Planned Approach to Community Health

Visual Aids

Community Group Meeting for Phase I: Mobilizing the Community

Overheads

PATCH Goal I-O-1

Five Phases of PATCH ..... I-O-2 or I-O-3

Phase I: Mobilizing the Community I-O-4

Phase II: Collecting and Organizing Data I-O-5

Phase III: Choosing Health Priorities I-O-6

Phase IV: Developing a Comprehensive Intervention Plan ..... I-O-7 and I-O-8

Phase V: Evaluating PATCH ..... I-O-9 and I-O-10

Percentage of Deaths Due to Leading Causes I-O-11

Leading Causes of Death Among Adults Aged 45–64, Shelby County, Tennessee, 1988 ..... I-O-12

Mortality Rates for Three Causes of Death Among Black Men Aged 45–64 Years, Shelby County, Tennessee, 1988 ..... I-O-13

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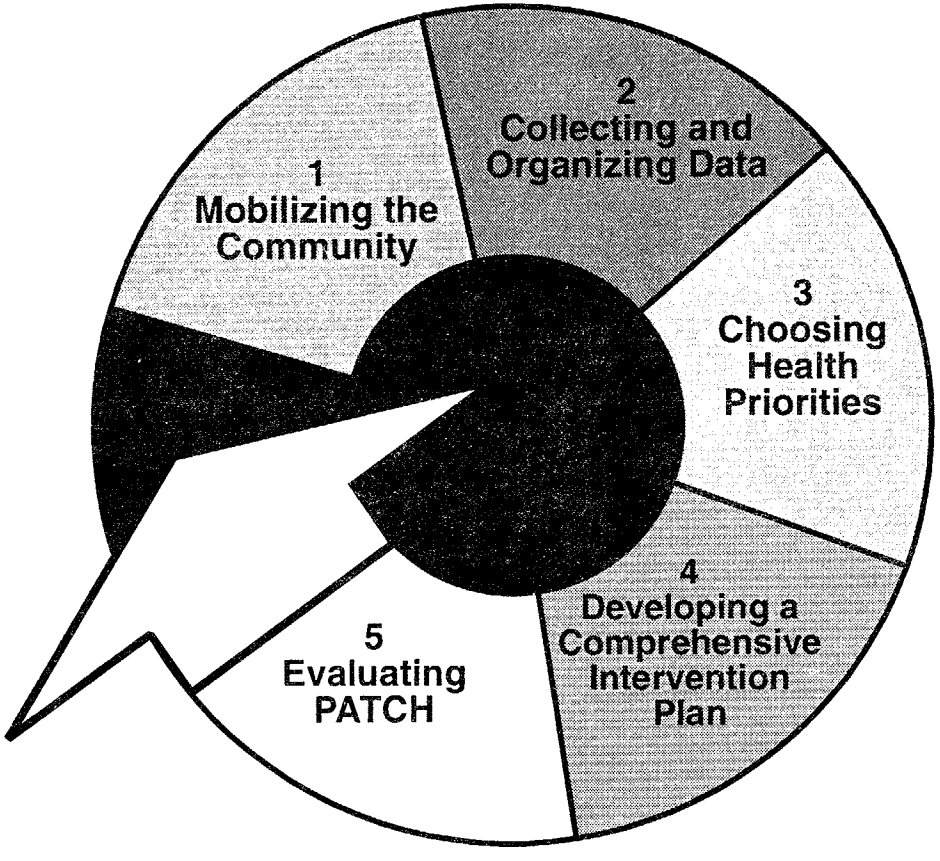
Interview Tips I-O-21

PATCH Goal

To promote health and quality of life by preventing and controlling disease, injury and disability.

Five Phases of PATCH



Five Phases of PATCH

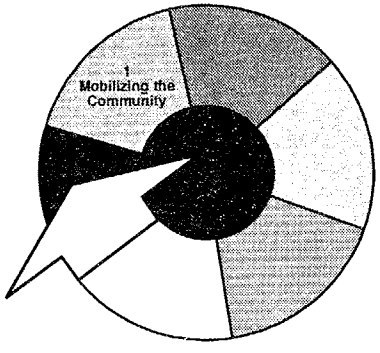
I. Mobilize the community

II. Collect and organize data

III. Choose health priorities

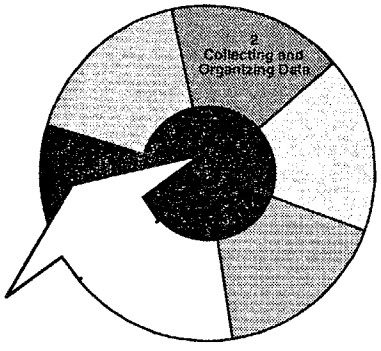
IV. Develop comprehensive intervention plan

V. Evaluate PATCH and interventions



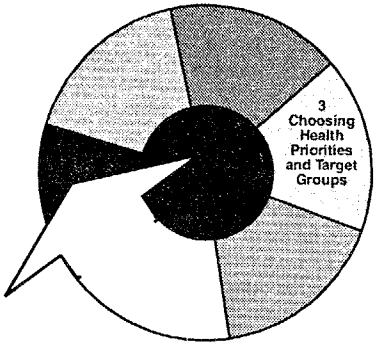
Phase I
Mobilizing the Community

- Define the PATCH community
- Complete community profile
- Publicize PATCH to the community
- Organize the community group and the steering committee
- Conduct the first community group meeting
- Form working groups



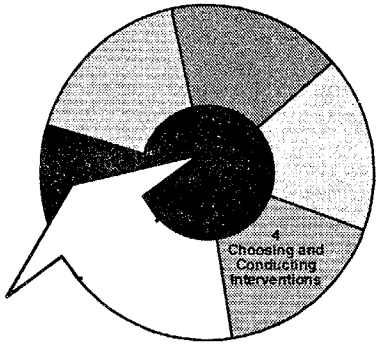
Phase II
Collecting and Organizing Data

- Obtain mortality, morbidity, behavioral and opinion data
- Analyze data
- Present data to the community group
- Identify health priorities
- Identify additional data needs
- Identify ways to share data with the community



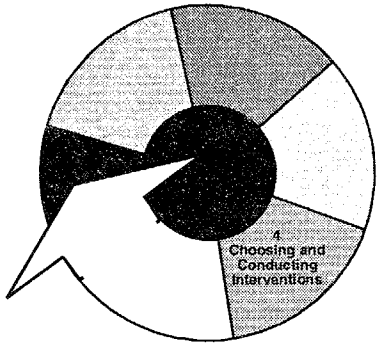
Phase III
Choosing Health Priorities

- **Present behavioral and additional data to the community group**
- **Choose health priorities**
- **Set community objectives**



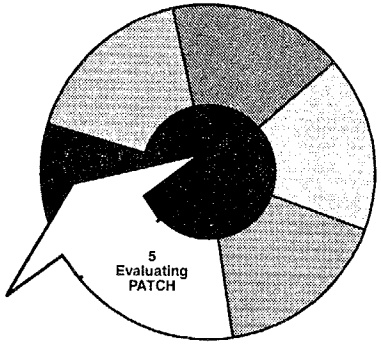
Phase IV
Developing a Comprehensive Intervention Plan

- Complete community resource inventory
- Develop community health promotion strategy
- Set behavioral objectives for intervention
- Select interventions
- Involve target groups



Phase IV Developing a Comprehensive Intervention Plan (continued)

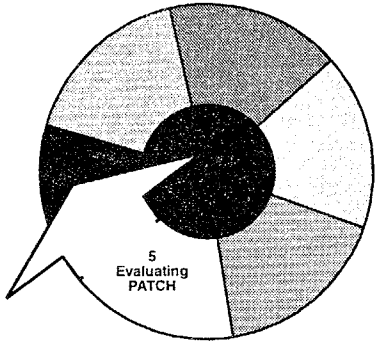
- **Develop an intervention and evaluation plan**
- **Prepare activity and master timetables for interventions**
- **Recruit and train volunteers**
- **Publicize interventions and their results**
- **Conduct interventions**



Phase V
Evaluating PATCH

Interventions

- Review behavioral objectives
- Set criteria for success
- Identify evaluation questions and data sources
- Collect and analyze data
- Use results to enhance interventions



Phase V
Evaluating PATCH
(continued)

