

## Community Engagement

# Community Views and Public Health Priority Setting: How Do Health Department Priorities, Community Views, and Health Indicator Data Compare?

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**Objectives.** *New York, like many other states, provides county-level health statistics for use in local priority settings but does not provide any data on public views about priority health issues. This study assessed whether health department priorities are notably different from community concerns about health, and how both groups' priorities compare with local health statistics. Method.* *Data from a 2009 rural survey on community health concerns were compared to priorities named by the seven area county health departments, and to local health indicator data. Results.* *Health care/insurance cost (60%), obesity (53%), and prescription cost (41%) were leading community concerns, regardless of age, education, sex, or Internet in the home. Six of seven county health departments selected access to quality health care (which includes health care/insurance cost) as a leading public health priority, but only three identified obesity. The following leading local health issues were suggested by health indicators: Physical activity and nutrition, Smoking, and Unintentional injury. Conclusions.* *Health departments diverged from community priorities, from health indicator data, and from one another in choosing priorities. Adding a question about community health priorities to existing state telephone surveys on health behavior and lifestyle would provide an important tool to local health departments.*

**Keywords:** *community assessment; program planning and evaluation; rural health, needs/assets assessment; surveys*

## ► INTRODUCTION AND BACKGROUND

All across the United States, city and county health departments provide a range of critical health services, from low-cost clinics to community education and prevention programs. In recent years, many state departments of health have required local health departments to develop formal strategic plans, called Community Health Assessments (CHAs; National Association of City and County Health Officials, 2012; New York State Department of Health [NY DOH], 2008; North Carolina

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**Authors' Note:** *This research was largely supported by the Bassett Healthcare Network. Additional support was provided by Community Memorial Hospital, Hamilton, New York; and the Golub Foundation, Schenectady, New York. The authors would like to acknowledge significant assistance and participation by County Public Health Departments of Chenango, Herkimer, Delaware, Madison, Montgomery, Otsego, and Schoharie Counties, New York, as well as the residents of these counties. Underlying research materials can be obtained by contacting the Bassett Research Institute, Bassett Healthcare Network. Address correspondence to Giulia Earle-Richardson, Epidemiologist, Bassett Medical Center Research Institute, Bassett Medical Center, One Atwell Road, Cooperstown, NY 13326, USA; e-mail: GERglobal2014@gmail.com.*

### Health Promotion Practice

January 2015 Vol. 16, No. (1) 36–45

DOI: 10.1177/1524839914528180

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Department of Health and Human Services, 2010). These CHAs are increasingly being used by local health departments seeking federal accreditation (Robert Wood Johnson Foundation, 2011), and by nonprofit hospitals, in anticipation of the Affordable Care Act requirement that they conduct such assessments by 2014 (U.S. Department of Health & Human Services, 2012).

In New York, as in many other states, the Department of Health provides a range of county-level disease and injury indicators for local health departments to use in planning. Telephone survey data from the Behavioral Risk Factor Surveillance System (BRFSS) provide prevalence information on a range of health conditions and behaviors (Centers for Disease Control and Prevention, 2013). State databases of hospitalization, mortality and cancer diagnoses are also provided, painting a more complete picture of disease and injury at the county level than was previously available. The NY DOH has identified 50 key indicators that pertain to 10 broad categories of public health: *Access to quality health care; Chronic disease; Community preparedness; Healthy environment; Healthy mothers, healthy babies, healthy children; Infectious disease; Mental health and substance abuse; Physical activity and nutrition; Tobacco use; and Unintentional injury* (NY DOH, 2011).

In addition to using health indicator surveillance data, local health departments are expected to incorporate meaningful community involvement into their planning process (NY DOH, 2008; National Association of City and County Health Officials, 2012); however, in small rural health departments, gathering meaningful public opinion data can be challenging. For example, among the seven local health departments in the study region, only one used randomized public survey data in its analysis (Chenango County Public Health Department, 2009; Delaware County Public Health, 2009; Herkimer County Health Department, 2009; Madison County Department of Health, 2009; Montgomery County, 2010; Otsego County Health Department & Bassett Research Institute, 2009; Schoharie County, 2009). Instead, most health departments used a small number of focus groups, community meetings, or other methods of gathering input that can reach only a small and unsystematic sample of the community.

