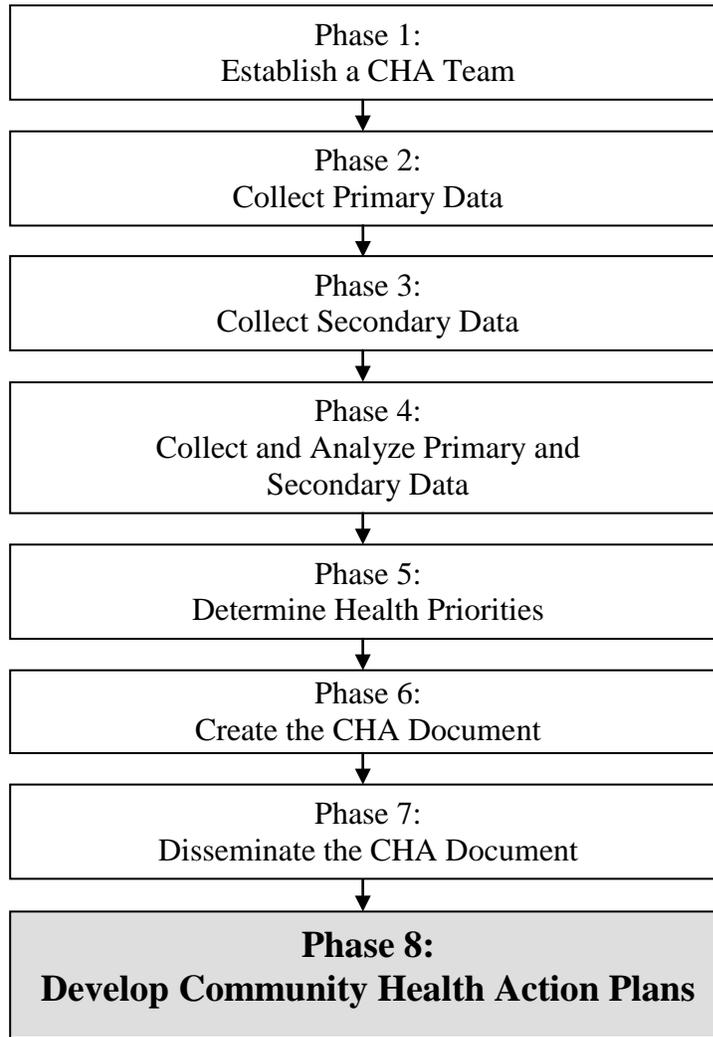


NORTH CAROLINA COMMUNITY HEALTH ASSESSMENT PROCESS



Objective:

- Create Community Health Action Plans

Activities:

- Develop interventions for addressing priority health issues
- Complete *Community Health Action Plan* forms

Tools:

- Resources for Evidenced-based Interventions
- Guidelines for *Community Health Action Plan* forms

Appendix: (Appendix at

<http://www.healthycarolinians.org/assessment/resources/survey.aspx>)

- *Community Health Action Plan* forms

Essential Services #4 Mobilize community partnerships to identify and solve health problems

Benchmark #1 LHD shall conduct and disseminate results of regular community health assessments

Accreditation Standard 1.1.k Identify leading community health problems

Benchmark #11 LHD shall convene key constituents and community partners to identify, analyze and prioritize community health problems/issues

Benchmark #12 LHD shall develop strategies in collaboration with community partners to solve existing community health problems

Benchmark #13 LHD shall identify and build upon community assets and direct them toward resolving health problems

Benchmark #21 LHD shall lead efforts in the community to link individuals with preventive, health promotion, and other health services

Benchmark #22 LHD shall serve as a health care provider when local needs and authority exist, and the agency capacity and resources are available

Benchmark #38 Local board of health shall participate in the establishment of public health goals and objectives.

Consolidated Agreement Include community action plans to address the priority issues

Additional Accreditation Benchmarks may apply to the CHA (verify by Accreditation Site visit and LHD self-assessment instrument)

Phase 8: Develop Community Health Action Plans

An important use of the CHA findings and document is to develop effective community health strategies. The goal of Phase 8 is to develop plans of action for addressing those health issues that have been identified as priorities by the community through the CHA process. It is critical that the activities selected seem feasible to implement. The point is not to become overwhelmed with the process, but rather to clearly define the health priorities, actions, and expected results. The key to developing successful plans is to begin with health priorities identified by the community, develop measurable objectives to address these priorities, use evidence-based interventions, and plan realistic evaluation methods. Each plan should align with the Healthy NC 2020 Objectives.