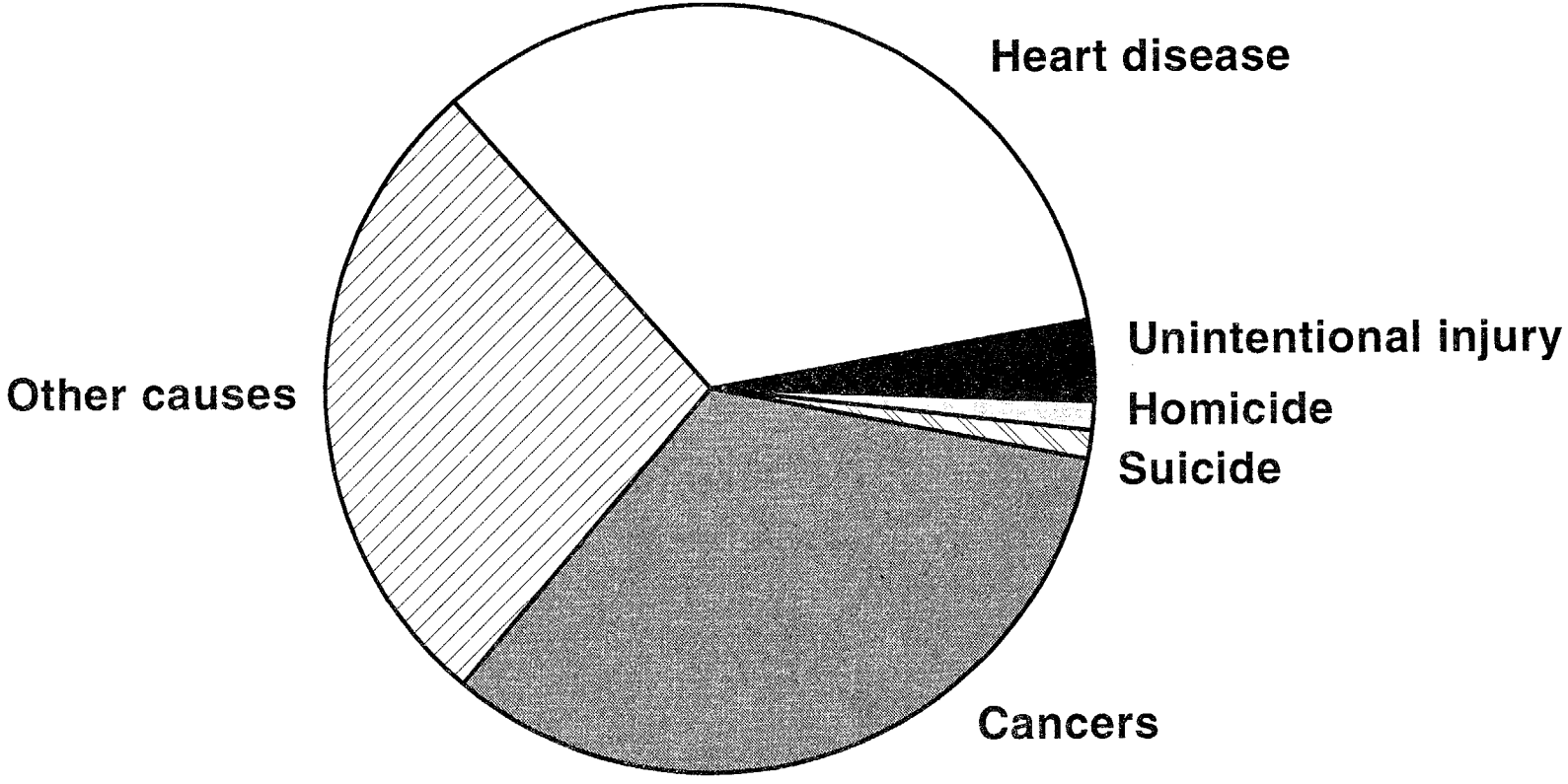
Process

- Assess progress in completing phases
- Monitor participation
- Determine effect of PATCH on the community
- Use results to improve process

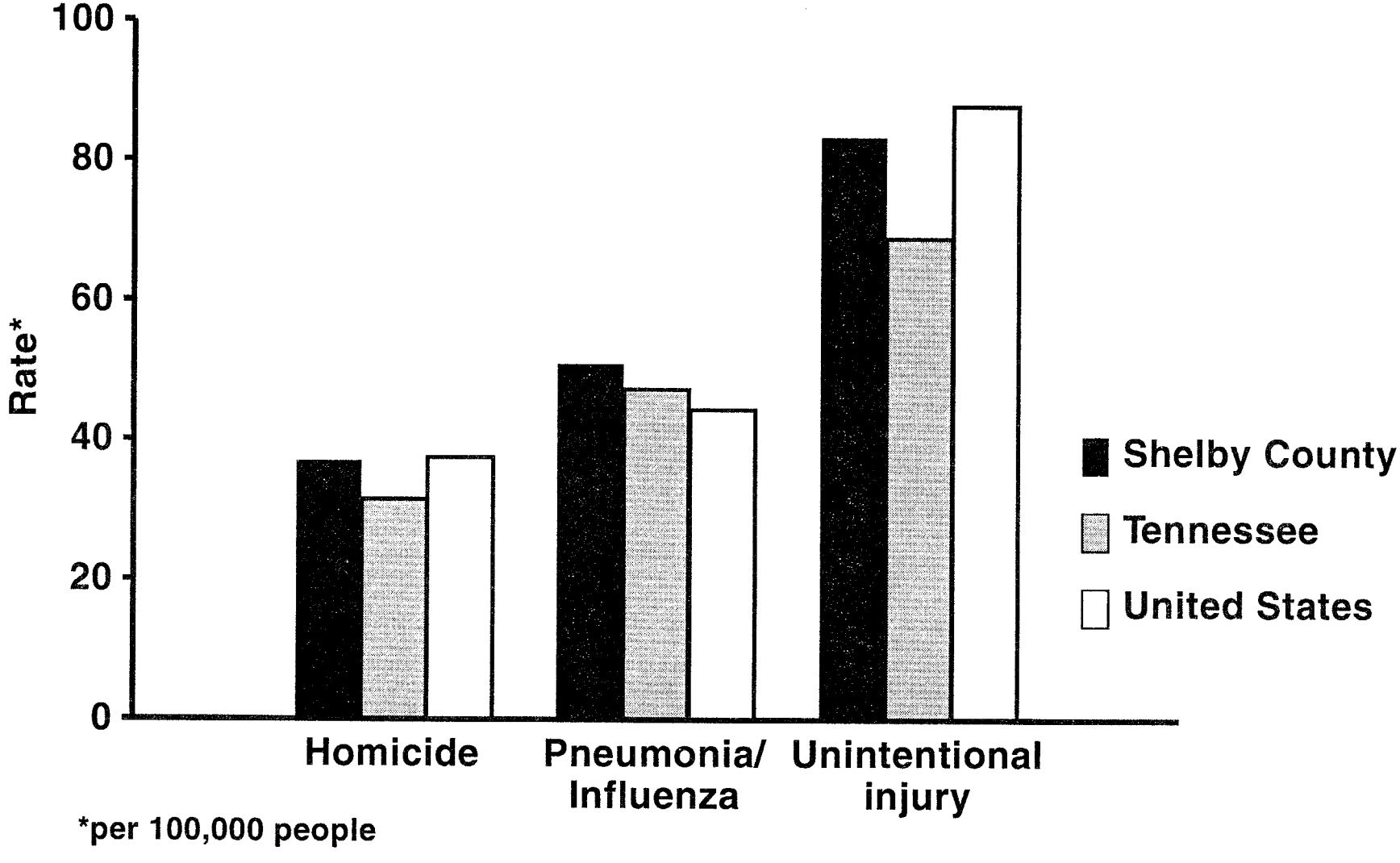
Percentage of Deaths Due to Leading Causes

Cause of death	Your guess	U.S. data 1990
Heart disease	_____	35%
Unintentional injuries	_____	5%
Cancer	_____	22%
Stroke	_____	7%

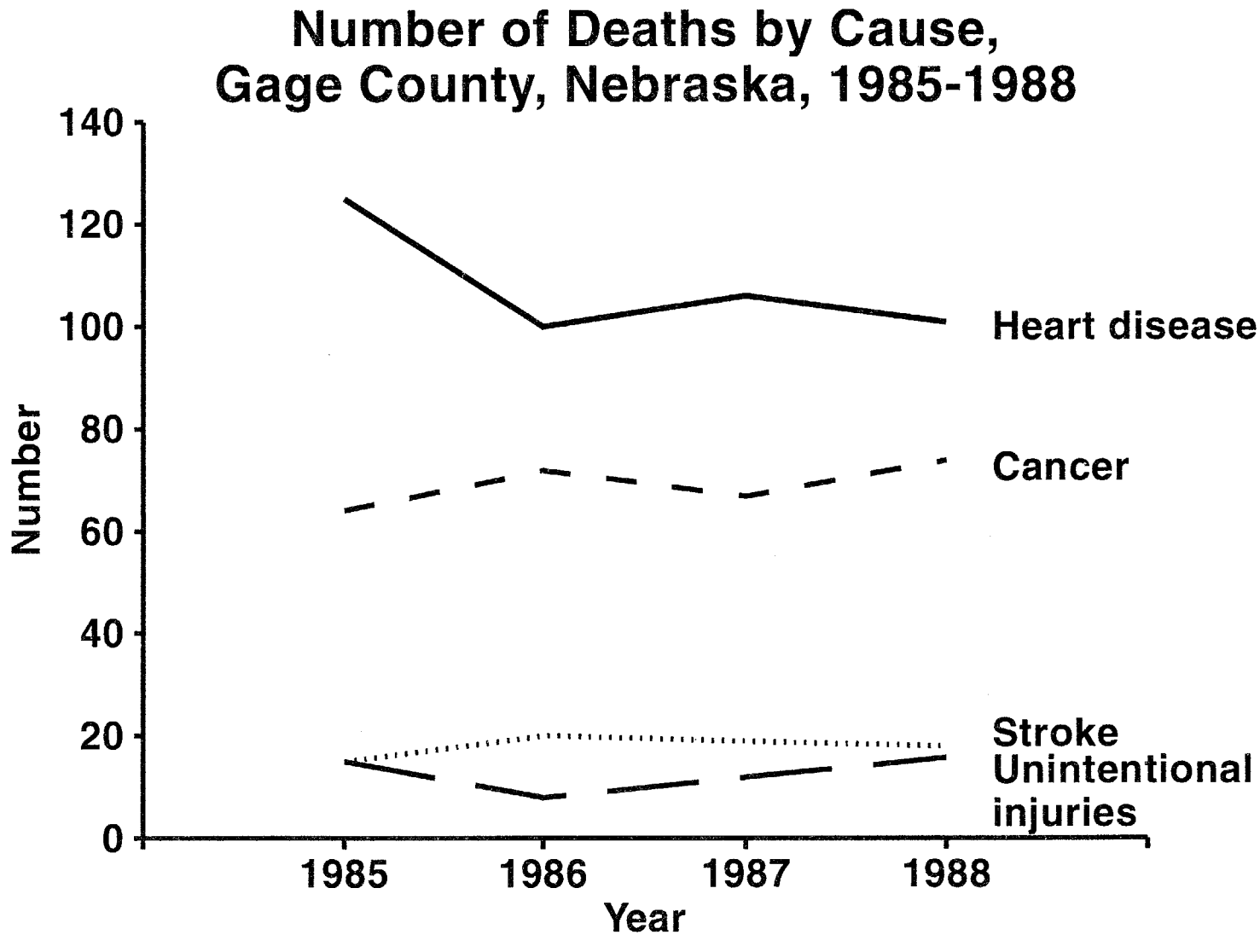
Leading Causes of Death Among Adults Aged 45-64, Shelby County, Tennessee, 1988

