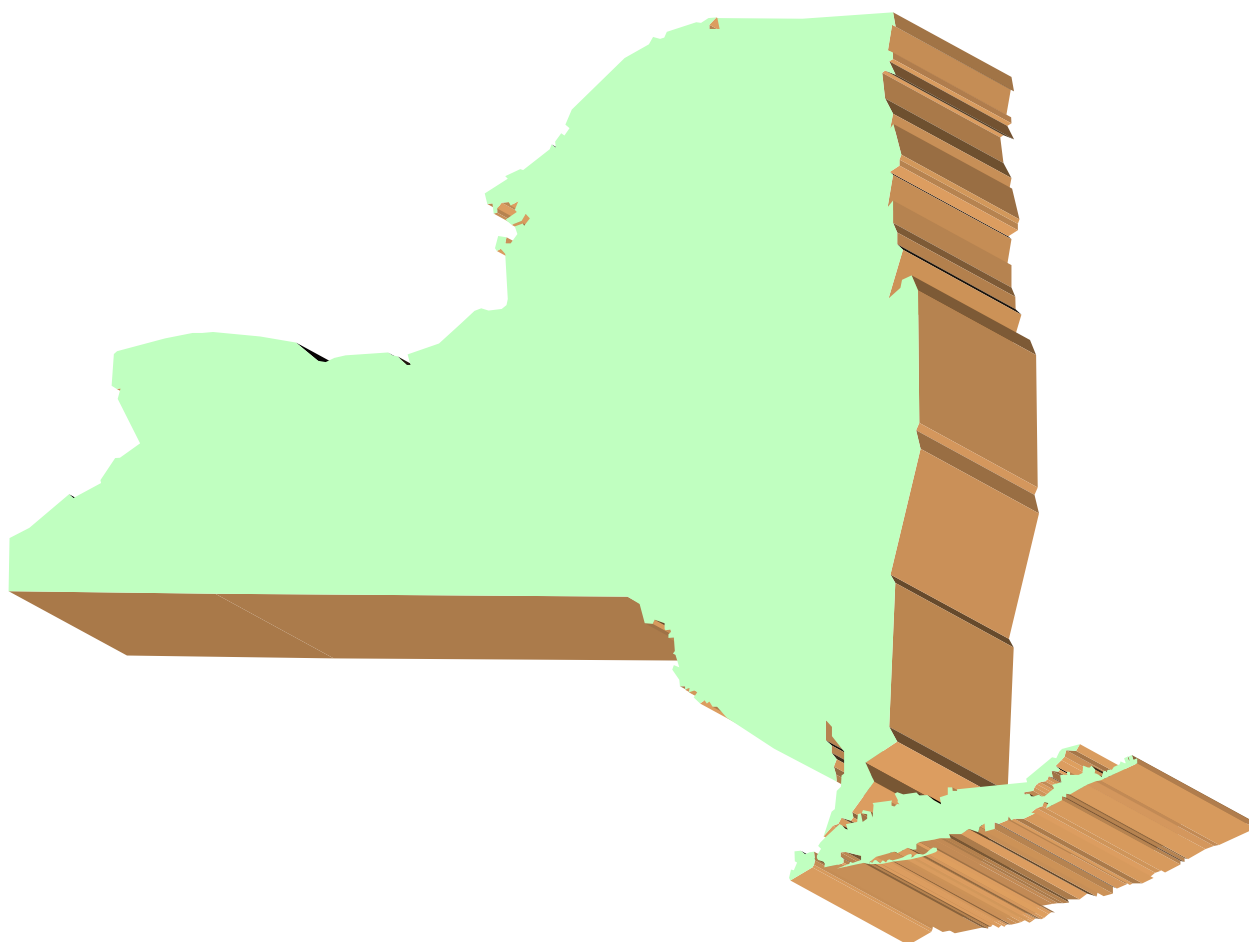


1999 - 2004 Community Health Assessment

Preliminary Review



NEW YORK STATE DEPARTMENT OF HEALTH

MAY 2000

1999-2004 COMMUNITY HEALTH ASSESSMENT PRELIMINARY REVIEW

New York State Department Of Health

Center for Community Health

Local Health Services Unit • Public Health Information Group

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Executive Summary

Background

In New York State, local health departments are required by Public Health Law (Article 6) to complete Community Health Assessments (CHAs) to obtain state aid for local public health services. In April 1998, an 18-member Public Health Agenda Committee (PHAC) made up of county and state health department representatives, were charged with reviewing and reforming the local health department planning, implementation, monitoring and funding processes.

Among the PHAC recommendations was that the CHAs should be on a six-year cycle, with local departments providing biennial updates and/or supplements. The PHAC proposed that CHAs should reflect the unique needs of the community, engage community input, and provide a more realistic basis for a restructured Municipal Public Health Services Plan (MPHSP). The MPHSP is a plan that describes public health objectives, current services, and estimates long-term public health services. The PHAC drafted a guidance document for the CHAs.

These recommendations were implemented for the 1998 CHAs, and marked the beginning of the 6-year cycle. All of the 57 counties were required to submit CHAs in 1998, and New York City in 1999. Fifty-six were submitted at the time of this review. Teams made up of 4-5 New York State Department of Health Central and Regional Office staff reviewed CHAs submitted. Reviewers analyzed the sections for content, usability, readability and completeness, and their comments are summarized in this report.

Evaluation of CHA Sections and Guidelines

Local health departments were not required to use the CHA guidelines, and were given wide latitude in how they chose to produce the CHA. LHD staff may question why this review evaluates CHAs relative to the sections and format suggested in the guidelines, when they were optional and not closely followed by many LHDs. First, most LHDs followed the guidelines and suggested sections to some degree, and most completed the checklist to indicate where the section information was provided. The sections are common to most CHAs, but may have different names, titles, and formats. This commonality allowed the reviewers to evaluate: 1) the *quality of the CHAs* overall and for each of the suggested sections within the guidelines and; and 2) the *quality of the guidelines*, including clarity, ability of LHDs to incorporate in the CHA's, and how well they contributed to strong sections. One of the major reasons for undertaking this careful review was to evaluate the guidelines and determine if revisions to the guidance are needed to improve CHA's, based on the findings of the review team and input from the LHDs.

