe exercise breaks should be regularly scheduled in our schools?” This question should be divided: “Do you believe scheduled exercise breaks should be offered in our schools? If so, how often?”
- Avoid biased questions: “You think we need more health education in the schools, don’t you?”
- Because lengthy questions are easily misinterpreted and tire both the respondent and the interviewer, brief questions are recommended. Words should be simple–questions should be short.
- To make responses to sensitive questions easier, provide a checklist of responses or a series of statements that the respondent can agree or disagree with, or use a vignette or story describing a situation and have the respondent comment about it.

PD-VI. Community Leader Opinion Survey Data

_____ Data collection method	_____ Number of interviewers
_____ Total number of people interviewed	From: _____ To: _____ Date collected

Rank	Health problem	Number of persons identifying problem	Percentage of persons identifying problem
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Source:

Preparing for community group meeting

As you and the working group analyze and organize the opinion data for presentation to the community group, prepare to give a listing of the responses as well as the top 10 items listed in the Program Documentation page. In particular, emphasize those items that have the most responses and those items that are substantiated by quantitative data.

Prepare a Community Opinion Data Packet containing handouts and overheads to display your community's data. The packet should list all responses from the Community Leader Opinion Survey and emphasize questions 1 and 4. Question 1 states, "What do you think the main health problems are in our community?" Question 4 states, "Which one of these problems do you consider to be the most important one in our community?" Record the top 10 responses for question 4 on the PD-VI page, Community Leader Opinion Survey Data. This page would then be included in the packet.

If you have data from your phase I exercise (see Meeting Guide) in which participants interviewed one another with the Community Leader Opinion Survey, you may want to collate the information as described previously and place it on a separate copy of PD-VI. If the group collects communitywide opinion data, rank responses by frequency and report in a format similar to PD-VI. Be certain you do not combine data from different sources. Review the section on *Presenting Data* in this chapter.

In addition to a ranking of the health problems, you will want to discuss additional insights such as the level of awareness in the community of major health problems as well as potential allies and the likelihood of their support.

As you organize your opinion data, note when problems identified through the quantitative data and through community opinion do not reflect the same concerns. You will need to determine whether more data, quantitative or opinion, should be collected to present all the information the community group will need to determine priority health problems.

Presenting data

As you present data to your PATCH community group, keep in mind the following principles (in appendixes 2 and 5, see the Tipsheets and the sections of Bibliography on Data Analyzing and Display and Epidemiology):

1. *Present data in a simple, straightforward manner*. The more understandable data are to community group members, the more likely members will be to use the data in planning health interventions.
2. *Include a frame of reference for the data*. For instance, compare your community's data with national data, state data, or data from similar communities.
3. *Explain any limitations of the particular data set*.
4. *Be sure any presentation of data on paper can stand alone, regardless of the particular format you choose*. Label tables, charts, and graphs; specify the data source.
5. *Be sure that the measure you select for display (count, percentage, rate, or their measure) is appropriate for your message and the constraints of your graphic display*.
6. *Choose the graphic display most appropriate for your task*. When you present health data to help with health planning, you may want to use a graphic display to focus attention on differences between diseases, population groups, or other variables. Some graphic aids are more appropriate than others for illustrating certain types of data, fostering comparisons, and allowing your audience to quickly grasp important points. Which visual display you choose depends on the message you want to convey.

Prepare a Community Opinion Data Packet containing handouts and overheads.

Here are a few basic guidelines for using the most popular charts and graphs:

- Select only one main message per visual display. If you want to focus on several aspects of the data, consider making a set of visual aids.
- A horizontal bar chart can be used to focus attention on how one category differs among several groups.
- A vertical bar chart is often most appropriate when you want to focus attention on a change in a variable over time.
- Consider using a cluster bar chart when you want to contrast one variable among multiple subgroups.
- A line graph can be used to plot data for several periods and show a trend over time.
- A pie chart is sometimes used to show the distribution of a set of events or a total quantity.

Adapting phase II to address a specific health issue or population

When a health issue of high priority is selected before beginning the PATCH process, some of the activities related to data collection are modified accordingly. For example, if the health problem to be addressed is cardiovascular disease (CVD), your community might want to modify the mortality pages of the Program Documentation and complete the appropriate sections with only CVD-related data. Or it might wish to collect some of the data recommended in the Program Documentation to determine the relative importance of CVD in your community. In most U.S. communities, CVD is a leading cause of both death and years of potential life lost. Similarly, the opinion survey might be modified to address CVD only or some of the general questions provided might be used with follow-up questions related to CVD. Behavioral data obtained might be limited to risk factors for CVD.

As you work with your community group, working group, and partners to identify data sources specific to CVD, the material in this chapter may prove valuable in helping you to collect, display, and present those data. When using PATCH to address the health needs of a specific population, such as older adults, make similar modifications.

Chapter 4

Choosing Health Priorities

Contents

Chapter 4
Choosing Health Priorities

Introduction

Most PATCH communities do not have the resources to address all of their health problems and target groups at once. They must set priorities and plan to address some problems initially and others over time. We recommend that the community group select only one or a limited number of health problems to better focus resources in a comprehensive manner.

To determine which health problem or problems to address first, the community group should complete the following tasks:

- Set criteria, examine community data, and develop a list of health problems.
- Assess the community's capacity to address the health problems.
- Determine the changeability and importance of priority health problems.
- Assess social, political, economic issues that might influence the ability to address the health problems.
- Identify community programs and policies already addressing the health problems.

Setting priorities is a dynamic process that varies with every community. In many communities, especially those where most data highlight the same health problem, reaching consensus on which problem and associated risk factor(s) to address first may be a simple task; in other communities, it may be more difficult. Some community groups may need extra time for reviewing data and discussing why each health problem should be considered a priority. You may need to repeat the nominal group process or other priority-setting techniques several times as the group goes through the different steps of decision making described in this chapter.

You should review carefully the Meeting Guides for phases II and III because they provide guidance for helping your group through the process of determining what problem to address first. You may want to involve in your meetings people who have expertise in areas such as health, community development, and media to answer questions and discuss issues.

Realize that the PATCH community group does not have to address every priority problem it identifies. In many communities, when the community data and priorities are shared, official agencies and other organizations reflect some of the priorities in future work plans and resource allocation. A task for you, your working groups, partners, and program champions is to encourage such "spin-off" activities within the community.

Using data to identify health problems

On the basis of information collected during phase II, the community group needs to identify health priorities and determine which ones it wants to address first. As the community group reviews different types of data, it develops criteria for determining priorities within the data. For example, as members review mortality data, they might consider something a priority if

- it causes a large number of deaths.
- it is a leading cause of years of potential life lost.
- it is a greater problem in your community than in the state or nation.

By matching the mortality data to the criteria, they would identify problems and add them to the List of Health Problems tool located in the handouts. The group would undertake a similar process of setting criteria, examining the data, and identifying priorities for each of the other types of data: morbidity, community opinion, behavioral, and other community data. After using the different sources of data to identify health problems, you may want to use a nominal group process or some other technique with the group to reduce the list of health problems to a manageable number, say no more than five to 10 items in each column.

The following is an example of what the List of Health Problems might look like as the community group examines its community data and adds items in the appropriate columns. Risk factors are divided into two columns: one for behavioral risk factors and one for nonbehavioral risk factors. The nonbehavioral factors include social, physical, and environmental factors that have an impact on health. You should anticipate that some nonbehavioral risk factors will appear in your community's opinion data. This information may prove valuable to the community group when designing interventions because some nonbehavioral risk factors are not health problems but contribute to health problems. When a respondent lists a risk factor as a health problem, the interviewer should probe for more information. For example, when a respondent is asked to

discuss further his or her comment that the "lack of recreational facilities" is a major problem, the respondent might say it is because idle teens are getting into drug and alcohol abuse. The health problem is the drug and alcohol abuse, and the respondent believes that the lack of recreational facilities contributes to the problem. (See Chapter 5.) Note that the list is not designed to be read horizontally.

For example:

List of Health Problems

Causes of Death/Disability	Behavioral Risk Factors	Nonbehavioral Risk Factors
heart disease	smoking	lack of jobs
auto injuries	lack of physical activity	lack of medical care
HIV infection	drinking/driving	poor road maintenance
homicides	drug abuse	lack of recreational facilities
infant deaths	excessive drinking	lack of knowledge/health information

Selecting the intervention focus

As the community group works to set priorities, it must examine its capacity to address one or more problems and agree on which problem or problems to address first.

Identifying which problem(s) to address first

As the community group works to identify which health problem(s) to address first, members need to review the List of Health Problems and the sets of criteria used to develop this list. The group may want to use the nominal group process to discuss these criteria and to identify criteria for determining which problem to address first.

When reviewing the Causes of Death and Disability section of the List of Health Problems, you might consider the criteria listed earlier in this chapter in the section on Using Data to Identify Health Problems. When examining priority behavioral risk factors, you might consider the following:

- **importance**–evidence that the behavior change will make a difference
  - How widespread is the behavior?
  - How serious are the health consequences?
  - How close is the connection between the behavior and the health problem?

- **changeability**–evidence that the behavior is amenable to change
  - Is the behavior still in developmental stages?
  - Is the behavior only superficially tied to lifestyle?
  - Has the behavior been successfully changed in other programs?
  - Does the literature suggest that the behavior can be changed?

Many community groups find it helpful to use the nominal group process or other techniques to identify the top three to five health problems. These three to five problems are then analyzed further to determine which to address first. Some issues to consider when ranking problems include legal and economic factors, political viability of the intervention, possibility of continued funding, probability of quick success, ability to build on community strengths, and level of public concern. Also, consider whether the problem falls within the realm of state, partner, or local expertise.

Although a literal translation of the PATCH process suggests that first a leading cause of death should be selected as the focus of the intervention and second a related risk factor, this sequence is not critical. Many PATCH communities opt to first select a behavioral risk factor as the focus of their intervention and then determine to which cause(s) of death it contributes. (In Chapter 3, see chart on Contributors to the Leading Causes of Death.)

Determining capacity

As stated earlier, few PATCH communities have the resources needed to address all the health problems identified. The community group needs to assess the community's resources and determine if it should address one or more priority health problem. Some things to consider include the tradition of volunteerism, any history of community agencies working together, the level of commitment of community group members and partners, the number of agencies that can provide resources and expertise, and the strength of communication networks within the community.

The community group needs to assess the community's resources and determine if it should address one or more priority health problem.

We recommend that the community limit the number of problems to be addressed so resources can be used to address the problems in a comprehensive manner. For each health problem addressed, interventions should target the community at large as well as at least one selected target group. They should also address several factors that contribute to the problem. To be comprehensive, inter-

ventions should include different *strategies*, such as educational programs, policy advocacy, and environmental measures, conducted in various *settings*, such as schools, health care facilities, community sites, and the workplace.

Many communities find it helpful to start small and use their early successes to build momentum for the program. Over time, more and more risk factors, target groups, or problems are addressed. For example, to reduce heart disease you might first address physical inactivity among school-age children and subsequently address additional populations, such as older adults, or other risk factors, such as poor nutrition and smoking.

Using the matrix

To prevent duplication of efforts, the community group should complete the Existing Community Programs/Policies Matrix (see page CG4-6) for the health problem(s) and the related risk factors to be addressed. Some communities choose to complete the matrix for the top two or three health problems under consideration. Other communities wait until the community group has virtually decided on the health problem to be addressed first and complete the matrix as a final step in the decision-making process.

The matrix helps you organize your investigation of ongoing policies and programs by two features: the strategy or method used, such as education, and the setting where the programs or policies are located, such as schools. You fill in each box or cell to complete the matrix. For example, if the community group wants to reduce deaths due to heart disease by addressing physical inactivity, you would note in the upper left-hand cell any educational programs promoting physical activity provided through schools.

After using the matrix to examine what is ongoing, the community group may decide that the health problem is being adequately addressed and move on to examine another priority health problem. Or it may decide it has a role in coordinating activities, increasing ongoing activities, or working in areas not currently being addressed. The matrix may also help the community group identify potential new members, partners, and allies in its efforts to address the health problem. (Chapter 5 contains more information on the use of the matrix. A larger version of the matrix is included in the handouts.)

Existing Community Programs/Policies Matrix

Health Problem: _____

Behavioral Risk Factor: _____

Fill in names of existing programs and policies that serve the Health problem and risk factor that you have selected.

	School (students)	Worksite (employees)	Health Care (patients)	Community (groups)	Other
Education -Communication					
-Training					
Legislative/ Regulatory Policies					
Environmental Measures					

Targeting the community and specific groups

Do any specific groups of people in your community have a higher rate of premature death? Do any suffer more from risk factors that may lead to premature death? If so, should you focus your intervention efforts on the persons with the greatest problems? Should you prevent the adoption of a risk factor by targeting children and youth? What in the community supports healthy lifestyle choices? These are the types of questions the community group should be asking as it sets criteria for identifying target groups. (See Chapter 5 for information on involving selected target groups in designing interventions.)

Each PATCH community should strive to reach at least two targets: the community at large and a specific target group.

Each PATCH community should strive to reach at least two targets: the community at large and a specific target group. Because people are more likely to change and maintain their change when there is support from the rest of their community and their social and physical environment, a primary target should be the entire community. Members of the community need to be informed about the health problem and the need for change. They also should be asked to take an active role in improving the health status of their community and in encouraging change within members of the community. Also many decisions, policies, and environmental changes that influence health and quality of life occur at the community level. Examples include improving the nutritional quality of school lunches, removing cigarette machines from county buildings, turning old railroad beds into walking and biking paths, erecting a traffic light at the intersection near an elementary school, and having the local billboard company establish a policy not to advertise alcohol or tobacco products on billboards near schools.

In addition to targeting the community at large, providing more intensive efforts to reach special groups is important. Identifying potential groups to target requires careful thought about resources, importance, and impact. The community group should use mortality, behavioral, and other data sources to elaborate on the scope and

impact of the health problem on different populations and to help identify target groups. Some additional issues to consider include taking

- a *curative* approach by selecting those persons who have the greatest problem or risk.
- a *preventive* approach by focusing on younger people who have not yet developed poor habits.
- a *cost-effective* approach by focusing resources on a group that is most likely to cooperate.
- a *greatest need* approach by trying to help the group most neglected and hardest to reach.

Some communities decide to begin with populations that are easy to reach and then, after learning from earlier successes, target harder to reach populations.

For example:

The older adults in one PATCH community suffered a high rate of injuries due to falls. Concerned, the PATCH group decided to focus first on residents who lived in housing for older adults because they were easy to identify and reach with educational and environmental interventions. Later the group targeted older adults who resided in private homes.

Writing goals and objectives

Goals are broad, abstract statements of intent that help create a vision of what you are striving to accomplish. Objectives are measurable, specific statements that lead toward program goals and define what change the community will try to achieve. The importance of both in anchoring the community health-planning process cannot be emphasized enough, for vague goals and objectives are likely to yield scattered, unfocused efforts.

The data collected during phase II provide valuable baseline figures from which to write objectives that guide the intervention. Each objective should answer these questions:

- **Who** will receive the intervention? (Whose health is its focus?)
- **What** health benefit should these persons receive?
- **How much** of that benefit should they receive?
- **By when** should it be achieved?

For example:

By 1998, the prevalence of smoking among county residents aged 18 years and older will be reduced by 15% from 25% (BRFSS 1991 baseline) to 21%.

Objectives are active, working tools and not merely academic exercises. An objective

- specifies a single key result.
- specifies a target date.
- is specific and quantitative.
- specifies what and when, not why and how.
- is readily understandable to those involved.
- is realistic, attainable, yet a challenge.
- provides limits to expenditures of time and effort.
- identifies criteria for evaluating achievement.
- provides orientation to cooperating agencies in the community.

Quantifying the amount of change may take some research. Consult local and state experts and other PATCH communities. Identify intervention efforts with goals similar to yours, and then find out what the success rates were in order to determine reasonable expectations for change. As you design your interventions and examine resources in phase IV, you may need to revise your objectives to assure that they are realistic and achievable.

PATCH uses two types of objectives to clarify community goals:

- behavioral objectives–for the leading behaviors that contribute to death or disability and are the focus of the intervention
- intervention objectives–for the interventions you wish to undertake

Writing community goals

Use community goals as guideposts under which behavioral and intervention objectives and activities can be listed to start a work plan. How you write community goals may vary depending on whether you are addressing short-term problems, such as injuries and infant mortality, or long-term problems, such as heart disease, lung cancer, and other chronic diseases.

For long-term problems, the community goal is more of a mission statement to anchor and guide the program than a basis for program evaluation. (See Chapter 6 on evaluation.) For example, much of

the lung cancer your community may experience over the next 10 years may be due to the use of tobacco over the past 40 years, and efforts to reduce the onset and prevalence of smoking may not be reflected in mortality data for another 10, 20, or more years.

Stating a goal helps the community group and later the whole community develop a "vision" of the healthier community it is striving to create. For example, the following goal is based on the shared vision of a healthy community in which no one dies prematurely due to heart disease.

Our goal is to reduce the number of premature deaths due to heart disease in our community.

For short-term problems, you may be able to quantify your goal. If you do so, allow a realistic amount of time before changes in mortality rates occur. Also, when the number of deaths is small, you may want to group years of data. For example:

By 1998, the rate of fatal injuries among county residents caused by drinking and driving will be reduced by 15% from 7/1,000 to 5/1,000 (comparing 1993-1994 and 1997-1998 rates).

Writing behavioral and intervention objectives

Behavioral objectives refer to those behavioral risk factors that contribute to the cause of death specified in your community goals. The intervention objectives refer to the intervention activities you plan to undertake. It is important that the objectives be coherent across levels, with objectives becoming successively more refined and more explicit, level by level. The community goal is the more general, the behavioral objectives the more specific, and the intervention objectives the most specific. Using the above example, the heirachy of objectives would include the following:

Community goal:

Our goal is to reduce the number of premature deaths due to heart disease in our community.

Behavioral objectives:

By 2000, the prevalence of county residents who smoke will be reduced by 20%, from 32% (1994 BRFSS data) to 25.6%.

By 2000, the prevalence of physically inactive adults in our county will be reduced by 15%, from 38% (1994 BRFSS data) to 32%.

Intervention objectives:

By January 1995, 20% of participants in a "Quit and Win" smoking cessation contest will still be nonsmokers one year after the contest (January 1994).

By January 1996, the rate of onset of smoking among county school students, grades 6-9, will be reduced by 20% from 158/1,000 (1993 YRBS data) to 128/1,000.

By January 1995, the county school board will set policy that allows the community to use school playing fields for evening and weekend recreational activities.

By July 1996, 5 companies that employ 50 or more workers in the community will provide access to programs that address physical activity, good nutrition, and cessation of tobacco use.

Using state and national health objectives

To provide a starting point and a connection to national and state efforts to improve health, the community group may wish to review the national health objectives published in *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.*

Consult the objectives for the nation when you set your own behavioral objectives. A second resource developed to help states and communities set objectives specific to their needs is *Health Communities 2000 Model Standards: Guidelines for Community Attainment of the Year 2000 National Health Objectives*. As of 1994, 40 states had developed state objectives that relate to the national objectives. Check with your state health department for further information.

Preparing for the phase III community group meeting

As with the previous phases of PATCH, the tasks are so interrelated that it is important to have a working knowledge of the materials relating to all the phases. For this meeting, give special attention to the meeting guides for phases II and III; chapters 4, 5, and 6 of the Concept Guide; and the Tipsheets on nominal group process and other group dynamics issues. Also review the items added during phase II to the List of Health Problems. You may want to review and prepare to share information with the community group on state and national health objectives. It might also be helpful to invite experts to attend the meetings to discuss issues and answer questions, as needed.

Adapting phase III to address a specific health issue or population

Even when you initiate a community-based process with a health problem or target group already determined, you will need to do much of the analysis recommended for this phase. If the health problem is known, the community group will need to examine data, set criteria, and determine which risk factors and target groups should be addressed first. If the target group is known, the community group will need to examine data, set criteria, and determine the health problems to be addressed. To ensure community ownership and appropriateness of the interventions, you must allow ample time for the community group to discuss issues and make decisions relating to setting priorities.

Chapter 5

Developing a Comprehensive Intervention Plan

Contents

Chapter 5
Developing a Comprehensive Intervention Plan

Introduction

As you begin phase IV, you do so with three major strengths: a community group and partners that are committed to improving the health of their community, data on the problems and needs in your community, and consensus on the health problem and target group to be addressed first. Designing an effective intervention plan requires that you pull together all you have learned about your community throughout the PATCH process. While keeping an eye on what is realistic in terms of your resources, do not underestimate what a community can accomplish when it focuses its resources and energies.

According to definitions of the World Health Organization, health-related behaviors include not only those actions that may be defined as healthful lifestyles and preventive behaviors but also societal actions that support the establishment of equitable health, environmental, and social policies. Thus the health of your community does not depend just on the health of individuals, but also on whether the physical and social aspects of the community make it possible for people to live healthy lives.

The health of your community does not depend just on the health of individuals, but also on whether the physical and social aspects of the community make it possible for people to live healthy lives.

Therefore, a comprehensive intervention plan

- includes the use of multiple strategies, such as educational, policy, and environmental strategies, within various settings, such as the community, health care facilities, schools, and worksites.
- targets the community at large as well as subgroups within the community.
- addresses the factors that contribute to the health problem.
- includes various activities to meet your audiences' levels of readiness.

Through the PATCH process, community group members have gained insight into the needs of the community and the reasons why those needs exist. But to ensure the interventions designed are appropriate and will be used by the target group requires careful planning by the community group and working groups. The Checklist for Designing a Successful Intervention, located in the handouts, is a tool to help you plan intervention activities. Once you know the health problem, related risk factor(s), and target group(s) to be addressed, the Checklist will help you identify the following:

The Checklist for Designing a Successful Intervention, located in the handouts, is a tool to help you plan intervention activities.

- factors that contribute to the presence or absence of the risk factor in your target group (i.e., motivators, enablers, rewards)
- programs and policies currently in the community that address the risk factor and target group
- partners and resources
- the needs and interests of the target group
- ways to enhance your program by coordinating with other local, state, or national activities and media
- ways to coordinate and monitor activities through the use of timetables, work plans, and evaluation plans

As you begin to focus your PATCH activities, you must examine the membership of the community group, forge new partnerships, and gain an understanding of the perceived needs and interests of your target group. Gaining this understanding means asking questions directly of the persons you want to learn more about.

Updating organizational and functional structures

Now that the health problem and target group have been selected, the community group should reexamine its membership and the tasks to be performed by working groups. Additional people might want to join the community group because of their interest in the health problem or target group or because they want to help with the intervention phase. Likewise, some members may wish to become less active. You may also want to recruit members from new partners, gatekeepers, and the target group.

Take ample time to orient new members of the community group and to identify and meet specific training needs of the community group and working groups related to tasks to be accomplished. (See Functional Structure section, Chapter 2, p. CG2-15.) Also, be sure to clarify the evolving roles of working groups and to establish new working groups as needed. Often communities, for example, choose to have the public relations working group, established

during phase I, find various ways, such as press conferences and kickoff activities, to release their community's health status data and information about interventions.

Communities also establish new working groups to design and carry out intervention activities. These working groups often include a few members of the community group and volunteers. In one PATCH community, a working group was made up of two community group members and members of the Pioneer Club, a volunteer group from the local telephone company. You or the community group may want to develop working group task sheets similar to those referenced in Chapter 2. You may also want to develop a written job description to clarify the role of volunteers.

Broadening alliances

As the community group examines its structure, its members should also determine if new or broader alliances are needed. As a comprehensive intervention plan is developed, the group should ask itself at each step in the process if there are other individuals, groups, or organizations in the community who should be involved and how. Should they be asked to join the community group or working group? Could they help you reach your target group with your message or service? Could they advise you based on their experience with the health problem or target group? Could they help provide or recruit volunteers? Could they collaborate with you to address a particular health problem, contributing factor, or target group? (Review the List of Collaborating Groups, Chapter 2, p. CG2-10 when determining "who" and "how.")

Potential partners include individuals or groups that have an official or personal interest in the health problem or the target group being addressed. Other partners include the gatekeepers of the target group, that is, those people who have responsibility for or access to the target group. For example, gatekeepers of school children might include teachers, principals, members of parent-teacher organizations, parents, and peer leaders among the children. Gatekeepers of school-aged children outside of the school setting might include pediatricians, providers of afterschool programs, youth athletic directors, and youth ministers. If you are addressing, for instance, the initiation of tobacco use among school-aged children, you might form alliances with groups interested in preventing tobacco use as well as groups interested in the well-being of children who could add your tobacco prevention message to their agenda, whether their issue is immunization, job skills, or sports.

As you proceed through the planning process and through the Checklist for Designing a Successful Intervention, you will identify factors that contribute to whether a young person uses or does not use tobacco. As you identify these contributing factors, ask who in your community is addressing those factors. For example, studies have shown one factor that helps young people to not use tobacco is the skill to resist peer pressure. Because this skill relates to many other health issues, new alliances might be formed with individuals and groups addressing such issues as teenage pregnancy, drug and alcohol abuse, or HIV infection. Furthermore, if young people state that they needed a safe place to go and be with their friends–away from pressures to use tobacco or alcohol or engage in other nonhealthy behaviors–look for additional alliances that might be appropriate. In one rural community, alliances were formed with the county recreation department, county government, sheriff's office, local business people, and entrepreneurs to convert a vacant building into a youth center. Young people elected a youth council who helped design renovations and the activities to be offered.

Potential Alliances at Different Levels of Program Planning

Health problem: Heart disease	County affiliate of the American Heart Association, County Medical Society
Risk factor: Tobacco Use	Local coalition for a smoke-free county
Target group: Youth (aged 12-21)	YMCA, YWCA, adolescent clinic, public and private schools, community college
Contributing factors: Lack of	
- skills to resist peer pressure	Teen pregnancy prevention program
- safe place/recreation	County recreation department, county government, local business people

You can undertake a similar process to determine if there are alliances with groups or individuals outside of the community that should be formed or expanded. Community group members that relate to state or national organizations (e.g., the voluntary health organizations, local health agency, agricultural extension agency, chamber of commerce) should contact their state or national counterparts for assistance with identifying interventions, media campaigns, and other resources that might help the community group in its planning. Strengthen ties with the state health agency and other appropriate state agencies and with communities using the PATCH process, especially those addressing the same health problem or target group. Other resources include community colleges, universities, and public and private sector organizations at the regional, state, or national levels. (See Gaining Commitments section, Chapter 2, p.CG2-6.)

Involving the target group

Everyone has heard of interventions that were designed and delivered with great effort by a well-meaning group only to have them rejected by the target audience. One example is the exercise class that was beautifully designed but that no one attended. When the planners began to question members of the target audience, the women in a particular neighborhood, as well as respected elders within the community, they quickly learned that the women did not have anyone to take care of their children at night because their husbands worked the evening shift at the mill. When child care was provided onsite, so many women attended that additional classes were offered.