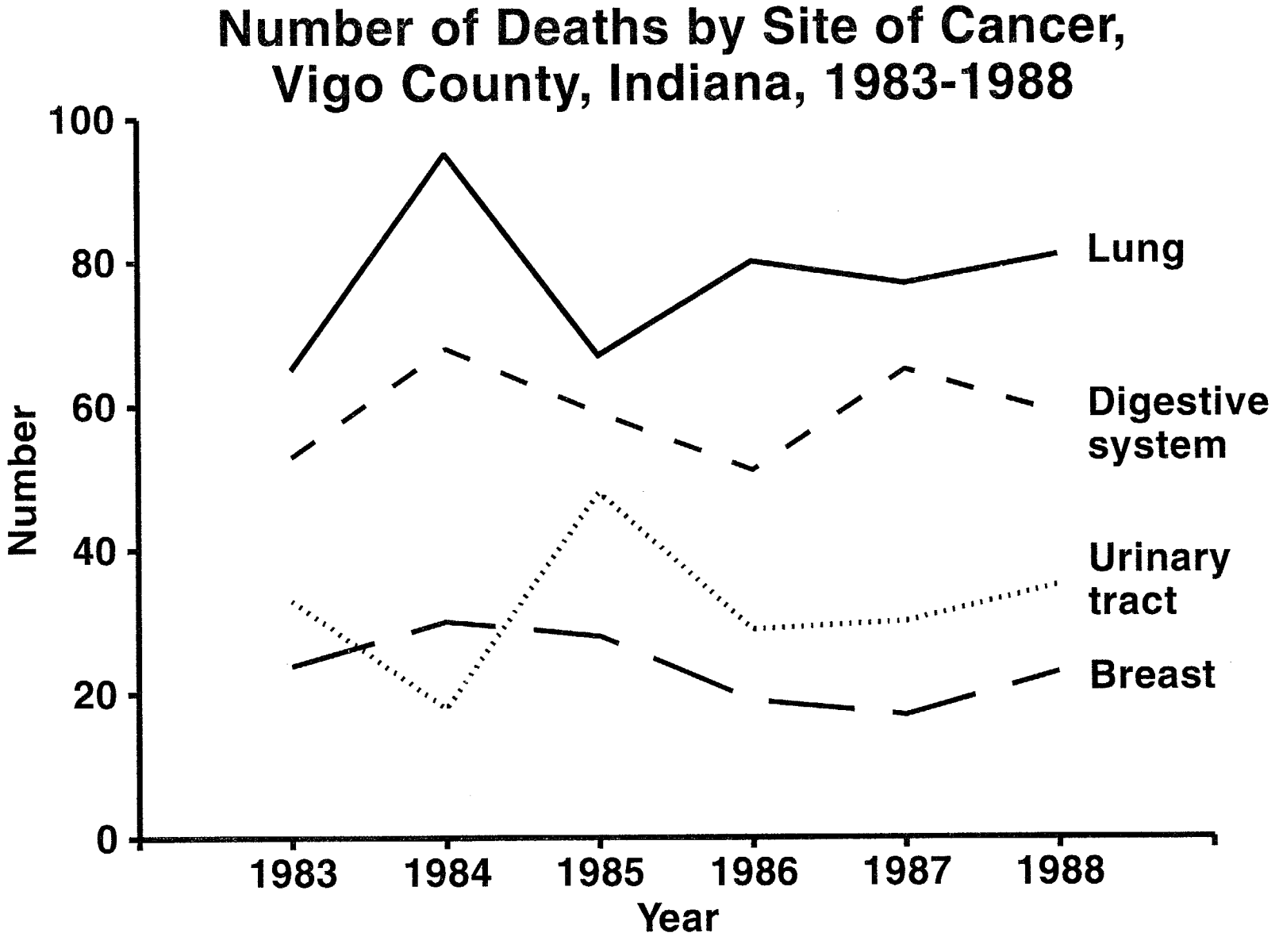


Mortality Rates for Three Leading Causes of Death Among Black Men Aged 45-64, Shelby County, Tennessee, 1988



*per 100,000 people


Number of Deaths by Cause,
Gage County, Nebraska, 1985-1988
140
120
100
80
60
40
20
0
Number
1985
1986
1987
1988
Year
Heart disease
Cancer
Stroke
Unintentional injuries


Number of Deaths by Site of Cancer,
Vigo County, Indiana, 1983-1988
100
80
60
40
20
0
Number
1983
1984
1985
1986
1987
1988
Year
Lung
Digestive system
Urinary tract
Breast

Leading Causes of Death, United States

1900	1990
Pneumonia/influenza	Coronary heart disease
Tuberculosis	Cancer
Diarrheal disease	Stroke
Coronary heart disease	Injuries
Stroke	Bronchitis, emphysema,
Kidney disease	Pneumonia/influenza
Injuries	Diabetes
Cancer	Suicide
	Cirrhosis
	Homicide

Percentage of Adults* at Risk

Risk factor	Your guess	State data	National data %
Obesity (120% or more of ideal weight)	_____	_____	23
Smoking	_____	_____	23
Alcohol use (60 or more drinks per month)	_____	_____	9
Seatbelt nonuse (seldom or never)	_____	_____	26

*Aged 18 years or older.

Behavioral Risk Factor Survey Items

- Seatbelt nonuse
- High blood pressure
- Lack of physical activity
- Poor diet
- Tobacco use
- Alcohol misuse

Reason for BRFSS Data Items

Linked to at least 1 of 10 leading causes of death

Describe current personal behaviors

Amenable to health promotion

Can be self-reported

Opinion Leaders

Hold positions of power

Have a reputation for getting things done

Are active in community organizations

Are formal or informal neighborhood leaders

Interview Tips

Introduce yourself, PATCH, and its purpose.

Ask permission if you plan to use a recorder.

Ask questions as written and in order.

Let the interviewee talk 90% of the time.

Probe for more information but keep to the subject.

Remain unbiased.

Thank the interviewee.

Write up the interview promptly.

Community Group Meeting for Phase I: Mobilizing the Community

Handouts

Agenda . . . . . To be developed
PATCH Program Summary I-H-1
Inventory of Collaborating Groups (Optional) I-H-2
Communitywide Opinion Survey I-H-3
Community Leader Opinion Survey I-H-4
Making an Interview Appointment I-H-5
Interview Introduction I-H-6
Description of Respondent I-H-7
Interview Self-Assessment I-H-8
Guidelines for Interviewers I-H-9
Task Sheet: Public Relations Working Group–Media Channels Worksheet . . I-H-10
Sample PATCH Logos I-H-11
Task Sheet: Mortality and Morbidity Data Working Group–Responsibilities . . I-H-12
Task Sheet: Opinion Survey Working Group–Responsibilities I-H-13
Task Sheet: Behavioral Data Working Group–Responsibilities: Preparing for a Behavioral Survey to be Completed by Community Volunteers I-H-14
Task Sheet: Behavioral Data Working Group–Responsibilities: Preparing for a Behavioral Survey to be Completed by Contractor I-H-15
Task Sheet: Behavioral Data Working Group–Description of Point-in-Time Behavioral Risk Factor Survey I-H-16
Task Sheet: Public Relations Working Group–Goals I-H-17
Task Sheet: Evaluation Working Group I-H-18
Meeting Evaluation Form . . . . . To be developed

Planned Approach to Community Health

Program Summary

PATCH Program Summary

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, the PATCH planning process 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 activities targeted toward priority health problems. CDC promotes the use of PATCH in helping achieve the year 2000 national health objectives. 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.

Background of PATCH

PATCH was developed in the mid-1980s by 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, 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 links 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 to the public and private sectors on the application of PATCH. Presently, most state health departments have staff trained in 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, 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.

- *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 issues 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 select health priorities and develop and evaluate program activities.

- *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 modifications, 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 improvement.*

  Timely feedback is essential to the people involved in the program. Thorough 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.

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, 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 (i.e., vital statistics and survey) and qualitative data (i.e., opinions of community leaders). Community 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 the health priorities. 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 each phase of the process and to monitor and assess PATCH intervention activities. 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 community membership for your community group while identifying and including community members or agencies who have a special interest in the specific health issue. Modify the forms provided in this guide 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 selected. 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.

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							

Communitywide Opinion Survey

1. Where do you usually go for health information?

   _____ Friends

   _____ Health department

   _____ Magazines or other publications

   _____ Pharmacist

   _____ Private doctor or health professional

   _____ TV or radio

   _____ Other:

2. From the list below, choose three areas that you believe should receive more emphasis in the community than they do now. Rank them 1, 2, and 3, where 3 is the least emphasis.