The reviewers were instructed to evaluate the quality of each section in terms of how well the information presented met the purposes of the section (e.g. to profile unmet need in the community). The guidelines were one of many criteria used to evaluate the section. CHAs that deviated from the guidelines were not rated lower for this reason. In fact, this review helped to identify other very effective ways that LHDs are presenting and organizing CHA information, and these methods will be shared with state and local health staff, and will contribute to discussions about modifications to the guidelines.

Summary of Findings

This preliminary review outlines strengths, weaknesses, major findings, recommendations, and capacity building areas for the CHA as a whole, and for each section identified in the CHA guidance document.

Among the many strengths identified in CHAs were:

- Use of current data;
- Using charts, tables, graphs and other presentation aids;
- Use of sub-county data;
- Presenting information that was concise, easy to understand and find;
- Summarizing priorities and major recommendations after each section;
- Involving and explaining roles of community partners.

Among the weaknesses identified in the CHAs were:

- Using outdated data;
- Presenting charts with no reference or explanation;
- Presenting data in narrative form only;
- Presenting regional data without drawing its relevance to the county;
- Not integrating information across the sections;
- Not identifying or explaining local priorities;
- Not identifying or explaining local health resources;
- Not acknowledging or describing relationships with community collaborators.

Major opportunities for enhancing the capacity of counties to conduct assessments were also identified. These include:

- Locating and applying timely and comprehensive data from various sources;
- Collecting, analyzing and presenting sub-county data;
- Clearly communicating and integrating local priorities across the CHA;
- Identifying community assets and resources;
- Linking priorities to an action plan.

Next Steps

The short-term goal is to strengthen the CHA process so that it results in a meaningful, effective and timely document for the community partners, local and state health departments. The next step will be to modify the guidance document using feedback from the local and state health departments and community partners. Model CHAs and sections will be identified and shared with all counties.

This review is envisioned to be a catalyst for dialogue among local health departments, community partners, and state department of health staff for improving the CHA document, process, and capacity. The long term goal is to have more meaningful, realistic, efficient, manageable and timely CHA update supplements in 2000 and 2002, and an improved CHA that is more closely linked to the Municipal Public Health Services Plan (MPHSP) in 2004.

I. Introduction

A Community Health Assessment (CHA) “should be judged by how well it tells the story of the health of a particular community”. The Public Health Agenda Committee (PHAC) states this in their interim report entitled “Planning and Funding Local Public Health Services in New York State: The New Public Health Agenda”, April 1998.¹

The Public Health Agenda Committee, composed of nine representatives each of the New York State Department of Health (NYSDOH) and the New York State Association of County Health Officials (NYSACHO) accepted a charge to review and reform, if necessary, the current process by which local public health planning, implementation, monitoring and funding is conducted in New York State. They studied and made recommendations regarding these formal process which include the Community Health Assessment (CHA), the Municipal Public Health Services Plan (MPHSP), performance monitoring, and the State Aid Application (SAA), and clarified the current State and Local Health department roles. The PHAC drafted a guidance document for the CHAs.

In their report, the PHAC states that LHDs’ role is to “develop a CHA that collects, integrates and analyzes health statistics and identifies problems, available resources and needed public health services; identify and prioritize public health needs; involve input from community groups; and submit it to the state for approval.” The role of the state health department is to “maintain, update, and provide statewide information relating to public health programs and functions; review and make recommendations for modifications; and approve a local public health services plan for every LHD”.

Among the recommendations made by PHAC was that CHAs should be on a six-year cycle, with local departments providing biennial updates and/or supplements. It should be a process that reflects the unique needs of the community, includes community input, and links closely with the planning process. This recommendation was implemented in 1998, and marked the beginning of the recommended 6-year cycle.

Central and regional DOH staff from many public health programs were recruited to help review the Community Health Assessments. Their observations are summarized. The Review will also serve as a basis for discussion of the methods by which the NYSDOH can work collaboratively with local health units/departments and community partners to improve the quality, usefulness and accessibility of CHAs. It will describe the characteristics observed in the 56 CHAs submitted in 1998-99, and determine to what extent “they tell the story of the health of their communities”.

¹ “Planning and Funding Local Public Health Services in New York State: The New Public Health Agenda”, an interim report published in 1998 by the Public Health Agenda Committee.

II. Vision, Goals and Underlying Principles

The shared **Vision**¹ for public health is “healthy people creating healthy communities” by achieving the public health mission – promoting physical and mental health and preventing disease, injury, and physical disability.

The vision for the new CHA is that it “should be the basis for all local public health planning, giving the local health unit the opportunity to identify and interact with key community leaders, organizations, and interested residents about health priorities and concerns. This information forms the basis of improving the health status for the community through a strategic plan.”¹

Underlying Principles

The assessment process should be open and collaborative. The CHA should be a more meaningful, realistic, efficient, manageable, and timely document for community partners, the local and state health departments. There should be a clear link between the CHA and MPHSP.

Goals of the Community Health Assessment Review

- Improve the quality, usefulness and accessibility of data for community health assessment, assurance and improvement.
- Ensure that the Community Health Assessment is a working document that serves as the basis for strategic planning and is useful for the development of the Municipal Public Health Services Plan (MPHSP).
- Strengthen local capacity to present, interpret, and use data and other tools for planning, monitoring and evaluation.

III. Evaluation Process

Local health departments were required to submit their Community Health Assessments in October 1998. A guidance document developed by the PHAC was mailed to counties to assist with the CHA process. Of the 57 counties and New York City required to submit CHAs, 56 were submitted. A team of four or five evaluators reviewed each CHA. The staff represented the DOH central, and regional offices, including programs relating to chronic disease, communicable disease, environmental and occupational health, among others; the Local Health Services unit; and the Public Health Information Group. Reviewers noted their observations using a tool developed for the purpose. The team met once to reach consensus on, and share their observations. The primary reviewer reported the team’s comments and consensus scores on one summary evaluation sheet. The observations, findings and recommendations are based on the written comments, and interviews with representatives of the evaluation team. Figure 1 illustrates the CHA Review and Feedback Process.

¹ “Planning and Funding Local Public Health Services in New York State: The New Public Health Agenda”, an interim report published in 1998 by the Public Health Agenda Committee.