To ensure that interventions are appropriate, culturally sensitive, and meet the needs of the target audience, it is vital to involve members of the target audience and gatekeepers in the planning process. Sometimes the focus of an activity is an intermediate group and not the target group. For example, a comprehensive intervention plan targeting drunk drivers might include working with bartenders to increase their skills in refusing to serve someone who has had too much to drink and for making and promoting nonalcoholic drinks. Although the drunk driver is the target group, the bartender is the intervention group for this activity.

You already have some information on your target group, such as the leading causes of death or disability and risk factors. You may need to collect more information on the risk factor from specific community data; local experts; review of the literature; and, most importantly, from the people themselves. As you develop your

intervention plan, frequently ask yourself who should be involved at each step and why. Members of the target group can help early in the planning process by providing information and insight on their behaviors, attitudes, beliefs, and values and on barriers to reaching the stated objectives. They can help identify factors that contribute to their behavior; channels for reaching the group; appropriate materials, messages, and ideas; and activities that will be effective. (See the Checklist for Designing a Successful Intervention for further guidance.)

If you have members of the target group on the community group and working groups, involve them as much as possible in planning. Have them identify additional members of the target group who can provide guidance or serve as key informants. Individual interviews, on-the-spot interviews, focus groups, and questionnaires are other ways to obtain information from the target group. Those methods can also be used with gatekeepers and intervention groups, staff who deliver the intervention, and people in agencies providing related activities. Such people may provide valuable information based on personal experience with the target group.

Although the community group may be eager to design activities for a specific target group(s), we recommend that one of your targets be the community at large. Members of a specific target group are more likely to change and maintain their change when there is support from the rest of their community and from their social and physical environment.

Determining contributing factors

To intervene in a health problem, you must determine what factors contribute to the presence or the absence of a health risk that affects the health problem. Determining contributing factors should involve as much commitment by the community group and working groups as did identifying the health problem and risk factors to be addressed. The community group should explore appropriate literature and sources of expertise at the state health department, academic institutions, and other agencies.

You should also identify community-based programs under way elsewhere and review the contributing factors being addressed, methods used, and evaluation results. One resource that might prove useful is CDC's Combined Health Information Database (CHID). CHID is a computerized bibliographic database of health information and health education/health promotion resources. The database provides bibliographic citations for major health journals, books, reports, pamphlets, audiovisuals, hard-to-find information

sources, and health education/health promotion programs under way in state and local health departments and other locations. It is available through CD Plus Technologies. The database can be accessed through hospital or university libraries or any library service that subscribes to CDP Online Services. For more information, contact CD Plus Technologies, CDP Online, 333 Seventh Avenue, 4th Floor, New York, NY 10001, (800) 950-2035.

Once you have identified potential contributing factors, you will need to involve your target group in confirming that the contributing factors are present and significant in your community. The target group might also provide valuable insights into which contributing factors more strongly influence the risk behavior and how you might address these factors in your intervention plan.

To ensure that the range of possible contributing factors is covered in the analysis, classify the contributing factors into three types:

- *Motivators*–factors *motivating* a person to take action. This group includes attitudes, beliefs, values, and knowledge. Motivating factors exist within the individual.
- *Enablers*–factors *enabling* a person to take action. This group includes skills as well as availability and accessibility of resources. Enablers include individual and environmental factors.
- *Rewards*–factors *rewarding* a person's behavior. This group includes the attitudes and climate of support from providers of services, families, and community organizations that reinforce the behavior of a person. Included are social as well as physical benefits and tangible, imagined, or vicarious rewards. Approval or punishment for a behavior also fits into this category.

Interventions work best when

- they address contributing factors in each of these three groups.
- they are specifically focused on the contributing factors appropriate for the intended audience.

Therefore, when you design your intervention, be sure it addresses all three types of contributing factors and applies to the particular motivators, enablers, and rewards of your target group. The factors that contribute to a health risk may be quite different among groups. Factors that contribute to adolescents abusing alcohol, for instance, may be quite different from those for adults. The factors might also differ for adolescents in urban and in rural sections of a community. Involve your target group in determining or verifying the accuracy and importance of contributing factors to be addressed.

Look at both *positive* and *negative* factors: factors that contribute to the absence of the health risk in the target group and factors that contribute to the presence of the health risk. These positive and negative factors can be listed on Table 1 of the Checklist. The following example lists contributing factors that lead to or help prevent smoking among adolescents.

Table 1. Contributing Factors

Target Group: Adolescents

Risk Factor: Cigarette Smoking

Motivators

Positive	Negative
• Parents' attitudes about the importance of not smoking • Family history of not smoking • Knowledge of the dangers of smoking	• Parents smoke • Family history of smoking • No knowledge of the dangers of smoking • No knowledge of how to quit • Enjoyment of smoking

Enablers

• Skill in rejecting peer pressure • Smoking cessation clinics • School policy of no smoking • Increase in cost of cigarettes • Restriction of sale to minors	• Peer pressure to smoke • Lack of skill to stop smoking • Inexpensive cigarettes • Cigarettes readily available in community

Rewards

• Encouragement of parents, teachers, and others not smoke • Smoking not accepted by friends • Restrictions on smoking	• Encouragement by family or peers to smoke • Parents smoke

Now that you have identified contributing factors to smoking and verified them with your target group, where do you go from here? You may not have the resources or the ability to address each and every contributing factor–to decrease the factors that contribute to the smoking and to increase the factors that contribute to not smoking. Thus you may need to set priorities. You may find it helpful to go back to the criteria of importance and changeability used in Chapter 4.

Importance:

The importance of a contributing factor is determined by how strongly it influences the health risk in the target population. To illustrate, obtaining information from adolescents and adults in the target group and a review of the literature on smoking may identify the following as the most influential contributing factors.

- Motivators: Enjoyment and lack of knowledge of how to quit.
- Enablers: Lack of skills to enable the adolescent to stop smoking.
- Rewards: Acceptance and even encouragement of friends.

Changeability:

The changeability of a contributing factor is determined by how easily the factor can modify the health risk. To identify changeable factors, you may review what has been changed in other communities by programs designed to help adolescents stop or to not start smoking. The factors identified through such a review as most changeable may include

- Motivators: Knowledge of the health risks of smoking.
- Enablers: Availability of skill-building activities related to smoking cessation.
- Rewards: School policies that encourage nonsmoking and forbid smoking on school property.

Designing effective interventions

Previously in the PATCH process, the community group has identified the health problem, related risk factors, and target groups to be addressed. Each community is encouraged to address at least two populations: the community at large and one specific target group (see Chapter 4). The community group should strive to design a comprehensive plan that

- uses multiple intervention strategies in various settings.
- addresses the contributing factors, those things that influence and enable people to engage in health-related behaviors.
- is appropriate for the specific target population.

The Checklist includes tools to help you plan your intervention activities. A copy of the Checklist should be completed for each risk factor and each target group addressed.

Intervention strategies

To be effective, your intervention plan should use educational, policy, and environmental strategies. We recommend combining educational, policy, and environmental strategies because each enhances the others. Expecting members of your community to make behavior changes that are discouraged by existing policies or by environmental or social norms is unreasonable. To expect communities or organizations to enact policy or change the physical or social environment when there is not broad-based understanding and support is equally unrealistic.

Together the three intervention strategies can be helpful in changing knowledge, attitudes, skills, behavior, policies and environmental measures to improve the health and well-being of the community. The demarcation between policy and environmental efforts is not always clear; policies may be used to bring about environmental change. Examples of activities that might be included under each strategy are as follows:

- **Educational strategies**–includes communication and skill-building.
  - communication methods: media advocacy, lecture-discussion (group), print materials (small or mass media, self-help), audiovisual aids, educational television, and programmed learning.
  - training methods: classes to develop skills, simulations and games, inquiry learning, small-group discussion, modeling, and behavior modification.

- **Policy strategies**–includes policies, regulations, and laws as well as informal rules and understandings of government and of local organizations, such as schools, service organizations, and businesses; includes both positive and negative policies, that is
  - policies designed to restrict or limit unhealthy actions: restrictions on sale of tobacco products in public buildings, policy to strictly enforce laws against sale of alcohol and tobacco products to minors, penalties for driving under the influence of alcohol, restaurant codes, and regulations on the handling of toxic wastes.
  - policies designed to encourage healthful actions: flex time at worksites for employees to engage in physical activity, dis counts on insurance for nonsmokers, extended clinic hours to meet needs of working parents, availability of condoms at university clinics, and extended hours to use community recreational facilities.
- **Environmental strategies**–changes that alter the physical or social environments; includes efforts to make the environment
  - more supportive of health: installing breakaway poles along highways, adding more streetlights to discourage crime and encourage physical activity, making low-fat dairy products readily available in stores, converting railroad beds into walking trails, and constructing shower facilities at worksites for employees who exercise.
  - more discouraging of actions that are not supportive of health: removing cigarette vending machines from public buildings.
  - more supportive of normative changes in attitudes and behaviors: community expectations that passengers will use seatbelts, teens will not drink and drive, and people having sex with multiple partners will use condoms.

Program settings

The intervention strategies in a community health promotion program are most effective when done in as many of the following settings as appropriate. These settings serve as channels through which you can reach your target group as well as sites for using educational, policy, and environmental strategies.

- **School**– including preschool to university level. Schools can be viewed as the most important setting for ultimately educating the entire population and more immediately for educating children and youth. A comprehensive school health program can be conducted in schools, and projects can be assigned that require parental involvement, thus educating parents.

- **Health care facility**–including hospitals, clinics, and offices. A person sees a doctor an average of four times a year; health care providers are seen as credible sources; patients are often at a "teachable moment" and more receptive to education and advice. Health care providers can lend expertise and credibility to your intervention efforts. They can also provide preventive education and advocate for healthy public policy and environmental change. They can also refer patients to health promotion services in the community and distribute health promotion materials.
- **Worksite**–including buildings and outdoor sites. Work settings and coworkers have a substantial impact on one's health; educational programs and policy and environmental actions that support health can be beneficial to both management and employees. Schools and health care facilities, mentioned earlier, are also worksites. They may be priority settings for worksite interventions because their policies and employees serve as models for others in the community.
- **Community**–including the entire community, public facilities such as parks, local agencies, and social, service, faith, and civic organizations. Your community has many organizations, groups, and public facilities that can serve as settings for interventions designed to reach people where they shop and play. These groups and organizations can examine how they function to ensure they support health. They can also be strong advocates for educational, policy, and environmental changes within the community.

The matrix of existing community programs and policies

Most communities already have a number of worthwhile health programs and policies. By investigating and tapping into what already exists in the community, the PATCH effort can identify potential alliances and ensure that PATCH activities do not duplicate efforts but build on and complement existing programs and policies.

The Existing Community Programs and Policies Matrix, introduced to you in Chapter 4 and Table 2 of the Checklist, is a tool to help you identify ongoing policies and programs. The matrix format allows you to organize existing programs and policies by two of the components described earlier:

- Intervention strategy–method used to achieve objectives
- Program setting–where program or policy is located and persons affected

Use separate copies of the matrix for each target group and each risk factor you plan to address. You can also use the matrix anytime you want to identify ongoing programs and policies relevant to any issue. It is especially helpful to use the matrix in relation to contributing factors. To illustrate, if a contributing factor is that adolescents do not have the skills to resist peer pressure, you might use the matrix to identify programs and policies within the community that address the "skill on rejecting peer pressure." This information can also help you identify potential alliances and resources (see Broadening Alliances section of this chapter).

To complete the matrix, you fill in each box or cell. For example, when addressing adolescents and smoking, in the left-hand column you would list what is being done in the school setting in relation to each intervention strategy. (See example in Table 2, which follows this section.) You would complete the matrix by asking the same question for each setting and filling in the respective column. Communities that have only a few resources available may wish to write the information within the respective cell of the matrix. You can make a larger version by drawing it on flipchart pages or using a photocopier. If there are many items to be entered, it may be easier to enter symbols or numbers on the matrix and keep more detailed information on the Community Resource Inventory (Table 3 of the Checklist). Table 2 provides an example of how one comunity might begin to fill in the matrix.

Table 2. Existing Community Programs/Policies Matrix

Target Group: Adolescents

Risk Factor: Cigarette smoking

Fill in names of existing programs and policies that impact the target group, risk factor, or other issues such as contributing factor that you have selected.

	School (students)	Worksite (employees)	Health Care (patients)	Community (groups)	Other
Education -Communication	Comprehensive School Health Program in 8 of 12 schools				
-Training	Resist peer pressure– all 6th grade students		American Lung Association trains health professionals twice a year about cessation techniques	Stop Smoking Cinic	
Legislative Regulatory Policies	No smoking on school property or at school functions	No smoking in fast food restaurants	No smoking in hospitals, clinics; no sale of tobacco products in hospital or county health department	No smoking and no tobacco ads on public transit	
Environmental Measures			No cigarette vending machines in hospital or county health department		

Community resource inventory

As you list the programs and policies that already exist in your community, you will need to judge the quality of each item and the reach or the number of target group members served. This assessment will help you identify ways the community group can assist ongoing programs and areas for which interventions should be designed. For example, if an effective program serves only 15% of those who need the service, possible roles for the community group might be to identify new channels of communication to ensure that the target group knows of the service, to encourage the agency to provide the program in such a way to attract at-risk groups, or to endorse or refer people to the service. Likewise, when looking at policy and environmental factors, the group might identify effective policies that could be recommended to other sectors of the community or areas in which policy or environmental changes should be the focus of the intervention plan.

As you complete the Community Resource Inventory (Table 3 of the checklist), you may also identify potential alliances and resources. Having an understanding of the quality and reach of the existing programs and policies will also help you match the matrix (Table 2) with the contributing factors you have identified (Table 1). This comparison will show where additional efforts are needed and help you determine where to focus your intervention efforts.

Checklist: tools for developing the intervention activity

Beginning with Section 3, Obtain Support in the Community, complete the Checklist for each activity to be designed (e.g., fun run, poster contest in schools, media campaign, clean indoor air policies, and increased availability of low-fat foods in local grocery stores). Review each section, and complete the ones that relate to your particular activity.

Community groups have found that the most effective programs are those with work plans that specify what needs to be done, by when, and who has the lead responsibility. Although formats for work plans may vary, the work plan needs to be detailed adequately so as to be clear to working group members and volunteers carrying out the activities. The format for the work plan in the Checklist divides tasks to be done into four categories: preparation, delivery, follow-up, and evaluation. Before developing the section of the work plan addressing evaluation, the working group should use the evaluation worksheet in the Checklist to determine criteria for considering the activity a success. The Checklist also includes an activity timetable and a master timetable. Complete an activity

See examples of the work plan and evaluation worksheet at the end of this section.

timetable for each risk factor you have selected to address. Mark on your timetable any major events that the working group hopes to coordinate or "piggy-back" with such others as major national events (e.g., Great American Smokeout, National Nutrition Month), state events (e.g., state fair, statewide fitness promotion week) or local events (e.g., high school graduation, spring festival, employee appreciation day).

All the activities concerning a risk factor should be put onto one activity timetable to ensure coordination and to distribute activities in such a way that they do not overwhelm either the community or the working groups and volunteers. Complete the master timetable by combining the different activity timetables to ensure coordination of activities and to guard against competition between activities.

Work Plan

Intervention group: Middle-school students

Activity: Poster contest for middle-school students on the benefits of physical activity

Preparation tasks	Completion Date	Who
1. Talk to someone who has managed a poster contest.	1. 8/1	Sarah
2. Plan to use the winning posters:	2. 8/15	Sarah
a. arrange to have posters to be exhibited		
b. arrange for posters to be exhibited		
3. Write down contest rules.	3. 8/15	Paul
4. Develop plan for evaluating success.	4. 8/15	Carlos
5. Meet with middle-school principals.	5. 8/25	Sarah
6. Meet with sponsoring teachers to explain contest, set dates, and determine materials needed	6. 8/30	Sarah
7. Meet with other groups (eg., PTA)	7. 9/8	Sarah
8. Determine prizes (involve students/teachers).	8. 9/10	Arica
9. Solicit prizes.	9. 9/10	Arica
10. Select and arrange for judges.	10.9/20-30	Judy
11. Finish and distribute teacher packet with contest information and lesson plan on benefits of physical activity.	11. 9/1- 10/20	Sarah
12. Prepare PR packet for media.	12. 10/28	Yvette

Delivery tasks	Completion Date	Who
1. Assist teachers as needeed with lesson on contest rules and the benefits of physical activity.	1. 10/1	Sarah
2. Collect posters for judging.	2. 10/30	Judy
3. Review rules with judges.	3. 11/1	Judy
4. Judge posters.	4. 11/1	Judy
5. Award prizes.	5. 11/1-3	Judy
Follow-up tasks	**Completion Date**	**Who**
1. Arrange PR for award winner.	1. 11/3-5	Yvette
2. Deliver posters to calendar company.	2. 11/4	Nancy
3. Exhibit poster at arranged sites.	3. 11/15-3/1	Nancy
4. Send thank-you letters to sponsors, principals, teachers, and others.	4. 12/1	Sarah
5. Distribute calendars.	5. 12/1	Nancy
6. Return posters to students.	6. 4/1	Nancy
7. Write summary of this activity:	7. 4/1	Sarah,
b. PR and activities resulting from contest		Carlos
c. evaluation of success		
d. recommendations for improvement		
Evaluation tasks	**Completion Date**	**Who**
1. Test students concerning the benefits of physical activity.	1. 9/10	Sarah
2. Count posters submitted (goal: 100).	2. 11/1	Nancy
3. Posttest students.	3. 12/1	Sarah
4. Clip and save newspaper articles concerning the activity.	4. 12/1	Yvette
5. Obtain feedback from teachers via questionnaires.	5. 12/5	Carlos

Example: Evaluation Worksheet

Risk Factor: Physical inactivity

Intervention population: Middle-school students

Activity: Poster contest for middle-school students on benefits of physical activity

We will consider this activity successful if. . .	How will we know?	When?	Who?
• at least 100 posters are submitted	Count submitted posters.	by Nov.1	Nancy
• an article about the contest and the benefits of physical activity appears in the local newspaper	Observe and save article.	by Nov. 10	Yvette
• 20% of students show increase in awareness of benefits of physical activity	Administer tests before and after the intervention.	Nov. 15	Sarah, Carlos
• 85% of sponsoring teachers state they would participate if program was repeated	Review questionnaire.	Nov. 30	Sarah, Carlos

Conducting effective interventions

As you work to design and carry out effective interventions, make sure you

- **Integrate all three strategies: educational, policy, and environmental.** Much of this chapter is dedicated to the importance of using all three strategies. The balance among them will depend on the needs and resources of your community.
- **Work within systems.** Working within systems can effectively and efficiently improve the health of a large segment of your community. For example, by providing lunches that meet nutritional guidelines or a smoke-free school environment, you affect the health of many children and teachers. Often, government agencies have the authority and resources to make changes supportive of health. Many communities have found that when their community data and priorities are shared, official agencies and other organizations reflect these priorities in future work plans and resource allocations. You may also identify systems or networks unique to your community or neighborhood that would assist you with program delivery.
- **Use the community's data effectively.** Data collected by the community group can be valuable for designing interventions, educating the community about its health status, supporting policy or environmental change and for resources, and preparing requests for funding.
- **Start simple and build on successes**. According to Margaret Mead, "Never doubt that a small group of thoughtful committed citizens can change the world: indeed, it's the only thing that ever has." A few people can accomplish much even in a community with limited resources. Many communities find that if they undertake small, visible activities and build the confidence and visibility of the group, they can then begin addressing more complicated issues and tasks.
- **Use different methods–be persistent**. To bring about change, intervention plans should include components that *motivate, enable,* and *reward* the person or organization to change. By addressing these components with an array of methods, you can capture the attention of many types of people. People learn through repetition, seeing the same message over and over through different channels and sources and in different contexts. Behavioral science theory, including Green's theory of diffusion of innovation and Prochaska's transtheoretical approach, supports the fact that people adopt a behavior at varying rates. Some

immediately jump on the bandwagon, whereas others are extremely slow to act, if they act at all. In addition, there is a lag time between awareness of an idea, agreement with the idea, and actually acting on the idea. One way to classify these stages of readiness to change is as following:

- Awareness: bringing the idea to the individual's attention.
- Motivation: providing incentives or rewards to encourage the individual to change the behavior.
- Skills and resources: making certain the individual has the skill needed to change the behavior and the resources (e.g., facilities) with which to use the skill.
- Reinforcement: giving positive feedback (praise, reward) to the individual who has adopted the behavior.
- Maintenance: encouraging individuals to continue the healthy behaviors through new motivators, building new skills or sharpening old skills, or reinforcing the behavior.

Thus, an intervention is not a one-time event. Continue the programs you have begun, vary the media messages, and add new activities to attract previously uninvolved persons or to sustain those already involved.

- **Coordinate messages and resources**. If you use media to encourage older adults to get their flu shot, you should also work with providers to ensure the vaccine is available and accessible. There may be occasions in which increasing demand may be used to encourage an increase in supplies. Customers, for example, might be encouraged to ask restaurant owners to offer more low-fat entrees or to enlarge the nonsmoking section.
- **Nurture and train community group members and volunteers.** According to Paulo Friere, "To be successful in community work we need a good sense of history, humility, and a deep respect for the people with whom we work." Taking time to nurture and build skills within your community group, working group, partners, and volunteers so they can continue the community health planning process is important. Likewise, ensuring that the PATCH efforts are perceived favorably by the community is vital. (See Chapter 2 and Appendix 2, the Tipsheets.)

Appendix 1

PATCH Assessment and Tracking

PATCH Assessment and Tracking

The PATCH Assessment and Tracking (PAT) tool serves as a checklist to aid program development and to track the progress made in undertaking the PATCH process. PAT is designed to serve a variety of functions. It can be used as a

- checklist for negotiating tasks to be done and timeframes.
- checklist for tracking progress and reporting completion of tasks.
- tool for planning the details of the PATCH process.

The goals of your program should determine which items to include. Some items may need to be altered or omitted when you are using them to address a preselected health problem or population. PAT should be used any time a phase in the PATCH process is undertaken. The section on phase IV, for example, should be used each time a different intervention activity is planned and implemented. Information generated is recorded on the Program Documentation, located in Appendix 3.

Phase I: Mobilizing the Community

1. _____Define the PATCH community.
2. _____Complete the Community Profile.
3. _____Inform the groups and the community about PATCH.
4. _____Gain the necessary community-level commitments.
5. _____Organize the community group.
6. _____Organize the steering committee.
7. _____Agree on the responsibilities of PATCH participants and on how the resources will be coordinated.
8. _____Conduct a community group meeting.
9. _____Prepare for collecting data.
    - _____Educate participants about data collection.
    - _____Form working groups for
        - _____Mortality and morbidity data
        - _____Community opinion data
        - _____Behavioral data
        - _____Public relations
        - _____Evaluation
        - _____Other:_____

Phase II: Collecting and Organizing Data

1. _____ Obtain community data.

   _____Mortality and morbidity

   _____Community opinion

   _____Behavioral

   _____Other:_____

2. _____ Analyze community data.

   _____Mortality and morbidity

   _____Community opinion

   _____Behavioral

   _____Other:_____

3. _____ Complete the program data forms in the Program Documentation (modify as necessary when the health priority is known).

   _____Unique Health Events

   _____Number of Deaths and Years of Potential Life Lost by Major Disease Categories

   _____Number and Percentage of Deaths Due to Five Leading Causes of Death by Age Group

   _____ Mortality Rate for Leading Causes of Death by Race, Sex, and Age Group

   _____Community Opinion Survey

4. _____ Present data to the community group.

   _____Mortality and morbidity

   _____Community opinion

   _____Other: _____

5. _____ Share data with the community.

Phase III: Choosing Health Priorities

1. _____ Present data to community group.

   _____Behavioral

   _____Other requested data

2. _____ Complete program data form, Prevalence (%) of Health Risk Behaviors Among Adults, by Community, State, and Nation.

3. _____ Complete the Priority Health Problems form, and select one or more health priority.

4. _____ Select behavioral risk factors related to health priority.

5. _____ Select target groups.

6. _____ Determine existing community policies and programs that relate to the behavioral risk factor and target group.

   _____Complete Existing Community Programs/Policies Matrix.

   _____Complete Community Resource Inventory.

7. _____ Develop community objectives and complete the Community Program Objectives form.

8. _____ Develop behavioral objectives.

9. _____ Complete the Community Participants form.

10. _____Inform community of the health priority and the intervention selected.

Phase IV: Developing a Comprehensive Intervention Plan

1. _____ Establish intervention working group.
2. _____ Involve the target group in planning.
3. _____ Determine factors contributing to risk behaviors.
4. _____ Determine a health promotion strategy that includes multiple strategies and settings.
5. _____ Develop written objectives for interventions.
6. _____ Develop interventions that target the entire community.
7. _____ Develop interventions that target subgroups and settings within the community.
8. _____ Complete components of the Checklist for Designing a Successful Intervention.
9. _____ Obtain support and volunteers from the community.
10. _____ Prepare a timetable for each activity and its evaluation.
11. _____ Prepare a master timetable for activities and evaluation.
12. _____ Recruit and train volunteers to help with activities.
13. _____ Publicize interventions.
14. _____ Conduct interventions.
15. _____ Complete the Intervention Plan.
16. _____ Complete the Intervention Activity Follow-Up.
17. _____ Present results of the intervention to
    - _____ Planners and volunteers.
    - _____ Community.
18. _____ Incorporate changes on the basis of results from the evaluation.

Phase V: Evaluating PATCH

1. _____Complete the Evaluation Worksheet for each intervention activity.
2. _____Ask persons and groups who have contributed to the program what information they would like in return.
3. _____Determine criteria for success.
4. _____Write evaluation questions.
5. _____Select data sources.
6. _____Collect process data.
    - _____Collect program activity data
    - _____Collect data from participants
        - _____ demographic
        - _____ knowledge
        - _____ attitude
        - _____ behavioral
    - _____ Analyze process data
    - _____ Adjust program as data indicate
7. _____Collect impact data.
    - _____Collect data on changes in
        - _____ knowledge
        - _____ attitudes
        - _____ behaviors
        - _____ risk factors
        - _____ morbidity
        - _____ mortality
        - _____ policies
        - _____ facilities and the environment
        - _____ methodology or administration of other health promotion agencies, programs, or plans
    - _____Analyze impact data
    - _____Adjust program as data indicate

Appendix 2

Tipsheets

Tipsheets

Most of the planning and decision making in PATCH is done in group meetings. The tipsheets provide suggestions for handling various group management issues. Please review the tipsheets and share them with others, such as community group members and working group chairpersons.

Tipsheet topics:

- Brainstorming
- Facilitating meetings
- Icebreakers
- Making and using overheads
- Presenting data
- Principles of working with adults
- Problem solving
- Reaching consensus
- Recording the minutes
- Resolving conflict
- Understanding diversity
- Using the nominal group technique
- Working with volunteers

Brainstorming

Brainstorming is a problem-solving technique that encourages all members of a group to contribute ideas. Brainstorming can be used to identify causes of problems, potential solutions, and suggested activities. A successful brainstorming session supports the spontaneous flow of ideas; wild ideas are welcomed, and the more ideas, the better. Here are a few guidelines for the facilitator of a brainstorming session.