   ___A. Alcohol misuse
   ___B. Cigarette smoking
   ___C. Cost of medical services
   ___D. Drug abuse
   ___E. Drunk driving
   ___F. Environment
   ___G. Health problems of older adults
   ___H. Heart disease
   ___I. Injuries (other than traffic injuries)
   ___J. Mental illness
   ___K. Unhealthy diet and weight control
   ___L. Physical inactivity
   ___M. Poverty
   ___N. Teen pregnancy
   ___O. Traffic injuries
   ___P. Unemployment
   ___Q. Violence
   ___R. Other:

3. Where do you go for health services–that is, nonemergency services?

   ___ Health department
   ___ Health maintenance organization
   ___ Hospital emergency room
   ___ Private physician
   ___ Walk-in clinic
   __ Other:_____

4. Which specific health services and health education programs or activities are most needed in our community?

5. How could the existing health services be improved?

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. Would you please suggest three other people I might talk with 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?

Making an Interview Appointment

My name is _____. I am a member of a group of citizens who are interested in improving the health of our community. We are undertaking a process developed by the Centers for Disease Control and Prevention in collaboration with state health departments and communities throughout the United States. This process is called PATCH, the Planned Approach To Community Health.

I am presently working with many other members of our community to identify health priorities and determine what we can do to improve the health of our community. I have volunteered to interview people–leaders like you–about the health problems of our community. Would you be willing to allow me 20 to 30 minutes of your time for a personal interview?

Which day and time would be the most convenient for you?

Where would you like to meet?

Thank you. I look forward to seeing you on _____
at _____. .

Interview Introduction

My name is _____. I am a member of a group of citizens here in _____who are interested in improving the health of our community. As I mentioned when I set up this interview, we are undertaking a process developed by the Centers for Disease Control and Prevention in collaboration with state health departments and communities throughout the United States. This process is called PATCH, the Planned Approach To Community Health.

I have volunteered to interview people–leaders like you–about the health problems of our community. Information from this interview will be used along with other health data to identify priority health concerns. We will then design programs to reduce these problems.

I would like to ask you a few questions. Everything you say will be kept anonymous; we will not be able to connect your name with your answers. However, I would like to put your name on a mailing list so that you will receive a summary of this survey and be invited to a meeting to discuss our community health problems. May I do that? ___ Yes ___ No

(If taping)

I would like your permission to tape our interview. You can stop the tape recorder at any time by pressing the pause button. Would taping our interview be all right? ___ Yes ___ No

Thank you for your time and your help.

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 survey coordinator.

1. Sex: ___Female ___Male
2. Race: ___White ___Black ___Hispanic
   ___American Indian or Alaska Native
   __Asian or Pacific Islander __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: _____

Interview Self-Assessment

Did I. . .

- introduce myself, PATCH, and the purpose of the survey?
- explain that responses are kept confidential?
- appear familiar with the questionnaire?
- wait for the interviewee to answer?
- clarify questions without making leading remarks?
- appear interested?
- understand all the interviewee's answers?
- probe for details or clarification?
- thank the interviewee?
- invite the interviewee to attend PATCH meetings?

Opinion Survey Working Group

Guidelines for Interviewers

The success of an interview depends greatly on the ability of the interviewer to communicate well with the person being interviewed and to keep the conversation on target. Guidelines for interviewers include the following.

1. Test your questionnaire before conducting interviews. Practice on people who are similar to your target group. These dry runs can be used to point out any difficulties in language or length of the interview.
2. Introduce yourself and PATCH to the respondent. Clearly state the purpose of the interview and that all information will be confidential. Results of the interviews will be reported for the group and not for individuals.
3. Interviewers must always be courteous and careful not to offend in any way. It is important not to do or say anything that could be regarded as judgmental. Reassure people that it is their opinions you want.
4. Do not allow the respondent to interview you. Turn questions around to clarify the respondent's position. If a respondent tries to solicit your opinion, you need to be polite, but move quickly on to the question you were asking.
5. Never try to reproduce the respondent's slang or dialect.
6. Know the reason for each question so that you can anticipate or recognize when a respondent has misinterpreted a question. Repeat or restate the question as needed to ensure that it is understood.
7. Be prepared to ask follow-up or probing questions to clarify a respondent's answer. Follow-up questions are especially valuable when a respondent sites a nonbehavioral risk factor as a health problem. For example, a respondent might state "the lack of recreational facilities." When asked "would you explain this further?" the respondent might state that teens are abusing drugs and alcohol because they have nothing to do. In this case, drug and alcohol abuse is the health problem, and the lack of facilities is perceived to be a contributor to the problem.
8. Respondent should do 90% of the talking.
9. Close the interview with thanks and casual conversation. Ask permission to contact the respondent in the future if needed.
10. Record the interview as soon as possible after completing the interview. You can take notes and write up the interview based on your notes, or you can tape record the interview. Before you tape an interview, get permission to record the interview, familiarize yourself with the mute or pause button, show the respondent the mute or pause button, and let him or her control the tape recorder.

Public Relations Working Group—Media Channels Worksheet

Identify by category the various media in your community.

Newspapers:

Radio stations:

TV stations:

Newsletters and bulletin boards (of businesses, churches, community groups, agencies, etc.):

Computer bulletin boards:

Flyer distribution points:

Identify other channels for information sharing besides the media.

Posters:

Bus cards:

Mailing lists:

School announcements:

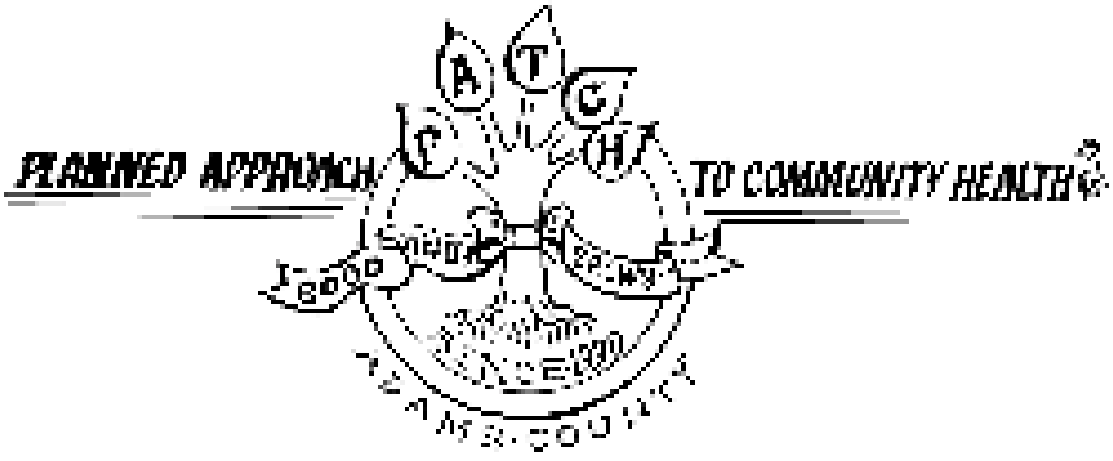
Billboards:

Ads in movie theaters:

Other:

Sample PATCH Logos

Planned Approach To Community Health



Mortality and Morbidity Data Working Group—Responsibilities

Review and revise the program documentation

- If the population or health problem to be addressed is preselected, determine the data to be collected and revise the program documentation accordingly.

Identify sources of 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 other sources of community data (e.g., motor vehicle collision reports and public health clinic records).

Prepare data for presentation

- Determine the best ways to express the data. Review the following terms, as appropriate: ICD codes, rates, frequency, prevalence, and incidence.
- Prepare the data for presentation to the community group. Review the Preparations for the Community Group Meeting section of Chapter 3 of the Concept Guide and develop a Mortality Data Packet.

Opinion Survey Working Group—Responsibilities

Finalize survey instrument

- Alter or add to the survey, especially when the population or health problem to be addressed has been preselected. Have someone experienced in instrument design review the modifications.
- Arrange for typing and printing.

Finalize the list of interviewees

- Make sure the people to be interviewed represent different segments of our community.

Select and train interviewers

Coordinate interviews

- Set a deadline for completing interviews.
- Assign interviewers to interviewees.
- Distribute copies of survey to interviewers and arrange for collecting the completed surveys.

Analyze data

- Tally responses. Simple rank the problems according to how often they are stated as being a problem. If similar responses are grouped together, do so in a reasonable and consistent fashion.
- Summarize results, and complete section VI of the program documentation.

Prepare and present a report of results for the community group

Behavioral Data Working Group—Responsibilities: Preparing for a Behavioral Survey to Be Completed by Community Volunteers

Finalize the survey instrument

- Determine if additions or modifications to survey are needed.
- Have the state coordinator review additions and changes.
- Arrange for state coordinator to have data tape edited and analysized.
- Arrange for analysis of additional questions.

Develop a sample

- Determine sample size.
- Generate telephone prefixes and suffixes.
- Obtain a list of telephone numbers.

Collate questionnaire materials

- Code questionnaires before printing.
- Arrange for printing.
- Number questionnaires after printing.

Coordinate interviews

- Select interviewers.
- Arrange interviewer training.
- Ensure monitoring of interviews.

Coordinate logistics

- Set a deadline for completing interviews.
- Arrange for space.
- Secure telephones and lines.

Arrange for analysis

- Arrange for data entry.
- Submit data tape to the state for editing and analysis.
- Prepare written and oral summaries for presentation.

Behavioral Data Working Group—Responsibilities: Preparing for a Behavioral Survey to Be Completed by the Contractor

Finalize the survey instrument

- Determine if additions or modifications to survey are needed.
- Have the state coordinator review additions and changes.
- Arrange for analysis of additional questions.