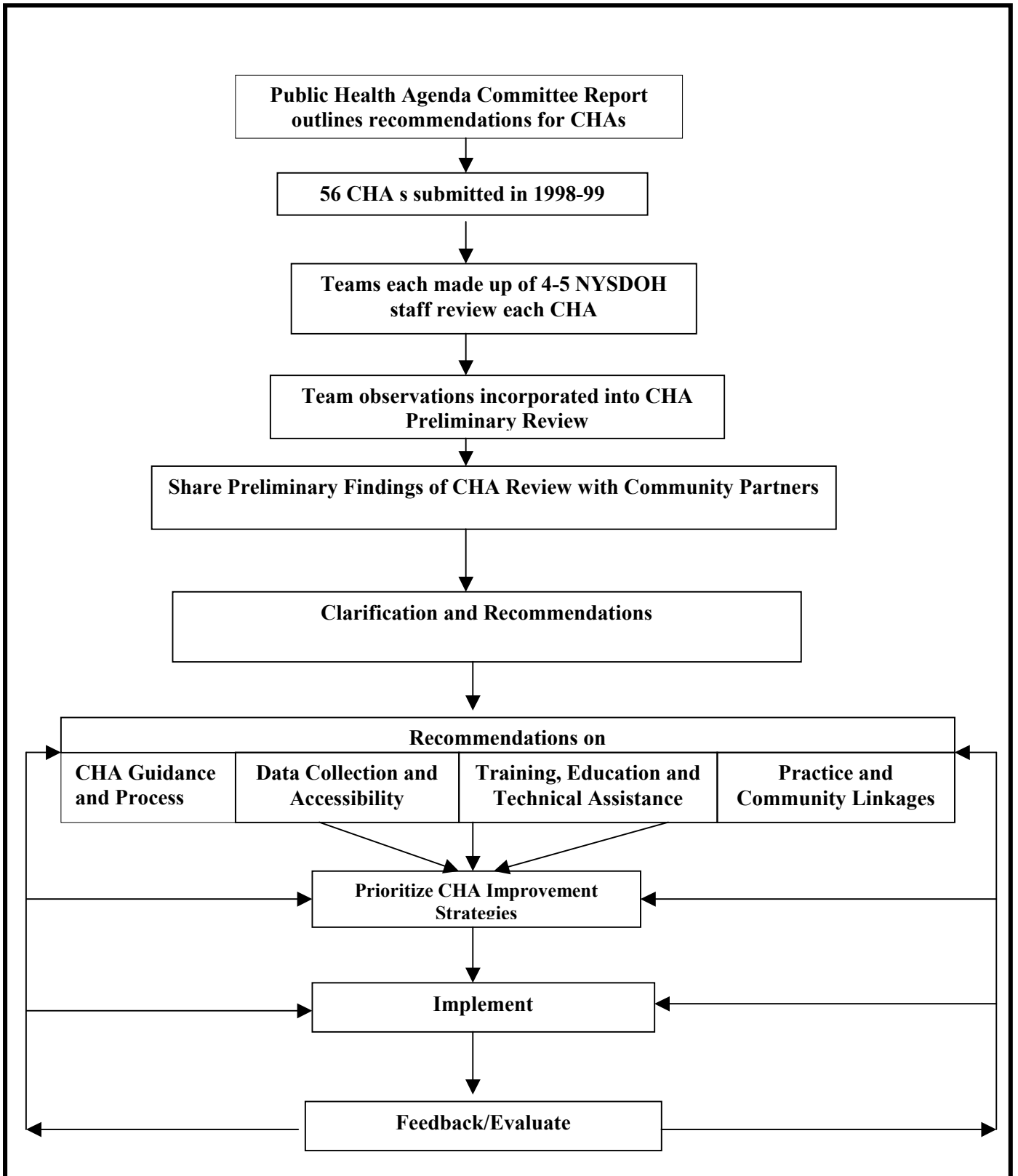


Figure 1 CHA Review and Feedback Process

IV. Review of CHAs by Sections

In all, 56 of the 58 local health departments submitted CHAs as of November 30, 1999. Reviewers' observations of each of the CHA sections have been reviewed and summarized by section.

Please note when reviewing CHA Review:

- Local health departments were not required to use the CHA guideline outlined in the guidance document, and were given wide latitude in choosing to produce the CHA.
- No minimal standards were set for CHA submission.
- Reviewers used a tool developed that was consistent with the suggested guidance document. The main purpose was to test the guidance document's clarity, effectiveness and relevance.
- Reviewers examined sections for content, usability, readability and completeness using a five-point rating system ranging from Excellent to Poor. A 'Not Completed' rating implies the content is missing in the CHA, and may be indicative that counties perceive the information is not relevant or available.
- A three-point rating system was utilized for reviewing overall usability, readability and completeness.
- The major strengths, common weaknesses, and major findings are identified by section. Capacity Building Areas identify opportunities that may be addressed through training or technical assistance, while Recommendations to NYSDOH identifies opportunities that need to be further explored.
- The ratings provide an indication of whether counties perceive specific content is relevant in a CHA; help identify problem areas around data accessibility and currency; and the extent to which the counties perceptions on CHAs were consistent with suggestions from the guidance document.
- Section 6 on "Performance Indicators" is missing because a core set was not identified, and thus not sent with the guidance document.

Summary of Review Comments for all Sections of the CHA

Major Strengths

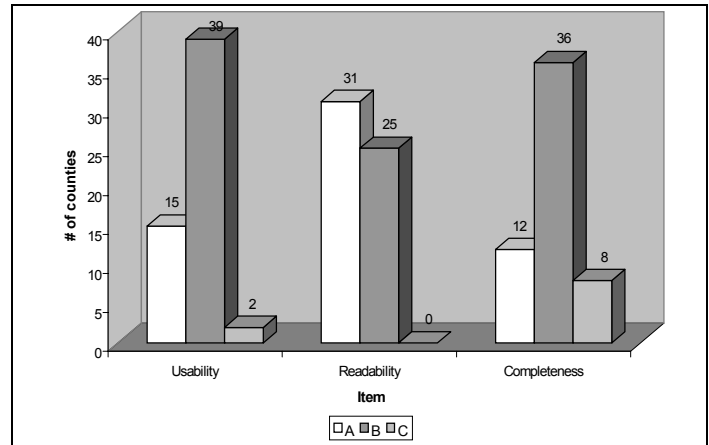
- Used current data as opposed to outdated data.
- Appropriately used charts, tables, graphs, other information presentation aids with interpretation. For example, trend information was not presented, or only using bar charts did not explain the issue.
- Included local and state data.
- Information was concise, easy to understand and find.
- Explained roles of community partners.