The CHA process is rooted in the socioecological model of health and health behavior (Levy et al., 2004; McLeroy, Bibeau, Steckler, & Glanz, 1988; Stokols, 1996). This theoretical framework posits that health is influenced by a range of interacting individual, interpersonal, group, community, and policy influences. From this perspective, health departments can positively affect health of populations best by understanding a range of influences on health that may be external

to the individual. This perspective also overlaps with the participatory health promotion tradition first popularized by Paulo Freire (Wallerstein, 1992; Wallerstein & Bernstein, 1988) and now applied to health in the form of community-based participatory research (Israel, Eng, Schulz, & Parker, 2005). The participatory health perspective asserts not only that community members are important sources of health information but also that the community is the most appropriate body for making community health planning decisions. To the extent possible, health professionals should serve only as advisors to the community. These two theoretical constructs underpin the research question presented here regarding the state of the community voice in rural health decision making.

Currently there is little published research on the priority setting process in rural communities (Fuller, Bentley, & Shotton, 2001; Horne, Miller, Silva, & Anderson, 2013; Timmons et al., 2007), and no research looking at the potential benefits of adding questions about health concerns and priorities to current health surveys such as the BRFSS. In the current study, we present the results of a community survey on health priorities across a seven-county region of rural New York State, and compare them to county health department priorities and to local health statistics for the region.

## ► METHOD

### *Rural Household Survey*

*Upstate Health and Wellness Survey.* In 2009, a household survey of residents in a rural seven-county region (Chenango, Delaware, Herkimer, Madison, Montgomery, Otsego, and Schoharie) of Upstate New York was undertaken by a regional health care network. It had been preceded by two previous health surveys using the same general design in 1989 and 1999 (Jenkins, Earle-Richardson, Burdick, & May, 2008). The survey was mailed to 18,339 eligible households (permanent noncommercial residences) and could be completed and returned by mail or via Internet. The random sample of eligible households was drawn from a commercially available sampling frame (Genesys Corporation, Fort Washington, PA).

The survey was structured so that one individual answered a range of individual and household health questions. This “index respondent” was also asked, “In your opinion, what are the biggest health problems in your community today?” They were provided a list of 29 possible responses, and blank write-in space. The response list was based on the NY DOH 10

priority areas for tracking from its Prevention Agenda Toward the Healthiest State (NY DOH, 2011). This list was extensively pilot-tested with health departments, community agencies, meetings of community volunteer groups, and focus groups. This was done to devise a response list that offered the most common response choices, and it provided a free-text space for less common responses. Respondents were also asked whether they would like to be contacted if new programs or services related to health conditions they named were to become available. Researchers calculated frequencies of answering this question positively for each of the 10 leading community health concerns. Human subjects' protection approval was obtained from the Bassett Medical Center Institutional Review Board.

Following the Dillman (1978) method, a publicity campaign then began 6 weeks prior to the initial mailing of the survey. This included advertisements in several newspapers, television and radio appearances throughout the seven-county area, and presentations to area hospitals and health departments.

Each household was mailed an initial postcard 2 weeks before the survey. Surveys were then mailed along with a self-addressed return envelope, a study information sheet, and a coupon for a free quart of milk. Respondents were also entered into two drawings for a \$100 grocery store gift card. A reminder letter with a replacement survey was mailed to those who did not respond to the initial mailing within 3 weeks.

Survey recipients who did not return the replacement survey were termed *nonresponders*. This nonresponder group was divided into households with and without published telephone numbers, and a random sample of each was recontacted either by telephone or by mail and offered \$20 to complete the survey. The data from the initial responders were combined with the data from the two separate nonresponder groups to form single estimates of prevalence using a simple extension of the weighting methodology for multi-stage sampling described by Neyman (1938), Hanson, Hurwitz, and Madow (1993), and Jenkins et al. (2008).