Develop a sample

- Determine sample size.
- Generate telephone prefixes and suffixes.
- Obtain list of telephone numbers.

Prepare for a contractor

- Screen list of telephone numbers.
- Make arrangements with contractor or assist state in making arrangements.
- Prepare written and oral summaries for presentation.

Behavioral Data Working Group—Description of Point-in-Time

Behavioral Risk Factor Survey

Method	Telephone survey using randomly selected banks of telephone numbers.
Sample	400–800 questionnaires completed for adults (aged 18 years or older) representative of the community by age, sex, race, and geographic location.
Survey Period	Three to 5 months, including 4–6 weeks for planning; 2–3 weeks for interviewing; 4–8 weeks for entering, editing, and processing data; and 2 weeks for analyzing data.
Interview Schedule	10 minutes to conduct a full interview. 1.5 interviews completed per hour. 800 interviews require 520 hours (10 interviewers working four hours per day for 13 days). Best times to interview are 2 p.m. to 9 p.m. weekdays, 10 a.m. to 2 p.m. Saturdays, and 2 p.m. to 6 p.m. Sundays.
Personnel	Eight to 12 interviewers (at least one man) Required who have a good telephone personality and who will follow instructions. One supervisor to manage logistics. One editor to check for errors and missing information. One monitor to ensure that interviews are performed correctly.
Preparation	Create list of valid telephone prefixes. Create list of random telephone numbers (screened for businesses and nonworking numbers). Train interviewers in coding and numbering questionnaires.
Data	Enter data and work with state health processing department or professional survey group to edit core and analyze core questionnaire responses. Analyze any added questions.
Supplies and pencils.	Telephones and telephone lines, questionnaires,

Public Relations Working Group—Goals

Communicate

- Get as many people as possible involved in PATCH planning and interventions.
- Keep in touch with community leaders.
- Keep in touch with the community group and the steering committee.
- Recruit individual volunteers and organized groups to help with special tasks.

Publicize

- Collect information from PATCH working groups.
- 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.
- Disseminate health information through multiple communication channels (see "Media Channels Worksheet").

Create a community identity

- Coordinate the design of a PATCH logo and its use on materials.
- Help to publish and distribute a PATCH newsletter.

Evaluation Working Group

- Ask PATCH participants and partners what information they need and what type of evaluation would be appropriate.
- Serve as a resource for the steering committee, the working groups, and the entire community group.
- Provide technical assistance for collection and analysis of process and impact data.
  - Ensure that intervention objectives are written so that accomplishments can be measured.
  - Assist with developing written evaluation plans.
  - Determine criteria for success.
  - Determine evaluation questions.
  - Determine data sources.
- Help improve programs by incorporating evaluation results.

Community Group Meeting for Phase II: Collecting and Organizing Data

Overheads

Goals of Meeting II-0-1

Five Phases of PATCH . . . . . I-O-2 or I-O-3

Phase II: Collecting and Organizing Data I-O-5

List of Health Problems II-0-2

Mortality Data Packet . . . . . To be developed

Morbidity Data Packet . . . . . To be developed

Opinion Data Packet . . . . . To be developed

Meeting Goals of Phase II

- To analyze mortality, morbidity, and opinion data
- To begin to identify leading health problems in community

List of Health Problems

Cause of Death and Disablity	Risk Factor	
	Behavioral	Nonbehavioral

Community Group Meeting for Phase II: Collecting and Organizing Data

Handouts

Agenda . . . . . To be developed

List of Health Problems II-H-1

Mortality Data Packet . . . . . To be developed

Morbidity Data Packet . . . . . To be developed

Opinion Data Packet . . . . . To be developed

Meeting Evaluation Form . . . . . To be developed

List of Health Problems

Cause of Death and Disablity	Risk Factor: Behavioral	Risk Factor: Nonbehavioral

Community Group Meeting for Phase III: Choosing Health Priorities

Overheads

Five Phases of PATCH . . . . . I-O-2 or I-O-3

Phase III: Choosing Health Priorities I-O-6

Meeting Goals III-O-1

List of Health Problems II-O-2

Behavioral Data Packet . . . . . To be developed

Criteria for Determining Priority III-O-2

Ways to Assess Importance III-O-3

Ways to Assess Changeability III-O-4

Setting Priorities: Importance and Changeability III-O-5

Objectives are SMART III-O-6

An Objective States III-O-7

Community Objective III-O-8

Behavioral Objectives III-O-9

Target Groups III-O-10

Existing Community Programs/Policies Matrix III-O-11

Meeting Goals for Phase III

- **To review behavioral data**
- **To add to “List of health problems”**
- **To determine priority health problems, risk factors, and target groups**
- **To set community objectives**

Criteria for Determining Priority

Importance

- **Change will make a difference**
- **Health problem has serious consequences for the community**

Changeability

- **Behavior can be voluntarily changed**

Ways to Assess Importance

Is behavior widespread?

Is prevalence higher than that for the state or nation?

Are the consequences serious?

Are behavior and problem closely related?

Ways to Assess Changeability

Behaviors still in developmental stages

Behaviors superficially tied to lifestyle

Behaviors successfully changed in other programs

Literature suggests behavior can be changed

Setting Priorities

	Important	Less Important
Changeable		
Less Changeable		

Objectives are:

- **Specific**
- **Measurable**
- **Achievable**
- **Realistic**
- **Time bound**

An Objective States:

Of what

By when

Where

To whom

How much

Community Objective: An Example

By 1990, the rate of deaths from motor vehicle injuries will decrease from 32/100,000 (1985 rate) to 28/100,000 for X county residents.

Behavioral Objective: An Example

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

Target Groups

Curative approach: Select the group with greatest problem or risk.

Preventive approach: Select the group that has not yet developed the behavioral risk factors.

Cost-effective approach: Select the group that would yield the most results with the fewest resources.

Greatest need approach: Select the group that is most neglected or needs the most help.

Existing Community Programs/Policy Matrix

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

Community Group Meeting for Phase III: Choosing Health Priorities

Handouts

Agenda . . . . . To be developed

Contributors to Leading Causes of Death III-H-1

Behavioral Data Packet. . . . . To be developed

List of Health Problems II-H-1

Existing Community Programs/Policies Matrix III-H-2

Target Group Profile III-H-3

Behavioral Objectives for the Nation. III-H-4

Meeting Evaluation Sheet . . . . . To be developed

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

Table 3

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					

Target Group Profile

In addition to targeting the community at large, you may also want to target a subgroup within the community.

There are many considerations to weigh when deciding which group(s) within the community should be the focus of interventions.

If we take the **Curative** approach, we would focus on the group that seems to have the greatest problem or be at greatest risk.

With the **Preventive** approach, we would look at the group that has not yet developed patterns of behavior involving the risk factors.

The most **Cost-Effective** approach would require us to put our efforts where the fewest resources would yield the most results.

And by the **Greatest Need** approach, we would look at the most neglected group or the one most in need of help.

Take a few minutes and write down your own, personal answers to the following questions. Then we'll discuss the questions and try to reach a consensus about the target group for our first intervention.

For the health problem we have selected, which group(s) seems to be at greatest risk?

Which group(s) would be the easiest to reach?

Most difficult to reach?

Which group would we be likely to have the most influence on?

Other observations about the target group(s):

Behavioral Objectives: Examples

The objectives for the nation which are found in the publication *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* can be useful to communities as they try to establish realistic behavioral objectives. Here are a few examples.

Hypertension

By the year 2000, increase to at least 50 percent the proportion of people with high blood pressure whose blood pressure is under control. (National baseline: 11 percent controlled among persons aged 18 through 74 in 1976-1980; an estimated 24 percent for persons aged 18 and older in 1982-1984.)

Obesity

By the year 2000, reduce overweight to a prevalence of no more than 20 percent among persons aged 20 and older and no more than 15 percent among adolescents aged 12 through 19. (National baseline: 26 percent for persons aged 20 through 74 in 1976-1980, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12 through 19 in 1976-1980.)

Physical Activity

By the year 2000, increase to at least 30 percent the proportion of persons aged 6 and older who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day. (National baseline: 22 percent of persons aged 18 and older were active for at least 30 minutes 5 or more times per week and 12 percent were active 7 or more times per week in 1985.

Smoking

By the year 2000, reduce cigarette smoking to a prevalence of no more than 15 percent among persons aged 20 and older. (National baseline: 29 percent in 1987, 32 percent for men and 27 percent for women.)

Community Group Meeting for Phase IV: Developing a Comprehensive Intervention Plan

Overheads

Five Phases of PATCH . . . . . I-O-2 or I-O-3

Phase IV: Developing a Comprehensive Intervention Plan . . . . . I-O-7 and I-O-8

Community Goals and Objectives . . . . . To be developed

Meeting Goals . . . . . To be developed

Contributing Factors (Table 1 of Checklist) IV-O-1

Involving the Target Group: Why IV-O-2

Involving the Target Group: When IV-O-3

Involving the Target Group: How IV-O-4

Health Promotion Strategies IV-O-5

Program Settings IV-O-6

Activities that Match the Contributing Factors IV-O-7

Existing Community Programs/Policies Matrix: Example IV-O-8

Quote from Van Goethe IV-O-9

Diffusion Curve IV-O-10

PATCH Master Timetable (also in Checklist) IV-O-11

PATCH Activity Timetable (also in Checklist) IV-O-12

Table 1

Contributors to the Risk Factor

Behavioral Risk Factor:

Target Group:

List the factors that may contribute to whether or not member of the target group has the behavioral risk factor listed above.