Common Weaknesses

- Used out-dated data.
- Presented regional data without drawing out its relation to the county.
- Content of CHA was not integrated across sections.
- Did not identify or explain local priorities.
- Used only narrative to explain data.
- Attached tables, graphs in the appendices without adequate referencing or explanations.
- Did not explain local health care environment, for example, did not explain local health-related resources.
- Did not explain the existence or relationship with collaborators.

Capacity Building Areas

- 1 Locating and applying timely and comprehensive data from various sources.
- 2 Collecting, analyzing and presenting sub-county data to better describe variations within county.
- 3 Describing services provided in the county in relation to priorities, strengths and barriers identified.
- 4 Linking priorities to an action plan.
- 5 Improving the usability and readability of a CHA .
- 6 Working with community partners to complete a CHA.
- 7 Presenting information that is factual, jargon-free and culturally sensitive.



A = Very Good B = Fair C = Poor

Chart 1: CHAs rated by Usability, Readability and Completeness

Major Findings

- CHAs that were rated highly used current data, appropriate survey methodologies, graphical tools to present data, explained local health priorities clearly, followed them up with an action plan and listed community partners.
- CHAs that were rated poorly used outdated data, poorly constructed tables and graphs, lacked organization in the flow of the content, and did not identify local public health priorities.
- While majority of the counties compared rates with other areas, rural counties were less likely to compare rates against state and national indicators.
- In general, discussion on accessibility and availability of health services was rated low by evaluators.
- Urban counties scored slightly lower than rural counties in discussions of new partnerships that addressed priorities.
- A majority of the CHAs were rated average or lower on description of agency's ability to perform a CHA, adequacy of skill level and adequacy/deployment of resources.

Recommendations for NYSDOH

- The guidance document needs to clearly explain the relevance of information suggested for each of the sections. The flow and organization of the sections need to be revised based on feedback from CHA evaluators, LHDs and community partners.
- Assistance ranging from accessing and presenting data to analysis and usability has been recommended under each section. A short- and long-term action plan should be developed that would enable the CHA to be a more useful document.

Section 1A - Populations at Risk

Guidelines: Describe demographic and health status, issue identification and justification

Major Strengths

- Data was comprehensive.
- Data presented at sub-county level.
- Used Charts , Graphs, Tables and Maps.
- Supplemented with Local Data (providers, economic development, managed care, school surveys).

Common Weaknesses

- Lacked sub-county data.
- Presented regional data without drawing out its relation to the county.
- Limited to no use of maps.
- Small area data needed aggregated measures.
- Data was presented without adequate interpretation.
- Not integrated with other sections of CHA.
- Lacked comparisons with regional, state or national standards.

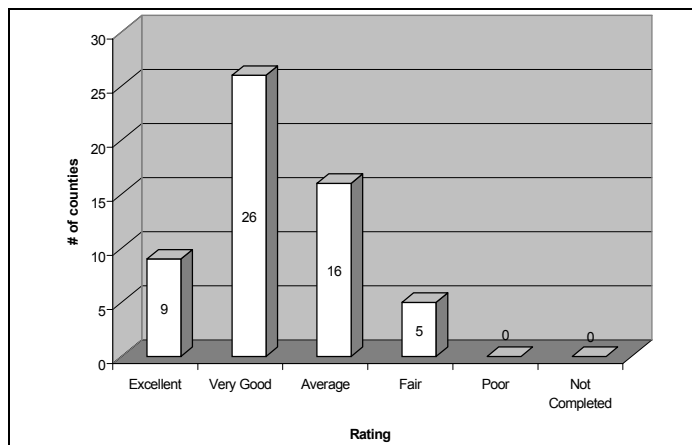


Chart 2: County CHA Rating for Section 1A

Capacity Building Areas

- 1** Locating and applying more timely, relevant and comprehensive data.
- 2** Collecting, analyzing, and presenting sub-county data to better describe variations within the county, pockets of risk, assets, target areas and populations.
- 3** Assistance to smaller counties in analyzing and reporting data with relatively small number of events.
- 4** Linking findings from this section to rest of CHA
- 5** Locating and using local data sources.
- 6** Public Health Informatics: Accessing electronic data sources.

Major Findings

- All 56 CHAs reviewed completed this section.
- Use of old data, lack of analysis, errors in computation, and data presentation problems commonly identified.
- Majority, though not all, counties compared with standards such as Healthy People 2000, or 'Communities Working Together for a Healthier New York'.
- Counties have the ability to develop tables and charts and document data sources.
- Few counties presented sub-county level data; when available this raised the quality of the CHA.

Recommendations to NYSDOH

- Guidelines were clear and do not need to be changed.
- Help Local Health Departments (LHD) locate more timely and locally relevant data.
- Assist counties with using maps to portray problem and/or need.
- Enhance and promote use of indicators data on the HIN and Other Web Sites.
- Show model uses of data, sources, and standards.
- Familiarize counties with ways to compare local data against regional, state and national standards.
- Focus training on identified capacity-building areas.

Section 1B - Populations at Risk

Guidelines: Describe Access to Care

Major Strengths

- Analyzed access to managed care-related services.
- Described linkages among providers and services.
- Maps displayed location of services.

Common Weaknesses

- Laundry list of providers included without relating to priorities or need areas.
- Common barriers to service in relation to access not discussed.
- Resources were listed in appendices without clear references.

Capacity Building Areas

- 1 Developing a checklist for analyzing services, community assets and resources.
- 2 Assisting with using maps, charts or similar graphical tools.
- 3 Presenting illustrations of how services can be linked to providers, and ways barriers can be discussed.
- 4 Linking findings from this section to rest of CHA.
- 5 Locating and using local data sources.

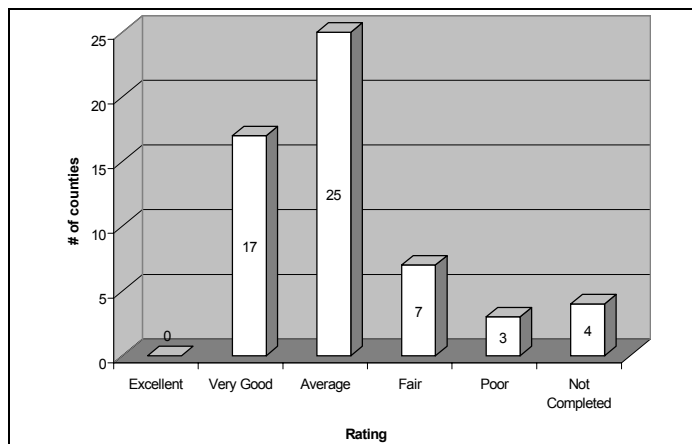


Chart 3: County CHA Rating for Section 1B

Major Findings

- Four of the 56 counties who submitted the CHAs did not complete this section, and a significant number did not prepare this section according to the new suggested CHA guidance format.
- Among the providers/resources most often mentioned were: Hospitals/Inpatients/ER; County DOH Preventive Services; Dental; Private Physicians; County DOH Clinic Services; Prenatal and perinatal care; Elder Care; Health Center/Clinics; Mental Health; Other Prevention/education/Outreach; County DOH Prevention Services.
- Among resources least mentioned were: Community-based organizations; Work-site health programs; Substance Abuse and Emergency Medical Services.
- A variety of responses submitted underscored the different types of services provided in the counties. Some counties placed greater emphasis on the LHD's clinic availability.