Hints

- Explain the rules (listed below) before beginning.
- Ask one or two people to record the ideas.
- Give all participants a chance to share their ideas.
- Keep a lively tempo.
- Praise the quantity rather than the quality of ideas.

Rules

- No critical remarks are allowed; evaluation comes later.
- Give the thought only; explanation comes later.
- Give only one idea at a time.
- Adding to or improving on someone else's idea is appropriate.

Methods

To manage the brainstorming session and make it most productive, choose one of the following methods.

Free-wheeling. Participants call out ideas, which are recorded as suggested. Results tend to be creative and spontaneous, and ideas tend to build on other ideas. However, some group members may dominate, while quiet members are reluctant to join in. If the group is large or dominated by a few members, the round-robin or slip methods may be more appropriate.

Round-robin. Ask each member for an idea, in turn, and have the ideas recorded in order. Members can pass on any round, and the rotation continues until all members have passed during a single round. This method, which is more organized than the first, prohibits anyone from dominating and still makes it possible for participants to build on each other's ideas. Some participants, however, may find it hard to wait until their turn and may forget ideas while waiting.

Slip. Ask members to write down ideas on a slip of paper or a note card. The slips are collected, and the ideas are recorded on a flip chart. Because contributions are anonymous, participants are free to express themselves without concern for embarrassment or disagreement. However, written comments may be unclear, and creativity may be hindered because ideas are not shared until the process is complete.

Facilitating Meetings

Most of the planning and decision making in PATCH is done in group meetings. Meetings should be facilitated to encourage participation and build a sense of vision and cohesiveness among participates. You can use many techniques to promote interaction among group members and encourage team work. Here are a few suggestions.

- Create an environment conducive to communication. Try seating participants around small tables or in semicircles; move extra chairs out of the way.
- Make participation an expectation. Ask questions frequently, and use open-ended questions to encourage thought and participation. Avoid answering your own questions or talking more than participants. Thank participants for their comments.
- Create opportunities for participants to work in teams during the community group meetings. Use some small-group or partner exercises.
- Give small assignments in advance, and ask participants to come to meetings prepared to share their work. Preview a question or problem that participants can think about between meetings, or mail out worksheets before meetings.
- Get participants to talk about themselves as a group. Ask them to consider several questions:
  - Are we working together smoothly?
  - Can we improve how we interact?
  - Can we put some more fun into our PATCH work?
- Talk with quiet participants during breaks. Help them express their ideas, and ask them to share their thoughts with the group.
- Use flip charts or overhead transparencies to record comments. At intervals throughout the meeting, summarize the main points or ask a group member to paraphrase comments or review the minutes.
- Suggest the next step if the meeting seems to be stagnating.
- Walk around to gain attention, but look directly at participants. Face participants while writing on flipcharts, or ask someone else to do the writing. Join in. Participants will want to know about you too, and they should feel that you are a part of the group.
- Expect to make some mistakes; acknowledge them, correct them, and move on.

Common problems

No matter how well planned a meeting may be, it may not go smoothly. In fact, a certain amount of discussion and dispute is necessary for healthy interaction. However, you may lose control of a meeting if certain problems occur. Here are several common problems followed by some suggestions for resolving them.

No participation. Ask for opinions, then remain silent. When participants speak up, compliment them for sharing their views.

Off the track. Interrupt the discussion, and remind participants of the original topic of discussion. Try to select a moment that would not result in anyone's being embarrassed. Suggest that the newly introduced issue be discussed at a later time, or refer the issue to a working group.

Too much talk. At the outset of the meeting, ask participants to set a time limit for individual contributions and appoint a timekeeper. Ask the timekeeper to inform participants when they go over the time limit.

Disputes among participants. Remain neutral and allow the participants to disagree. If the dispute must be resolved, encourage the group to reach a consensus. If more information would help resolve the issue, refer the dispute to a working group for further discussion.

Unyielding participants. Give the group a chance to bring them around. Often, the majority opinion will cause participants to reconsider their point of view. Suggest that the participants accept the group's view for now, and offer to discuss the issue with them further after the meeting.

Icebreakers

An icebreaker is an activity that is informal, creative, fun, and unrelated to the purpose of the meeting. It is designed to help participants get acquainted. An icebreaker provides the following advantages:

- Communicates that the meeting will be relaxed and friendly.
- Reduces any tension, anxiety, or separateness participants may feel.
- Promotes group interaction.
- Provides insight into the skills, knowledge, experience, and personality of participants.

Icebreakers can range from individual introductions to activities involving movement or imagination. Things to consider when selecting and designing icebreakers include group composition, time available, when on the agenda the icebreaker is to be used, topic for the meeting, culture of the sponsoring organization, and style and personality of the trainer(s).

Examples of icebreakers:

- To pair participants for personal introductions, shuffle a deck of prepared index cards and ask attendees to select one. Use 5"x7" index cards and make sure to print clearly. Each index card has half of a pair of words that relate to the topic/theme of the program. The paired words can be of the same meaning (e.g., health/wellness) or opposite meaning (e.g., exerciser/coach potato). Be consistent in your use. Explain the relationship of the pair words to participants before you ask them to find their "other half." Once pairs are matched, trainees interview their partners and introduce each other to the class.
- For a good laugh and an instant discussion starter, put signs related to the subject matter on the tables. As participants come in, ask them to sit at the table with the sign that best describes them. For example, if the course deals with stress management, include table signs such as, "Burned Out" or "Help"; for time management, "Will be late for my own funeral" or "Disgustingly Punctual."
- Members of a group learn one another's name quickly with this exercise. Participants stand in a circle. The facilitator states his or her name and tosses a tennis ball to a participant. That person, in turn, says his name and tosses the ball to another person. This activity continues until everyone has had the ball several times. Then the rules change. As players toss the ball, they say the recipient's names instead of their own.

Making and Using Overheads

A well-developed set of overheads can help organize your presentation, focus the attention of your audience, clarify and reinforce your ideas, and make abstract concepts concrete. Here are a few guidelines to keep in mind when making and using overheads. Most of the items are also valid for making slides.

Making overheads

- Limit each visual to one main idea. Use no more than 6 to 8 lines of text and no more than 40 characters per line.
- Show only the information you plan to discuss.
- Use key phrases rather than sentences. Avoid jargon.
- Use bullets to list key points. Numbers should be used only when the numerical order of the items is important.
- Make text bold, sans serif, and use upper and lower case because letters in all caps appear too similar from a distance.
- Use lettering 1/3" high so that text can be easily read from the back of the room. Double space between lines.
- Use one color scheme for an entire set of overheads.
- Use contrasting complementary colors and make the background dark and the letters light.

Using overheads

- Leave the projected image on the screen only as long as it supports your oral presentation.
- Turn off the projector when you do not have an image to project.
- Rehearse your presentation to become comfortable with the sequence and timing of the visuals.
- Adjust your pace to the complexity of the information and the characteristics of the audience.

Presenting Data

The PATCH process can generate a substantial amount of data. How data are presented can affect an audience's ability to process the information. Here are a few guidelines about presenting data.

- Present data in a simple, straightforward manner. The more understandable data are to community group members, the more likely members will be to use the data in planning health interventions.
- Include a frame of reference for the data. For instance, compare your community's data with national data, state data, or data from similar communities.
- Explain any limitations of the particular data set.
- Be sure any presentation of data on paper can stand alone, regardless of the particular format you choose. Label tables, charts, and graphs; specify the data source.
- Be sure that the measure you select for display (count, percentage, rate, or their measure) is appropriate for your message and the constraints of your graphic display.
- Select only one main message per visual display. If you want to focus on several aspects of the data, consider making a set of visual aids.
- Choose a graphic display most appropriate for your task. Some graphic aids are more appropriate than others for illustrating certain types of data, fostering comparisons, and allowing your audience to quickly grasp important points. Which visual display you choose depends on the message you want to convey. Here are a few basic guidelines for using the most popular charts and graphs.
  - A horizontal bar chart can be used to focus attention on how one category differs among several groups.
  - A vertical bar chart is often most appropriate when you want to focus attention on a change in a variable over time.
  - Consider using a cluster bar chart when you want to contrast one variable among multiple subgroups.
  - A line graph can be used to plot data for several periods and show a trend over time.
  - A pie chart is sometimes used to show the distribution of a set of events or a total quantity.

As you present a graphic to a group, read, and clarify it for your audience:

- Read the heading and contents of the overhead.
- Compare community data with state and national data.

- Clarify numerical units on graphics (e.g., units are expressed in numbers or rates and why).
- Discuss any adjustments made to the data (e.g., 3 years of data were grouped together because the numbers were too small).
- State any limitations of the data (e.g., may be for county, and the PATCH community may not include the entire county; numbers may be small so place the emphasis on looking at trend data; data may not be available for subpopulations because of small numbers).
- Review the differences in groups presented in the data: between men and women; among races; between age groups.

Summarize the main findings in the last two minutes of your presentation, and give participants summary handouts. Limit your presentation to less than half an hour, and ask for questions.

Principles of Working With Adults

A goal of PATCH is to increase the capacity of community members to address health issues by strengthening their community planning and health promotion skills. When choosing activities and exercises for each phase in the PATCH process and when designing interventions, keep in mind some of those characteristics of adults.

Characteristics of adult learners

- Most adult groups are heterogeneous. Individuals bring a wide range of experience to a group, but their experiences will vary in quantity and quality.
- Many adults are independent and self-directed learners who take responsibility for making decisions.
- Many adults are interested in information related to the specific problems and tasks at hand and in learning that is life centered.
- Many adults believe that the immediate application of new information is important. They are interested in learning to improve their own performance or the overall quality of life.
- Although some external factors may motivate adults to action, motivation is primarily internal. Self-esteem, a desire for personal growth and skill-building, an interest in improving the quality of life, and other similar factors may motivate the participants in your community.

Techniques for working with adults

People generally remember only 10% of what they read; 20% of what they hear; 50% of what they see and hear; and 90% of what they see, hear, and do simultaneously. Thus, experiences that involve multiple channels enhance learning and retention. Here are several techniques particularly suitable for working with adults.

Prior work. Give participants an assignment before a meeting. Advance preparation may stimulate curiosity, increase motivation to participate, and make meetings more productive.

Group discussion. Use this approach for goal setting, decision making, and problem solving. The technique requires a facilitator who can encourage interaction by asking good questions, listening well, and allowing participants adequate response time.

Mixed instructional media. Choose from among five types of instructional media: printed materials (handouts, assignment sheets, instructions), nonprojected visuals (flip charts, posters), projected visuals (overhead transparencies, slides), audiovisuals (audiotapes, films, slide-tape programs, videotapes), and computer-based materials. Choose the media most suited to group size and activity, and consider the materials and equipment each medium requires.

Simulation. Use this approach to allow participants to practice skills or rehearse activities. For example, one component of an injury-prevention strategy might be to have parents practice buckling a doll into a child safety seat. Interviewing techniques might also be practiced during a simulation activity before conducting opinion surveys. The practice session is intended to trigger interactions similar to those that are encountered in real life. Simulation can be used for individual or small-group instruction.

Problem Solving

Here is a five-step, common-sense approach to solving problems.

1. Define the problem, and then state it clearly and concisely. Be realistic about solving the problem, and consider working on parts of it rather than all of it at once. Determine how you will know whether a solution has been reached.
2. Gather information about the problem.
3. Generate ideas for solving the problem. Use one of the group techniques described in this section or another technique.
4. Choose from the alternative solutions. Set some criteria for making choices, rank the alternatives, and consider the consequences of a few alternatives before making a final decision.
5. Put the solution into effect. The solution should be explicit about responsibilities and achieving tangible results. Appoint one or more participants to oversee progress and to ensure that plans are correctly implemented.

Reaching Consensus

Groups sometimes find it hard to reach a consensus, or general agreement. Remind participants of the following guidelines to group decision making.

- Avoid the "one best way" attitude; the best way is that which reflects the best collective judgment of the group.
- Avoid "either, or" thinking; often the best solution combines several approaches.
- A majority vote is not always the best solution. When participants give and take, several viewpoints can be combined.
- Healthy conflict, which can help participants reach a consensus, should not be smoothed over or ended prematurely.
- Problems are best solved when all participants try both to communicate and to listen.

If a group has trouble reaching a consensus, consider using some special techniques. See the tipsheets on brainstorming, the nominal group technique, and resolving conflict.

Recording the Minutes

If you are asked to record the minutes of a meeting, review the guidelines below.

- Listen for key words and phrases; do not try to take down every word that is said.
- Be sure to record the following:
  - Date and time of the meeting.
  - Names of attendees.
  - Topics discussed and the process used (e.g., brainstorming, nominal group technique, discussion).
  - Actions taken or decisions made.
  - Tasks to be done between meetings and persons or working groups responsible for them.
  - Items to be carried over to the next meeting or referred to a working group.
  - Date and time of the next meeting.
  - Number and date on each page of the minutes.
- If you are writing on a flipchart, print clearly in large letters so that the text can be read by everyone in the room.
- Use different colors or formats to distinguish process from content.
- Use symbols, numbers, or other graphic devices to lend order and emphasis to the text.

Resolving Conflict

Conflict resolution is the process of settling disagreements among group members. Here are four ways to resolve conflicts about goals, plans, activities, or procedures.

Avoidance. One way to handle conflict is to ignore it. You might choose this method if the conflict does not seem important enough to discuss. Avoidance might also be the best temporary solution. However, avoiding a problem does not solve it. Emotional tension, misunderstanding, and intolerance can result from unresolved conflict, so reassess the problem later.

Accommodation. Ask participants to yield or conform to the positions of others–even at the expense of their own ideas or values. Asking a participant to accommodate another person's position requires great tact and discretion.

Compromise. A compromise is a solution accepted by all members of the group. Everyone wins something, but everyone has to give up something as well. When a consensus cannot be reached, compromise may be the only solution.

Collaboration. Collaboration requires all group members to acknowledge the conflict, consider many possible solutions and the consequences of each, and select the alternatives that best meet the needs of the group. When persons in a group collaborate, they draw on shared values, needs, interests, and resources; therefore, this approach is generally accepted as the best. Because the process takes time, however, it is best reserved for issues of greatest importance.

Understanding Diversity

Members of a group come from many different backgrounds. Some members may be much older or much younger than other members; some may represent different cultural, racial, or ethnic groups; and some may represent different educational levels and abilities. Extra awareness and flexibility are required for the facilitator and other group members to remain sensitive to different backgrounds. Below we suggest a few ways to improve your awareness of differences. In general, new information is acquired so that different perspectives can be understood and appreciated.

- Become aware of differences in the group by asking questions and getting involved in small-group discussions.
- Seek involvement and input and listen to persons of different backgrounds without bias, and avoid being defensive.
- Learn the beliefs and feelings of specific groups about particular issues.
- Read about current and emerging issues that concern different groups, and read literature that is popular among different groups.
- Learn about the language, humor, gestures, norms, expectations, and values of different groups.
- Attend events that appeal to members of specific groups.
- Become attuned to cultural cliches, stereotypes, and distortions you may encounter in the media.
- Use examples to which persons of different cultures and backgrounds can relate.
- Learn the facts before you make statements or form opinions about different groups.

Using the Nominal Group Technique

The nominal group technique is useful for determining which items are of highest priority to a group. The items may result from brainstorming or may be responses to questions or selections from a list of options. Because participants work independently, no one can dominate the process. To direct the process, follow these four steps.

1. Pass out index cards to all members of the group.
2. Ask member of the group to list on their cards the three to five items of highest priority, with the first item being the most important.
3. Collect the index cards and ensure that rankings are anonymous.
4. Read the cards out loud, and record the rankings on a flip chart as follows. When only three items are ranked, a number 1 ranking is worth 3 points, number 2 is worth 2 points, and number 3 is worth 1 point. (In a ranking of the top five, the number 1 ranking receives 5 points.) For the ranking of each item on each card, make a hatch mark under the column for the appropriate number of points.

For Example

Item	3 points	2 points	1 point	Total
A	///	/	///////	18
D	/	////	//	13
G		/	////////	11
J	/////	///////	/	30
M				0
P	/	//////	//////	21
S	////////	/	/	27
V			/	1
Y	/	///	/	10

In the example, the top priority items are J, S, P, and A. Because P and A are close in score and significantly greater than the next highest score, they are included among the highest ranking items, making a top priority grouping of four items, rather than three or five.

When participants feel free to express opinions and discuss issues, you can use a less-formal approach. Ask for a show of hands for ranking each item. If priority items are identified but not ranked, record one point for each item, and the total points indicate which items are of highest priority to the group.

Working With Volunteers

Volunteers work for self-satisfaction, personal growth, fun, and other intangible rewards. Each volunteer should be treated as a colleague and recognized as an official part of the team. However, offer volunteers more flexibility than you can to employees, and adjust your expectations accordingly. For example, because volunteers cannot contribute as much time as paid, full-time workers do, they cannot complete tasks as quickly. When scheduling activities, be realistic about how long a busy PATCH participant will need to complete it.

Get to know each volunteer personally so that you can learn about special abilities and limitations and match responsibilities to skills. Vary responsibilities as desired by the volunteers.

Be sure to assign specific and clearly defined tasks and to explain procedures and expectations. Develop a work plan or job description for the volunteer to help ensure that roles and responsibilities are understood. Provide training and give credit for work done. Give lots of feedback, encouragement, and signs of appreciation. Be willing to change the placement of volunteers, if that seems appropriate, or even dismiss a volunteer if necessary.

Keep in mind the following key points of working with volunteers. They want to be

- appreciated for the work they do.
- busy with worthwhile and varied tasks.
- provided with clear communication about tasks and expectations.
- developed through training.

Appendix 3

Program Documentation

Program Documentation

The purpose of the Program Documentation tool in the Planned Approach to Community Health (PATCH) process is to provide for the collection of basic information. It may serve as an ongoing recording document for monitoring program objectives, activities, and accomplishments. It may also be used to record significant events that have an impact on the community's health. The Program Documentation outlines data a community may wish to obtain when assessing the health status of the community and identifying major health priorities. The community should review the data forms and adapt them to meet its needs. If the community is addressing a preselected health problem or population, the data collected may need to be significantly changed. The program documentation contains the following forms:

I. Community Profile

II. Unique Health Events

III. Number of Deaths and Years of Potential Life Lost by Major Disease Categories

IV. Five Leading Causes of Death by Age Groups

V. Comparison of Mortality Rates for Leading Causes of Death by Race, Sex, and Age Groups

VI. Community Leader Opinion Survey Data

VII. A Comparison of Behavioral Data (Percentage) Among Adults by Community, State, and Nation

VIII. Priority Problems Identified

IX. Community Program Objectives

X. Community Participants

XI. Intervention Plan

XII. Intervention Activity Summary

PD-I. Community Profile

Community: _____

Lead agency: _____

Contact person: _____

Address: _____

_____

Telephone number: _____ Fax number: _____

Source of data: _____ Year: _____

Community type: Urban___ Rural___ Suburban___ Other___

Geographic size or description: _____

_____

Total population:

Unemployment rate: Community _____ State _____

Per capita income: Community _____ State _____

Families below poverty level (%): Community _____ State _____

Age distribution in years:

Community

Age	%	No.
<1:		
1-14:		
15-24:		
25-64:		
≥65:		
total population		

State

Age	%	No.
<1:		
1-14:		
15-24:		
25-64:		
≥65:		
total population		

Number of households, by household size:

	Number of persons in household	
Community		**State**
1:		1:
2:		2:
3:		3:
4-5:		4-5:
6+:		6+:

Total number of households:

Annual household income:

	Community		**State**	
Amount	%	No.	%	No.
<$15,000:				
$15,000 to $24,999:				
$25,000 to $49,999:				
$50,000+:				

Marital status:*

			No. by sex	
	%	No.	Male	Female
Single:				
Married:				
Separated:				
Widowed:				
Divorced:				
Total:				

*Generally includes persons 18 years of age and older.

Racial/ethnic composition:

	No.	%	% by sex Male	% by sex Female
White:				
Black:				
Hispanic*:				
American Indian+:				
Asian#:				
Other:				

*Includes both blacks and whites. +Or Alaska Native. #Or Pacific Islander.

Education:

Number of persons currently enrolled:

	Community
Elementary school	_____
High school	_____
Technical school	_____
College	_____

Educational achievement (% of adults who completed):

	Community	State
Elementary school plus 3 years of high school	_____	_____
High school	_____	_____
Technical school	_____	_____
College:		
1-3 years	_____	_____
4 years	_____	_____
≥5 years	_____	_____

PD-II. Unique Health Events

A unique health event is an event or activity that takes place in the community that may have a short-term or long-term effect on the health or health risks of its citizens.

Examples of unique health events include special community health promotion and health education activities, health legislation, and environmental or natural events. Events can have a negative or positive effect on health. For instance, positive events might include the addition of fluoride to the drinking water or passing a law requiring the use of seatbelts. Negative events might include a hurricane or flood or the repeal of the tax on tobacco products.

Do not report PATCH program results or activities in this section. Report PATCH activities in PD-XII.

Date	Description of the Event	Number of People Affected

PD-III. Number of Deaths and Years of Potential Life Lost by Major Disease Categories*

Community_____ Year_____

Disease Category	Rank	# of Deaths	YPLL† Before Age 75
Heart disease			
All cancers			
Lung cancer		‡	‡
Cerebrovascular disease			
Emphysema			
Influenza and pneumonia			
All fatal injuries			
Motor vehicle injuries		‡	‡
Liver disease			
Suicide			
Homicide			
Diabetes mellitus			
Other			
Total			

* Based on leading causes of death.

† YPLL = Years of potential life lost for deaths > 1 year of age.

‡ To calculate the "Total" number of deaths or YPLL, add all numbers in the column except for lung cancer and motor vehicle injuries.

Source: _____

PD-IV. Five Leading Causes of Death by Age Groups

Community _____ Year _____

Age < 1 Cause	Total*	Percent†
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
All other causes		

Age 1-14 Cause	Total*	Percent†
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
All other causes		

Age 15-24 Cause	Total*	Percent†
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
All other causes		

* Total number of deaths from this cause.

† Number of deaths from this cause divided by total of all deaths in this age group.

Source: _____

PD-IV. Five Leading Causes of Death, by Age Groups in

Community_____Year_____

Age 25-44 Cause	Total*	Percent†
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
All other causes		

Age 45-64 Cause	Total*	Percent†
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
All other causes		

Age 65+ Cause	Total*	Percent†
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
All other causes		

* Total number of deaths from this cause.

† Number of deaths from this cause divided by total of all deaths in this age group.

Source: _____

PD-V. Comparison of Mortality Rates for Leading Causes of Death by Race, Sex, and Age Groups

Mortality Rates (per 100,000) for Leading Causes of Death Among Males Aged _____

Community _____/_____ (Year) State _____/_____ (Year) United States /_____ (Year)

Rank	Cause	# of deaths	Rate	Rank in state	# of deaths	Rate	Rank in nation	# of deaths	Rate
1.									
2.									
3.									
4.									
5.									

Mortality Rates (per 100,000) for Leading Causes of Death Among Females Aged _____

Community _____/_____ (Year) State _____/_____ (Year) United States /_____ (Year)

Rank	Cause	# of deaths	Rate	Rank in state	# of deaths	Rate	Rank in nation	# of deaths	Rate
1.									
2.									
3.									
4.									
5.									

PD-V. Comparison of Mortality Rates for Leading Causes of Death by Race, Sex, and Age Groups

Mortality Rates (per 100,000) for Leading Causes of Death Among White Males Aged _____

Community _____/_____ State _____/_____ United States /_____
(Year) (Year) (Year)

Rank	Cause	# of deaths	Rate	Rank in state	# of deaths	Rate	Rank in nation	# of deaths	Rate
1.									
2.									
3.									
4.									
5.									

Mortality Rates (per 100,000) for Leading Causes of Death Among White Females Aged _____

Community _____/_____ State _____/_____United States / _____
(Year) (Year) (Year)

Rank	Cause	# of deaths	Rate	Rank in state	# of deaths	Rate	Rank in nation	# of deaths	Rate
1.									
2.									
3.									
4.									
5.									

PD-V. Comparison of Mortality Rates for Leading Causes of Death by Race, Sex, and Age Groups

Mortality Rates (per 100,000) for Leading Causes of Death Among Black and Other Males Aged _____

Community _____/_____ State _____/_____ United States /_____
(Year) (Year) (Year)

Rank	Cause	# of deaths	Rate	Rank in state	# of deaths	Rate	Rank in nation	# of deaths	Rate
1.									
2.									
3.									
4.									
5.									

Mortality Rates (per 100,000) for Leading Causes of Death Among Black and Other Females Aged _____

Community _____/_____ State _____/_____ United States /_____
(Year) (Year) (Year)

Rank	Cause	# of deaths	Rate	Rank in state	# of deaths	Rate	Rank in nation	# of deaths	Rate
1.									
2.									
3.									
4.									
5.									

PD-VI. Community Leader Opinion Survey Data

_____ Data collection method	_____ Number of interviewers
_____ Total number of people interviewed	From: _____ To: _____ Date collected

Rank	Health problem	Number of persons identifying problem	Percentage of persons identifying problem
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Source:

PD-VII. A Comparison of Behavioral Data (Percentage) Among Adults by Community, State, and Nation

	Community			State			Nation		
	M	F	Total	M	F	Total	M	F	Total
Seatbelt (2)									
Seatbelt (3)									
Hypertension (1)									
Hypertension (2)									
Overweight (1)									
Overweight (2)									
Current smoking									
Acute (binge) drinking									
Chronic drinking									
Drinking and driving									
Sedentary lifestyle									
No leisure time activity									
Regular and sustained activity									
Regular and vigorous activity									
Cholesterol screening (1)									
Cholesterol screening (2)									
Cholesterol awareness									

Community data source: _____

State data source: _____

National data source: _____

PD-VIII. Priority Problems Identified

On the basis of an analysis of the behavioral data, community mortality data, community opinion data, and other pertinent information _____ (community) has identified the following community priority problems:

Rank	Problems
#1	
#2	
#3	
#4	
#5	

PD-IX. Community Program Objectives

1.

2.

3.

4.

5.

An objective may be written for each priority problem identified.

Example:
By December 31, 1998, the proportion of persons in X Community who report that they smoke will decrease from 33% (1994 survey data) to 30%.

PD-X. Community Participants

List of individuals participating in the Planned Approach to Community Health

Participant:
Address:

Telephone:
Affiliation:

Fax:

Date Started:
Date Ended:
Reason:

Involvement:
Steering Committee
Community Group
Other

Participant:
Address:

Telephone:
Affiliation:

Fax:

Date Started:
Date Ended:
Reason:

Involvement:
Steering Committee
Community Group
Other

Participant:
Address:

Telephone:
Affiliation:

Fax:

Date Started:
Date Ended:
Reason:

Involvement:
Steering Committee
Community Group
Other

Participant:
Address:

Telephone:
Affiliation:

Fax:

Date Started:
Date Ended:
Reason:

Involvement:
Steering Committee
Community Group
Other

PD-XI. Intervention Plan

On separate pages describe the planned interventions. Include a discussion of the items indicated below.