### **Survey Data Analysis**

*Postcollection Editing and Response Coding.* Whenever possible, the free-text responses were assigned to one of the 29 listed items. In certain cases, new categories were formed. Due to the subjective nature of this process, two researchers did this coding separately and then met with a third researcher to resolve any differences in coding. Once all of the responses were coded, simple frequencies were calculated.

Frequencies were also stratified by age-group (20-34, 35-64, 65+), education (no college vs. at least some postsecondary education), sex, and having Internet in home (yes/no). To determine whether the ranking of priority issues varied according to any of these factors, rank orders were tested using the Kendall coefficient of concordance ( $W$ ), which calculates the probability of the observed level of agreement occurring due to chance alone. Thus,  $p$  values at .05 and below indicate significant agreement. Race/ethnicity was not considered in this analysis since the sample is over 95% Caucasian.

### **Comparison Data**

*Identifying the Indicators of Leading Health Disparities for the Seven-County Region.* Researchers used the state's 50 key health indicators identified in its Prevention Agenda Toward the Healthiest State initiative (NY DOH, 2011), as a source for comparison between seven county means and state means. These indicators came from a range of sources: BRFSS, hospital discharge data, cancer registry, death certificates, and others. For example, one state health indicator was "% of adults who are obese (body mass index > 30)." When averaged across all of the study counties, the mean seven-county prevalence is 28.9%. For New York State as a whole, the prevalence is 24.5%. Therefore, the seven-county region has a disparity of 4.4 percentage points, or a prevalence 18% higher than the state. Each local indicator was classified as "poorer" than the state if it showed disease prevalence<sup>1</sup> at least 10% higher than the state. Similarly, any indicator in which the prevalence was at least 10% lower than the state was classified as "better" than the state. The rest were classified as being "the same" as the state. For positive health indicators (e.g., early-stage cancer diagnosis), the same process was used, only reversing the comparison such that "better" than the state meant higher local prevalence<sup>1</sup>.

*County Health Department Priorities.* The third source of data came from the 2010-2013 CHAs published in 2009 by the seven county health departments. These were obtained either from the county website or through direct request to the county health director. Counties are directed to identify three priority issues from among the ten specified by the health department through its Prevention Agenda Toward the Healthiest State (NY DOH, 2011). Researchers reviewed the reports and recorded each health department's stated top public health priorities.

## ► RESULTS

### Survey Respondent Characteristics

Across the seven study counties, there were in all 6,067 index respondents aged 20 or older. Although the initial response rate was 29.3%, the use of two additional waves of random sampling from among nonresponse households using incentives allowed researchers to increase the percentage of the population represented by the sample to 48.3% using the multistage sampling and weighting protocol. In addition, because the sample was found to be significantly older than the seven-county population, the study sample responses were further weighted to more accurately represent the age distribution of the seven-county region. Table 1 shows the demographic characteristics of the survey sample.

### Community Health Concerns

In all, 5,631 respondents selected at least one community health concern (92.8%). As shown in Table 2, the top three community health concerns were *health care/ health insurance cost* (61%), *obesity* (54%), and *prescription cost* (39%).

### Comparison of Health Concerns According to Age, Gender, Education, and Internet in the House

Table 3 shows the leading community health concern rankings stratified by four demographic characteristics. The statistical tests for concordance indicate that there was strong agreement across age strata ( $p = 0005$ ), sex ( $p = .0451$ ), and Internet in house ( $p = .0484$ ). Of all of the strata, the group “at least some college” is the only one where the order of the top three concerns varies notably. Rather than the *cost of health care*, *obesity* is the leading concern for this group (*cost of health care* being second), and *physical inactivity* moves into third place ahead of *prescription cost*. The higher education group appears to rank financial concerns slightly lower than any other stratified groups. There are other slight differences in rankings, for example, females, no college, and no Internet in the home rank physical inactivity slightly lower than other groups. Overall, there were few differences in item ranking across the groups. Although not shown in Table 3, there was also strong agreement across the seven counties (Kendall’s test of concordance,  $p < .0001$ ).