Recommendations to NYSDOH

- Share models of ways to identify, organize and present resources that relate to priorities and need.
- Rewrite guidelines so counties can understand why this is being asked, and how best to present critical information.
- Specifically encourage counties to evaluate the barriers to health care access in more depth.
- Assist counties with mapping resources.

Section 1C - Populations at Risk

Guidelines: Describe Behavioral Risk Factors

Major Strengths

- Presented appropriate data, making comparisons and providing explanations to give the data meaning.
- Utilized YRBS, or other data from local sources to discuss risk behaviors.

Common Weaknesses

- Section was not completed or submitted.
- Health risk behaviors were not understood or described.
- Few selected behaviors were described, and this does not provide the whole picture.
- Populations were not well defined.

Capacity Building Areas

- 1 Understanding what Behavioral Risk Factors are, and how they can influence health status.
- 2 Helping counties collect, analyze, and present local behavioral risk assessment data.
- 3 Linking findings from this section to rest of CHA .
- 4 Locating and using additional local data sources.
- 5 Accessing electronic data sources.

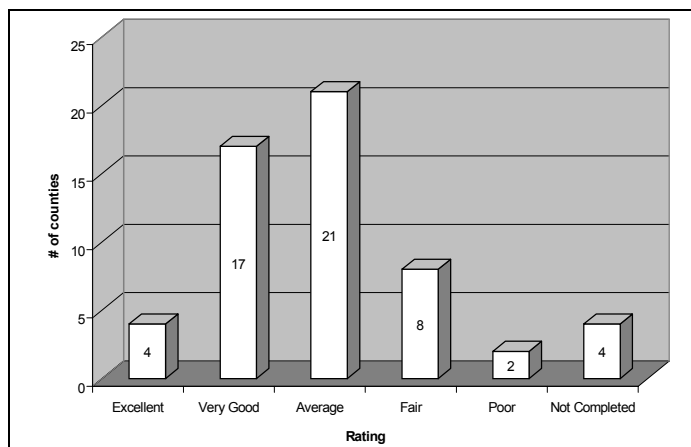


Chart 4: County CHA Rating for Section 1C

Major Findings

- Four of the 56 counties CHAs did not submit this section. In some cases, other reports or sources of data were used to meet the guidelines for the section. Unfortunately these substitutions were often incomplete or did not provide adequate or appropriate information.
- More than half of the counties that completed this section described “underlying” factors of mortality and morbidity using statewide and locally developed behavioral risk factors.
- Counties that were rated high for this section presented appropriate data with interpretation, and linked it to data supplied in other sections.

Recommendations to NYSDOH

- Clarify the meaning of behavioral risk factors, and identify minimal behaviors that should be discussed, and included.
- Help Local Health Departments locate more timely and locally relevant data.
- Enhance and promote use of behavioral risk factor indicators data on the HIN and Other Web Sites.
- Show model uses of data, sources, and standards.
- Familiarize counties with ways to compare local data against regional, state and national standards.

Section 1D - Populations at Risk

Guidelines: Describe Local Health Care Environment

Major Strengths

- Discussed health care resources including Medicaid Managed Care and Child Health Plus.
- Discussed access issues such as transportation, geographic issues, migrant health, immigrants and tourism.

Common Weaknesses

- Local health care environment was described superficially. It did not provide a comprehensive understanding of the health care environment.
- Described selected facets of local health care environment, making it difficult to understand local relationships and service delivery.

Capacity Building Areas

- 1 Assist in analysis of local health care environment.
- 2 Facilitate counties to link analysis of the local health care environment with the community's public health needs and strengths.

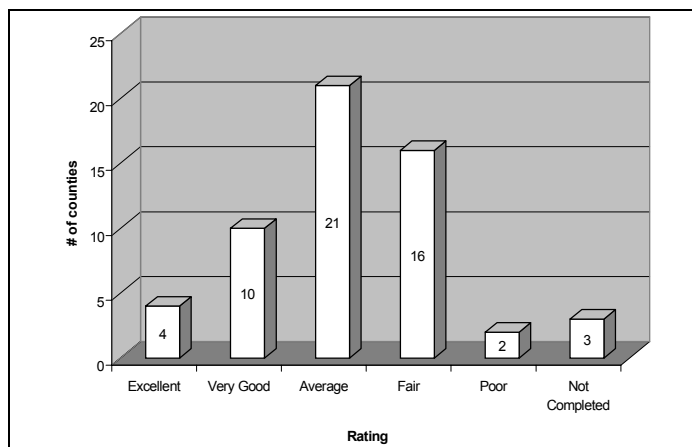


Chart 5: County CHA Rating for Section 1D

Major Findings

- Three of the 56 counties did not complete this section. Most counties had difficulty with section, or covered this information in other areas of the CHAs.
- Overall, counties frequently provided superficial descriptions.

Recommendations to NYSDOH

- Rewrite and clarify guidelines so counties understand to what extent they need to describe the local health environment. Explore if this section may be combined within another section such as Section 1B, Access to Care.
- Show model ways to describe health care environment.

Section 2 - Local Health Unit Capacity Profile

Guidelines: Profile of staff and program resources available for public health activity

Major Strengths

- Analyzed staff needs for training, expertise or increased personnel.
- Included organizational chart or listing to describe size and roles of staff.

Common Weaknesses

- Lacked explanation on whether number of staff, staff's capacity such as training, background and other records of performance were adequate or appropriate.
- Lacked organizational chart, staff description or staffing level details.