Problem or disease-oriented work groups are usually the best way to develop action plans. For each issue (problem or disease), the assigned work group should look at the county data, think through the factors that contribute to the issue, identify factors that could perpetuate it, and identify barriers to reducing each issue. They can then develop:

- A hypothesis about why the issue exists
- Research and select evidence-based interventions to address the issue
- Identify needed resources

Work groups should consist of county residents and representatives of agencies/organizations with special expertise or interest in the issue, and/or those who are affected by the issue. For example, a teen drug-use prevention work group may include:

- Substance abuse treatment counselors
- School teachers and administrators
- Parents
- Social workers
- Law enforcement officers
- Substance abuse prevention agencies
- Teens

Good action plans are developed after carefully considering all the factors that cause and perpetuate the problem or disease they address.

A community health action plan must be submitted for **each** local priority issue on a *Community Health Action Plan* form which is adapted every year. The work group should review this required form before beginning the development of their community health action plan. They should complete the following steps when developing their plan.

Step 1: Description of the health priority

Develop a brief description of the health priority including county data from the CHA document to support selecting the priority and the risk factors that contribute to the issue. Risk factors may be:

- Lifestyles (e.g., poor dietary habits, sedentary lifestyle, substance abuse)
- Environmental (e.g., unsafe drinking water, substandard housing conditions)
- Inadequate health care system (e.g., insufficient primary care providers, lack of prenatal care services)

Identify risk factors specific to the county, because they vary from county to county. It is essential that the work group think through the complete sequence of interacting and contributing factors and take all of this information into consideration when designing interventions. They need to be aware that the risk factors may be related to more than one issue and that other work groups may be working on issues with the same risk factors. The table below gives some examples of health concerns and possible contributing factors.

Health issue	Possible Risk Factors
High infant mortality rate	Lack of prenatal care and delivery services Available care not affordable/accessible Available care not culturally sensitive Lack of transportation to health care High percentage of teenage mothers Low education levels of mothers (high school drop outs) Poor maternal nutrition Maternal smoking during pregnancy Family and neighborhood stress Multiples: twins, triplets, etc
High unemployment	Large community employer closing Area-wide economic slow down Seasonal unemployment Inability to attract new businesses to the area Lack of "start up funds" for new businesses High number of high school drop outs Available workers untrained for new jobs

There are several ways to identify risk factors. Some of these may have been identified during the CHA process. Ask people affected by the problem (i.e. teens who've gotten pregnant, people with no health insurance, smokers, etc.) what they think might solve the problems. Look in academic literature – this can reveal some broader ideas with an evidence base. Talk with a local college or university for help gathering and interpreting academic data. Include people in the work group who've been working on this issue in the county or region. They will know the history of barriers and successes in the area.

Don't be too quick to identify "*the lack of a service*" as the cause of a problem. Look to find the root causes of the problems in the county, and *then* start to think about what services might address those causes. For example, the cause of infant mortality may not be lack of prenatal care services; it might be the emotional stress of parents from living in poor and unsafe neighborhoods. This would require a very different intervention.

Step 2: Develop a S.M.A.R.T. health objective

Develop a S.M.A.R.T. health objective to address each of the health priorities including the anticipated change in behavior or disease rate, target population, and anticipated time frame to complete the objective. Link the objective with the Healthy NC 2020 Objectives. A measurable objective includes:

- The people whose behaviors, knowledge, and/or skills are to be changed as a result of the intervention. Target populations with health disparities whenever appropriate.
- The desired outcome which could include intended behavior, increased knowledge and/or skill changes. The work group needs to think in terms of feasible "outcomes," or the change in health status of the target population; quantify or describe how the

S.M.A.R.T. Objectives
✓ Specific - Be precise about what you are going to achieve.
✓ Measurable – How are you going to measure your objectives?
✓ Achievable - Are you attempting too much?
✓ Realistic - Do you have the resources to make the objective happen (people, financial resources, and physical resources)?
✓ Timed - State when you will achieve the objective (within a month? By February 2018?)

interventions will ultimately change residents' health status.