A. Relate intervention to community health problem by describing the:

1. Community objective addressed
2. Behavioral objective(s) addressed
3. Contributing factors (e.g., predisposing, enabling, reinforcing factors)

B. Specify intervention objectives ("learning objectives" or descriptions of participants' status as a result of the intervention). These may relate to changes in knowledge, attitude, skills, behaviors, or policies.

C. Describe intervention activities.

D. Describe evaluation plans:

1. Process evaluation methods and instruments
2. Impact evaluation methods and instruments

PD-XII. Intervention Activity Summary

A. Describe the intervention activity including purpose and relationship to program objectives:

B. Check primary strategy used: educational ❑
policy ❑
environmental ❑

C. If the intervention is mainly educational, list the

–intervention setting:

–target group:

–total number of hours individuals participated (e.g., six two-hour sessions equal 12 hours):

–total number and sociodemographics of participants (e.g., age, gender, race):

D. Name the intervention coordinator:

Telephone number:

Address:

E. List resources required including in-kind.

Staff/Volunteer's time:

Tasks	# of workers	Total # of hours

Other resources:

Type	Amount	Source

F. List informational materials produced/used (attach sample):

G. Summarize the evaluation of the intervention, relating to the Evaluation Worksheet (page CG5-19). (Attach samples of letters, agendas, and questionnaires used to assist with evaluation and replication):

Appendix 4

Glossary

Glossary

Adjusted rate — A summary rate constructed for comparing groups differing in some important characteristic. Because there are many kinds of adjusted rates, no one formula applies. An adjusted rate is calculated by use of statistical procedures that remove the influence of differences in population distributions so that populations can become comparable on certain characteristics in their demographic compositions. Rates are adjusted according to a standard, usually a state or national population. Adjustments are used frequently to control for differences in population characteristics such as age, race, or sex.

Age-race-sex — A designation referring to population subgroups, often used in describing rates specific to, or that have been adjusted for, these factors. Each subgroup consists entirely of individuals who share a common age, common race, and common sex.

Attitude — A relatively constant feeling, predisposition, or belief directed toward an object, person, or situation.

Attributable risk — A measure of association that provides information about the excess risk of disease in a population in which some risk factor is present compared with a population in which that risk factor is absent. The measure is calculated as the difference between the incidence rate of the group in which a risk factor is present and the incidence rate of the group in which a risk factor is absent.

Behavior — An action that has a specific frequency, duration, and purpose, whether conscious or unconscious.

Belief — A statement or thought, declared or implied, intellectually or emotionally accepted as true by a person or group.

Bias — An error or effect in any stage of program planning, implementation, or evaluation that distorts results.

Brainstorming — A problem-solving technique that encourages all members of a group to contribute ideas.

Cause of death	The disease, injury, or other condition that resulted in or contributed significantly to an individual's death, or the circumstances surrounding the prognosis of the disease or incident in which injuries were inflicted; may refer specifically to the event or condition identified on the death certificate as the cause of death.
Chronic disease	A disease marked by long duration or frequent recurrence. Examples are diabetes, cancer, hypertension, and heart disease.
Community	An entity for which both the nature and the scope of a public health problem, as well as a capacity to respond to that problem, can be defined. In most instances, the community can be defined as a geopolitical unit, such as a county, city, town, or neighborhood.
Community health education	Community health education is the application of methods that result in the education and mobilization of members in actions for resolving health issues and problems that affect the community. These methods include group process, mass media, communication, community organization, organization development, strategic planning, skills training, legislation, environmental measures, policy making, and advocacy.
Contributing factors	Behavioral or environmental factors that have a potential for affecting health behaviors. These factors can be categorized as motivators, enablers, or reinforcers.
Crude rate	A measure of disease, health problems, or some other event in a population during a given time. Crude rates are calculated by dividing the number of events occurring in a total population during a particular time by the total population at risk during that time.
Dependent variable	The condition or characteristic assumed to depend on or be caused by some other condition or characteristic (the independent variable) (e.g., rate of dependent variable skin cancer is determined to some extent by levels of UV light exposure).

Diagnosis	Information that designates or describes a health problem for the purpose of planning and evaluating interventions or establishing a prognosis.
Diffusion theory	People adopt new ideas at different rates: some immediately, some never, and most at varying points in between. According to the diffusion theory, individuals can be categorized as innovators, early adopters, early majority, late majority, and laggards. With respect to adapting new ideas, individuals may pass through five stages: awareness, interest, trial, decision, and adoption. These factors can be used to identify points in time when different communication methods and channels are more or less effective.
Educational diagnosis	The delineation of factors that motivate, enable, or reinforce a specific health behavior.
Educational tool	Any material, such as a bulletin board, leaflet, or videotape, designed to aid learning and teaching through sight and sound; term is used interchangeably with educational and audiovisual aids.
Enabler	Any characteristic of the environment, such as accessibility and availability of resources, that brings about an individual's or group's health behavior; any skill a person, organization, or community needs to perform a health behavior.
Epidemiology	The study of the extent, distribution, and causes of a health problem among a defined population.
Evaluation	Evaluation is broadly defined as the comparison of an object of interest against a standard of acceptability. Evaluation is a process of determining a phenomenon's merit and assessing the extent of its success in achieving a predetermined objective. It usually includes at least the following steps: formulating objectives, identifying criteria to be used in measuring success, collecting data/information, and determining and explaining the degree of success.
Evaluation research	Using rigorous scientific methodology to produce evidence in support of a research hypothesis and to demonstrate a cause-effect relationship between the educational intervention and the outcome. The objective is to obtain knowledge that applies to similar groups in other settings.

Formative	Evaluation that produces information used during the developmental and operational stages of a program to improve the program.
Health	A state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity.
Health communication	The crafting and delivery of messages and strategies, based on consumer research, to promote the health of individuals and communities.
Health education	A health education program is a planned combination of activities developed with the involvement of specific populations and based on a needs assessment, sound principles of education, and periodic evaluation using a clear set of goals and objectives.
Health information	Health information is the content of communications based on data derived from systematic and scientific methods as they relate to health issues, policies, programs, services, and other aspects of individual and public health that can be used for informing various populations and in planning health education activities.
Health promotion	The combination of educational and environmental supports for actions and conditions of living conducive to health.
Health promotion and disease prevention	Health promotion and disease prevention activities are designed to improve personal and public health through a combination of strategies, including those that change behaviors, health education, health protection measures, risk factor detection, health enhancement, and health maintenance.
Health problem	Any condition of being unsound in body, mind, or spirit that affects the quality of life of an individual or population.
Healthy lifestyle	A healthy lifestyle is a set of health-enhancing behaviors, shaped by consistent values, attitudes, beliefs, and social and cultural forces.

Icebreaker program — An activity conducted during a meeting to help participants get acquainted. The activity is usually informal, creative, and unrelated to the purpose of the meeting.

Impact evaluation — An evaluation that assesses the overall effectiveness of a program in producing favorable cognitive, belief, and behavioral effects in the target population. Impact evaluation is designed to determine whether a project's objectives have been achieved and whether observed changes in the population can be attributed to program efforts.

Incidence — Number of new cases of a disease or other event occurring during a given period. (Compare with prevalence.)

Incidence rate — The number of new cases of a disease or other health problem occurring over a particular time per 1,000, 10,000 or 100,000 population at risk. The population at risk includes the total population minus the population already inflicted with the disease or health problem.

Independent variable — A characteristic or condition under study that is assumed to precede or influence the appearance of another characteristic or condition (the dependent variable). For example, the rate of lung cancer depends on the independent variable smoking cigarettes.

Intervention — The part of a strategy, incorporating method and technique, that actually interacts with an individual or population.

Interviewer bias — Intentional or unintentional influence exerted by an interviewer in such a way that the actual or interpreted behavior of respondents is consistent with the interviewer's expectations.

Likert-type scale — A type of scale that attempts to standardize subjective responses on a survey questionnaire through ranked response categories such as "strongly agree," "agree," "disagree," and "strongly disagree."

Mean — An average computed by summing the values of several observations and divided by the number of observations. The mean of 2, 3, 4, 6, 7 and 8 is $30/6 = 5$.

Median	An average that represents the middle value when all values are arranged in ascending order. If there are nine values, the median is the fifth one.
Mode	An average representing the most frequently observed value in a collection of data.
Morbidity rate	The incidence of nonfatal disease or some other health problem in a population during a specified time. Morbidity rates are calculated by dividing the number of reported cases of disease by the total population at risk.
Mortality rate	The incidence of death among a particular population during a period of time. Mortality rates are calculated by dividing the number of fatalities among a population by the total population.
Motivators	Personal preferences (knowledge, values, beliefs, or attitudes) of an individual or group that either support or inhibit health behavior.
Nominal group technique	A priority-setting technique in which participants identify and rank items by total points to indicate which items are of highest priority to the group.
Objectives	Defined as results of specific activities or outcomes to be achieved over a stated time. Objectives are specific, measurable, and realistic statements of intention. Objectives state ***who*** will experience ***what change or benefit*** and ***how much*** change is to be experienced in ***what time***.
Obtrusive measures	Methods of data collection that involve or impinge upon the individuals being studied so that they are aware of being measured, tested, or assessed.
Open-ended question	A type of question that does not limit a respondent's answer to preselected choices. The respondent is free to answer using his or her own words.
Outcome evaluation	An assessment of changes in health status indicators, such as morbidity and mortality, for a specified population.

Participant observer	A method of gathering data during which the researcher participates in a phenomenon of interest to learn about it.
Pilot test	A test of a data collection instrument on a group as similar as possible to the group on which the instrument will actually be used. A pilot test assesses the clarity, sequence, length, and appropriateness of the instrument.
Population at risk	All those people who might have been affected with a disease or other health problem or by their behavior or other characteristics have a greater chance for developing a disease/health problem, whether or not they become affected.
Posttest	Measurement of a given variable after an intervention is completed.
Pretest	Measurement of a given variable before an intervention begins.
Prevalence	A measure of all cases of disease or other health problems that exist at a given time. It includes both new and old cases of disease. (Compare with incidence.)
Prevalence rate	The number of existing cases of a disease at a particular time per 1,000, 10,000, or 100,000 population at risk.
Priorities	Alternatives ranked according to some criterion or criteria such as effectiveness, value, or importance.
Process evaluation	An ongoing examination of both what is delivered and how it is delivered, including program conception, staff, methods and activities, and effectiveness and efficiency in reaching the target group.
Program	A set of planned activities designed to achieve specified objectives over time.
Program effectiveness	The extent to which program objectives are attained as a result of program activity.
Program efficiency	The proportion of resources used in the actual attainment of objectives relative to the total resources expended.

Program evaluation — A systematic assessment of the planning, implementation, and effectiveness of a specific program.

Qualitative data — Verbal, narrative, or pictorial data that are collected by observation, discussion, and interview and do not always readily lend themselves to quantification. Such data are often presented descriptively.

Quantitative data — Objective information that can be given a numerical value, such as test scores, reading ability, income, morbidity prevalence, mortality rates, and behavioral risk factor prevalence.

Rate — A measure of the probability of an occurrence of a particular event within a particular population. Rates are calculated with a basic formula:

$$(X/Y) \times K$$

X = number of events of interest observed in a population during a specific time interval

Y = population at risk during time interval

K = a constant value, usually 100, 1,000, or 100,000 by which the rate is expressed, e.g., deaths per 1,000 population.

Relative risk — A mathematical expression of the likelihood that an event will occur in the presence of a certain risk factor as compared with the likelihood that it will occur in the absence of that factor. It is calculated as the ratio of the incidence of some disease or health problem in one group in which the risk factor is present to the incidence of that same disease or health problem in another group in which the risk factor is absent.

Reliability — The degree to which measured results can be replicated.

Response rate — The number of completed interviews or questionnaires divided by the number of eligible respondents.

Reinforcers — Incentives or punishments that encourage or discourage desired health behaviors.

Risk	A probability that an event will occur, e.g., that an individual will become ill or die within a stated time or at a particular age.
Risk factors	Characteristics of human biology and genetics, behavior, and the social and physical environment that contribute to health problems.
Semi-structured interviews	Personal interviews in which general interview content is guided by some predetermined agenda, but specific questions are formulated in the context of the interview conversation.
Specific rate	A rate computed for a particular population group, such as age, race, and sex groups.
Stages of behavior change model	Individuals move through a series of stages (precontemplation, contemplation, preparation, action, maintenance) as they progress toward their goal of adopting or altering a behavior pattern or lifestyle.
Standard	A criterion against which objectives are measured; a minimum level of performance used to judge the level of quality.
Statistical significance	The unlikeliness that observed phenomena, such as differences in behavior before and after an intervention, can be explained by chance alone.
Strategy	A plan that anticipates barriers and accounts for resources in relation to achieving a specific objective.
Structured interview	Personal interviews in which both the questions and the choices for answers are predetermined.
Summative evaluation	Evaluation that emphasizes a final judgment of program effectiveness, usually rendered after the fact.
Surveillance	An ongoing system to collect information.
Target group	The group of individuals an intervention is intended to affect.

Unobtrusive measures	Methods of data collection that do not affect or impinge upon the individuals being studied, such as reviewing medical records or other documentation. Subjects may be unaware that they are being assessed.
Unstructured interview	Personal interviews with a general interview goal but a flexible format that allows respondents free reign in the responses they provide and allows the interviewer to investigate any part of the interview more fully.
Validity	The extent to which a method measures what it purports to measure.
Variable	A logical set of attributes or characteristics. Sex, for example, is a variable comprised of the attributes male and female.

Appendix 5

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Planned Approach to Community Health

Meeting Guide

PATCH Meeting Guide

Contents

Meeting guide for phase II: collecting and organizing data

Meeting guide for phase III: choosing health priorities

Meeting guide for phase IV: developing a comprehensive intervention plan

Meeting guide for phase V: evaluation PATCH

The guides are not intended to be comprehensive but are suggestions based on experience in many PATCH communities. The text provided may reduce the amount of time you need to prepare for meetings and may help set the tone for the additional text or activities you develop to meet your needs and those of your community. Please feel free to adapt the materials to meet your needs and circumstances. Further, you may prefer to hold two or three shorter meetings for each phase; the guides include suggestions for shortening or varying each agenda.

PATCH Meeting Guide

Overview

PATCH Meeting Guide: Overview

Using the PATCH meeting guide

This Meeting Guide is part of a three-part package of materials designed for the local coordinator, the person who facilitates the Planned Approach to Community Health (PATCH) process in the community. This Meeting Guide is designed to assist you with planning and conducting the various meetings used to carry out the PATCH process. a It is intended to be used in conjunction with the other two parts: the PATCH Concept Guide, which includes information and tools for carrying out the PATCH process, and the Visual Aids packet, which includes camera-ready copy of overheads and handouts.

This Meeting Guide includes guides for five meetings, one for each phase of PATCH. For each meeting, there is an agenda, an estimate of the time required to conduct the meeting, and suggested text or activities you can use to facilitate each segment of the agenda. All suggested wording, in italic type, is set off from instructions and recommendations. As you proceed through the PATCH process, you will need to determine the level of skills and understanding of your community group and expand, shorten, or omit segments of the agenda as appropriate. Consideration also should be given to the level of detail that is appropriate for the community group and for the working groups. In phases IV and V, for example, many of the segment of the agenda might be provided as an overview for the community group and provided as detail training for the working group. You will want to refer to the corresponding chapter of the Concept Guide for valuable discussion points and examples that are not repeated in the Meeting Guide.

The guides are not intended to be comprehensive but are suggestions based on experience in many PATCH communities. The text provided may reduce the amount of time you need to prepare for meetings and may help set the tone for the additional text or activities you develop to meet your needs and those of your community. Please feel free to adapt the materials to meet your needs and circumstances. Furthermore, you may prefer to hold two or three shorter meetings for each phase; the guides include suggestions for shortening or varying each agenda.

Throughout the guides, optional content is noted and suggestions are provided on how to prepare for different segments of the meetings. These activities, which are introduced by the label "Preparation:" and terminated by the symbol ■, include background information, options to be considered, decisions to be made, and materials to be prepared before the meeting. Although it is assumed you have a working knowledge of the entire PATCH Concept Guide, the Preparation sections identify specific sections of the Concept Guide and other materials to review before each meeting.

As local coordinator, you have responsibility for ensuring that tasks are completed, meetings are conducted cooperatively and productively, and the program is community owned. You should review the working group products before the meeting and debrief after the meeting with such groups as the steering committee, partners, and working group chairpersons. Many communities have found that they actually hold three meetings concerning each phase of PATCH: a community group meeting and a meeting before and after the community group meeting that may include steering committee members, partners, and working group chairpersons. Because much of the work in PATCH is done by working groups and others outside of the community group meetings, a list of "Topics for Discussion" after each community group meeting is provided at the end of the meeting guide for each phase.

Meeting reminders

Here are a few reminders that pertain to all meetings you will moderate during the PATCH process. Additional information about group process and meeting management is included in the Tipsheets in Appendix 2 of the Concept Guide.

- Work with the steering committee or working group to determine operational procedures, including making decisions, communicating within and between groups, and carrying out administrative tasks.
- Schedule meetings at times and locations most convenient to the participants.
- Prepare an agenda so that sessions are focused. Divide the suggested agenda among multiple meetings if doing so would better suit participants.
- At the beginning of each meeting, review accomplishments and outline what remains to be done.

- Keep meetings short and on schedule. If an issue requires more time than is scheduled, use time planned for another issue, defer discussion until another meeting, or refer the issue to a working group for resolution.
- Encourage participants to ask questions and make comments throughout the meeting. Involve participants in brainstorming, decision making, problem solving, and other activities. Avoid lecturing.
- Arrange meeting rooms to enhance participation; for example, place chairs in a semicircle or in clusters.
- Make sure that you have enough sets of handouts for all participants. Give participants a folder or looseleaf binder for storing materials such as reports, handouts, and notes.
- Incorporate an informal activity or a social component, such as sharing a meal, refreshments, or a holiday party, when possible. Some unscheduled time will add fun to the event and allow participants to get to know each other personally.
- Provide enriching and skill-building experiences, such as speakers, training seminars, and workshops.
- Ensure that meeting minutes are prepared and distributed to community group members, partners, and others in the community. Use multiple channels to keep the community informed and to encourage participation.

Evaluating the community group meetings

PATCH is designed to be carried out through a series of community group meetings in which issues are discussed, tasks are assigned, and decisions are made. Your role is to facilitate the meetings and to encourage participation and ownership by the group. You will want to carefully observe the communications and actions within the group and to ask the group for feedback on how things are going and how things might be improved.

At each community group meeting, it is desirable to obtain structured feedback on one or more of the following:

- content of sessions
- group process used
- skill levels and training needs.

The decision to evaluate one or more of these areas should be tailored to the purpose and the expected outcome of the meeting. In the Concept Guide, review the Meeting Format section of Chapter 2 (page CG2-16) and the Monitoring the Phases of PATCH section of Chapter 6 (page CG6-3). Review the Tipsheets of Appendix 2 for hints on managing group process. The information and tools presented may also be used with working groups.

Evaluating the content of the sessions

There may be times when you would like to evaluate the quality of an informational or training session. Doing so is especially important if the session will be repeated in the community because the results of the evaluation may indicate revisions that might be needed. One way to approach the evaluation of content would be to ask participants to rate and comment on individual sessions.

A partial example:

Community Group Meeting for Phase I

Opinionnaire

Please specify how helpful you found the information provided during each session by circling a number for each session and writing your comments below each entry.

Session	Not Helpful				Very Helpful
1. Overview of PATCH	1	2	3	4	5
Comments:					
2. Importance of gathering information	1	2	3	4	5
Comments:					

If you would like feedback on the effectiveness of visual aids or exercises that were used, you might want to include items evaluating them.

A partial example:

Workshop Evaluation

Please rate the extent to which you agree with the statements concerning each topic of the workshop.

Interventions: Policy and Environmental Actions

	Strongly Disagree		Neither Agree nor Disagree		Strongly Agree
The topic covered will be useful in my understanding of PATCH.	1	2	3	4	5
The presentation was well organized.	1	2	3	4	5
The overheads added nicely to the presentation.	1	2	3	4	5
The exercise in this session was meaningful to me.	1	2	3	4	5
The speaker allowed adequate time for questions and discussion.	1	2	3	4	5

Comments:

Evaluating the group process used

The functioning of the community group is vital to the success of the program. Because community-based programs go through several phases of organizing, planning and setting priorities, keeping track of how each phase is working and how groups are functioning is important. In the Monitoring the Phases of PATCH section of Chapter 6 of the Concept Guide (page CG6-3) are examples of questions you might ask to track and evaluate each phase of the PATCH process. You might also wish to ask members of the community group and working groups to complete a self-assessment form for how the group is progressing.

For example:

Self-Assessment by the Group

Please provide input to the process and the policies that govern meetings. Please indicate your agreement or disagreement with the statements below by circling the number on the scale that best represents your experience in group meetings. Please give written comments as appropriate.

	Strongly Disagree		Neither Agree nor Disagree		Strongly Agree
1. The atmosphere is friendly, cooperative, and pleasant.	1	2	3	4	5
2. The purpose of each task or agenda item is defined.	1	2	3	4	5
3. Everyone, not just a few, participates in discussions.	1	2	3	4	5
4. There is no fighting for hidden agendas.	1	2	3	4	5
5. Members stay on task.	1	2	3	4	5

6. The group adjusts to changing needs and situations.	1	2	3	4	5
7. Members feel safe in speaking out.	1	2	3	4	5
8. Tasks are usually done on time.	1	2	3	4	5
9. Materials are prepared adequately and in advance of meetings.	1	2	3	4	5
10. Members attend regularly.	1	2	3	4	5
11. I am usually clear about my role as a group member.	1	2	3	4	5
12. My assignments are manageable and not overburdening.	1	2	3	4	5
13. Meeting times work well with my schedule.	1	2	3	4	5

14. Do you feel that your expertise or talents are being used well?

__Yes __ No

If no, how could they be used more effectively?

15. What changes would make the group more effective?

16. What changes would make serving on the group more enjoyable?

17. Other comments/suggestions:

Evaluating skill levels and training needs

Strengthening skills is an ongoing process in which the skills needed to do tasks are identified, the level of skills in the community are determined, and training or other skill-building activities are provided to increase those skills. Some communities systematically address skill-building by looking at the work plans for accomplishing tasks during a period of time (e.g., during the next month, the next three months, or the next phase) and developing a skill-building plan for the same period. This form of evaluation allows you to identify and provide for the skill-building needs of the group.

A partial example:

Work Plan

Activity: To pass a clean indoor air ordinance.

Task	Completion Date	Who	Skills/Training Needed
Review procedures for passage	5/1	Jane	Attend training for legislative aids

Meeting Guide for Phase I

Mobilizing the Community

Meeting Guide for Phase I: Mobilizing the Community

Introduction to phase I meeting guide

Mobilizing the community is an ongoing process that starts in phase I as a community organizes to begin PATCH and continues throughout the PATCH process. In phase I, the community to be addressed is defined, participants are recruited from the community, partnerships are formed, and a demographic profile of the community is completed. The community group and steering committee are then organized, and working groups are created. To gain support, during this phase the community is informed about PATCH, particularly from community leaders.

During the meeting for phase I, you will discuss the importance of assessing a community's health status and determining its major health problems. You will also discuss the types of data to be collected and encourage members to form working groups to accomplish tasks. This meeting guide is designed to reduce the amount of time you need to prepare for the meeting and to help set the tone for the additional text you develop. Review the material and adapt it as necessary for your community. Feel free to modify the meeting goals and agenda as well.

This Meeting Guide for Phase I is designed to assist you with planning and conducting the community group meeting(s) related to phase I of the PATCH process. It is intended to be used in conjunction with the other two parts of the PATCH materials: the PATCH Concept Guide, which includes information and tools for carrying out the PATCH process, and the Visual Aids packet, which includes camera-ready copy of overheads and handouts. This guide includes a suggested agenda, an estimate of the time required to complete the agenda, and suggested text or activities you can use to facilitate each segment of the agenda.

You should plan to debrief after the meeting with such groups as your steering committee, partners, and working group chairpersons. At the end of this guide, see the section on Topics for Discussion After the Community Group Meeting for Phase I.

Preparations for the community group meeting for phase I

Suggested agenda:

Community Group Meeting

Agenda

Welcome, introductions, and meeting goals	15*
Overview of PATCH	20
Gathering information	10
Mortality data	15
Morbidity data	10
Behavioral data	15
Opinion survey	10
Identifying interviewees	30
Interviewing techniques	20
Interviewing practice	40
Rallying the community	25
Forming working groups	20
Wrap-up	10
Closing and evaluation	20
Meeting as working groups	varies

*Estimated time in minutes

Time required: About four hours. Material may be covered in one or more meetings. For example, the segments Identifying Interviewees, Interviewing Techniques, and Interviewing Practice can be summarized for the community group and reviewed in more detail with the opinion data working group. Likewise, some activities in the Rallying the Community segment can be initiated by the community group and referred for completion to the public relations working group.

Preparation: In the Concept Guide, review Chapters 1, 2, and 3 and the Monitoring the Phases of PATCH section of Chapter 6 (page CG6-3); the Tipsheets on group process of Appendix 2; and the Program Documentation in Appendix 3. In this Meeting Guide, review the sections on Meeting Reminders (page MGO-2) and on Evaluating the Community Group Meetings (page MGO-3). Develop a meeting evaluation form. Prepare a meeting agenda. Determine if there are special guests to be introduced or given time on the agenda.

Consider providing participants with notebooks in which they can place handouts received throughout the process. Determine how the community might obtain recommended data, especially behavioral data, by discussing options with your state and local health departments, hospitals, universities, and other resources. Consider skills needed by various working groups and individuals who might be effective chairpersons. You may want to select chairpersons before the meeting. Review the content in this Meeting Guide for Phase I for recommendations concerning each segment of the suggested agenda. Review and prepare the overheads and handouts. ■

Welcome, introductions, and meeting goals

Preparation: Provide name tags or table tents for participants. If you will use paired or group exercises during the meeting, give each person an identifier (symbol, color, letter, or number) from pairs or groups of identifiers. Read the Tipsheet on "Icebreakers" and decide if and which kind of activity you will use. If you use the visioning activity included in this meeting guide, tape several flip charts or pieces of newsprint available around the room. List the goals of the meeting on a flip chart or transparency. Review the agenda and prepare to introduce any special guests. ■

Call the meeting to order, welcome attendees, and thank them for their interest. Introduce yourself and briefly introduce PATCH. Refer to the handout of the PATCH Program Summary.