Capacity Building Areas

- 1** Using organization charts to describe capacity.
- 2** Using APEX or other organizational review protocol.
- 3** Strengthening capacity by working collaboratively with partner agencies and describing this in the CHA.

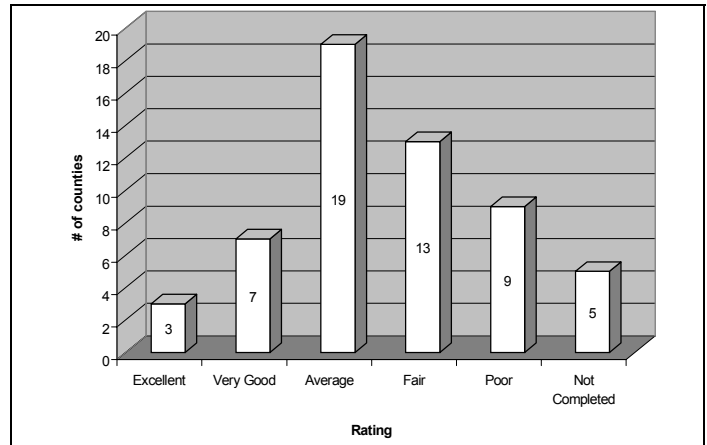


Chart 6: County CHA Rating for Section 2

Major Findings

- Five of the 56 counties that submitted CHAs did not complete this section.
- About 35 counties submitted organizational charts, discussed staffing level, and slightly fewer discussed ability to seek other sources of expertise or resources.
- Only 12 counties discussed or mentioned ever using of APEX or other review protocol.
- Most often counties listed staff member titles, and indicated number of individuals in that title, but failed to analyze adequacy, training, backgrounds in relation to doing an assessment.

Recommendations to NYSDOH

- Guidance for this section needs to be strengthened or clarified so counties understand the minimal information requested, and the purpose for the information.
- Review teams also need clarification on the purpose of this section.
- Re-evaluate whether this section should be integrated with Local Health Care Environment.

Section 3A - Problem and Issues in the Community

Guidelines: Describe profile of community resources

Major Strengths

- Submitted a list of providers, resources, collaborators, and described the role and availability of each of them in relation to current and potential initiatives.
- Mentioned collaborative efforts on development of other assessments, community service plans, or planning process.

Common Weaknesses

- Most counties submitted a list of providers, however, they failed to detail other local health-related resources available.
- Many counties did not detail the relationship between these partners, which presented an incomplete snapshot of the community's situation.
- Most counties did not discuss service accessibility and availability, outreach efforts and availability of services for Medicaid recipients.

Capacity Building Areas

- 1 Strategies or tools in profiling community resources that provide useful information to help determine community assets as well as unmet needs.
- 2 Describe relationship between community resources and provider with respect to public health priorities.

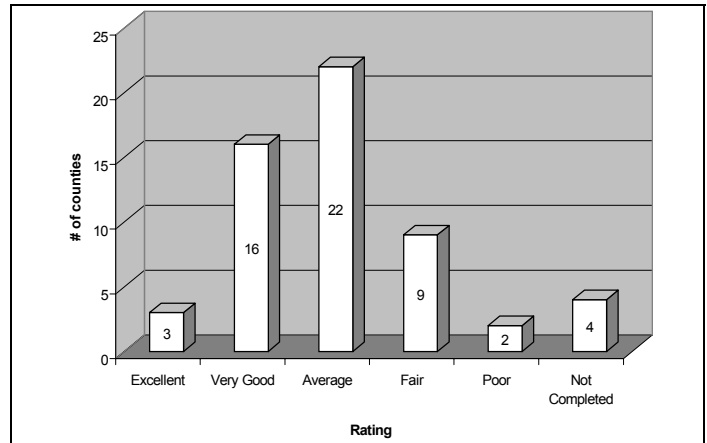


Chart 7: County CHA Rating for Section 3A

Major Findings

- Four of the 56 counties did not complete this section.
- In general this section was often incompletely addressed. For example, most counties submitted a list of healthcare providers, however, they failed to detail other local health-related resources available.
- Most counties did not discuss access to preventive health services for Medicaid recipients.

Recommendations to NYSDOH

- Guidelines need to be revised, and better integrated with Section 1B-Access to Services, as many counties did not complete this section or use the new guidelines.
- Enhance and promote model sections on the HIN and other web sites.

Section 3B - Problems and Issues in the Community

Guidelines: Profile of Unmet Need for Services

Major Strengths

- Identified priorities and problems.
- Listed priorities were outside the purview of the local health unit; this implies an understanding that non-health related factors influence, health, wellness and services.

Common Weaknesses

- Unmet needs and/or gaps were described using only anecdotal evidence such as the opinion of few residents instead of basing the needs on a representative sample.
- Counties did not mention all priorities.

Capacity Building Areas

- 1 Linking problems and need to other sections of CHA so that it is more comprehensive.
- 2 Explaining processes for developing local priorities using multiple sources of information.
- 3 Illustrating strategies for determining “unmet need”.

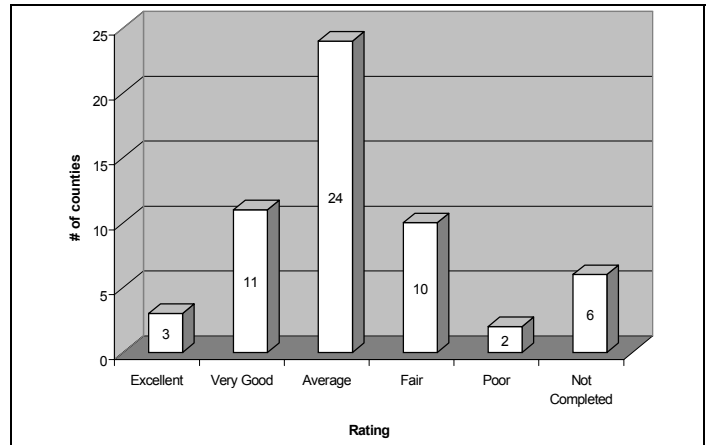


Chart 8: County CHA Rating for Section 3B

Major Findings

- Six counties that submitted CHAs did not complete this section.
- The manner in which this section was completed varied greatly from county to county, but most comprehended the purpose of this section.
- Counties identified priorities and problems, but often failed to provide solutions in the CHAs.
- Used anecdotal evidence to identify gaps.
- While counties listed priorities that were outside the purview of the local health department, counties failed to explain how the LHD could impact the problem, if at all.