- How the progress will be measured or evaluated. The work group needs to consider available resources and capacity (time, staff, funding, etc.) when planning the measurement.
- What will be considered a success for this health priority? This needs to be realistic.
- What is the time frame for success?

Step 3: Develop interventions and prevention activities

An intervention is a process or action intended to address an existing or potential problem. Research evidence-based interventions that have been effective in address the health priority and select the intervention that is most feasible for the county. List five interventions that were researched on the *Community Health Action Plan* Form. See Phase 8 Tools section for sources of evidence-based interventions and policies. Use evidence-based interventions whenever possible because they:

- Provide a recipe or road map to address the problem - don't reinvent the wheel
- Are likely to succeed
- Help use scarce resources (\$, time, volunteers/partners) wisely
- Are increasingly required by funders – important if seeking outside funding to support action plans

After determining the interventions in the county that are already addressing the issue, select the new intervention and describe the proposed evidence-based intervention including the organizations that will provide and coordinate the intervention activities. Explain how the intervention addresses health disparities, individual, policy, or environmental change. Indicate who benefits most by the intervention and including information on the health disparities in a particular population. Detail each of the measurable steps involved in the intervention, including a time frame to accomplish the steps. State the setting where the steps will be accomplished (such as school, work site, faith group, health care system, or other community setting). Identify organizations and/or individuals who will be partners and describe their roles and responsibilities in implementing the steps of the planned intervention.

Intervention statements should not be simply the “flip-side” of the problem. For example, if teenage pregnancy is a problem in the county, “reducing teenage pregnancy” would be an objective of an intervention, but would not define the intervention itself. Rather, it is necessary to identify the process or action by which the problem will be targeted. For example, one community found that one of the reasons for high teen pregnancy rates in their area was that teens didn't have access to the local health clinics for information and appointments, because it was only open while they were in school. Therefore, their intervention was to increase teens' usage of local health clinics by opening the clinics during weekends and evenings.

Step 3: Consider community resources

Use information gathered in the Community Health Resources Inventory and by Asset Mapping if that was completed in Phase 2. This information will help identify institutions, organizations, and individuals who can play a role in targeting the health issues identified in the CHA process. When developing interventions, the work group may identify the absence of a

needed resource within the county. Outline which agencies/groups commit to which tasks or roles in getting the intervention accomplished.

Step 4: Describe the evaluation method

An evaluation method or plan must be developed to determine if the measurable objective was met and to determine its effectiveness. Evaluation can help the county have a better understanding of the health issue and lead to stronger programs or improved capacity to address the issue. The CDC Evaluation Working Group has provided additional information at www.cdc.gov/eval/resources.

There are two kinds of evaluation: process evaluation and impact/outcome evaluation.

Process evaluation measures the process of delivering an intervention. This is generally used to track numbers (e.g., programs, participants, etc.) that measures the implementation of the intervention or program. If this is collected while carrying out an intervention, it can be useful in identifying potential or developing problems, (i.e. whether the intervention is being delivered as planned, are target levels being met, is the intervention reaching the target population, and whether the plan needs to be modified). The main measurement collection methods for process evaluation are review of intervention documents which contain numbers of programs and participants, type of participants, and interview and survey responses.

Impact/outcome evaluation is used to measure intermediate (impacts) and longer-term (outcomes) effects of an intervention or program. This measures whether the intervention is having an impact on target population. The main method of measuring outcome evaluation is a comparison of the intervention group(s) with another group that does not receive the intervention (the control group). This is a difficult evaluation measure to use with community health action plans because of the need for controlling for so many factors. It is possible to measure changes at the individual level by measuring the same individuals' pre and post intervention in a randomly selected sample of individuals. Someone with skills in research and/or epidemiology will need to develop this evaluation design to fit the community health action plan.