During the 1980s, CDC worked with state and local health departments and community groups to develop the Planned Approach To Community Health. PATCH is a method for community health planning. The process suggested by PATCH helps a community establish a health promotion team, collect and use local data, set health priorities, design interventions, and evaluate their effect.

Introduce visitors and special guests, who may include the PATCH state coordinator or other community or state partners. As appropriate, request that the head of the lead agency or key partner welcome the group. Ask participants to state the professional or group affiliation or interest that contributed to their becoming involved with PATCH.

You may want to use an icebreaker activity so that participants have a chance to get to know each other. One that many communities have found helpful is a *visioning activity*.

Divide participants into groups of three to five. In the large group, have participants visualize a "healthy community." You may ask them to close their eyes and see what would be in their "healthy community." Have each group go to a different piece of newsprint; members should introduce themselves quickly within the group, as needed; one person would then drawn one item from his or her "healthy community" on the newsprint, discuss it with the group, and pass the marker to another person. The process can continue until participants have completed their community or until time is called. Ask each group to discuss what they included in their "healthy community." After all groups have reported, lead discussion of common items and what people learned from the activity.

Review the agenda and the goals of the meeting listed on the flip chart or transparency (tie to visioning activity, if done):

- Learn about the PATCH process.
- Begin working together as a group.
- Plan for gathering information about the community's health status.
- Identify people to be interviewed in the opinion survey.
- Practice interviewing skills for conducting the survey.
- Establish working groups.

If they are present, invite the state coordinator or other partners to say a few words. For example, the state coordinator might project a map of the United States that shows where other PATCH communities are located and describe the successes of some of these communities. The speaker might also describe the relationship between the community, the state health department, and other partners.

Project overhead "PATCH Goal" and discuss it:

PATCH programs strive to prevent unnecessary disease, disability, and premature death and to improve the quality of life.

As we work to improve the health of our community, the PATCH process will help us

- *assess our needs*
- *set priorities*
- *plan and carry out programs to reduce identified health problems and improve the health of our community*.

Overview of PATCH

Preparation: Review Chapter 1 and the Organizational Structure and Functional Structure sections of Chapter 2 of the Concept Guide. Determine the appropriate level of detail for this session based on previous overviews provided before this meeting. Review Tipsheet on Brainstorming, and make copies if you wish to share with the group. Review the Inventory of Collaborating Groups located in Chapter 2 of the Concept Guide, and provide it as a handout, as appropriate. ■

Display and review overhead "Five Phases of PATCH."

PATCH is a five-phase process, but the phases are not cut and dried. Mobilizing the community and evaluating PATCH, for example, are important throughout the entire process. Let's review the activities of each phase.

Discuss each phase by using the following information and by drawing on the information in Chapter 1 of the Concept Guide. Whenever possible, try to relate each phase to your particular community.

Display overhead "Phase I: Mobilizing the Community."

The first phase of the process concerns defining the limits of the PATCH community and informing citizens and groups about PATCH and the health issues of the community. During this phase, we learn about the makeup of the community, gain commitments, and organize into working groups. This meeting, when we come together and plan for the collection of data, is a crucial component of mobilizing our community. Mobilizing activities will continue throughout the process to keep the community informed and energized and to keep health on the community's agenda.

Explain what you have done so far, including how the community has been defined, who has helped mobilize the community, and what commitments or partnerships have been formed. Describe the responsibilities of the community group and the steering committee; indicate that the responsibilities of working groups will be discussed later.

Display overhead "Phase II: Collecting and Organizing Data."

During the second phase, we will obtain mortality data, morbidity data, community opinion data, and other data we believe will be useful. These data will help us identify the major health problems of our community and select the ones we want to address first.

Display overhead "Phase III: Choosing Health Priorities."

During this phase, we will examine behavioral data. We emphasize behavioral data because more than half of all deaths can be attributed to behavioral factors such as not smoking, eating a proper diet, and being physically active–that is, how we choose to live our lives. Even with minimal resources, we can have a greater impact on behavioral factors than on other factors that affect health–such as genetic factors. Thus, we will determine which behavioral factors contribute to the health priority we select and begin to decide which of those factors we want to address. We may also use community data to identify possible target groups.

Project overhead "Phase IV: Developing a Comprehensive Intervention Plan."

As we move into phase IV, we will inventory community resources and policies to enhance collaboration and prevent duplication of programs and services already available in our community. We will also develop an overall health promotion strategy to have an impact on the health problem in as many ways as possible in our community.

The comprehensive strategy should include educational programs, policy advocacy, and environmental changes–strategies that can be used in different settings, such as schools, health care centers, community sites, and the workplace.

Educational strategies provide information and skills through courses, media campaigns, and educational events. Policy strategies aim to discourage or restrict the practice of certain risk behaviors and to encourage practice of healthy behaviors. For example, restricting smoking in public places discourages tobacco use, and allowing flexitime to employees encourages physical activity.

Environmental strategies encourage community members to select healthy behaviors, for example, by making healthy products available (such as low-fat dairy products in groceries). They can also discourage the selection of unhealthy behaviors, for example, by making tobacco less available by removing vending machines from public buildings.

We will also identify the interventions we will use to improve a health problem and involve members of the target groups in developing an intervention plan. We will collaborate with other groups and programs to ensure that our efforts complement rather than duplicate one another. We will attempt to coordinate activities with other community events and develop timetables to ensure that we do not overextend ourselves. We will also recruit and train volunteers to help us conduct and evaluate interventions.

Project overhead "Phase V: Evaluating PATCH."

We use evaluation throughout the PATCH process to find out what is and is not working so that we can improve our efforts. We will evaluate PATCH interventions so that we can make them better and so that we can provide the community with information about the effects of the interventions. We will also evaluate the PATCH process to see how it can be improved.

After you have reviewed the phases, remind participants of the commitment PATCH requires.

Making the PATCH process work is a long-term commitment. Planning alone often takes several months, and interventions can go on indefinitely. After one health problem is addressed, we can apply the process we have learned to other problems.

Over the next several months, we will meet as a group to identify health priorities and plan our first interventions. How we function as a group is important to our success. I would like for us to agree on the procedures and ground rules we would like to use as a group.

Proceed to discuss the importance of open discussion, decision making, and working as a team. Ask the group to brainstorm ground rules for the meetings. You might start by reviewing the ground rules for brainstorming. (You may want to distribute the Tipsheet on Brainstorming.)

As appropriate, discuss that the community group will not be working alone. Discuss the roles of different partners. Distribute and review the "Inventory of Collaborating Groups."

Gathering information

Preparation: Review Chapter 3 of the Concept Guide, and prepare to explain to the participants why data are important and which types of data will be collected. You may want to distribute copies of the Community Profile section of the Program Documentation and discuss ways the groups can use the data. Have available the data required to complete the overhead "Percentage of Deaths Due to Leading Causes." ■

As I mentioned during the overview, we will collect and analyze a variety of community data:

- *Causes of death, or mortality data.*
- *Causes of illness and disability, or morbidity data.*
- *Community opinion data.*
- *Behavioral data.*
- *Other community data you deem important.*

Sometimes, we believe we know what the major health problems are and don't see the need to collect these data.

Use the following exercise to persuade participants about the importance of collecting data. Display the overhead "Percentage of Deaths Due to Leading Causes" and cover up the right-hand column. Ask participants to write down their estimates of the percentage of people in the United States who died in 1990 from the causes of death listed. Ask a participant to share an estimate with the group. Ask if anyone has a higher estimate, then a lower estimate. Repeat until you record the highest and lowest estimates for each cause listed on the overhead. Uncover the right-hand column and point out the wide range of estimates. Explain that this exercise illustrates that we sometimes do not know the real extent of a problem until we collect information about it.

Mortality data

Preparation: Review the Mortality and Morbidity Data section of Chapter 3 of the Concept Guide. Prepare to moderate a discussion about mortality data and how they can be collected, analyzed, and displayed. ■

The death certificate is the official source of information about deceased persons and the cause of their death. Data from the death certificate are maintained by all state health departments. These state data are compiled by CDC's National Center for Health Statistics into a national mortality data set. The following overheads illustrate the many ways in which mortality data can be analyzed.

Display the overheads listed below and say a few words about each one.

- Leading causes of death can be examined for different age groups: overhead "Leading Causes of Death Among Adults Aged 45–64, Shelby County, Tennessee, 1988."
- Community data can be compared with data for other areas (e.g., state and nation) to help gain perspective on the magnitude of selected health problems; also, mortality data can be analyzed by age, race, and sex groups: overhead "Mortality Rates for Three Leading Causes of Death Among Black Men Aged 45–64 years, Shelby County, Tennessee, 1988."
- Data can be compiled for several years to show trends: overhead "Number of Deaths by Cause, Gage County, Nebraska, 1985–1988."
- A single cause of death can also be explored in more depth: overhead "Number of Deaths by Site of Cancer, Vigo County, Indiana, 1983–1988."

Explain the concept of years of potential life lost (YPLL). Point out that when YPLL values are used instead of mortality data, the ranking of the leading causes of death for the community may change.

Continue to discuss things pertinent to obtaining mortality data. Ask the group participants if they know of any unique sources of data.

Morbidity data

Preparation: Review the Mortality and Morbidity Data section in Chapter 3 of the Concept Guide and prepare to moderate a discussion about morbidity data and how they can be obtained, analyzed, and displayed. ■

Morbidity data provide information about the leading causes of illness, injury, and disability. Morbidity data indicate why people are hospitalized and why they see health care providers.

Morbidity data are not, however, always reliable. Record-keeping is generally not standardized, as it is for mortality data through the death certificate. Community hospitals may serve people other than members of our community, so our hospital data may under-report or overstate the true values for our PATCH community.

Sources of morbidity data include:

- *public health clinic records*
- *hospital discharge summaries*
- *police motor vehicle injury records*
- *school nurse records*
- *state or regional disease registries.*

It is often difficult to obtain community morbidity data, but we will try to identify sources of existing data in our community.

Continue to discuss things pertinent to obtaining morbidity data. Ask the group participants if they know of any unique sources of local data.

Behavioral data

Preparation: The text hereafter assumes that you will use some level of data from your state's Behavioral Risk Factor Surveillance System (BRFSS): state-level, subset of the state, community-level, or synthetic estimate of community data. If your community is not using BRFSS data, decide how behavioral data will be collected or what alternative sources of data will be used, and modify this guide accordingly. Review the Behavioral Data section of Chapter 3 in the Concept Guide. If possible, have available the state data required to complete the overhead "Percentage of Adults at Risk Due to Behaviors." ■

Project overhead "Leading Causes of Death, United States."

The importance of collecting behavioral data becomes apparent when we compare the leading causes of death in the United States in 1900 and 1990. At the beginning of the century, infectious

diseases were the primary causes of death. Gradually, as living conditions improved and advances were made in sanitation, immunization, and medicine, deaths due to infectious diseases decreased. Now the leading causes of death are the chronic diseases, which are strongly affected by our lifestyle. In fact, of four factors that contribute to premature death–genetic factors, environmental factors, inadequate access to the health care system, and lifestyle–lifestyle accounts for more than half of all deaths.

Thus, the PATCH process emphasizes changing unhealthy behaviors and maintaining healthy ones to reduce mortality and morbidity. The analysis of behavioral data can provide perspective on behavioral practices among community residents. Comparisons can often be made by age, sex, race, and multiple risk factors.

Use the following exercise to inform participants about how common certain behavioral risk factors are.

Display overhead "Percentage of Adults at Risk Due to Behaviors" and cover up the filled-in column(s).

Ask participants to write down their estimate of the percentage of people in the United States (or state, if state data are available) to whom the given risk factors apply. Ask a participant to share an estimate with the group. Ask if anyone has a higher estimate, then a lower estimate. Repeat until you record the highest and lowest estimates for each cause listed on the overhead. Uncover the right-hand column and discuss the range of values.

We need to find out which unhealthy behaviors are contributing to the health problems of our community. To do this, we will use our state's BRFSS, a surveillance systems presently maintained by all states with assistance from CDC.

Explain what the BRFSS is and review what has been accomplished.

The BRFSS measures the extent of behaviors and conditions that most strongly contribute to the leading causes of death in the United States.

Display overhead "Behavioral Risk Factor Survey Items," which lists these behaviors and conditions, and briefly discuss them.

Explain why information about these behaviors and health conditions is collected by the BRFSS.

Display overhead "Reason for BRFSS Data Items."

The survey also collects basic demographic information–such as sex, age, race, and income–from participants.

Continue to discuss things pertinent to obtaining behavioral data.

Opinion survey

Preparation: Review the Qualitative Information section of Chapter 3 of the Concept Guide. Be prepared to introduce the opinion surveys and explain why opinion data are collected. If you plan to refer some of these activities to the working group, alter this segment, the overheads, and the handouts accordingly. ■

Although it is important to collect the different types of quantitative data discussed, it is equally important to collect information from residents about what they believe the community health problems are. A combination of statistical and opinion data helps us define problems and develop meaningful goals and objectives for our community's health. Quantitative information (mortality, morbidity, and behavioral data) can either substantiate or disprove community opinions.

Consider this example: Residents of one community believed that cancer was a particular problem in their community because of unsafe drinking water. They requested assistance from the state health department and undertook the PATCH process. The data that were gathered and analyzed showed that lung cancer was the cause of most cancer deaths in residents and that cancers of the digestive tract were extremely rare. The community ultimately decided to address lung cancer by designing an intervention program to reduce tobacco use.

Knowing what the community perceives as its health needs is extremely important when planning programs to address those needs. Opinion information also gives us an idea of the community's level of awareness of health issues. This information may guide us in designing press releases and educational information to increase awareness.

Opinion data also reflect community values and other qualitative factors not provided by quantitative data. Also, the process of collecting opinion data gives us an opportunity to inform community members about PATCH and helps build support for planning and carrying out health programs. It also helps us identify sources of support and opposition within the community.

It is important for us to collect opinion data from community leaders. We might also want to consider collecting opinion information from the community at large. Examples of questions that some PATCH communities have used in communitywide surveys are included with your handouts.

Direct participants to the handout "Communitywide Opinion Survey," and review the questions with them. Note that conducting and then tallying the results of a communitywide survey can be a big undertaking.

The purpose of the survey must be very well defined. For results of a survey to be valid, respondents must be representative of the entire community. Because this is often impossible, less precise surveys are often done, and the data from these surveys are analyzed separately from results from the community leader survey. Some communities collect communitywide data in malls and health fairs or by placing mail-in coupons in newspapers. Although the data may not weigh heavily during decision making, they may increase our awareness of issues that need to be explored further when designing interventions later in the PATCH process.

Ask participants to think about doing a communitywide survey, which you can discuss further at a later time. Indicate that you will concentrate now on the survey of community leaders.

Ask participants to look in their handouts for the packet of material on "Community Leader Opinion Survey." Go through the packet, which includes information on making an appointment, introducing the interview, a respondent page, and the interview questions. Review the questions with the participants. Tell participants that respondents may answer the questions by giving causes of death and disability as well as behavioral and nonbehavioral risk factors but that all this information is useful. Interviewers may need to probe for details or clarification of comments by asking follow-up questions. Tell participants that questions are asked as written to allow for comparison among all PATCH communities but that more questions can be added. Indicate that the survey is done in person, rather than over the telephone, because telephone surveys are impersonal and do not allow the public relations opportunity that in-person contact allows.

Continue to discuss things pertinent to obtaining opinion data in your community.

Identifying interviewees

Preparation: Refer to the handout "Description of Respondent" and list the categories of potential interviewees on a flip chart. Read the Tipsheet on Brainstorming. Decide whether participants will brainstorm names in small groups or in one large group. If you use small groups, you might assign particular geographic locations or affiliations to each group. Plan to circulate among the groups while they work independently. Even if you create small groups, consider having all participants work together on identifying communitywide leaders, such as business leaders, clergy, legislators, judges, and other public officials. Decide what you hope participants will accomplish and what you will recommend be referred to the working group. ■

Display overhead "Opinion Leaders."

Explain that the people in the community who are opinion leaders can be described by one or more of the characteristics listed. Briefly discuss each characteristic. Ask participants to begin thinking about which community leaders they will want to interview. Remind participants of the following considerations.

We do not want to interview only those people in official positions. Many influential people remain behind the scenes. These people may include well-respected neighbors, volunteers who have served in the community for a long time, and spokespersons for special-interest groups.

Try to identify people who represent the different segments of the community. Include both men and women; people of different ages, races, and ethnic groups; and people who live in different areas of the PATCH community. Think of people who are known for getting things done. Who really has a finger on the pulse of the community? Which people would be pleased to offer their opinions and be likely to support PATCH? Who might feel overlooked if not included in the survey and then be disinclined to participate? Remember that the people we identify as opinion leaders will be valuable resources throughout the PATCH process. We will want to involve them as the program develops and keep them informed of activities.

Begin the brainstorming session either as a group or by organizing participants among small groups, and ask someone to record the ideas for each group. You might prefer to use flip charts to display categories of interviewees and to record leaders recommended by participants. Ask participants to give either the names of specific

individuals or the titles of positions. If participants work in small groups, review all names together when the brainstorming session is over. Identify any categories that seem incomplete and determine whether the leaders identified indeed represent of the makeup of the community.

Interviewing techniques

Preparation: If your community group is small and you plan to use virtually all members to collect opinion data, proceed with this section and the Interview Practice section that follows. Otherwise, use the following two sections when you train your opinion data working group. Rehearse a five-minute role play of an interview using the questions from the Community Leader Opinion Survey. You or selected participants can role-play a sample interview. Be sure to include setting an appointment, the introduction, all five survey questions, and closing remarks. Incorporate examples of what to do if the interviewee

- gives a vague answer or does not answer the question at all
- appears hesitant and unclear about the purpose of the interview
- asks for the opinion of the interviewer or other interviewees
- gets off the subject. ■

In a few minutes, you will all have a chance to practice using the opinion survey. Each person will be an interviewer and an interviewee. First, here are a few guidelines for conducting a successful interview.

Display overhead "Interview Tips" and discuss each point by using the text below.

To begin the interview, introduce yourself, the PATCH process, and the purpose of the interview. In your handouts, we have included samples of what you might say when you call a potential interviewee to schedule an appointment and when you arrive for the interview.

Give participants a few moments to find and review the handouts "Making an Interview Appointment" and "Interview Introduction."

The introduction is your opportunity to let interviewees know you respect their opinions. Be cautious of too much social conversation, however, because the interview may then take too long and interfere with an interviewee's busy schedule. Try to relax and perhaps the interviewee will too.

If you want to tape record the interview, ask permission. Furthermore, the interviewee may feel more at ease if he or she has control of the recorder. Point out the pause button and allow the interviewee to practice using it before the interview begins in case he or she wants to shut the recorder off and say something "off the record." Using a tape recorder ensures that you have an accurate record of the opinions expressed. But be sure to practice using the tape recorder; interviews are sometimes lost because the wrong button was pushed! If you do not use a tape recorder, use a copy of the survey for taking notes.

So that all interviews are similar, ask questions as written and in the order they are listed on the survey. Let the interviewee do most of the talking. Some people may try to solicit your comments and engage you in conversation. Instead of answering, repeat your question or ask a related question to encourage the interviewee to begin talking again. Remaining silent for a moment may also encourage people to answer questions more fully. Try to clarify questions, if asked to do so by the interviewee, but try not to say anything that might influence responses.

Probe for more information, if necessary. Repeat the interviewee's answer and ask for clarification, or ask a follow-up question that might clarify the response. Maintain control by keeping to the subject yourself and repeating survey questions to draw the respondent back to the task at hand.

Do not bias the interviewee or show judgment of the interviewee's opinions by expressing your opinions or by reacting through your body language.

Close the interview with thanks and casual conversation, and ask permission to contact the interviewee in the future. Invite the interviewee to participate in a PATCH meeting, and offer to send the survey results or the PATCH newsletter.

Write up the interview as soon as it is over, and document information about the interviewee.

Ask participants to find the page "Description of Respondent" in their handouts.

This page collects demographic information that we will use to determine whether we have interviewed people who represent different segments of our community. Record this information for each interviewee–without asking, if possible. To preserve confidentiality, separate it from the survey instrument and give it to the survey coordinator when you turn in the completed surveys.

Finally, be sure to practice. Conducting a successful interview requires poise, and preparation is essential.

Role-play the sample interview prepared for participants and discuss the problems illustrated by the exercise.

Interviewing practice

Preparation: Decide how you will establish teams for the practice session. Decide when and how you will analyze and present the results of the opinion survey that participants will conduct among themselves during the practice session. ■

Now we will practice interviewing. Because your opinions should also be known, the responses you give during this practice session will be tabulated and compared with the opinions we collect from other people in the community.

Tell participants when that information will be available and how it will be communicated. Tell participants the guidelines for the practice interviews–that teams of two people will interview one another for 30 minutes (15 minutes for each interview) and that interviewers should record all responses. Ask participants to join their partners and begin interviewing. You may need to cut some interviews short to keep to the schedule. Ask participants to practice again with family or friends. Encourage them to complete the "Interview Self-Assessment," and draw their attention to the "Guidelines for Interviewers," both of which are in the handouts.

Rallying the community

Preparation: Collect examples of logos, posters, bumper stickers, and other materials from other community health or nonhealth projects. Review the section in Chapter 2 of the Concept Guide on Communication Networks and on the uses of a newsletter. Plan to have participants think about how to rally the entire community around PATCH. The handout "Media Channels Worksheet" is available to help you with this activity. You may want to ask the group to brainstorm items on the worksheet and then have the public relations working group complete the worksheet. ■

Devote a few minutes to inspiring enthusiasm in participants for the work they are about to begin. Show examples of good promotional materials that you have collected from other communities and projects. Describe how these materials served to attract the attention of the public. Discuss what has worked well in the past in the community. Ask participants for local examples. Suggest developing of a PATCH newsletter for the community. Also draw their attention to the PATCH logos, developed by other communities, which are also included in the handouts. Discuss the possibility of having a contest or using another means for developing a logo for your community program.

Remind participants about the importance of

- making PATCH a household word and gaining widespread support for the project.
- communicating with each other and with the community at large throughout the PATCH process.

Forming working groups

Preparation: Review the Working Groups section of Chapter 2 of the Concept Guide. Review working group task sheets and other tools in the handouts. Decide whether an evaluation working group will be formed. List on a flip chart the names of the working groups you plan to recommend be formed. ■

Display the flip chart that lists the working groups and describe the responsibilities of each group. Refer participants to the task sheets included in their handouts. Ask participants whether they see the need for any additional working groups, and list on the flip chart those groups you want to form at this time.

Ask participants to volunteer as members of the different groups. Suggest that they assess their skills, interests, resources, and contacts and how they relate to the tasks of the different groups. Discuss with participants the expectations for working group members, including how long the different groups are expected to be active and how members can rotate responsibilities among groups if such arrangements are preferred. Tell participants that the groups will meet at different locations around the room when the formal part of the meeting is over.

When you organize into the working groups, you may meet for as long as you like and begin to discuss tasks and make assignments. Or you can take the opportunity to get further acquainted and set

a date and time for a first meeting that will be more convenient for the participants of your group. Before you leave today's meeting, however, your group must elect a chairperson who will moderate the group's activities. This person has four main responsibilities:

- *Lead group members in planning a strategy for accomplishing activities.*
- *Ensure that the necessary activities are completed before the next meeting.*
- *Maintain communication with me regarding progress and need for assistance.*
- *Serve as a member of the steering committee and report on progress.*

Wrap-up

Preparation: Create a to-do list of tasks to be accomplished before the meeting for PATCH phase II. You may want to do this by consulting with your state coordinator or other advisor and your steering committee members. List the activities on a flip chart. Some activities you may include are to

- obtain and analyze mortality and morbidity data.
- identify sources of behavioral data.
- interview opinion leaders and summarize results.
- inform community leaders and the general public about PATCH.
- design a logo and develop a newsletter.

Set a date for the meeting for phase II. You may want to plan to meet in about one and a half or two months to allow time for data collection and analysis. ■

Display the to-do list, and ask for other items from participants. Have participants set the date of the next meeting–when the results of the opinion survey, as well as the analysis of the mortality and morbidity data, will be presented. The public relations working group will also report about its activities.

Closing and evaluation

Preparation: Review the Evaluating the Community Group Meetings section of the Meeting Guide. Develop a meeting evaluation form to obtain feedback from participants. Bring paper or index cards for participants to use. ■

Thank participants for their time, interest, and contributions.

Distribute the paper or index cards and ask participants to write on one side any thoughts or feelings they would like to share about the meeting, PATCH in general, or a related topic. Ask them to write on the other side what they are committing themselves to help with–participation in a working group, an activity from the to-do list, or another activity.

Ask participants to complete the meeting evaluation form and return it to you before they leave.

Meeting as working group

Designate tables or areas of the room where the working groups will meet, and help participants find the other members of their groups. Tell participants that you, the state coordinator, partners, and others, as appropriate, will be available to assist the working groups for whatever time remains.

Topics for discussion after the community group meeting for phase I

The following are topics for discussion with members of the community including partners, steering committee members, and working group chairpersons.

1. Discuss what happened during the community group meeting, including group dynamics and decisions made, and review the results of the evaluation of the meeting.
2. Review tasks to be done by working groups and others. Determine training and technical assistance needs and how these needs will be met.
   - Determine the plan and timeline for assisting the opinion data working group to finalize the questionnaire and list of interviewees, train interviewers, and analyze and display data.

- Clarify plan for obtaining mortality data and the role of the state health department and others in providing these data and in data analysis. Review potential sources of morbidity data. Determine plan and timeline for assisting the mortality and morbidity data working group to collect, analyze, and display data.
- Clarify plan for obtaining community behavioral data, such as using state and national BRFSS data to develop synthetic the estimates. Determine the plan and timeline for assisting the behavioral data working group to collect, analyze, and display data.
- Determine plan and timeline for assisting the public relations, evaluation, and other working groups with their duties.

3. Schedule regular communications with PATCH partners, community members, and working groups.
4. Plan for distributing a summary of community group meeting for phase I to attendees, partners, and others in the community. Plan to update individuals absent from the community group meeting.

Meeting Guide for Phase II

Collecting and Organizing Data

Meeting Guide for Phase II: Collecting and Organizing Data

Introduction to phase II meeting guide

Gathering information is an important task and one of the five critical elements of the PATCH process. The tasks in phase II of PATCH include collecting certain types of information, analyzing them, and arranging the data in ways that will be meaningful to the community group. Your working groups should be a major help in completing all parts of this process. Encourage chairpersons or members of working groups to present the groups' data as appropriate. Chapter 3 of the Concept Guide provides background information on the types of data the community group needs to collect and on how to analyze and display the data. If you have questions, identify expertise within your community, or call your state health department, college, university, or other resources for assistance.

Once data are collected, you will hold a meeting of the community group to discuss the information. This Meeting Guide for Phase II is designed to assist you with planning and conducting the community group meeting(s) related to phase II of the PATCH process. It is intended to be used in conjunction with the other two parts of the PATCH materials: the PATCH Concept Guide, which includes information and tools for carrying out the PATCH process, and the Visual Aids packet, which includes camera-ready copy of overheads and handouts.