Recommendations to NYSDOH

- Guidelines seemed to be clear.
- Re-examine the placement of this section. For example, a few counties discussed population at risk, and then discussed related problems and issues, followed by opportunities for action. Reviewers noted that organizing discussion around specific populations or priority areas was an effective and cohesive way to present information.

Section 4 – Local Health Priorities

Guidelines: Describe new areas identified as priority by recent collaborative efforts

Major Strengths

- Referred to data presented in previous sections, and explained priorities that were based on data among counties rated highly.
- Included partnerships and resources that could be used to address the priority.
- Described strategies that might be pursued.
- Clearly explained process used to identify priorities.

Common Weaknesses

- No meaningful linkage of data with corresponding priorities among counties rated average or lower.
- Identified priorities in this section that were not identified as problems/priorities in other parts of the CHA.
- Priorities often based on areas currently receiving funding rather than using data to set priorities.

Capacity Building Areas

- 1** Providing skills and tools for strategic visioning.
- 2** Facilitating training on cross-referencing related issues in a CHA.
- 3** Provide skills and tools for priority setting techniques and processes.

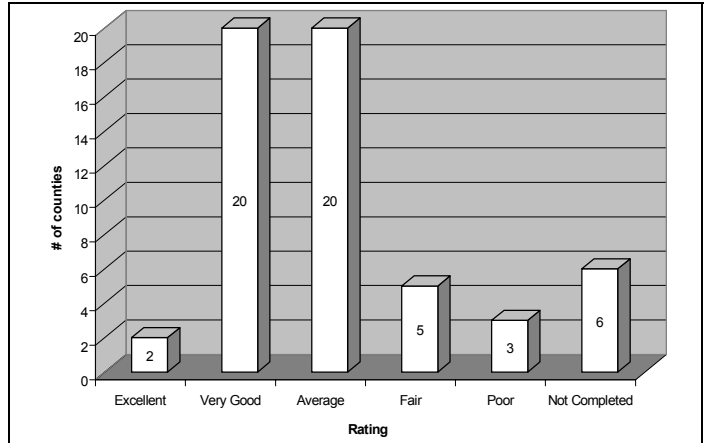


Chart 9: County CHA Rating for Section 4

Major Findings

- Six counties did not complete this section.
- The proper linkage of data with corresponding priorities was a consistent problem in this section.
- 38 counties attempted to identify strategies to address the priorities, and described the process that led to the identification of the priorities. However, some did a better job than others in describing their process.

Recommendations to NYSDOH

- Guidelines need to be clarified.
- Help Local Health Departments relate data to priorities.
- Enhance and promote use of model sample of this section on the HIN or other web sites.

Section 5 - Opportunities for Action

Guidelines: Identify opportunities that will alleviate priority public health problems

Major Strengths

- Addressed all components of the guidance which included listing priorities for their county, describing the strategies to address the priorities, listing potential partners for the initiatives and their roles, and in some cases, detailing the LHD's capacity to perform the necessary activities, education and outreach.

Common Weaknesses

- All components suggested in the guidance document were not completed. For example, some counties simply provided a list of potential partners to show the opportunities and resources available to the LHU but did not explain them or the relationships.
- Presented priorities in this section that were different from priorities listed in other section of the CHA
- While counties listed priorities that were outside the purview of the local health department, counties failed to explain how the LHD could impact the problem,
- Section was not integrated with problems identified in section 3B.

Capacity Building Areas

- 1** Effective strategic planning and preparing action plans.
- 2** Develop and distribute resources to help local health departments build or strengthen coalitions and consensus.

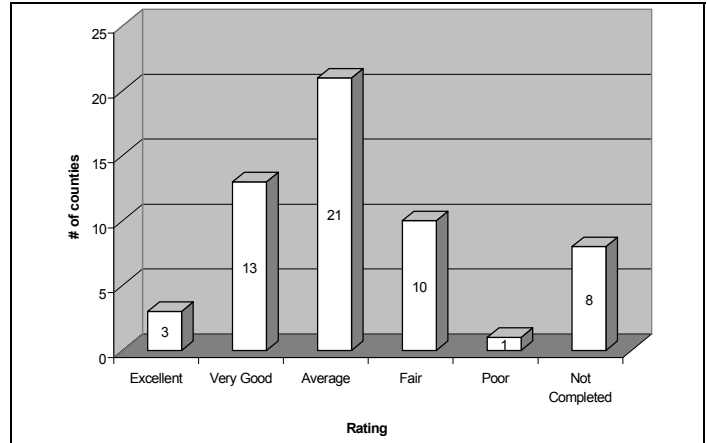


Chart 10: County CHA Rating for Section 5

Major Findings

- Eight of the 56 counties who submitted CHAs did not complete this section.
- Counties with the best submission tended to address all components of the guidance.
- Community-based organizations and health care providers/insurers were mentioned most often for contribution or roles played, while the food industry and media and non-traditional partners were mentioned less often.

Recommendations to NYSDOH

- Guidelines were clear, however, could be reorganized. Some counties described data, resources, gaps and opportunities for action all together. This made the CHA flow better.
- Enhance and promote model sections on the HIN and other web sites.
- Develop and distribute resources for coalition building and consensus-building.

Section 7 – Report Card

Strengths

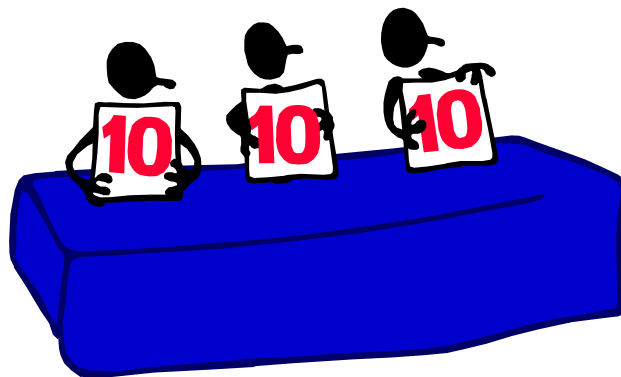
- Provided clear statements on whether priority health issues were identified.
- Provided summaries of issues.
- Analyzed trends thoughtfully.
- Used graphics to present data.
- Presented information in eye-catching manner.
- Stated clear goals.
- Outlined next steps.

Weaknesses

- Comparisons were not made against state or national standards. Thus it was unclear if the health issue discussed in the report card was doing better or worse.
- Used only state-generated indicators without including local priorities.
- Stated goals that were unrealistic.
- Data sources were not cited.