### Comparison of Health Concerns According to Employment Type

Issue choice order was also assessed by employment type, using the following categories: *unemployed*,

**TABLE 1**  
Rural New York State Household Survey Index  
Respondent Characteristics, 2009,  $n = 6,067$

Characteristics	Study Sample (Weighted), %
Age range	20 <sup>a</sup> -102 years
Median age among adult respondents	55.2 years
Male	60.7 <sup>b</sup>
Caucasian	95.6
Highest level of education	
Less than 12 grade	6.2
12th grade or GED	43.1
4-year college or graduate degree	27.5
Other (2-year college, professional certificate, or training)	23.2
Employment status (“Check all that apply”)	
Employed full-time or self-employed	54.4
Retired	31.4
Employed part-time	8.5
Homemaker	5.4
unemployed	5.0
Student	0.9
All others	8.6
Professional classification	
Staff/worker	37.3
Professional/specialist	31.6
Management	17.4
All others	13.7

a. 20 years was used as the age cutoff for adults because the federal census age-groups on which the weighting was based used 20 years as the youngest adult age.

b. The preponderance of male index respondents is believed to have resulted from the Genesys Corporation sampling frame, which named mail individuals more frequently (66% of time) in the address list. Once it was determined that choice of priority health issue was not associated with sex, no further steps were taken to account for this imbalance.

*retired, homemaker, farm employed, nonfarm employed* (staff or worker), and *nonfarm employed* (management or professional). *Student* was initially also a stratum but was eliminated due to extremely small cell size. Choice of the top two issues (“health care/health insurance cost” and “obesity”), was consistent across employment type. There was some minor variation,

**TABLE 2**  
**Leading Community Health Concerns Among Index Respondents and Interest in Being Contacted Again, Seven-County Survey Respondents, New York, 2009, n = 6,067 (Index Respondents Aged 20+)**

	<i>Number (Proportion<sup>a</sup>) Naming Issue as Leading Community Health Concern<sup>b</sup></i>	<i>Number (Proportion) Willing to Be Contacted in Future for Programs<sup>b</sup></i>
Named at least one concern	5,631 (92.8)	
1. Health care/ health insurance cost	3,342 (61.2)	1,901 (60.0)
2. Obesity	3,105 (53.5)	1,738 (59.1)
3. Prescription cost	2,315 (39.1)	1,335 (61.3)
4. Physical inactivity	1,737 (30.6)	979 (60.4)
5. Shortage of doctors	1,660 (28.7)	956 (61.6)
6. Stress	1,447 (28.2)	895 (65.3)
7. Dental care	1,465 (25.9)	935 (68.1)
8. Alcohol abuse	1,219 (20.9)	690 (61.2)
9. Drug abuse	1,154 (20.2)	670 (62.3)
10. Working too much	807 (17.2)	479 (60.6)

a. Percentages weighted for age and sampling stage

b. Because multiple selections are permitted for each respondent, these percentages can sum to greater than 100%

with “dental care” being slightly higher in ranking among the unemployed and homemakers (placing “physical inactivity” lower). Also among the three employed categories, “working too much” was ranked more highly than among the nonworking groups.

### **County Health Department Priority Choices**

The seven county health departments in the study region were asked to identify three public health priority areas for the coming 3 years from among 10 areas provided by the state. Six of the seven county health departments selected *Access to quality health care* as their leading public health priority, while one selected *Tobacco use* as its top priority. Their choices for second and third priority were mixed between *Physical activity and nutrition* ( $n = 3$ ), *Mental health/substance abuse* ( $n = 3$ ), *Chronic disease* ( $n = 3$ ), *Tobacco use* ( $n = 1$ ), and *Healthy mothers, healthy babies, healthy children* ( $n = 1$ ). Although not part of the 10 choices offered by the state, one health department named *Community economic development* and *Health literacy* as priorities.