This guide includes a suggested agenda, an estimate of the time required to complete the agenda, and suggested text or activities you can use to facilitate each segment of the agenda. Many of the overheads and handouts for the meeting need to be developed to display your community's data. This meeting guide is not comprehensive but is designed to reduce the amount of time you need to prepare for the meeting and help setting the tone for the additional text you develop. Review and adapt it as necessary for your community. You may want to modify meeting goals, change the agenda, and hold more than one meeting to complete the tasks related to phase II. For example, the group may have collected morbidity data from multiple sources and may require more time on the agenda. Although it is a lot of information to discuss at once, some community groups want to include behavioral data in this meeting. If your group does, refer to phase III meeting materials of information concerning behavioral data. The relationship between behaviors and leading causes of death and disability should be emphasized.

You should plan to review working group accomplishments before this community group meeting and debrief after the meeting with such groups as your steering committee, partners, and working group chairpersons. At the end of this guide, see the section on Topics for Discussion After the Community Group Meeting for Phase II.

Preparations for the community group meeting for phase II

Suggested agenda:

Community Group Meeting

Agenda

Welcome and announcements	10*
Participant feedback (optional)	25
PATCH update and meeting goals	10
Mortality data	45
Morbidity data	30
Opinion data	45
Prioritizing health problems	45
Updates from working groups	20
Wrap-up and closure	15
Meeting as working groups	varies

*Estimated time in minutes

Time required: About four hours.

Preparation: In the Concept Guide, review Chapter 3, Chapter 4 and the Monitoring the Phases of PATCH section of Chapter 6 (page CG6-3). Assist working groups to complete tasks and, as appropriate, to present results or an update of accomplishments at the meeting. Also review the Program Documentation located as Appendix 3 of the Concept Guide. In this Meeting Guide, review the sections on Meeting Reminders (page MGO-2) and on Evaluating the Community Group Meetings (page MGO-3). Develop a meeting evaluation form. Review the content in this Meeting Guide for Phase II for recommendations concerning each segment of the suggested agenda. Prepare an agenda. ■

Welcome and announcements

Preparation: Provide name tags or table tents for participants. Allow participants several minutes to arrive, casually converse with others, and find a seat. Provide newcomers with a notebook of PATCH materials, including the PATCH Program Summary and other relevant materials. ■

Distribute the agenda.

Call the meeting to order, welcome attendees, and thank them for their interest. Make brief introductions as needed. Make any general or administrative announcements.

Display and review overhead "Meeting Goals."

Our plan for today is ambitious:

- *To interpret the data collected: mortality, morbidity, opinion, and other data.*
- *To begin to identify leading health problems for our community.*

Briefly review the agenda.

Participant feedback (optional)

Preparation: The purpose of this optional exercise is to get participants actively involved in the meeting right from the beginning. They have spent weeks working hard on PATCH activities and may want to share their experiences. Be aware of successes or problems that may have occurred during this time. ■

Sometimes people are slow to volunteer to describe their own feelings and experiences. You may have to prompt someone to describe an experience that you are already privy to in order to get things going.

Before we begin to hear from our working groups and look at the data the groups have collected, I would like for anyone who wishes to share comments about your experiences in undertaking any of the activities in PATCH, collecting opinion data, performing public relations functions, collecting behavioral data, and so on.

Limit discussion to 20 to 25 minutes. Ask others to contribute their comments throughout the day as the appropriate subjects arises.

PATCH update and meeting goals

Preparation: Review The PATCH Process section of Chapter 1 of the Concept Guide. ■

Display and review overhead "PATCH Wheel."

We have accomplished a great deal since our last meeting. We have

- *defined our community.*
- *worked together as a team.*
- *gathered information on the health status of the community.*
- *surveyed community leaders regarding their opinions concerning health problem.*
- *compiled data on causes of death and disability.*

Display overhead of PATCH wheel that lists tasks for phase II.

We have already completed much of phase II. As part of phase II we have collected and analyzed data. Today we will examine mortality, morbidity, community opinion, and other data that we will use to select priority health problems and later design interventions to address those health problems.

We also will begin to identify health priorities and other information that we might want concerning those health priorities. We will develop a wealth of information on our community and will want to discuss how best to share the data with the community.

Distribute handout "List of Health Problems."

Display overhead "List of Health Problems."

The "List of Health Problems" is a tool to help us identify health priorities as we review our community data. As we examine our data during the meeting, we will fill in health problems in the appropriate column on the list. After we look at each type of data–mortality, morbidity, opinion, and other data–we will discuss criteria for determining which items we consider to be health problems. More items will be added to the list during phase III as we discuss the behavioral data and any additional data you request we collect. Any health problems that the group identifies will fit in one of the columns on the list.

Mortality data

Preparation: Prepare a matching set of overheads and handouts, referred to as the Mortality Data Packet, to display your community's data. Review Chapter 3 of the Concept Guide, Mortality and Morbidity Data and Presenting Data sections, for suggestions as to what to include and how. Encourage the working group chairperson or a working group member to present the data as appropriate. Have mortality sections in the Program Documentation available in case detailed questions are asked. Have your state coordinator, epidemiologist, or other resource person available as needed. ■

Distribute the Mortality Data Packet.

Review materials in the Mortality Data Packet. Also review any relevant items on the Unique Health Events section of the Program Documentation that might have influenced the data.

Display overheads made of your Mortality Data Packet.

As you show a graphic, read and clarify it for your audience:

- Read the heading and contents of the overhead.
- Compare community data to state and national data.
- Clarify numerical units on graphics (e.g., graphic was expressed in numbers or rates and why).
- Discuss any adjustments made to the data (e.g., three years of data were grouped together because the numbers were too small).
- State any limitations of the data (e.g., data may be for county and PATCH community may not include the entire county, numbers may be small so emphasize trend data, or data may not include all subpopulations because of small numbers).
- Overview the differences in groups presented in the data (e.g., between men and women, among races, or between age groups).

As your community's data are displayed and discussed, ask participants to ask questions and note whether any additional data may be needed. For example, automobile-related injuries can be further explored to find out where the injuries occurred, at what time of day, and whether seat belts were used or whether the driver was drinking. Cancer deaths can be broken down by site of the cancer. Some of the additional information requested will not be available

on a community level, but state or national studies can be reviewed to draw inferences for the community.

Ask for a volunteer to list throughout the meeting all requests for additional data on flip chart or note pad.

Display overhead "Five Leading Causes of Death." Read and clarify the five leading causes and the numbers of each.

Why are our people dying? The top five causes of death for our community are ...

Display and clarify overheads of trends in leading causes of death.

Display and clarify overheads of mortality by race, sex, and age groups. Present an overview of differences in the causes of death between men and women, among races, and between age groups.

Display the overhead(s) showing your community's leading causes of years of potential life lost (YPLL). Alter the script depending on the method used to calculate YPLL. See Chapter 3 of Concept Guide, Measures of Mortality and Morbidity section.

We may get one perspective of our community when we look at mortality rates. Now we will examine our leading causes of death in terms of YPLL. YPLL is a way to look at premature deaths or deaths that occur before a selected age end point. Internationally this end point is usually considered to be 65 years of age. Because the average life span in the United States is longer than in many countries, premature death is often defined nationally as death before age 75.

Describe how YPLL was calculated for your community. Read and clarify overhead(s). Emphasize the five to 10 leading causes of years of life lost for deaths under 75 years of age.

Because YPLL is greater for deaths among younger persons than older persons, this concept emphasizes the impact of causes of death that affect the young. In other words, a disease that kills 40-year-olds would result in more potential years of life lost to a community than one that kills 74-year-olds.

YPLL also shows the impact of premature deaths due to certain chronic diseases, such as coronary heart disease. YPLL will help us view these causes of death not only as life lost to individuals but as valuable years lost to the community.

Identifying health problems from mortality data

Preparation: Review Chapter 4 of the Concept Guide. You may want to use the overhead provided or use flip charts to make a large version of the "List of Health Problems." Review information on brainstorming and nominal group technique in the Tipsheets, Appendix 2 in the Concept Guide. ■

Have the community group develop a list of criteria for selecting causes of death to be identified as health problems. This may be done by brainstorming criteria such as leading causes of death (i.e., magnitude or number of deaths), leading causes of YPLL, rates higher than the state and nation, or rates higher for a particular subpopulation. If more than five criteria are listed, you will want the group to set priorities within the list and determine the most important three to five criteria. The nominal group technique can be used for this step.

Have the group use these criteria to look through the mortality data and brainstorm problem statements. For example,

- "Too many people in our county die of heart disease."
- "Too many 25-44-year-olds die of vehicular injuries."
- "Too many years of potential life are lost due to cancer."

Have the group review the list of problem statements. If more than 10 are listed, you will want the group to set priorities within the list and determine the most important items, generally between five to 10 items. The nominal group technique can be used for setting priorities. When the group has finalized its problem statements, enter the identified health problems on the overhead or flip chart labeled "List of Health Problems" in the death/disability column.

It is important to have some criteria to use for determining whether a health problem is a priority for your community. We don't all have to agree on each criterion, but we should reach general agreement on a set of criteria we can all use.

Once again, briefly explain to the participants that more of the list will be filled in during this meeting and during the phase III meeting when they examine behavioral data and any other data collected by the group.

Morbidity data

Preparation: Prepare a matching set of overheads and handouts, referred to as the Morbidity Data Packet, to display your community's data. Compare community data to state and national data whenever possible. Review Chapter 3 of the Concept Guide, Mortality and Morbidity Data and the Presenting Data sections, for suggestions as to what to include and how. Encourage working group chairperson or member to present the data as appropriate. Frequently, the only morbidity data available to a community are hospital records: reason for hospitalization, length of stay, etc. If your group has obtained other community data of interest, prepare appropriate handouts and overheads and include time to display and discuss them. ■

Distribute the Morbidity Data Packet, display overheads from the Morbidity Data Packet, and describe briefly the data that have been collected and how they were obtained.

As you show a graphic, read and clarify it for your audience:

- Read the heading and contents of the overhead.
- Compare community data to state and national data.
- Discuss any adjustments made to the data.
- State any limitations of the data (e.g., hospital discharge data may be available for primary diagnosis only and not for the group of related diagnoses, people served by a hospital may not all be from the community, people in community may go elsewhere for care, or numbers may be small so emphasize trend data).
- Overview the differences in groups presented in the data (e.g., between men and women, among races, or between age groups).

As your community's data are displayed and discussed, encourage participants to ask questions and note whether any additional data may be needed. Have a volunteer continue to list requests for additional data on flip chart or note pad.

Identifying health problems from morbidity data

Preparation: Continue discussion concerning morbidity data. Summarize for the group the developing list of requests for additional data. Have group add items from the data to the "List of Health Problems" in the death/disability column. ■

In most communities, there are few sources of morbidity data. Community group members can usually review the data and determine if any item should be listed on the "List of Health Problems." If you believe your group can agree about whether an item should be a priority, have members recommend items to remain on the list and try to gain consensus within the group. A simple vote should suffice. If consensus is not reached on a particular item, simply include it among the list of priorities.

If your community has a lot of data or if you determine the process to be of value, you may proceed as you did with mortality data and have the community group develop a list of criteria, determine the most important three to five criteria, develop problem statements, and identify health problems from the problem statements to be entered on "List of Health Problems."

Opinion data

Preparation: Prepare a matching set of overheads and handouts, referred to as the Opinion Data Packet, to display your community's data. Review Chapter 3 of the Concept Guide, Community Opinion Data section, for suggestions as to what to include and how. Encourage a working group chairperson or member to present the data. ■

Prepare to give an overview of the Community Leader Opinion Survey. Spend most of the time on questions 1 and 4: "What do you think the major health problems are in our community?" and "Which one of these problems do you consider to be the most important one in our community?" Review the Unique Health Events section of the Program Documentation and, as appropriate, discuss any event that may have influenced your survey results.

If appropriate, have similar overheads and handouts for the responses from any additional opinion data, including any Communitywide Opinion Survey and the practice interviews performed during phase I, in which the participants interviewed one another. These materials should also display a line listing of the most frequently given responses.

Distribute the Opinion Data Packet. Display overheads made from the Opinion Data Packet.

As you show a graphic, read and clarify it for your audience:

- Characterize those interviewed in the Community Leader Opinion Survey by describing the number of individuals who were in the different categories on the respondent page of the survey instrument. Continue to identify interviewees: age, length of residence, sex, race, place of residence. (It might be helpful to fill in a copy of the respondent page and give it as a handout.)
- Review the heading and content of the graphic.
- Explain how responses were tallied and what assumptions were made when grouping similar responses.
- Briefly review responses to all the questions. Spend most of the time on the two previous questions noted.

Display overhead showing the most common responses.

Let's look at how our leaders answered the question "What do you think the major health problems are in our community?"

As you can see on the overhead and on the handout in you packet, the most common responses to the question in order of frequency of responses were ...

Display overhead showing the problems considered to be the most important. Review the list of the most common responses to the survey question "Which one of these problems do you consider to be the most important one in our community?" Note how the lists differ for questions 1 and 4.

Display overheads on other opinion data sources, if applicable.

Compare responses to the same two key questions from the optional practice interviews performed during phase I, in which the participants interviewed one another. Warn participants that these responses should not be considered in future decision making because the sample size is small, but that the information may be of interest to the participants and may provide a way to stimulate discussion.

Display the results of a communitywide opinion survey, if performed (optional activity).

As you show a graphic, read and clarify it for your audience:

- Describe how the survey was conducted and then characterize those interviewed, including the number of individuals surveyed and any descriptors.
- Review the heading and content of the graphics.

- Explain how responses were tallied and what assumptions were made when grouping similar responses.
- Review any relevant items on the Unique Health Events section of the Program Documentation and explain how they might have influenced the data.

Identifying health problems from opinion data

Have participants discuss all opinion data and determine which of the leading health problems are priorities and should be entered on the "List of Health Problems."

In most PATCH communities, opinion data are usually easy to analyze because five to eight health problems receive multiple responses, whereas other responses receive singular responses. Community group members can usually review the data and determine if any item should be considered a health problem and listed on the "List of Health Problems." If you believe your group can agree about whether an item should be a priority, have members recommend items to remain on the list and try to gain consensus within the group. A simple vote should suffice. If your community has less conclusive data or if you determine the process to be of value, you may proceed as you did with mortality data and have the community group develop a list of criteria, set priorities within the list to determine the most important three to five criteria, develop problem statements, and identify health problems from the problem statements to be entered on "List of Health Problems."

Opinion data results may include causes of death, risk behaviors, and other items as health problems. Encourage discussion by asking the PATCH participants to help complete the list. Some participants need time and discussion to clarify the difference between causes of death and the contributing risk factors. As necessary, remind participants of the definitions of a cause of death or disability (such as cancer or heart disease), a behavioral risk factor (such as smoking or a behavior-related medical problem such as uncontrolled hypertension), and a nonbehavioral risk factor (including human biology, health care system, and environmental issues).

Ensure the recorder writes the health problems noted by the group in the appropriate columns in the "List of Health Problems" or refer the task to a working group.

Prioritizing health problems

Preparation: Review this activity and be prepared to do if needed. Provide time for participants to look through the Program Documentation and other handouts and to ask additional questions about the data. The group must understand its data enough to use them in identifying health problems and potential target populations. ■

Ask the volunteers to review the list of requests for additional data. Ask if there are any additions.

Have the group review the "List of Health Problems." If the list contains 10 items or fewer in any one column and if there is no further discussion, you may go on to the next topic on the agenda. If the list contains more than 10 items, you will want to rank the top 10 items listed to help focus the process.

If you believe your group can agree as to which items should be a priority, have members recommend items to remain on the list and try to gain consensus within the group for keeping that item. A simple vote should suffice. Repeat the process until five to 10 items remain on the list. If consensus is not reached on a particular item, simply include it among the list of priorities.

If a more structured process is desired, you may proceed as you did with mortality data and have the community group determine the most important three to five criteria. Use the nominal group technique to set priorities and reduce the number of health problems entered on "List of Health Problems" as described later.

Have group select criteria from those listed throughout the meeting and write them on a flip chart. Ask if there are additional criteria to be considered. Criteria generated by the group may include

- magnitude of problem in numbers (e.g., number of deaths).
- number of years of potential life lost.
- specific problem in a target group (e.g., priority age group).
- problem that is greater in magnitude than national or state rates.
- a problem that can be solved.
- a problem that falls within the realm of state, CDC, or local expertise.
- a major concern within the community that is based on opinion data.
- has a major affect on the quality of life.

Use the nominal group technique to have the group select the top three to five criteria. Give participants a few minutes to review the "List of Health Problems" and the criteria for determining the priority health problems for the community.

Have participants indicate which items recorded on the "List of Health Problems" are significant enough in the community to be considered priorities. Remind them that in phase III the list will be filled in further after the participants look at behavioral and requested additional data and that the items will be prioritized again as appropriate.

Updates from working groups

Preparation: Select and help prepare working group chairpersons or members to present an overview of their activities and accomplishments since the last meeting. Refer to the working group task sheets located in the handouts. ■

Have the public relations working group briefly summarize what has been done so far to inform the public and to rally the community, including updates on developing a logo, newsletter, and press releases. Lead a brainstorming session of ideas for informing the community about PATCH and health status of the community. Share what other PATCH communities have done.

Our community has a collection of data that is a valuable resource to share with the community. Some PATCH communities announce data in press releases after each meeting. Others wait until after the behavioral data have been considered in phase III and release all the data at one time. Some communities wait and announce their data when they also announce the priority health problem(s) the group has decided to address.

Other issues you might want to discuss include whether to recruit more volunteers for specific tasks and how to recruit them, policies relating to use of logo, and ways to keep the community informed about PATCH.

Have the behavioral data, evaluation, and other working groups report on their activities.

Wrap-up and closure

Preparation: Before the meeting develop a list of activities that need to be accomplished before the next meeting. List these items on a flip chart. Examples might be collecting additional informa-

tion requested by the group during the meeting and publishing of the data. In the Concept Guide, review the Monitoring the Phases of PATCH section of Chapter 6. In this Meeting Guide, review the section on Evaluating the Community Group Meetings. Decide on a meeting evaluation method to obtain feedback from participants. You may wish to develop an evaluation form, plan a group discussion, or both. ■

Discuss the to-do list with the group. Ask for chairpersons and volunteers to carry out the tasks. In some cases the task will be assumed by working groups that were established in phase I. In other cases the group will want to establish a new working group.

Have participants set the date for the next meeting.

Distribute the workshop evaluation form, and ask participants to fill it out and return it to you before they leave.

Thank group members for their participation.

Meeting as working groups

Encourage working groups to meet at least long enough to clarify tasks and to set a time and place to meet. Identify participants who might be able to consult with the working groups (e.g., state coordinator, partner, or local coordinator).

Topics for Discussion After the Community Group Meeting for Phase II

The following are topics for discussion with partners and steering committee members, including working group chairpersons.

1. Discuss what happened during the community group meeting, including group dynamics and decisions made, and review the results of the evaluation of the meeting.
2. Review tasks to be done by working groups, partners, and others and determine training and technical assistance needs.
   - Review progress made analyzing and displaying behavioral data.
   - Identify sources for the additional data requested by the community group.

- Discuss any problems or needs identified by the working groups.
- Discuss progress made on monitoring the phases of PATCH (page CG6-3).

3. Schedule regular communications with PATCH partners, community members, and working groups. Plan for distributing a summary of the community group meeting to attendees, partners, and others in the community. Plan to update members absent from the community group meeting.

Meeting Guide for Phase III

Choosing Health Priorities

Meeting Guide for Phase III: Choosing Health Priorities

Introduction to phase III meeting guide

Most PATCH communities do not have the resources to address all of their health problems and target groups at once. They must set priorities and plan to address some issues initially and others over time. To determine which health problem or problems to address first, the community group should complete the following tasks:

- Set criteria, examine community data, and develop a list of health problems.
- Assess the community's capacity to address the health problems.
- Determine the changeability and importance of priority health problems.
- Assess social, political, and economic issues that might influence the ability to address the health problems.
- Identify community programs and policies already addressing the health problems.

Depending on the data collected, resources available, and dynamics of the community group, the activities and process during this phase of PATCH may vary. If the group wants more information before proceeding, assign tasks to working groups or to others and set a date for the community group to meet again. It is important for community group members to agree on the initial health problem to be addressed.

This Meeting Guide for Phase III is designed to assist you with planning and conducting the community group meeting(s) related to phase III of the PATCH process. It is intended to be used in conjunction with the other two parts of the PATCH materials: the PATCH Concept Guide, which includes information and tools for carrying out the PATCH process, and the Visual Aids packet, which includes camera-ready copy of overheads and handouts. This guide includes a suggested agenda, an estimate of the time required to complete the agenda, and suggested text or activities you can use to facilitate each segment of the agenda.

This guide is designed to reduce the amount of time you need to prepare for the meeting and to help set the tone for additional text you develop. Review the material, and adapt it to meet the needs

of your community. Feel free to modify the meeting goals and suggested agenda.

You should plan to review working group accomplishments before this community group meeting and debrief after the meeting with such groups as your steering committee, partners, and working group chairpersons. At the end of this guide, see the section on Topics for Discussion After the Community Group Meeting for Phase III.

Preparations for the community group meeting for phase III

Suggested Agenda:

Community Group Meeting

Agenda

Welcome and announcements	10*
PATCH update and meeting goals	10
Requested data	10
Behavioral data	30
Identifying health problems from behavioral data	20
Selecting the health problem to be addressed	30
Existing programs and policies	30
Final decision	30
Focusing on target groups	15
Setting goals and objectives	20
Updates from working groups	15
Wrap-up and closure	10
Meeting as working groups	varies

*Estimated time in minutes

Time Required: About 4 hours. The time needed will vary depending on the data collected, resources available, and dynamics of the community group. The moderator should be prepared to refer tasks to working groups or others and to call additional meetings as needed until agreement is reached on which health problem to address first.

Preparation: Review results of previous meetings before proceeding. In the Concept Guide, review the Behavioral Data section of Chapter 3 (page CG3-20), Chapter 4, the Monitoring the Phases of PATCH section of Chapter 6 (page CG6-3), and the Tipsheets on nominal group techniques and brainstorming of Appendix 2. In this Meeting Guide, review the section on Evaluating the Community Group Meetings (page MGO-3). Develop a meeting evaluation form. Prepare an agenda. Review the content in this Meeting Guide for Phase III for recommendations concerning each segment of the suggested agenda. ■

Welcome and announcements

Preparation: Prepare to overview the agenda. ■

Welcome participants, thank them for their efforts, and make general announcements.

Distribute and discuss briefly the agenda.

PATCH update and meeting goals

Preparation: Determine the accomplishments to be highlighted. Alter meeting goals as appropriate. ■

Display overhead "Five Phases of PATCH" and discuss it with the group.

- Review PATCH phases and where in the process the group is .
- Review the results to date, including highlights from mortality, morbidity, and community opinion data. Quickly review summary overheads generated during phase II, and summarize items placed on "List of Health Problems."
- Review the importance of behavioral risk factors and the accomplishments of the behavioral data working group.
- State that the public relations and other working groups will report on their accomplishments later in the meeting.

Display overhead "Phase III: Choosing Health Priorities." Discuss the things to be accomplished during phase III.

During this phase, we will examine behavioral data. Behavioral data are important because more than half of all deaths can be attributed to behavioral factors–that is, how we choose to live our

lives. Even with minimal resources, we can have a greater impact on behavioral factors than on other factors that affect health–such as genetic factors. Thus, we will determine which behavioral factors contribute to the health priority we select and which of these factors we want to address. We will also use data to identify possible target groups.

So that we do not duplicate programs and services available in our community, we will inventory existing community programs and policies. This inventory will also help us in phase IV to develop an overall health promotion strategy to address our priority health problem. This comprehensive strategy will include educational, policy advocacy, and environmental measures–strategies that can be used in different settings, such as schools, health care centers, the community, and worksites.

Educational strategies provide information and skills through courses and media campaigns. Policy strategies aim to restrict the practice of certain behavioral risk factors, such as smoking. Environmental strategies encourage a healthy environment (for example, by making cigarette smoking inconvenient through removing vending machines from government buildings) and make healthy products available (such as low-fat dairy products in groceries).

Display and review overhead "Meeting Goals" in order to

- review behavioral data.
- add to the "List of Health Problems."
- determine priority health problems, risk factors, and target groups.
- set community objectives.

Requested data

Preparation: If during phase II the community group requested that additional mortality, morbidity, or other data be collected, help the working group identify, analyze, and display the data. ■

Help the chairperson or member of the working group briefly summarize the data. Lead a discussion of the data and have the community group add items to the "List of Health Problems."

Behavioral data

Preparation: Prepare a matching set of overheads and handouts, referred to as the Behavioral Data Packet, to display your community's data. Review Chapter 3 of Concept Guide, the Behavioral Data and the Presenting Data sections, for suggestions on what to include and how. Encourage the working group chairperson or member to present the data. Have available Section VII of the Program Documentation, Comparison of Behavioral Data (Percentage) Among Adults by Community, State, and Nation. Provide Section VII as a handout as appropriate. Have your state coordinator, epidemiologist, or other resource person available as needed. ■

Distribute handout "Contributors to the Leading Causes of Death." Review the connection between risk factors and causes of death.

Distribute handout Behavioral Data Packet, and display the overheads from the packet material.

Review materials in the packet emphasizing data that show a greater prevalence of the behavior than state or national data. Also highlight variations in group data that show greater risk among gender groups, income levels, educational levels, or other variables. As you show a graphic, read and clarify it for your audience.

- Read the heading and contents of the overhead.
- Compare community data to state and national data.
- Clarify numerical units on graphics (e.g., percentages).
- Discuss any adjustments made to the data (e.g., 3 years of data were grouped together because the numbers were too small.)
- Discuss any limitations of the data (e.g., the sample was not representative of the entire community; numbers may be small, so emphasis should be placed on the total data and not data on subpopulations; numbers are synthetic estimates based on state data).
- Summarize the differences in groups presented in the data (e,g., between men and women, among races, between age groups).

As the community's data are displayed and discussed, encourage participants to ask questions.

Identifying health problems from behavioral data

Preparation: Have available the "List of Health Problems" with the items added during phase II. You may want to use flip charts and to ask for a volunteer to record the problem statements generated by the group. ■

Continue any discussion concerning behavioral data. Help the community group discuss criteria for selecting behaviors to be added to the "List of Health Problems." Have the group use these criteria to look through the behavioral data and brainstorm problem statements. For example, "too many people in our county smoke cigarettes" or "too many men aged 25 to 44 years old binge drink."

Review with the group the problem statements. Help the group set priorities among the problem statements, and determine the most important items, generally the top five to 10 items. Use the nominal group technique, if necessary. When the group has ranked its problem statements, add the identified health problems to the "List of Health Problems."