Step 5: Complete the Community Health Action Plans

At this point in the planning process, all major health problems should have been identified and reviewed. All known factors that contribute to each problem should have been considered. Interventions should have been developed for those problems selected as priorities, and the appropriate resources reviewed. The final step in this phase is to complete a *Community Health Action Plan* form for the **current** year, which is a required form to document this information. Use a separate form for each priority health problem or disease. Sample form and instructions are located in the Appendix I and the current form is available on the Healthy Carolinians website: www.healthycarolinians.org.

The local health department must approve the Community Health Action Plans for the county and submit these plans by the **first Friday of June** of the year following the December in which the CHA was due. Once the plans have been approved, the CHA Team should turn responsibility for the leadership and/or implementation of the plans over to organizations and individuals identified in the plans.

CHECKPOINT

Before leaving Phase 8, check to see if the following tasks are completed:

- ✓ Developed intervention and prevention activities to address the health priorities identified in Phase 5.
- ✓ Completed community health action plan forms.
- ✓ Turned responsibility for planned actions over to the individuals and organizations identified in the Community Health Action Plans.

Appendix at

<http://www.healthycarolinians.org/assessment/resources/survey.aspx>

PHASE 8 TOOLS

Resources for Evidenced-based Interventions

Information on evidenced based interventions is available at the following sites.

- The Community Guide to Preventive Services at www.thecommunityguide.org. The Community Guide is an essential resource for people who want to know what works in public health. It provides evidence-based recommendations and findings about public health interventions and policies to improve health and promote safety. The Task Force on Community Preventive Services -- an independent, nonfederal, volunteer body of public health and prevention experts -- makes these findings and recommendations based on systematic reviews of scientific literature conducted under the auspices of the Community Guide. CDC provides ongoing scientific, administrative, and technical support for the Task Force. This organization reviews over 200 interventions and describes what elements of interventions are effective, not just the whole interventions.
- Canadian Best Practices Portal at cbpp-pcpe.phac-aspc.gc.ca. This site has a user-friendly interface. To scroll through their list of 324 interventions click on cbpp-pcpe.phac-aspc.gc.ca/intervention/list.
- Cochrane Reviews at www.cochrane.org/cochrane-reviews. This is geared toward a medical audience, but it includes community interventions and provides a lay-language summary at bottom of each review.
- ERIC search engine for education journals, including school health at www.eric.ed.gov.
- Google Scholar at scholar.google.com. The information on this is not necessarily peer-reviewed so quality-screening is necessary. The search can be tailored using “Advanced Scholar Search”
- Healthcare innovation information is available at
 - AHRQ Health Care Innovations Exchange: www.innovations.ahrq.gov
 - Federal clearinghouse of programs
 - US Preventive Services Task Force Recommendations: www.uspreventiveservicestaskforce.org/recommendations.htm
- MedlinePlus at www.nlm.nih.gov/medlineplus.
- NC Health Info at nchealthinfo.org.
- PubMed search engine for medical articles at www.ncbi.nlm.nih.gov/pubmed. Search for health topic and “evidence-based intervention,” then narrow search by age group/ethnicity/ etc.

Appendix is located at

<http://www.healthycarolinians.org/assessment/resources/survey.aspx>

APPENDIX A – NORTH CAROLINA PUBLIC HEALTH STANDARDS

CORE PUBLIC HEALTH FUNCTIONS

ACCREDITATION STANDARDS FOR COMMUNITY HEALTH ASSESSMENT

ACCREDITATION CHECKLIST FOR COMMUNITY HEALTH ASSESSMENT

ACCREDITATION CHECKLIST FOR SOTCH REPORTS

APPENDIX B - FREQUENTLY ASKED QUESTIONS

APPENDIX C - PROBLEMS WITH RATES BASED ON SMALL NUMBERS PRIMER

APPENDIX D - AGE-ADJUSTED DEATH RATES PRIMER

APPENDIX E - SAMPLING GUIDE FOR COMMUNITY HEALTH ASSESSMENT

APPENDIX F - TWO-STAGE CLUSTER SAMPLING

APPENDIX G - SMALL GROUP DISCUSSION TOOL KIT

APPENDIX H – DATA RESOURCE GUIDE

APPENDIX I - SAMPLE COMMUNITY HEALTH ACTION PLAN FORM