### **Comparison Between Leading Community Health Concerns and Local Health Disparity Indicators**

Table 4 shows how the 10 leading community health concerns chosen through community survey compare with the priorities of the seven county health

departments. To simplify the comparison, each of the 10 survey responses is grouped under the corresponding health topic designated by the NY DOH (since the state topics are broader). Table 4 shows that all 10 of the community survey priorities fit into three of the 10 health priority areas defined by the state: *Access to quality health care*, *Physical activity and nutrition*, and *Mental health and substance abuse*. Table 4 also shows that county health departments and the survey sample substantially agree that *Access to quality health care* is the issue of greatest concern.

There is less emphasis by health departments on the other two topics of greatest public concern: *Physical activity and nutrition* and *Mental health and substance abuse*. Only three of the seven health departments selected either topic among their top three priority issues. In terms of seven-county health indicator data compared to state means, the highest proportion of indicators showing poorer health in the seven-county region were *Tobacco use* (1 out of 1), *Physical activity and nutrition* (3 out of 4), and *Unintentional injury* (3 out of 5). The specific indicators showing local disparities within these leading categories were: cigarette smoking in adults: 23.3% (vs. New York: 18.1%); obese adults (body mass index > 30): 28.9% (vs. New York: 24.5%); obese children 2 to 4 years (Special Supplemental Nutrition Program for Women, Infants and Children): 15.0% (vs. New York: 13.1%); adults

**TABLE 3**  
**Rank<sup>a</sup> of Leading Health Concern by Age-Group, Gender, Education, and Internet in Household, Seven-County Survey Respondents, New York, 2009, n = 6,067 (Index Respondents Aged 20+)**

	<i>Ranking Concordance Between Strata (Significance Indicates Concordance)</i>									
	%	<i>Age, p = .005, Rank Order</i>			<i>Sex, p = .0451, Rank Order</i>		<i>Education, p = .0597, Rank Order</i>		<i>Have Internet in Household, p = .0484</i>	
		20-34	35-64	65+	Male	Female	No College	Some College	Yes	No
1. Health care/health insurance cost	61.2	1	1	1	1	1	1	2	1	1
2. Obesity	53.5	2	2	2	2	2	2	1	2	2
3. Prescription cost	39.1	3	3	3	3	3	3	4	3	3
4. Inactivity	30.6	5	5	5	4	7	7	3	4	6
5. Shortage of doctors	28.7	7	6	4	6	4	6	5	6	4
6. Stress	28.2	4	4	9	5	5	4	6	5	7
7. Dental care	25.9	6	7	6	7	6	5	7	7	5
8. Alcohol abuse	20.9	10	8	8	8	8	9	8	8	9
9. Drug abuse	20.2	9	10	7	9	9	8	9	9	8
10. Working too much	17.2	8	9	10	10	10	10	10	10	10

a. Percentages weighted for age and sampling stage. Rankings based on weighted percentages.

eating five or more fruits or vegetables per day: 24.2% (vs. New York: 26.8%); motor vehicle-related mortality (per 100,000): 12.7 (vs. New York: 6.1); unintentional injury mortality (per 100,000): 32.2 (vs. New York: 22.7); and unintentional injury hospitalizations (per 10,000): 74.8 (vs. New York: 64.0). Overall, there were 17 health indicators in which seven-county means were classified as “poorer” than the state.

## ► DISCUSSION

There was a high degree of agreement across the community about the top priorities, *high cost of health care /insurance* and *obesity*. Half of all respondents chose these two issues, showing great concern about these issues. These concerns largely transcend age, sex, education, or employment type. The extent of agreement about health care cost is perhaps not surprising, given the current national health care cost crisis. However the level of agreement that obesity is a priority concern was more surprising. Although some public opinion poll data confirm the high level of public concern about obesity (Gold, 2009; Lake, Snell, Perry & Associates, 2003), the extent to which this concern would be observed in a rural community with

high levels overweight and obesity was previously unknown.