Contributors

Contribute to positive behavior (absence of risk factor)	Contribute to negative behavior (presence of risk factor)
Motivators	Motivators
Enablers	Enablers
Rewards	Rewards

Involve the Target Group

Why:

- **current attitudes and knowledge**
- **appropriateness of an intervention**
- **ideas about what may work**

Involve the Target Group

When:

- in learning what encourages participation:
  - type of activity
  - time and place
  - transportation
  - incentives (child care)

- in reviewing materials:
  - messages and slogans
  - fliers and posters
  - credibility of messages and sources

- during and after the intervention
  - feedback
  - making changes

Involve the Target Group

How:

- face-to-face interviews
- questionnaires
- focus groups

Health Promotion Strategies

Educational: to change values, beliefs, attitudes, opinions, and behaviors

Policy: to encourage adherence to healthy behavior and discourage unhealthy behavior

Environmental: to make the environment safe to encourage healthy behaviors

Program Settings

School

Worksite

Healthy care system

Community

Activities that Match the Contributing Factors

Cause of Death: **Cancer**

Risk Factor: **Smoking**

Target Group: **Pregnant Women**

Factor	Example	Interventions
Motivators:	does not know affect on fetus	education, counseling
Enablers:	lacks skills for quitting	cessation programs
Rewards:	spouse smokes friends smoke	cessation programs bans in public places

Existing Community Programs and Policies: Example
Risk Factor: Driving Under the Influence
Target group: 18 - 34 year olds

	School (students)	Worksite (employees)	Health Care (patients)	Community (groups)
Education –Communication	Driver Ed. component (M/E)		Patient education (M)	Media campaign (M/E)
–Training	How to say "no" (E)	Employee Assistance Program (E)	Addiction clinics (E)	
Legislative/ Regulatory Policies	No alcohol on premises (E)	No alcohol at school functions (R)		Ban happy hours Strict DUI laws (R)
Environmental Measures		Nonalcoholic recreational activities (E)		Ban billboard alcohol ads (R) happy hours (R)

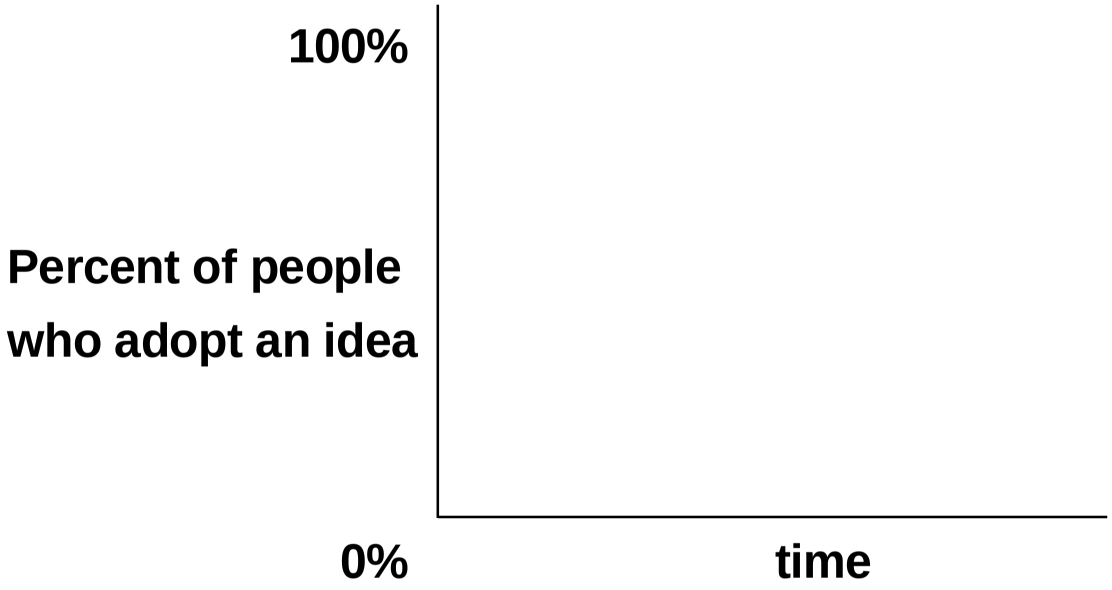
M = motivators E = enablers R = rewards

"Whatever you can do,
or dream you can,
begin it.

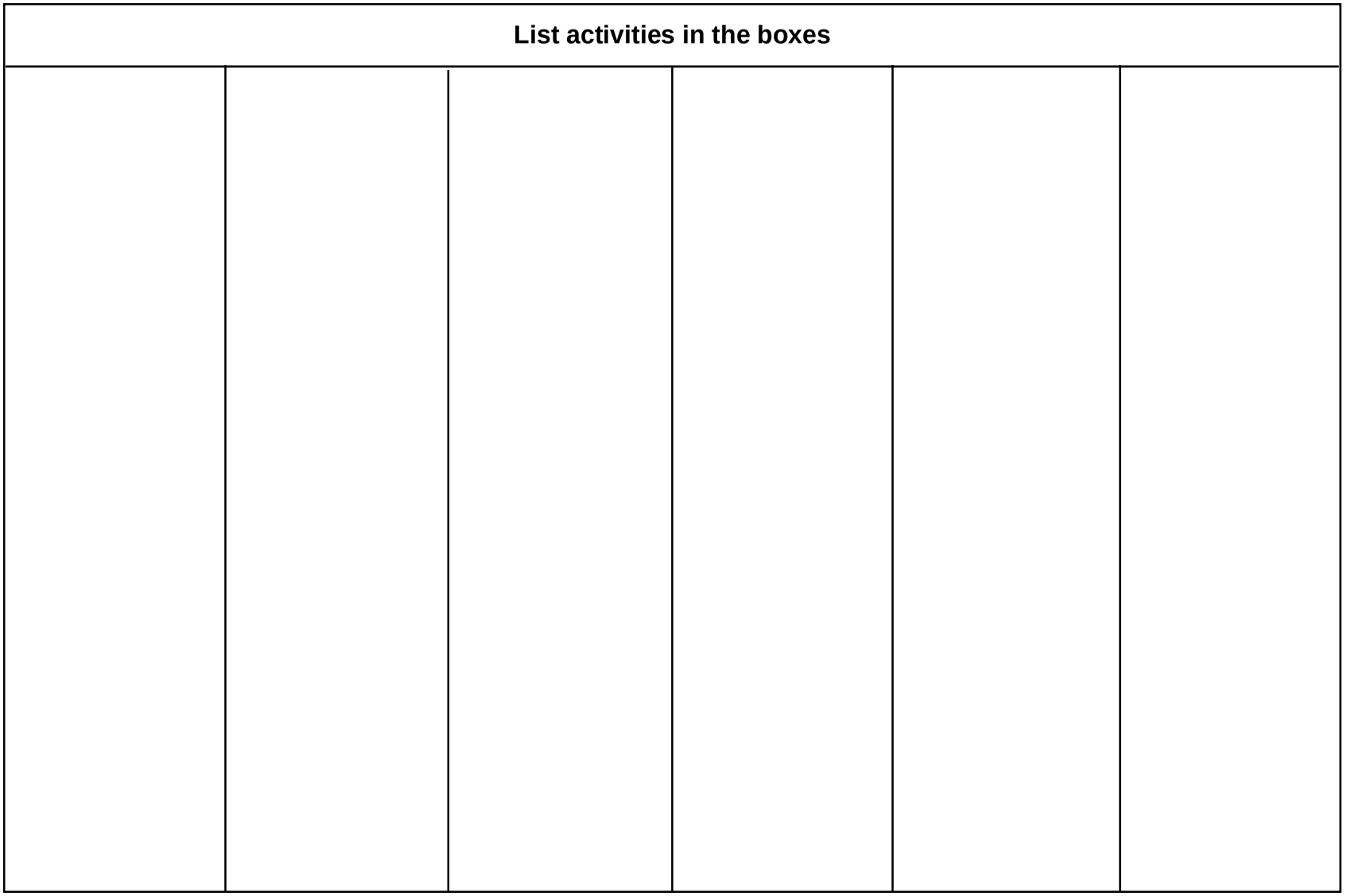
Boldness has genius,
Power, and magic In It."

-Johann Wolfgang van Goethe

Diffusion Curve



PATCH Master Timetable



PATCH Activity Timetable

Risk Factor: _____

List activities in the boxes					
Jan/Feb	**Mar/April**	**May/June**	**July/Aug**	**Sept/Oct**	**Nov/Dec**

Community Group Meeting for Phase IV: Developing a Comprehensive Intervention Plan

Handouts

Agenda . . . . . To be developed

Checklist IV-H-1

Types of Contributing Factors IV-H-2

Contributors to the Risk Factor IV-H-3

Priority Risk Factors and Intervention Methods IV-H-4

Existing Community Programs/Policies Matrix III-H-2

Community Resource Inventory IV-H-5

Stages of Change IV-H-6

PATCH Work Plan: Example IV-H-7

PATCH Work Plan (blank) IV-H-8

Task Sheet: Obtaining Information from the Target Group IV-H-9

Task Sheet: Individual Interviews IV-H-10

Task Sheet: On-the-Spot Interviews IV-H-11

Task Sheet: Questionnaries IV-H-12

Task Sheet: Focus Group Interviews IV-H-13

Checklist for Designing a Successful Intervention

This document provides tools for examining a health problem and related risk factor (e.g., smoking, physical inactivity, poor nutrition) and designing effective community intervention activities. Additional information on how to complete and use this document is provided in Chapter 5 of the PATCH Concept Guide. This document is divided into the following sections:

- Introduction
- Determine contributing factors
- Identify existing programs and policies
- Obtain support in the community
- Involve the target group
- Determine potential barriers and solutions
- Set intervention goal
- Set specific objectives
- Develop work plan and timetables
- Assess resource needs
- Identify and train workers
- Develop the evaluation plan
- Use evaluation results

Introduction

This checklist provides practical guidelines for those involved with planning effective interventions. Obviously, it cannot cover all contingencies, but we do hope that it helps you to:

- develop an intervention that is appropriate for your target group.
- develop an intervention and evaluation plan for use when generating community support and resources.