Capacity Building Areas

- 1 Familiarizing with ways to develop report cards or community health indicators.
- 2 Increase knowledge and skills about social marketing.



Major Findings

- Only 17 of the 56 counties submitted report cards, and 8 counties indicated it was under development.
- Report cards, and sections around priority issues created as stand-alone documents tended to be of higher quality. Those that were of poor quality just presented data, and did not summarize conclusions on the community's health.

Recommendations for NYSDOH

- Provide technical assistance to counties for developing a report card or community health indicators report.
- Initiate dialogue with counties and identify challenges of developing a report card, and address issues identified.
- Enhance and promote model report cards or similar documents on the New York State Department of Health and other web sites.

Generalizations about the Quality of the CHA

Major Strengths

- Appropriate use of charts, tables, graphs, and other information presentation aids.

Common Weaknesses

- Public Health Priorities not identified or explained.
- Disjointed and inadequately referenced.
- Roles or services of community partners not identified.
- Did not provide a summary for the CHA.

Capacity Building Areas

- 1 Improving on strategies for organizing and presenting information in CHA.
- 2 Enhancing skills on writing a usable and readable CHA.

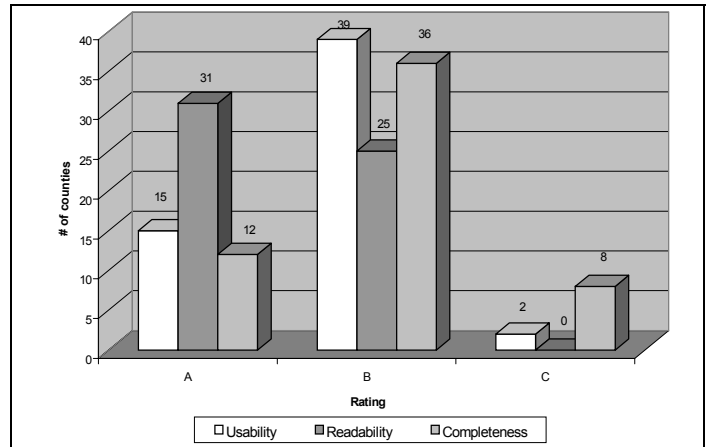


Chart 11: Section 7 Ratings by Usability, Readability and Completeness

Major Findings

- CHAs rated highly on usability were well written; sections were adequately referenced; used current data; summarized the sections; and survey methodology was credible.
- CHA rated highly for readability were grammatically correct, and easy to read; used charts, maps and tables to explain data rather than only in narrative form; included relevant tables in the main report rather than attaching in the appendix; adequately referenced content in appendix; and appropriately organized the content under sub-headings in a logical order.
- CHAs rated highly for completeness included all sections requested in the suggested new guidance document. Among the issues most commonly missing were Opportunities for Action, Health Care Environment and discussion of provider capacity, Local Health Priorities, and Profile of Community Resources.

Recommendations for NYSDOH

- Provide guidance on extent of detail required for each section.

V. Correlating observations to Needs Assessment Survey

In summer 1998, 55 of the 58 counties completed a Community Assessment and Information Training Needs Survey developed by the Public Health Information Group as part of the CDC Assessment/Turning Point initiatives. The surveys indicated that Vital Records such as death, pregnancy and birth data were most utilized by counties, and that counties relied on State Department of Health Data. This fact was reflected in the CHAs reviewed.

Among the significant barriers reported in the survey were 'knowing where the source of data is', 'availability of small area (e.g. zip code, neighborhood) data', and 'Timeliness and availability of recent data'. It was evident that sub-county data was not included in majority of the CHAs. In addition, some of the CHAs were rated poorly because they did not use the most recent data available through the New York State Department website and publications. It is not clear if these counties used outdated data because they did not know where to locate it, or if they did not have access to the data.

In addition, three quarters of the counties responding to the survey said they would like training in predominantly epidemiological and surveillance-oriented skills areas. The areas in which counties indicated an interest in are listed in Table 1 below.

Table 1: Skills Areas Of Interest Identified By Counties

Skill Area	Percent Requesting Training/TA (%)	Priority Rank for Training/TA*(%)
Design and implementation of data collection systems	77.8	4
Assessment Models (APEX/PH, PATCH)	75.9	1
Development of report cards and performance measures	74.1	7
Using small area analysis or mapping	72.2	9
Program evaluation	64.8	8
Data Analysis	61.1	6
Use of Spreadsheets (Excel, Lotus)	57.4	3
Use of the HIN to obtain other information	52.7	2
Community Health Assessment Theory and Methods	50.0	5
*Note: The Priority Ranking indicates an ordering of the item's average "priority rank" among all averaged responses		

It is interesting to note that the priority rank and the percentages of counties requesting specific training or technical assistance do not directly correspond. This is due to the fact that slightly fewer counties indicated a need for additional training in a certain area, but those counties placed it at a higher priority, which increased the skill area's overall priority rank. Counties were allowed the opportunity to provide rankings from 1 to 20 from greatest to least priority, respectively. Therefore, an average priority rank less than ten signifies that the skill area is a high priority for a majority of the responding counties.

The skill areas identified through this survey are consistent with needs reflected in the CHAs reviewed. One area not listed in the list above is an understanding what 'Behavior Risk Factors are, and how they influence health status. This need was identified through CHA Reviews.

VI. Next Steps

The next steps in this process involve:

1. **Share review and get feedback:** The findings of the Review will be shared among counties and community partners. In addition, individual counties will receive feedback on CHAs submitted.
2. **Prioritize technical assistance/training opportunities:** An exhaustive list of technical assistance/training opportunities has been identified. Opportunities will be prioritized with assistance from counties. In Spring 2000, a basic epidemiology course "Public Health Data: Our Silent Partner" will be offered to staff from LHD's and to community partners.
3. **Prioritize/Address data needs and ways to make data available for CHA Update in 2000:** A list of data resources will be distributed. State department of health staff will work with counties that submitted outdated data, or presented data poorly, and will implement strategies for improving data access and presentation.
4. **Post model sections and/or CHAs on HIN:** CHA reviewers identified model sections of CHAs. Counties will be asked for permission to post these sections on the web for other counties to reference.
5. **Review, revise, clarify CHA guidelines:** During the feedback process with counties and community partners, they will be asked specific questions on modifications suggested for the CHA guidelines.