Encourage the group to discuss items on the "List of Health Problems." Lead the group through an informal nominal group technique to rank the items and reduce them to a manageable number, say no more than five to 10 items in each column. (This ranking may have been undertaken for the left-hand column during phase II. If not, you may want to do it now.)

Selecting the health problem to be addressed

Preparation: Review the Tipsheets on nominal group process and consensus building of Appendix 2. Review Selecting the Intervention Focus in Chapter 4 of the Concept Guide. Prepare to lead a discussion of the items on the "List of Health Problems." Assess your resources, and discuss with such groups as steering committee and partners the number of problems the community has the capacity to address. ■

So far we have identified a variety of health problems in our community. Let me remind you that none of the health issues listed will be lost. We will work to address many of them over time. We will also highlight the problems and encourage community agencies with the authority to address them to do so. It is more important for us to address one health problem well, with as many interventions as possible, than to do a little to address several

problems. Our task now is to determine the top three to five health problems we consider as major health priorities to be addressed by our initial intervention activities.

Review the sets of criteria the group used to determine health problems. Offer additional criteria for determining which problem to address first. These criteria might include ranking problems as to importance and changeability and giving priority to those that rank high on both.

Display overhead "Criteria for Determining Priority." Discuss the definition of importance and changeability.

Display overhead "Ways to Assess Importance."

- How widespread is the health problem or behavior? Is the prevalence in our community greater than the prevalence in the state or the nation?
- Are the consequences of the health problem or behavior serious? Does it cause a disproportionate amount of death or disability?
- How closely connected are the behavior and the health problem?

Display overhead "Ways to Assess Changeability."

- Does research suggest that the health problem or related behaviors can be changed?
- Has the health problem or behavior been successfully changed by other community-based programs?
- Is the behavior still in the developmental stage?
- Is the behavior only superficially tied to lifestyle?

Provide the group with some other issues to consider when deciding which health problem to address first.

- Are there legal and economic factors to consider?
- Are there political issues or issues of social acceptability to consider?
- Would addressing the health problem help build on community strengths?
- What is the level of public concern for the health problem?
- What is the possibility of quick program success in addressing the health problem?

While referring to the "List of Health Problems," have the community group members use the nominal group technique to identify their top five priority problems. Tabulate votes and identify the top

three to five health problems. Ask a member of the group to discuss why he or she considers a particular problem to be a priority. A reasonable amount of discussion, debate, and disagreement is healthy and may be necessary to air feelings and reach a compromise.

Unless your community has an abundance of resources and can address all three to five health problems, repeat the nominal group technique to identify which health problem to address first.

Existing programs and policies

Preparation: Review the Using the Matrix section of Chapter 4 of the Concept Guide. Some communities choose to complete the matrix for the top three to five health problems under consideration. Other communities wait until the community group has decided on the health problem to be addressed first and then complete the matrix as a final step in the decision-making process. Your community group or steering committee may have a preference on how to proceed. When preparing examples of each intervention strategy, include examples from the community or examples related to the health problem.

After using the matrix to examine what is ongoing, the community group may decide that the health problem is being adequately addressed and move on to examine another priority health problem. Or it may decide it has a role in addressing the health problem. The matrix may also be used by the community group to identify potential new members, partners, and allies in its efforts to address the health problem. Chapter 5 contains more information on the use of the matrix. A larger version of the matrix is included in the handouts. ■

Distribute the "Existing Community Programs/Policies Matrix."

To prevent duplication of effort, we want to make sure we do not choose a health problem that is already being adequately addressed within the community. The "Existing Community Programs/Policies Matrix" is a tool to help us identify policies and programs that are ongoing in the community.

The matrix will help us organize our investigation of ongoing policies and programs by two features: the strategy or method used, such as education, and the setting where the programs or policies are located, such as schools. We will use the matrix again in phase IV to develop an overall health promotion strategy to address our priority health problem. This comprehensive strategy

will include educational, policy advocacy, and environmental measures–strategies that can be used in different settings, such as schools, health care centers, the community, and worksites.

We will fill in each box or cell to complete the matrix.

Review for the group, as appropriate, the components of the matrix.

The first are educational strategies, which include two broad methods:

- *Communication methods include lecture and discussion, individual counseling or instruction, and the four techniques of mass media (print materials, audiovisual aids, and educational television).*
- *Training methods include skills development, simulations and games, inquiry learning, small-group discussion, modeling, and behavior modification.*

Provide examples of educational strategies that already exist in the community and solicit others from the group.

The second category includes regulatory or legislative strategies. They involve using laws and regulations to discourage negative behaviors and to encourage positive actions. For example, local school boards have initiated regulations against smoking at board meetings and may also extend the hours that community people may use school exercise facilities. Again, solicit examples from the group.

The third category includes environmental strategies. They include actions taken by others to make our lives safer and may not require a behavioral change or any participation on our part. In fact, sometimes you are not aware of what is being done for you. Examples include air bags in cars, removal of cigarette machines from schools and government buildings, break-away light poles on highways, and fences around swimming pools or cliffs.

Other environmental strategies include making healthy choices available in the environment, such as having high-fiber foods available in grocery stores and low-fat milk offered at the worksite.

Ask if anyone in the group would like to provide additional examples.

Intervention strategies need to complement and support other efforts that are already in place. To prevent overlapping or duplication of efforts, we need to list existing community programs and policies. On the handout, we need to fill in existing programs and policies related to the health problem and risk factor we have identified.

Provide an example of how the matrix works.

If we want to reduce deaths due to heart disease by addressing physical inactivity, we would note in the upper left-hand cell any educational programs promoting physical activity that are provided through schools.

After going down the first column, you might also continue across the top of the matrix with questions such as "what does the health care system (doctors, school clinic, etc.) do to educate youths about the importance of physical activity?" or "what education or policies provided by employers of older teens encourage physical activity?" Please note: the OTHER category is available for items that do not fit elsewhere. For example, some automobile dealers place stickers on car windows reminding riders to buckle-up.

If time may not permit completion of the matrix, refer it to a working group for completion, and set a time to meet again to review the matrix and complete the following agenda items.

Final decision

Preparation: Review the Tipsheets on nominal group process and consensus building of Appendix 2. Be prepared to postpone a final decision if the group requests more information or appears not to be ready to do so. ■

Have the group discuss which of the three to five priority problems it would like to focus on initially. Try to reach a consensus through discussion. If impossible, have the members vote among alternatives by a show of hands or by repeating the nominal group technique, ranking their three top choices from the top five items listed. If you wish, repeat the technique to identify the top three choices for the group. Ask the participants to continue thinking about their initial focus between now and phase IV, when a final decision will be made.

Focusing on target groups

Preparation: In Chapter 4 of the Concept Guide, review the section on Targeting the Community and Specific Groups (page CG4-6). Review the community data and note subpopulations that are at greater risk for the problem to be addressed first. ■

When we begin to design our interventions, we should consider the community at large as one of our major targets. Groups we target within a community will be more likely to change behavior if the community at large supports that change.

We also want to identify groups within our community to be the focus of interventions. We might want to design interventions that target school children, pregnant women, black men aged 18 to 34 years, employees, or other groups within our community. By examining opinion, mortality, and morbidity data, we can determine who in our community may be at greater risk for a particular health problem. From the behavioral data, we can determine who is at an increased risk due to unhealthy behaviors. Today we will want to discuss potential target groups even though final selection of the target group will occur in phase IV.

Display and review overhead "Target Groups."

There are four approaches community groups have found useful when selecting target groups:

- *The curative approach selects the group with the greatest problem or at greatest risk.*
- *The preventive approach selects the group that has not yet developed patterns of behavior involving the risk factors.*
- *The cost-effective approach selects the group that would yield the most results with the fewest resources.*
- *The greatest-need approach selects the underserved group that needs the most help.*

To make a good judgment about which group (or groups) should be the focus of our intervention activities, we need to consider all four ways to select target groups for any particular health problem.

Discuss handout "Target Group Profile."

Ask participants to take a few minutes to write who they consider to be the target group(s) for each question. Make sure everyone is aware of the priority health problems that the community selected. They may also want to refer to data previously given as handouts.

Lead the group in a discussion of the answers to the questions. Ask someone to volunteer to record responses to the questions on the flip chart. Try to discuss differences of opinion and make sure everyone understands the rationale behind other people's responses. The purpose of this exercise is to reach consensus on the most likely targets so these potential targets can be examined further. You may find it helpful to take a vote or use the nominal group technique. Making a final decision on specific target groups will be done in phase IV.

Explain that in phase IV the group will finish identifying the target groups and examine individual or cultural factors that could help or hinder interventions.

In the discussion, you may find that you will need more information on specific target groups to make a final decision in phase IV. A working group may need to be created at the end of the meeting to collect such data.

Setting goals and objectives

Preparation: Review Chapter 4 section on Writing Goals and Objectives. Have blank overheads available. ■

Most of us set some short-term and long-term goals or objectives for our life. In PATCH, we want to set objectives to give us direction as well as standards against which to measure our accomplishments. We will not take much of our meeting time writing objectives; we will let a working group do that. We do, however, want to talk for a few minutes about objectives and the three kinds of objectives that we will develop: community objectives, behavioral objectives, and intervention objectives.

Display and review overhead "Objectives are SMART."

A well written objective is SMART. It is specific, measurable, achievable, realistic, and timebound. When we read it, we know ***what*** *should be done by* ***when, where*** *it will be done, to* ***whom,*** *and* ***how much*** *will be accomplished.*

We will set a community objective to address the leading cause of death or disability we select to address.

Display overhead "Community Objective." Review that it has the components of a SMART objective.

Display and review overhead "Behavioral Objective." Distribute handout "Behavioral Objectives for the Nation."

We will set behavioral objectives that address the leading behaviors that contribute to our priority health problem. Later, as we design interventions, we will set intervention objectives that relate to a particular intervention. Objectives are measurable statements that tell us what results we hope to accomplish. They are critical in community planning, and help to direct and focus community efforts.

Have participants talk through the process of writing a community objective for the top-ranked health problem. Write it on a blank overhead transparency. Issues the group needs to discuss include

- when to reasonably expect a change. (An objective to change mortality should allow at least 10 years.)
- whether change should be written for all deaths or only for premature deaths. (If the community has an increasingly aged population, the group might want to write objectives in terms of deaths before age 65 or 75 years or write them in terms of decrease in years of potential life lost.)
- the amount of change to anticipate. (You may set a target figure now and reexamine it after you have designed your intervention and can better forecast change.)

Once the community objective is developed, write a matching behavioral objective.

Tell the group that a working group will be formed at the end of the meeting to work on other objectives.

Updates from working groups

Preparation: Help working group chairpersons or members to prepare an overview of their activities and accomplishments since the last meeting. Refer to the working group task sheets located in the handouts. ■

Have the working groups report on their activities. For example, the public relations working group might summarize what has been done to keep the community informed of their activities, to inform the community of its health status, to encourage use of the logo, and to distribute newsletters and press releases.

Other issues the working groups might want to discuss include whether to recruit more volunteers for specific tasks and how to recruit them, policies relating to use of the logo, and ways to keep the community informed about PATCH.

Wrap-up and closure

Preparation: Prepare a brief outline of the day's accomplishments on a flip chart or overhead, and prepare to share it (orally) with the group. Also develop a to-do list. Remember to add activities that were referred to the working group for completion. In the Concept Guide, review the Monitoring the Phases of PATCH section of Chapter 6 (page CG6-3). In this Meeting Guide, review the section on Evaluating the Community Group Meetings (page MGO-3). Use a meeting evaluation method to obtain feedback from participants; for example, pass out an evaluation form and ask participants to complete it before they leave. ■

Your summary of accomplishments might look something like this example:

- Decided on the health problem to be addressed first.
- Identified potential target groups(s).
- Identified existing community programs and policies.
- Established working groups to...(specify tasks).

Prepare on a flip chart or overhead a to-do list that might include the following:

- Have the working group complete the "Existing Community Programs/Policies Matrix." (The working group may also want to match organizations listed on the matrix with the Inventory of Collaborating Groups found in Chapter 2 of the Concept Guide [page CG2-11] and as a handout for the phase I meeting.)
- Have the public relations working group continue to share the findings from our data collection activities within the community though such avenues as press releases and presentations to community groups.

Have participants set date for the next meeting.

Distribute the meeting evaluation sheet, and ask participants to fill it out and return it to you before they leave.

Thank group members for their participation.

Meeting as working groups

Preparation: Review existing task sheets for the working groups and update and revise them to meet your community's needs. Develop new task sheets as appropriate. ■

Encourage working groups to meet at least long enough to clarify tasks and set a time and place to meet. Identify participants who might be able to consult with the working groups, as needed (e.g., state coordinator, partner, or local coordinator).

Topics for discussion after the community group meeting for phase III

The following are topics for discussion with partners and steering committee members, including working group chairpersons.

1. Discuss what happened during the community group meeting, including group dynamics and decisions made, and review the results of the evaluation of the meeting.
2. Now that the community group has identified the health problem to be addressed first, discuss what might be done to broaden alliances and update organizational and functional structures (see the related sections in Chapter 5 of the Concept Guide [CG5-2 and CG5-3]).
3. Review tasks to be done by working groups, partners, and others, and determine training and technical assistance needs.
   - Identify sources of data on potential target groups.
   - Discuss any problems or needs identified by the working groups.
   - Discuss the monitoring of the phases of PATCH (see page CG6-3).
   - Discuss ways to accomplish the to-do list developed at the end of the meeting.
4. Schedule regular communications with PATCH partners, community members, and working groups. Plan to distribute a summary of the community group meeting to attendees, partners, and others in the community. Plan to update each person who missed the community group meeting.

Meeting Guide for Phase IV

Developing a Comprehensive Intervention Plan

Meeting Guide for Phase IV: Developing a Comprehensive Intervention Plan

Introduction to phase IV meeting guide

In phase IV of PATCH, community participants will decide what intervention activity to conduct to achieve the objectives they set. The tasks in this phase include

- identifying contributing factors to the priority health problem and related risk factors.
- reviewing intervention strategies and existing programs in the community.
- involving the target group in designing or choosing the intervention.
- completing the "Checklist for Designing a Successful Intervention."
- identifying new alliances, and revising organizational and functional structures.

This Meeting Guide for Phase IV is designed to assist you with planning and conducting the community group meeting(s) related to phase IV of the PATCH process. It is intended to be used in conjunction with the other two parts of the PATCH materials: the PATCH Concept Guide, which includes information and tools for carrying out the PATCH process, and the Visual Aids packet, which includes camera-ready copy of overheads and handouts. This guide includes a suggested agenda, an estimate of the time required to complete the agenda, and suggested text or activities you can use to facilitate each segment of the agenda. When conducting the activities described in this meeting guide, feel free to adapt the materials in this guide to meet your own needs and circumstances. Carefully review Chapter 5 in the Concept Guide for discussion points and examples not repeated in this meeting guide. Based on the level of understanding of your community group and on the level of detail appropriate for the community group and for the working groups, expand, shorten, or omit topics on the agenda.

You should plan to review working group accomplishments before this community group meeting and debrief after the meeting with such groups as your steering committee, partners, and working group chairpersons. At the end of this guide, see the section on Topics for Discussion After the Community Group Meeting for Phase IV.

Preparations for the community group meeting for phase IV

Suggested Agenda:

Community Group Meeting

Agenda

Welcome and announcements	10*
PATCH update and meeting goals	10
Designing a successful intervention	15
Selecting the target group	25
Determining contributing factors	30
Involving the target group	20
Intervention settings and strategies	10
Matrix of the existing community programs and policies	30
Community resource inventory	20
Checklist: tools for developing the intervention activity	15
Conducting effective interventions	10
Updates from working groups	15
Wrap-up and closure	10
Meeting as working groups	varies

*Estimated time in minutes

Time Required: About 4 hours. The time needed will vary depending on the level of understanding of the group members, the dynamics of the group, and the work already completed by working groups. Some topics on the agenda, such as the Checklist for Designing a Successful Intervention, might be discussed generally with the community group and in more detail with the working groups. Add time for invited speakers. If you would like to divide the agenda between two meetings, you might want to break after the section on Determining Contributing Factors (see note on page MG4-9).

Preparation: Review results of previous meetings before proceeding. Carefully review Chapter 5 in the Concept Guide and Checklist for Designing a Successful Intervention handout. Valuable discussion points and examples provided in Chapter 5 are not repeated in this meeting guide. Determine the level of understanding of your group, and expand or shorten the discussion of topics such as strategies of a comprehensive intervention. Determine the level of detail that is appropriate for the community group and for the working groups.

Many communities have found it helpful and enriching to involve **invited speakers** in the meetings. Experts and interested persons might talk to the group about the chosen health problem, risk behavior, target group, interventions, or such specialized topics as the use of media. Speakers may include major service providers, experts in dealing with the health problem or target group, and experts in designing interventions. Provide the speakers with guidelines for time allowed for presentation and for discussion, specific subject area, and questions and concerns of the PATCH group. Request that at least one-third of a speaker's time be devoted to a question-and-answer session. Adjust the agenda accordingly.

In the Concept Guide, review the Monitoring the Phases of PATCH section of Chapter 6 (page CG6-3). In this Meeting Guide, review the section on Evaluating the Community Group Meetings (page MGO-3). Decide on a meeting evaluation method to obtain feedback from participants, and develop an evaluation form or plan a group discussion or both. Review the content in this Meeting Guide for Phase IV for recommendations concerning each segment of the suggested agenda. Prepare an agenda. ■

Welcome and announcements

Preparation: Be prepared to give an overview of the agenda. Review and revise the meeting goals, and prepare them as an overhead or write them on a flip chart. ■

Welcome participants, thank them for their efforts, and make general announcements.

Distribute and briefly discuss the agenda.

PATCH update and meeting goals

Preparation: Determine the accomplishments to be highlighted. Make an overhead displaying any community and behavioral objectives developed in phase III. Provide the level of review appropriate for your group. Review the Meeting Guide for phase III and chapters 4 and 5 of the Concept Guide for valuable talking points and examples. Alter the meeting goals, as appropriate. ■

Display and discuss overhead "Five Phases of PATCH."

- Review PATCH phases and where in the process the group is.
- Review the results to date, including highlights of decisions made during phase III.
- State that the public relations and other working groups will report on their accomplishments later in the meeting.

Display overhead "Phase IV: Developing a Comprehensive Intervention Plan." Discuss what will be accomplished during phase IV.

During this phase, we identify the target group and ways to involve members of the target group in the planning. We will review the inventory of existing community programs and policies, and we will design interventions that will meet unmet needs or build on what is ongoing in the community. We will develop a comprehensive strategy for addressing the health problem that will include educational, policy advocacy, and environmental measures–strategies that can be used in different settings, such as schools, health care centers, the community, and worksites.

Summarize decisions made during phase III. Display overheads of community and behavioral objectives. Provide as much explanation or review as needed.

Display and review the meeting goals, which might include the following:

- Select a target group and ways to involve the target group in designing interventions.
- Identify factors that contribute to the health problem.
- Discuss components of a comprehensive health promotion strategy.
- Review tools that will help us design our intervention.
- Establish working groups to design comprehensive interventions.

Designing a successful intervention

Preparation: Review Chapter 5 of the Concept Guide and the handout "Checklist for Designing a Successful Intervention." ■

Explain that the health of your community does not depend just on the health of individuals but also on whether the physical and social aspects of the community are supportive of people living healthy lives. Therefore, a comprehensive intervention plan should

- include the use of multiple strategies, such as educational, policy, and environmental strategies, within various settings, such as the community, health care facilities, schools, and worksites.
- target the community at large as well as subgroups within the community.
- address the factors that contribute to the health problem.
- include various activities to meet your audiences' levels of readiness.

Distribute and review sections of handout "Checklist for Designing a Successful Intervention."

Explain that through the PATCH process, a lot has been learned about the needs of the community and possible target groups and the reasons why those needs exist. But to ensure that the interventions designed are appropriate and will be used by the target group requires careful planning by the community group and working groups. The "Checklist for Designing a Successful Intervention" is a tool to help the group plan intervention activities. Once the health problem, related risk factor, and target group to be addressed are known, the checklist can be used to identify

- factors that contribute to the presence or absence of the risk factor in the target group.

- programs and policies presently in the community that address the risk factor and target group.
- partners and resources.
- ways to involve the target group in designing the interventions.
- ways to enhance the program by coordinating with other local, state, or national activities and media.
- ways to coordinate and monitor activities through use of time-tables, work plans, and evaluation plans.

Selecting the target group

Preparation: Review decisions made during phase III. Review Chapter 4 of the Concept Guide. Prepare to display and discuss data collected on priority target groups. Make copies of phase III products. Review the Tipsheet on the nominal group process from Appendix 2. ■

As we design our intervention, we will want to make sure it is appropriate for our target groups. We will want to target the community at large as well as at least one specific group within the community. This specific group may be identified based on mortality, behavioral risk factor, community opinion, and other information.

Summarize the results of phase III activities. Review information collected on priority target groups. Ask for discussion of groups to be targeted. Determine the initial target group. Use the nominal group technique if needed to reach agreement.

Explain that choosing a particular target group does not mean that it will be the sole focus of the interventions. Some interventions may actually be geared toward people who influence the target group. For example, if motor vehicle injuries are selected as the health problem and 18-to-34-year-old men who drink and drive as the target group, an intervention might address those who influence 18-to-34-year-old men who drink and drive. It might include training bartenders to manage people who drink too much or producing community public service messages such as “friends don’t let friends drive drunk.”

Determining contributing factors

Preparation: In the Concept Guide, review the Determining Contributing Factors section of Chapter 5 (page CG5-6). Review section on contributing factors and Table 1 in the handout “Checklist

for Designing a Successful Intervention." You may wish to replace examples provided with ones that relate to your community's selected health problem or risk behavior. Prepare to lead the exercise with several small groups or with the full group, and alter the guide appropriately. If working in small groups of at least five persons per group, you might want to train a member of the steering committee or another person to help lead each group. If you are addressing two or more behavioral risk factors or target groups related to the initial health problem, you might ask that participants form groups according to which risk factor or target group they would like to analyze. Make a set of overheads and handouts for each group. If working with the full group, you might wish to ask for a volunteer to record responses on a flip chart. ■

Group exercise (small group)

Summarize the need to identify contributing factors, both positive and negative.

Ask participants to turn to "Table 1: Contributing Factors" in the checklist handout, and display it as an overhead.

For a particular risk factor and target group, ask each group to list as many contributors as it can by brainstorming. Have participants designate if the factor contributes to the presence or absence of the risk factor. Each group should select a recorder to list the contributing factors on the overhead or flip chart.

Distribute and review handout "Types of Contributing Factors."

Emphasize that all three types of contributing factors must be addressed in the intervention to have a comprehensive program that can make an impact on the target group.

Summarize the three broad categories of contributing factors. Each category should be included in the intervention design.

- Motivators that affect knowledge, attitudes, and values.
- Enablers that give the individual the ability to act.
- Rewards that positively or negatively affect behaviors.

Provide examples of motivators.

Knowledge - Individuals with high blood pressure may continue to eat large quantities of salt because they do not know about its effects on their blood pressure.

Beliefs - If a person with hypertension does not believe a particular medication will work, she or he is not likely to use it.

Attitudes - Persons with high blood pressure are not always willing to sacrifice existing eating habits for a more suitable diet.

Values - Although a long life and good health are valued dearly, sometimes people value certain detrimental practices (e.g., eating too much salt or smoking) even more.

Perceptions - People must perceive the potential seriousness, in terms of pain or discomfort, time lost from work, etc., as important for their behavior to change. If persons with hypertension have no sign of distress or pain, they may not perceive that stopping their medication may be damaging to their health.

Provide examples of enablers, which are those things that support a person's ability to take some actions, such as the availability and accessibility of resources or the skills necessary to undertake the action.

- To monitor their high blood pressure, people must either have the skills required to take their own blood pressure or have access to a facility where they can have it taken.
- To serve the community, clinics must be conveniently located and affordable to those who need them.
- For a family to buy low-fat dairy products, these products must be available in the stores.

Provide examples of rewards, which are the incentives or punishments that encourage or discourage certain health practices.

- Incentives may include reduced life insurance rates for nonsmokers.
- Punishments may include heavy penalties for driving while under the influence of alcohol.

We have all made certain changes (good or bad) in our lifestyles because society, family members, or friends encouraged us to do so or simply because we perceived the possibility of being praised for our actions.

There is evidence that strangers, rather than people close to us, may have more influence over our behavior in some circumstances. This phenomenon is known as the "strength of weak ties." Often, teens will adopt healthy behaviors on the basis of comments by complete strangers while ignoring health messages from parents or other people close to them.

Distribute handout "Contributors to the Risk Factor."

Have participants prioritize what they perceive to be the key contributing factors and write in each section of the handout the top five to eight factors.

Provide an opportunity for each group to present findings to the entire group. You might wish to review findings with the group. Ask groups to post the newsprint lists on the walls so that all participants can walk around and add items to the list or ask a representative from each group to report on the group's list Ask participants if they have questions or would like to add additional factors.

NOTE: If you plan to divide the agenda into two or more meetings, you might wish to stop here, type up the small group reports, and mail them to the community group members to review. At the next meeting, discuss the reports and continue with the agenda as follows.

Distribute handout "Priority Risk Factors and Intervention Methods."

Once you have listed the key factors that contribute to the risk behavior, you can then begin to see what activities or methods might be used to influence the behavior. Have participants, working as a full group or in the same small groups, review the items that have been added to handout "Contributors to the Risk Factor." Have participants determine the factors they consider to be priority and list these on handout "Priority Risk Factors and Intervention Methods."

Help them to consider issues such as importance and chanagebility. The priority list should include one or more items for each category of factors: motivators, enablers, and rewards. Encourage participants also to list at least one method that could reinforce or negate each contributing factor.

Remind them that as they plan they will also want to coordinate with existing programs, strengthening them when possible and supporting them with new initiatives when appropriate. Ask participants to keep in mind the available resources such as funds, space, and volunteers but to keep from feeling totally constrained by these.

Emphasize that because there is no way that all the contributing factors on the lists can be tackled simultaneously, the group must decide which factors to address first. The group will also need to involve the target group to ensure that the correct contributing factors are being addressed appropriately.

Involving the target group

Preparation: In the Concept Guide, review the Involving the Target Group section of Chapter 5 and the Techniques for Data Collection section of Chapter 6. Review the section on target group involvement in the "Checklist for Designing a Successful Intervention." Determine if you will give handout "Obtaining Input From Target Group" to the whole group or only to the working groups. ■

As we go through our intervention planning, we need to involve the target group. Many interventions fail because well-intentioned people plan them without involving the target group to make sure what is planned is appropriate. Why, when, and how can we get involvement from the target group?

Display and discuss overheads "Involve the target group: Why," "Involve the target group: When," and "Involve the target group: How." Elaborate on ways to obtain feedback from members of the target group.

- Face-to-face interviews–individual or on-the-spot interviews.
- Questionnaires–forms filled out by the individual.
- Focus groups–8 to 12 people interviewed as a group.