When planning a community-based health promotion program, you may wish to target various groups: the community at large and a specific group such as teenagers, older adults, workers, pregnant women, sixth graders, etc.

NOTE: You will need to complete a copy of this checklist for each risk factor and for each group being targeted. Sections 3-12 will need to be completed for each activity being planned.

Please list:

the health problem:

the risk factor:

the target group:

to be addressed by this guideline.

List the intervention working group members (names, telephone numbers, times available):

Name	Phone Number	Times Available

1. **Determine contributing factors**

   List the factors that influence the presence or absence of the risk factor in the target group. Complete Table 1. Identify the factors as to whether they are motivators, enablers, or rewards.

Table 1. Contributing Factors

Risk Factor:

Target Group:

+ Contributes to Absence of Risk Factor	- Contributes to Presence of Risk Factor

2. **Identify existing programs and policies**

A. Fill in names of existing programs and policies that address the risk factor and target audience you have selected. Complete Table 2. (You may use another copy of Table 2 to list programs that address a particular contributing factors (i.e., motivators, enablers, or rewards) that you hope to address in your target group.)

Table 2. Existing Community Programs and Policies Matrix

Risk Factor: **Target Group:**

	School (Students)	Worksite (Employees)	Health Care (Patients)	Community (Groups)	Other
Education –Communication					
–Training					
Legislative/ Regulatory Policies					
Environmental Measures					

B. Develop a Community Resource Inventory by adding information on key items listed in Table 2 into Table 3.

Table 3. Community Resource Inventory

Organization (name, contact person, address, telephone number)	Services (type and quality); Policies	Numbers Served

C. Determine the priority intervention activities to be under taken by your PATCH program:

NOTE: You may need to complete a set of the following pages for EACH major intervention activity you address.

Please list the activity:

3. **Obtain support in the community**

Have you identified the necessary contacts within the community (see Inventory of Collaborating Groups in Chapter 2 of the Concept Guide) that need to be informed (in writing, telephone contact, or both) of your proposed intervention? Also you should identify gatekeepers of the target group (e.g., counselors at the YMCA) who need to be involved and whose endorsements need to be solicited.

If so, who are they? How are they willing to collaborate to reach the target group (e.g., provide donations, materials, grants, volunteers, staff time, facilities, letters of support, or endorsements)? Enter information on Table 4.

Table 4. Collaborative Groups

Community Organizations	Contact Persons (name, address, telephone)	Form of Endorsement or Collaboration

4. **Involve the target group**

The target group is your best source for determining how to make an intervention appropriate and effective. There are times when your target group is not the focus of your intervention. You may, for example, target 18-34 year olds who drink and drive by designing interventions to train bartenders. The bartender would be your intervention group or intermediate target group. Although this document may refer to the "target group," substitute the word "intervention group" where appropriate.

A. Has the target group expressed an interest in addressing this health problem or risk factor? If so, cite the sources.

B. If the need has not been documented, will surveys and needs assessments be carried out?

   By whom?

   How and when?

C. How have members of the target group been involved in the development of your program (involved as key informants, in focus groups, etc.)? Describe.

D. What additional involvement of the target group is planned?

E. Is the target audience interested in group, individual, or combination activities?

F. What are the current levels of awareness and knowledge about this health problem and risk factor within the target audience?

G. Has the target group expressed an interest in changes in policies or environmental measures related to the health problem being addressed? If so, specify.

5. **Determine potential barriers and solutions**

A. Are there social, psychological, or cultural barriers (e.g., community taboos, values, social relationships, official disapproval)? Is the intervention group receptive?

How do you know?

What barriers to participation are most frequently mentioned by your intervention group?

B. Are there communication barriers (e.g., illiteracy, policies of local media)?

C. Are there economic and physical barriers (e.g., inability to pay, transportation)? Are there medical or other limitations to participation? Specify.

D. Are there legal and administrative barriers (e.g., agency policies, allocated resources)?

E. Is it likely that sufficient resources will be available to carry out the intervention? (You may want to review Section 9 on funding.)

F. Will the intervention compete unnecessarily with existing services? Specify.

G. How do you plan to overcome these barriers (e.g., change service time, provide transportation, or use specially trained personnel)?

6. **Set intervention goal**

Summarize the main purpose of the intervention activity:

7. **Set specific objectives**

A. What specific behaviors, conditions, policies or environmental measures are you expecting to change?

B. Specify your intervention objective stating how much of what change will occur and by when.

C. As appropriate, specify your objectives concerning changes in:

awareness

knowledge

attitudes

behaviors

skills

policies

environmental measures

8. **Develop work plan and timetables**

A. Develop a plan for intervention preparation, delivery, follow-up, and evaluation using the enclosed **PATCH Work Plan.**

B. Develop a timetable for your intervention activity using the following Activity Timetable. Mark on your timetable any major events that you hope to coordinate or "piggy-back" with major national events (Great American Smokeout, National Nutrition Month) or state events (state physical activity week) or local events (spring festival). Also the time frames for all activities concerning this risk factor should be put onto one timetable to ensure coordination and distribution of the activities in such a way they will not overwhelm either the community or the working groups.

Activity Timetable

Risk Factor:_____

List activities in the columns

January/February	March/April	May/June	July/August	September/October	November/December

IV-H-1

B. Is this intervention activity coordinated with PATCH strategies that are addressing other risk factors? Develop a Master Timetable by combining the Activity Timetables that address individual risk factors or target groups. (Use the Master Timetable form located at end of Section 8.) Individual activity timetables may need to be altered to ensure coordination of activities and to guard against competition between activities and overwhelming either the community or the working groups. If multiple risk factors are being addressed in your community, you may want to emphasize activities concerning a particular risk factor during a selected time of year.

C. List communication channels for marketing the intervention.

D. What incentives (praise, t-shirts, certificates) will you use?

E. How long will the intervention activity last and are the dates and times chosen appropriate (e.g., will the target group be available)?

F. What feedback (e.g., miles completed, pounds lost, policies enacted, environmental changes made) will you provide participants?

G. Who will design and print the educational materials? (See Section 9 on funding.)

H. If your intervention activity includes a major media component, what is the message you wish to convey?

What is your source for public service announcements (health department, private agency, business)?

How will the intervention population be involved in the formation of the message and modes of delivery?

What channels will be used to deliver the message (radio, television, print)?

Master Timetable

List activities in the columns

January/February	March/April	May/June	July/August	September/October	November/December

9. **Assess resource needs**

A. How much will the intervention cost?

___equipment
___incentives
___materials/printing
___personnel
___telephone/postage
___travel
___other:
___other:

B. Will you need to raise funds to implement this activity? If yes, through which of the following?

___business donations
___door-to-door
___events
___sales
___fees to participants
___grants/foundations
__other:

C. What materials will you need?

___brochures
___correspondence
courses
___flyers
___newsletters
___newspaper feature article
__pamphlets
___self-help materials
___training manuals
___t-shirts, buttons, etc.
___other:

D. How will the materials be produced and printed? How long will it take?

E. Which of the following will distribute them?

___businesses
___health care facilities
___religious organizations
___schools
___stores
__worksites
___other:

F. Will they be direct mailed?

Who will provide the addresses?

G. Will materials be mailed only upon request?

H. Will you need to charge a fee for materials? How much?

I. How will you evaluate or test your materials before they are used to determine acceptance and effectiveness?

On whom?

Where?

J. Will you need additional staff? (If so, specify number and qualifications.)
specialists:
students:
volunteers:
others:

K. Have you checked to see if all areas of liability are covered?
___equipment liability ___program liability
___facility liability

10. **Identify and train workers**

    A. What do you expect them to do?

    B. What are their necessary levels of knowledge and skills?

    C. Will you need different training sessions to accommodate the different levels of knowledge and skills?

    D. Do they understand their roles and responsibilities?

11. **Develop the evaluation plan**

    A. When will you and your stakeholders consider this activit to be a success? Complete enclosed **Evaluation Worksheet**.

    B. Who will be responsible for developing the evaluation plan?

    C. What resources do you have for evaluation?

    D. How will you determine if you are reaching your specified objectives concerning changes in:

    awareness:

    knowledge:

    attitudes:

    behaviors:

    skills:

policies:

environmental measures:

E. Describe the tools you will use.
questionnaires (pre/post)?

screening (pre/post)?

observational surveys?

participation records?

interview with participants, with providers?

other:

F. How will you determine the following?

Who has participated (number and demographic information)?

If your intervention is appropriate and effective?

If your target groups can understand the materials?

If your communication channels are working?

If you need to use more or different communication channels?

If the needs of your target group have changed?

G. Are you using your funds cost-effectively?

Are staff costs too high?

Is there overproduction of material?

Are printing costs too high?

other fees too high?

H. Where could you cut back?

12. **Use evaluation results**

A. How will you inform the community about the results of your intervention activity (newspapers, media, presentations)?

B. How will you share information with

– gatekeepers of the target group?

– participants of the activity?

– individuals or agencies that provide resources?

