Chapter 4

Choosing Health Priorities

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Introduction

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

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

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

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

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

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

Using data to identify health problems

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

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

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

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

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

For example:

List of Health Problems

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

Selecting the intervention focus

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

Identifying which problem(s) to address first

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

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

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

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

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

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

Determining capacity

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

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

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

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

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

Using the matrix

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

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

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

Existing Community Programs/Policies Matrix

Health Problem: _____

Behavioral Risk Factor: _____

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

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

Targeting the community and specific groups

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

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

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

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

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

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

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

For example:

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

Writing goals and objectives

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

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

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

For example:

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

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

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

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

PATCH uses two types of objectives to clarify community goals:

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

Writing community goals

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

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

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

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

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

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

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

Writing behavioral and intervention objectives

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

Community goal:

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

Behavioral objectives:

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

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

Intervention objectives:

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

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

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

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

Using state and national health objectives

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

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

Preparing for the phase III community group meeting

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

Adapting phase III to address a specific health issue or population

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