Distribute and briefly review handout "Obtaining Information from the Target Group" if you deem it appropriate for the full group. Challenge members as they participate in working groups to determine how best to involve the target group.

Intervention settings and strategies

Preparation: Review the Designing Effective Interventions section of Chapter 5 of the Concept Guide. ■

Review with the group that it should strive to design a comprehensive intervention plan that

- addresses the contributing factors.
- is appropriate for the specific target group.
- uses multiple intervention strategies in various setting.

Display overhead "Health Promotion Strategies."
Review the three categories of health promotion strategies.

Educational – to change knowledge, values, beliefs, attitudes, and opinions. This strategy includes two specific methods, communication and training.

Policy/regulatory. to help people adopt positive behavior or to discourage negative behavior.

Environmental measures: to make the environment safer or to make healthy choices easier (e.g., availability of low-fat dairy products or community recreational areas in all parts of town).

Display and discuss overhead "Program Sites."
Emphasize that a community health promotion program is most effective when conducted in as many of the following settings as appropriate.

School – Children spend one-third of their waking time in school. It may be the most important setting for ultimately educating the entire population.

Worksite – Adults spend a large portion of their waking time at work. Work settings and co-workers have substantial impact on lifestyle. The work environment and pressures can cause physical hazards and psychological stress, but they can also provide a supportive atmosphere through policies that promote safety, an environment that promotes health (e.g., a nonsmoking environment, lifestyle and exercise areas, and team sports), and educational opportunities (e.g., screening, smoking cessation classes, and health presentations).

Health care system – The average person sees a doctor four times a year. Patients are often at a "teachable moment" and thus more receptive to education and advice.

Community - With community programs, social norms can be influenced because they reach people where they shop and play. They can also involue the entire family. With policies such as nonsmoking regulations in public buildings, peoples' attitudes toward certain health behaviors can be changed.

Matrix of the existing community programs and policies

Preparation: Review the section of the phase III meeting guide concerning the matrix. Review the products of phase III and the working groups and vary this section appropriately. Prepare handouts or overheads based on these products. In Chapter 5 of the

Concept Guide, review the section on the Matrix of Existing Community Programs and Policies (page CG5-12). ■

Distribute and review handout "Existing Community Program/ Policies Matrix." Also distribute copies of a matrix filled in by the community group or working group as part of phase III or of Table 2 in Chapter 5 of the Concept Guide, as appropriate.

As needed, work with the group to fill in the names of existing programs and policies that serve the target group and risk factor selected. Also identify whether each item listed affects on a motivator, enabler, or reward for the target group.

As needed, refer the task to a working group for completion.

Community Resource Inventory

Preparation: In Chapter 5 of the Concept Guide, review the sections on Broadening Alliances and on the Community Resource Inventory. ■

Use as an overhead or handout the "Community Resource Inventory." Review the "Community Resource Inventory" and the need to have a working group describe further the programs and policies listed on the matrix, including the types and quality of services provided and the number of the target group members served.

Explain that the purpose of the inventory is twofold:

- By developing a rough idea of which programs and policies seem strong, which seem weak, and how many members of the target group are being served, the group can identify areas of need that they might wish to address.
- By identifying other groups in the community that are addressing the target group and risk factor, the group may identify new partners or collaborators.

As needed, refer the task to a working group for completion.

Checklist: tools for developing the intervention activity

Preparation: Review the handout “Checklist for Designing a Successful Intervention.” In Chapter 5 of the Concept Guide, review the sections on Checklist: Tools for Developing the Intervention Activity (page CG5-15and on Updating Organizational and Functional Structures (page CG5-2). Make copies of the work plan example provided in Chapter 5. ■

Review with the group many of the tools located in the checklist, including the work plan, timelines, and time tables.

Distribute copies of the PATCH work plan example provided in Chapter 5. Emphasize that many communities have found that the most effective programs are those with work plans that specify what needs to be done, by when, and who has the lead responsibility. Point out that the work plan includes a timeline.

Refer to the “PATCH Activity Timetable” and the “PATCH Master Timetable” in the handout “Checklist for Designing a Successful Intervention.” Discuss efforts to coordinate or piggyback with major events and to distribute activities so that they do not overwhelm either the community or the working groups and volunteers.

Quickly review other sections of the checklist, and explain how they can be used by the working groups as a planning aid.

Conducting effective interventions

Preparation: Review the Conducting Effective Interventions section of Chapter 5 of the Concept Guide. Review the meeting guide information, overheads, and the handouts, and decide how much of the information to include in this session. You may choose to put different levels of emphasis on the "different curve" and on the "stages of changes." ■

Display and read overhead “Quote by Goethe.”

Discuss the various topics included in this section of Chapter 5. Provide examples from the community whenever possible with emphasis on examples related to the health problem, risk factor, or target group.

Display overhead “Diffusion Curve.”

Emphasize that people adopt new ideas at different rates and that they learn in different ways. Various types of people adopt new ideas at different rates; some immediately, some never, and most in between.

According to the diffusion theory, there are five types of individuals within a population.

Innovators – They are considered venturesome because they are eager, daring, risky, and rash; they are also willing to accept occasional setbacks when a new idea proves unsuccessful.

Early adopters – They are considered respectable; they are opinion leaders, and serve as role models. They are frequently sought out by people attempting to implement innovative programs.

Early majority – They are cautious and deliberate; they rarely take a leadership role but often interact with their peers. They often spend a great deal of time thinking and rethinking before completely adopting new ideas.

Late majority – They are often cautious and skeptical. They are often forced into adoption by economic necessity and social pressures.

Laggards – They are suspicious of innovations and are the last to adopt them; they are considered isolates who dwell in the past.

These five groups of individuals determine what different methods and channels of communication are more or less effective; for example, mass media may influence the first three groups, but outreach programs may be necessary to influence the late majority and laggards.

Discuss with the group that there are two things to remember when designing “boldness” into your interventions:

- People learn in different ways. For some, media may bring about behavior change. Others may need the support of a group or other stimulus to change. You need to provide a variety of learning experiences by using various strategies and at different sites in your community. As appropriate, distribute and review the handout "Stages of Change."
- You do not have to get everyone in the community to carry out a program for it to be effective. If you can get that first school to initiate a program, before long other schools will hear about it and want it too. If one restaurant offers heart healthy foods, soon others will want to also.

Updates from working groups

Preparation: Select and help prepare working group chairpersons or members to present an update of their activities and accomplishments since the last meeting. ■

Have the public relations working group briefly summarize what has been done since the last meeting, including updates on newsletters and press releases.

Have other working groups report on their activities. Issues you might want to discuss are whether to recruit more volunteers for specific tasks and how to recruit them, policies relating to use of your program's logo as your begin interventions, and ways to keep the community informed about PATCH.

Wrap-up and closure

Preparation: Before the meeting, develop a list of activities that need to be accomplished before the next meeting. List these items on a flip chart. In the Concept Guide, review the Monitoring the Phases of PATCH section of Chapter 6 (page CG6-3). In this Meeting Guide, review the section on Evaluating the Community Group Meetings (page MGO-3). Use a meeting evaluation method to obtain feedback from participants; for example, pass out an evaluation form and ask participants to complete it before they leave. ■

Complete and discuss the to-do list with the group. Ask for chairpersons and volunteers to carry out the tasks.

Set a date for the next meeting.

Distribute the workshop evaluation sheet, and ask participants to fill it out and return it to you before they leave.

Thank group members for their participation.

Meeting as working groups

Encourage working groups to meet at least long enough to clarify tasks and set a time and place for their next meeting. Identify participants who might be able to consult with the working groups, as needed (e.g., state coordinator, partner, or local coordinator).

Topics for Discussion After the Community Group Meeting for Phase IV

The following are topics for discussion with partners and steering committee members, including working group chairpersons.

1. Discuss what happened during the community group meeting, including group dynamics and decisions made. Discuss the results of the evaluation of community group meeting.
2. -Review plan for completing the Existing Community Programs/Policies Matrix and the Community Resource Inventory.
   - Guide the working group that will design interventions and complete work plans and evaluation plans.
   - Identify how to enlist the help of others in intervention planning and evaluation.
   - Review the Inventory of Collaborating Groups to identify potential involvement of local agencies and groups.
   - Network with other states and communities that are using the PATCH process.
3. Review tasks to be done by working groups, partners, and others and determine training and technical assistance needs.
   - Discuss the monitoring of the phases of PATCH (page CG6-3).
   - Explore resources available for interventions and evaluation.
   - Discuss any problems or needs identified by the public relations or evaluation working groups. Plan for the release of data results to the community.

4.. Schedule regular communications with PATCH partners, community members, and working groups. Plan to distribute a summary of the community group meeting to attendees, partners, and others in the community. Plan to update individuals absent from the community group meeting.

Meeting Guide for Phase V

Evaluating PATCH

Meeting Guide for Phase V: Evaluating PATCH

Introduction to phase V meeting guide

Evaluation is an integral part of PATCH. As discussed in Chapter 2 of the Concept Guide, you need to plan for evaluation from the beginning of PATCH. Some communities find it helpful to establish an evaluation working group early in the PATCH process (page CG2-20). Other communities give these responsibilities to the steering committee and intervention working groups.

The evaluation process serves two major purposes. First, it will help you to monitor and assess progress during the five phases of PATCH. Is progress being made toward assessing needs, setting priorities, and carrying out interventions? In Chapter 6 of the Concept Guide, the section on Monitoring the Phases of PATCH includes examples of evaluation issues to be considered for each phase. A tool to help monitor progress during the phases is the PATCH Assessment and Tracking tool (PAT), which is located as Appendix 1 in the Concept Guide.

You will also want to determine if the group process used is working well. Is the group process for the community planning open, candid, and participatory? In the Meeting Guide, the section on Evaluating the Group Process Used (page MGO-8) contains a self-assessment tool that can be used with the community or working groups. Such self-assessments should be made throughout the PATCH process so that corrective actions can be taken to nurture or refocus the group. In the meeting guides for each phase, you will find suggestions for monitoring the phases in the sections on Preparation, Wrap-Up, and Topics for Discussion After the Community Group Meeting.

Second, the evaluation process enables you to examine interventions to determine if activities are completed and if positive changes occur. This Meeting Guide for Phase V focuses on evaluating interventions. Chapter 6 of the Concept Guide provides suggestions and steps for planning evaluations appropriate for your PATCH community. An example of an evaluation plan can be found in Chapter 5 of the Concept Guide, and an evaluation worksheet can be found in the "Checklist for Designing a Successful Intervention" located in the handouts for phase IV.

This Meeting Guide for Phase V is designed to assist you with planning and conducting the community group meeting(s) related to phase V. It is intended to be used in conjunction with the other two parts of the PATCH materials: the PATCH Concept Guide and the Visual Aids packet. This guide includes a suggested agenda, an estimate of the time required to complete the agenda, and suggested text or activities you can use as you undertake each segment of the agenda.

Feel free to adapt the materials in this guide to meet your own needs and circumstances depending on how your community approaches evaluation and how evaluation issues have been integrated into meetings in phases I–IV. Carefully review Chapter 6 in the Concept Guide for discussion points and examples not repeated in this meeting guide. Expand, shorten, or omit topics on the agenda on the basis of your community group's level of understanding and on the amount of detail appropriate for the working groups.

If you have questions, identify expertise within your community or call your state health department, college, university, or other resources for assistance.

You should plan to review working group accomplishments before this community group meeting and to debrief after the meeting with groups such as your steering committee, partners, and working group chairpersons. At the end of this guide, there is a section on Topics for Discussion After the Community Group Meeting for Phase V.

Preparations for community group meeting for phase V

Suggested Agenda:

Community Group Meeting

Agenda

Welcome and announcements	10*
PATCH update and meeting goals	10
Why evaluate?	15
Evaluating intervention activities	25
Deciding what to evaluate	30
Using the evaluation worksheet	20
Updates from working groups	15
Wrap-up and closure	10
Meeting as working groups	varies

*Estimated time in minutes

Time Required: About 2 1/2 hours. The time needed will vary depending on the level of understanding of the group members, the dynamics of the group, and the work already completed by working groups. Some topics on the agenda might be discussed generally with the community group and in more detail with the working groups.

Preparation: Review results of previous meetings before proceeding. Review Chapter 6 in the Concept Guide. Review, as needed, Chapter 4 for information on developing objectives, Chapter 5 for information on developing work plans and evaluation plans, and the "Checklist for Designing a Successful Intervention" located with the handouts for phase IV. Review PD-XII, the Intervention Activity Summary in the Program Documentation, located in Appendix 3. Valuable discussion points and examples provided in Chapter 6 of the Concept Guide are not repeated in this meeting guide. Discuss with stakeholders and funding sources, as appropriate, their expectations and requirements for evaluation.

Determine the level of understanding of your group, and expand or shorten the discussion of topics. You may want to omit or only briefly review evaluation issues that have been integrated into meetings in phases I–IV or those that have already been performed by a working group. Determine the level of detail appropriate for the community group and for the working groups. Prepare an agenda. ■

Welcome and announcements

Preparation: Review and revise the meeting goals, and prepare as an overhead or write on a flip chart. Prepare to quickly review the agenda for the group. ■

Welcome participants, thank them for their efforts, and make general announcements.

Distribute and briefly discuss the agenda.

PATCH update and meeting goals

Preparation: Determine the accomplishments to be highlighted and the level of review appropriate for your group. You may want to ask the intervention working groups established in phase IV to be ready to summarize their activities. ■

Display and discuss overhead "Five Phases of PATCH."

- Briefly review PATCH phases, where the group is in the process, and the results to date.
- Name the working groups that will report on their accomplishments later in the meeting.

Display overhead "Phase V: Evaluating PATCH." Discuss the things to be accomplished during phase V. Summarize decisions made during earlier phases, if needed.

Display and review the meeting goals, which might include the following:

- Review why it is important to evaluate interventions.
- Identify components of an evaluation plan.
- Identify steps in planning an evaluation.
- Focus our evaluation.

Why evaluate?

Preparation: Review Chapter 6 of the Concept Guide. ■

Ask the group to respond to the question, "Why should we evaluate our efforts?" Ask for a volunteer to record responses on a flip chart. Answers could include the following:

- Monitor progress.
- Assess success and effectiveness; prove we are making a difference.
- Provide accountability and to justify the program to sponsors or funders.
- Ensure we are reaching the people we hoped to reach with our activities.
- Document that we are doing what we planned.
- Provide information to help us make decisions about the program.
- Provide feedback for revising or refining our program.
- Provide feedback for staff and volunteers.
- Help obtain funding.
- Gain credibility.
- Identify unintended effects.
- Use results to publicize the program.
- Provide information to assist with replicating and disseminating the program.

As needed, display overhead "Major Reasons to Evaluate."

As we undertake an activity, we will want to know if it is a success and whether it will be worth our time and effort to repeat it or to take it to new places in the community. We will also want to know how it can be improved. Evaluation will provide the answers to these questions.

By evaluating our efforts, we can help ensure that we are using our energies and resources to do what is best for our community. Scrutinizing our efforts helps in giving feedback to the people who support us. This support can be in the form of funding, sponsoring events, or contributing time and skills.

Evaluating interventions activities

Preparation: Review in Chapter 6 the section on Program Effects (page CG6-7). ■

Display overhead "Types of Evaluation."

As we plan our evaluation we will want to include strategies for monitoring or overseeing the interventions, for determining the short- and long-term effects of the interventions, and for monitoring organizational change related to undertaking the phases of PATCH itself.

Three levels of evaluation provide a conceptual framework for developing an evaluation plan: process, impact, and outcome. Each serves a different purpose, and each is measured differently.

Process evaluation, the first level, concerns what was done. Our objectives and work plans describe the activities we will undertake to produce change. As we complete our work plans, we will want to ask: "What did we do? Did we do what we planned to do?" By comparing what was planned with what actually occurred we are conducting process evaluation.

Process evaluation will help us monitor, track, and document our activities. This information can help us understand what occurred and provide feedback to our sponsors, volunteers, and community. We can then fine-tune our program based on information about such things as which activities are working, which ones are not working, and who is–and is not–being served by the program.

Ask the group to respond to the question, "What kinds of process information do you think are important to collect?" Ask a recorder to write the answers on a flip chart. (If possible, elaborate on the responses with examples from your work plans.) The answers could include the following:

- the number of activities or sessions provided.
- the number of people who attended.
- demographics of the attendees (e.g., age, sex, ethnicity, and educational level).
- the number, type, and content of media activities.
- the activities completed to help bring about policy and environmental change.

Explain that *impact evaluation*, the second level of evaluation, is the measure of short-term effects of your intervention. Explain that many people use the term "outcome" for this level of evaluation and that you are following standard public health practice and using the term "impact" to measure the short-term effects of our program. Also explain that, in addition to focusing on process evaluation, the group should work to include impact data to strengthen the evaluation.

With impact evaluation, the important question is whether the intended changes occurred. We will want to examine the effects of our activities on individual behaviors, organizations, policy, and the environment.

Our objectives should indicate who or what we want to change, what we want to accomplish, and our criteria for success. We will want to know such things as (give examples from your work plans, if possible): *Have we achieved our attendance goals? Has the number of smokers in the intervention group declined? Have more grocery stores begun offering low-fat milk? Impact evaluation assesses the program's effectiveness in changing health-related behavior and factors that enable, motivate, and reward health-related behavior.*

Use examples from your work plans or use the following objectives to demonstrate measurable impacts that could be evaluated:

- Behavioral impact objective: By the end of our Fitness for Life course that meets once a week for 8 weeks, the percentage of participants who state they are physically active for 20 minutes three times per week will increase from 10% to 60%.
- Policy impact objective: By December 31, 1998, five of nine major worksites in the community without a clean indoor air policy will have adopted a clean indoor air policy.
- Environmental measure impact object: By December 31, 1997, three of four neighborhood grocery stores will increase the availability of low-fat dairy products as indicated by an increase in shelf space for low-fat milk.

Ask the group for examples of impact that they might wish to measure. Ask a recorder to write responses on a flip chart. Responses may include the following:

- changes in knowledge, skills, and attitudes.
- changes in behaviors.
- increases in amount of desired services and activities.

- changes in policy (e.g., restrictions of sale of tobacco products to minors or school board rule allows use of school exercise facilities by community members during nonschool hours).
- improvements in how community agencies work together (e.g., increases in communication or commitments of staff and resources to address community problems).
- changes in social and environment factors supportive of healthy behaviors (e.g., developing a support network for family members who are caregivers of patients with Alzheimer's disease, constructing walking trails, or increasing the availability of low-fat milk in stores).
- increases in the intent to change behavior.

As appropriate, you can distribute the handout "Stages of Change" and discuss Prochaska's Transtheoretical Model. Once again, use examples that relate to your community's objectives and work plans.

Explain that the third level of evaluation is *outcome evaluation.*

Discuss that outcome evaluation is concerned with the long-term effects of our program, such as changes in health status or disease prevalence. Has the number of deaths due to heart attacks dropped? Has the quality of life in your community improved?

Explain that evaluating outcomes may be feasible when addressing causes of morbidity and mortality that have short time frames, such as preventing infant deaths or drinking and driving injuries. When addressing long-term health problems, such as mortality from heart disease or cancer, evaluation of outcomes is beyond the scope of most community programs.

Discuss that for long-term problems, evaluating changes in the behavioral risk factors that influence the morbidity and mortality is more appropriate. Many of the Healthy People 2000 objectives are concerned with these kinds of behavioral changes. Provide an example such as (give an example related to your community's health priority, if possible): "Reduce overweight to a prevalence of no more than 20 percent among people aged 20 years and older and no more than 15 percent among adolescents aged 12 through 19 years. (Baseline: 26 percent for people aged 20–74 years, 24 percent for men and 27 percent for women, and 15 percent for adolescents aged 12–19 years in 1976–80)."

Although our evaluation may not address long-term outcomes directly, we should think of our health promotion programs and their impact as contributing to the long-term outcomes of morbid-

ity and mortality change in our community. We may not be able to prove that our efforts caused the changes in morbidity and mortality. But, if we aggressively track and document our efforts by collecting both process and impact data, we may be able to suggest that our efforts contributed toward these outcome goals.

Deciding what to evaluate

Preparation: In Chapter 6 of the Concept Guide, review the sections on Identifying Data Sources, Techniques for Data Collection, and Focusing Your Evaluation.

Determine how much discussion and priority setting the group should undertake at this time and how much will be done by working groups and the steering committee. Vary the contents appropriately. If appropriate, discuss these materials briefly with the community group or expand the contents of this section to include such things as the "Five Steps in Planning the Evaluation" (page CG6-13, which may be copied as handout) and information on data sources and collection techniques. ■

In designing and carrying out evaluations of program activities and in using evaluation results, we must make many decisions: What should be evaluated? What are appropriate levels of program evaluation? What steps should be used in planning the evaluation? How should we involve any major sponsors or funders in the evaluation?

Our evaluation should

- *be consistent with our program's goals and intervention plan.*
- *give us information we need to improve programs and to provide feedback to volunteers, staff, and the community.*
- *be achievable within a reasonable time.*
- *be accomplished with available resources.*

We may not have the resources to evaluate all of the many activities of our program, but we will want to evaluate our major activities and to document who was served, how well, and what changes occurred. We will want to use process data to improve programs and to provide feedback on activities to participants and volunteers that encourages future involvement. We will also want to monitor policy and environmental changes that support health and encourage healthy lifestyles.

Ask participants to discuss reasons why a group might decide to evaluate one activity more than others. Write responses on a flip chart, if desired. Items discussed might include the following:

- The activity has a greater potential for impacting the overall program (e.g., the eight-session Fitness for Life course might warrant a more complex evaluation plan than a fun run).
- The activity requires a greater amount of resources.
- The activity is closely related to the overall goals of the program.
- The activity reaches a target group of special interest.

If appropriate, distribute and review handout "Five Steps in Planning the Evaluation." Discuss each of the following steps and the role of working groups and others in developing the overall evaluation plan.

1. Describe your program activity.
2. Select evaluation measures.
3. Design data collection and analysis (discuss possible data sources and collection techniques, as appropriate).
4. Develop an action plan.
5. Report the results.

Using the evaluation worksheet

Preparation: Review the section of the "Checklist" on evaluation. Review handout "Evaluation Worksheet: Example." Determine how much discussion is appropriate for the community group and for the working groups or the steering committee, and vary the contents appropriately. ■

Discuss handout "Evaluation Worksheet: Example" and have ready the blank "Evaluation Worksheet."

Remind the participants that this worksheet is a tool for helping them come up with a few good evaluation measures for an activity. Explain the worksheet column by column. Go through it by using the example worksheet and explaining the process step by step.

First

Explain that the first step is to brainstorm the type of information the group would like to have to determine whether the activity was a success. Review the ideas recorded in the first column of the handout. Emphasize that it is important to be creative and to record a variety of options.

Second

Review that the second step is to discuss the items in the first column and cross off those that could not be realistically achieved or monitored. Review the items that were crossed off on the handout and the reasons given.

Third

Explain that the third step is to determine how the results would be achieved, and record this product or measurement in the second column. Review several of the examples in the handout. Explain that the responses should be specific–observable or reportable so that they can be measured or evaluated.

Fourth

Explain that the fourth step is to set a deadline for completing the tasks. Review several of the examples in the "When?" column of the handout. Mention that some items might give immediate results; others might take several months or even years.

Fifth

Explain that step five is to list in the "Who?" column the person responsible for following up on the results. Complete discussion of the handout.

Full group or small group activity (optional).

Distribute copies of the blank "Evaluation Worksheet." Select an activity from the group's objectives and work plans that is different from the example just reviewed, and explain the activity to the group. As a large group or several small groups, have the members complete the blank evaluation worksheet for the intervention activity. If using small groups, allow time for each small group to summarize results for the full group.

Review, as needed, that the primary criteria for determining the effects of the program should be the group's goals and objectives. State that as the group designs its evaluation plans, emphasis should be placed on the process evaluation and, to some extent, the impact evaluation because these two types of evaluation will provide the kind of information needed to assess if the activity was a success, if it was worth repeating, or how it could be improved. These types of evaluation will also provide information to share with the community, supporters, and volunteers.

Remind participants of the most appropriate uses of statistical information and opinion information, and encourage them to try to incorporate both kinds of evaluation into the evaluation plans. If appropriate, discuss briefly data sources and the need for quantitative and qualitative data. You might choose to discuss some sources of evaluation information, including the following:

- Existing information from program records–how many attended, how many completed a series of classes, how many maintained the desired behavior change after completing the classes, how many people reported on pretest and posttests changes in knowledge or behavior, etc.
- Personal interviews with staff or participants–asking for people's opinions about the activity by using questionnaires, interviews, or focus groups.
- Direct observations–measuring changes in behavior by noting increases in usage of exercise facilities, decreases in smoking in restaurants, etc.

At the end of the time allotted for this activity, summarize who in your community will be completing the evaluation plans. Encourage interested members to join working groups, etc.

Updates from working groups

Preparation: Help working group chairpersons or members to prepare an overview of their activities and accomplishments since the last meeting. ■

Have the working groups report on their activities, as appropriate. For example, the public relations working group might summarize what has been done to keep the community informed about the PATCH process and intervention activities.

Other issues the working groups might want to discuss include how to recruit new partners and volunteers to help plan and carry out intervention activities.

Wrap-up and closure

Preparation: Prepare a brief outline of the day's accomplishments on a flip chart or overhead, and prepare to share it (orally) with the group. Also develop a to-do list. In the Concept Guide, review the Monitoring the Phases of PATCH section of Chapter 6. In this Meeting Guide, review the section on Evaluating the Community Group Meetings. Use a meeting evaluation method to obtain feedback from participants; for example, pass out an evaluation form and ask participants to complete it before they leave. ■

Discuss the tasks on the to-do list and ask for working group or volunteers to work on the tasks.

Have participants set a date for the next meeting.

Distribute the meeting evaluation sheet, and ask participants to fill it out and return it to you before they leave.

Thank group members for their participation.

Working group meetings

Preparation: Update or develop new task sheets for the working groups, as appropriate. ■

Encourage working groups to meet at least long enough to clarify tasks and to set a time and place to meet again.

Topics for Discussion After the Community Group Meeting for Phase V

The following are potential topics for discussion with partners and steering committee members, including working group chairpersons.

1. Discuss what happened during the community group meeting, including group dynamics and decisions made.
2. Review tasks to be done by working groups, partners, and others and determine training and technical assistance needs.
   - Discuss any problems or needs related to working groups.
   - Determine what assistance is needed by the working group that will design and carry out evaluation plans.
   - Determine how stakeholders will be kept involved and informed.
3. Review evaluation resources.
   - Review the Inventory of Collaborating Groups to identify potential involvement of local agencies and groups.
   - Network concerning evaluation with other states and communities using the PATCH process.
   - Identify local or state expertise in evaluation.
   - Explore resources available for evaluation from groups such as foundations.
4. Schedule regular communications with PATCH partners, community members, and working groups. Plan for distributing a summary of the community group meeting to attendees, partners, and others in the community.