C. How will this information be used for program improvement?

PATCH Work Plan

Risk Factor: _____

Activity: _____

Preparation Tasks	By Whom	By When

Delivery Tasks	By Whom	By When

Evaluation Worksheet

Risk Factor:
Target Group:
Activity:

We will consider this activity successful if...	How will we know?	By Whom?	By When?

Follow-up Tasks	By Whom	By When

Evaluation Tasks	By Whom	By When

Types of Contributing Factors

There are three broad categories of factors that affect health behaviors: motivators, enablers, and rewards.

MOTIVATORS refer to a person's knowledge, beliefs, values, attitudes or perceptions.

Knowledge–factual information that may or may not initiate action on the part of the target group.

Beliefs–a conviction that phenomenon or object is true or real.

Values–something held dear without regards for consequences that may or may not result.

Attitudes–a constant feeling towards a person, place, or thing.

ENABLERS refer to the skills and resources that make certain individual actions more likely.

Skills– the ability to perform tasks that constitute desirable health behaviors.

Resources–the availability and accessibility of services, facilities, and products necessary to perform a health behavior (e.g., blood pressure screening at worksites, cigarette vending machines removed from schools, and low-fat dairy products readily available at stores). These resources are influences by the willingness of the local government to provide outreach clinics and health education in the schools, while restricting such things as students smoking on school property or cigarette machines in county buildings.

REWARDS refer to factors that provide incentives or punishment for a behavior. Included are social as well as physical benefits, and tangible, as well as imagined or vicarious rewards. For example, the positive or negative attitudes of significant people (family, friends, teachers, ministers, etc.) are well-known factors that influence behaviors. However, a stranger's disapproval (e.g., "It's dumb to get drunk, kid") may have more influence on the future behavior of a teen than does the advice of family or friends. We refer to this phenomenon as the "Strength of Weak Ties."

Table 1

Contributors to the Risk Factor

Behavioral Risk Factor:

Target Group:

List the factors that may contribute to whether or not member of the target group has the behavioral risk factor listed above.

Contribute to positive behavior (absence of risk factor)	**Contribute to negative behavior (presence of risk factor)**
Motivators	Motivators
Enablers	Enablers
Rewards	Rewards

Priority Risk Factors and Intervention Methods

Prioritize the items listed on the Contributors to the Risk Factor handout and enter the top five contributors to positive and negative behaviors. List at least one method or strategy that could be used to influence each.

Behavioral Risk Factor:
Target Group:

Top contributors to positive behavior	**Method/strategy**

Top contributors to negative behavior	**Method/strategy**

Community Resource Inventory

Behavioral Risk Factor:

Target Group:

Generate a thorough listing of the existing programs and policies in the community that address the risk factor and target group. The final list should include the name of the organization, contact person, address, telephone number, type and quality or relevant programs provided, and the number of target group members served.

Organizations (name, contact person, address, telephone numbers)	Services (Type and quality) Policies	Numbers Served

Stages of Change

When undertaking a behavior change, people move through the following stages.

Stage*	Description
1. Precontemplation	People have no intention to change behavior in the foreseeable future, are unaware of the risk, or deny the consequences of risk behavior.
2. Contemplation	People are aware that a problem exists, are seriously thinking about overcoming it, but have not yet made a commitment to take action.
3. Preparation	People intend to take action in the near future and may have taken some inconsistent action in the recent past.
4. Action	People modify their behavior, experiences, or environment to overcome their problems, the behavior change is relatively recent.
5. Maintenance	People work to prevent relapse and maintain the behavior over a "long" period of time.

*Adapted from Prochaska and DiClemente, 1986, Stages in the Transtheoretical Model

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

PATCH Work Plan

Risk Factor: _____

Activity: _____

Preparation Tasks	By Whom	By When

Delivery Tasks	By Whom	By When

Follow-up Tasks	By Whom	By When

Evaluation Tasks	By Whom	By When

Obtaining Information from Target Groups

As you begin to focus your PATCH activities, it is critical that you gain an understanding of the perceived needs and interests of the target and intervention groups. Gaining this understanding means asking questions directly of the persons you want to learn more about.

Characterize Your Target Groups

You already know a little about these people, such as the leading causes of death or disability, their risk factors, and perhaps the reasons they practice certain behaviors. Find out more from local experts or from reading articles on the subject.

Decide Which Intervention Groups to Learn More About

The PATCH members may have named several other types of people who should benefit from the intervention. But given limited resources, namely hours of your time, you may wish to interview only those intervention groups that will be a substantial focus of the intervention.

Decide Which Interviewing Methods to Use

Several different interview methods are available: focus groups, individual interviews, on-the-spot interviews, and questionnaires. You may select one or more methods based on your time frame and the method you feel most comfortable with.

Write the Questions You Wish to Ask

What do you want to know about the target and intervention groups? Do you want general insights, reactions to materials, messages, and ideas, or suggestions for activities?

Identify Respondents from the Groups

The individuals you interview should be typical representatives of the target and intervention groups you wish to learn more about. Some individuals are easy to identify, such as the elderly who live in subsidized apartments, patients at hypertension clinics, or smokers who have attended cessation clinics but have resumed smoking. Others will be more difficult to identify. Based on the characterization of your target and intervention groups, develop a brief list of key features to use in selecting interviewees. As you recruit interviewees, ask whether they have these features. The fewer people you interview, the more careful you must be in making certain the respondent is representative of the group.

Individual Interviews

Planning 3 weeks to design questions and arrange interviews

1 to 3 weeks to conduct interviews
1 to 2 weeks to analyze interview
30 to 60 minutes per interview

Resources question outline interviewers

10 to 25 interviewees per population
meeting space
tape recorder and tapes

Advantages can probe responses in depth
can obtain sensitive or controversial information
may provide a more trustful atmosphere

Disadvantages time-consuming to arrange, conduct, analyze
cannot be used for broad generalizations

On-the-Spot Interviews

Planning	1 to 2 weeks to design closed-ended questions, select sites (obtain permission if conducted on private property) 4 days to conduct interviews 2 weeks to analyze results 2 20 to 30 minutes per interview
Resources	questionnaire (interviewers) 20 to 50 respondents typical of populations access to a central, busy location
Advantages	can quickly interview large numbers of people can be used in a variety of locations use of closed ended question allows quick analysis
Disadvantages	not appropriate for sensitive or controversial topics interviews must be short

Questionnaires

Planning	1 to 2 weeks to design questionnaire 2 to 3 weeks to obtain responses 1 week to analyze results
Resources	list of interviewees means of distributing questionnaire at least 20 respondents per population
Advantages	inexpensive does not require interviewers may be able to query hard-to-reach audiences
Disadvantages	response and mail delivery is slow responses are only from those motivated to reply inability to probe responses

Focus Group Interviews

Planning	2 weeks for arranging groups and recruiting respondents and planning discussion outlines 2 to 4 days to conduct groups 45 to 90 minutes per group 1 week to analyze results
Resources	4 groups per target/subtarget population 8 to 10 respondents per group respondents typical of population moderators for groups meeting rooms tape recorder and tapes
Advantages	participants are stimulated by other group members information obtained from several people at once can be accomplished in relatively short time
Disadvantages	cannot provide quantitative data can only look at trends, not absolutes

Community Group Meeting for Phase V: Evaluating PATCH

Overheads

Five Phases of PATCH . . . . . I-O-2 or I-O-3

Phase V: Evaluating PATCH . . . . . I-O-9 and I-O-10

Meeting Goals . . . . . To be developed

Major Reasons to Evaluate V-O-1

Types of Evaluation V-O-2

Major Reasons to Evaluate

- **to document the program**
  - **– accountability**
  - **– replication**
- **to obtain feedback for program improvement**
- **to provide feedback to staff, volunteers, funders, and the community**
- **to document importance and effectiveness**

Types of Evaluation

- **Process:** "what did we do?"
  - monitor and document activity
  - feedback

- **Impact:** "short-term effects of program"
  - changes in knowledge, skills, attitudes, behaviors, policies, organizations, and environmental measures

- **Outcome:** "long-term effects of program"
  - mortality
  - morbidity

Community Group Meeting for Phase V: Evaluating PATCH

Handouts

Agenda . . . . . To be developed

Stages of Change IV-H-6

Five Steps to Planning an Evaluation (Optional) CG6-13

Evaluation Worksheet: Example V-H-1

Evaluation Worksheet (Blank) V-H-2

Meeting Evaluation Sheet . . . . . To be developed

Evaluation Worksheet: Example

Risk Factor: Physical inactivity

Intervention population: Middle-school students

Activity: Poster contest on physical activity

We will consider this activity successful if. . .	How will we know?	When?	Who?
• at least 100 posters are submitted	count submitted posters	contest	Carlos
• an article about the contest appears in the evening newspaper	observe and save article	by January	Carlos
• ~~the poster exhibits are visited by 50% of the population~~ unrealistic to do			
• ~~each contestant talks to his/her parent(s) about the importance of being physically active~~ *difficult to verify*	telephone survey	mid-December	Sarah, Carlos
• ~~teachers report that students understand the importance of physical activity as indicated in their classroom discussions, assignments and essays~~ *merge with feedback questionnaire*			
• ~~the middle school children grow up to be adults who are physically active~~ *unrealistic to check*			
• ~~the calendars are displayed in school offices, the public library, and the health department~~ *not worth doing*		before and after the activity	Carlos
• 20% of students show increased awareness of importance of being physically active	pretests and posttests		
• positive feedback is received from 80% of sponsoring teachers	questionnaire	early November	Carlos

Evaluation Worksheet: Example

Risk Factor:

Intervention population:

Activity:

We will consider this activity successful if. . .	How will we know?	When?	Who?