*Health departments appear to be basing priority decisions on factors other than community priorities or local health disparities suggested by health indicator data.* Given the consistency of both public opinion and health indicator data across counties, it is surprising that there was so much diversity among the seven health departments in terms of their priority choices. Although six of the seven named *Access to quality health care* as the top priority, no two health departments chose the same top three priorities overall. In the priority-setting guidance, health departments are instructed to use health indicator data, community input, and an analysis of community strengths, resources, and opportunities to guide priority setting. Although it is possible that the counties are diverse in terms of community strengths, resources, and opportunities, other research has shown that prioritizing is not always an entirely objective process. For example, in a recent study of the prioritizing process in North Carolina, researchers found health directors generally used subjective criteria more often than objective criteria when deciding on the most important health issues in their communities, even though county representatives

**TABLE 4**  
**Comparison of Leading Community Health Concerns From Survey,<sup>a</sup> County Health Department Priorities, and New York State Health Indicators Grouped by New York State Priority Topic Areas**

Survey Rank	Community Health Concerns From the Survey	% of Survey Respondents Indicating Concern	County Health Departments Selecting Issue <sup>b</sup>	How Health Indicators for Seven Counties Compare to State in Topic Area <sup>c</sup>
	Access to quality health care		6/7 health departments	1 poorer 3 same 0 better
1	Health care/health insurance cost	61.2		
3	Prescription cost	39.1		
5	Shortage of doctors	28.7		
7	Dental care	25.9		
	Physical activity and nutrition		3/7 health departments	3 poorer 1 same 0 better
2	Obesity	53.5		
4	Inactivity	30.6		
	Mental health substance abuse		3/7 health departments	1 poorer 2 same 1 better
6	Stress	28.2		
8	Alcohol abuse	20.9		
9	Drug abuse	20.2		
10	Working too much	17.2		
	Chronic disease		3/7 health departments	5 poorer 6 same 6 better
	Unintentional injury		0/7 health departments	3 poorer 1 same 1 better
	Healthy mothers, healthy babies, healthy children		1/7 health departments	1 poorer 3 same 2 better
	Tobacco use		1/7 health departments	1 poorer 0 same 0 better

a. Leading 10 concerns from the survey were categorized into the New York Department of Health's 10 priority health areas so that they correspond with health department priorities and indicator data. In addition to the seven categories shown in the table, *Community Preparedness*, *Healthy Environment*, and *Infectious Disease* were categories that were not selected by survey or health department or suggested by New York state indicator.

b. Each health department was charged with identifying three health priorities for the 2010-2013 period. The total number of priorities selected is 17 rather than 21 (7 × 3) because two health departments only selected two priorities, and one health department named two priorities not on the list of ten (*health literacy* and *community economic*).

c. Seven-county indicators not differing by 10% or more from state means were considered the same.

stated that objective criteria were more important (Platonova, Studnicki, Fisher, & Bridger, 2010). Even when the prioritizing process is highly systematized (Erwin et al., 2013), priorities are still established based on the preferences of those at the table, and the extent to which decisions are evidence based is unknown. Although local health departments and their collaborators may be well qualified to make subjective prioritizing decisions, the fact that the logic behind the choices is not clear is reason for some concern.

### **Implications for Practice**

*Health departments could benefit from having public opinion data along with health indicator data.* These results provide several examples of how community survey data could be very beneficial to the prioritizing process. First, had the study counties known the extent of public concern about obesity, and that so many respondents were willing to be contacted again about the issue, they might have counted the public interest as a local strength in their assessments and established programs that capitalized on the concern. Second, although the group differences were slight, given the fact that three health departments made *Mental health and substance abuse* a priority, it might have been of some value to know that *Stress* was rated more highly within younger age-groups and those with less education. Since there was such a high level of interest in being contacted again, these demographic groups could have received the initial outreach. In more diverse populations, this type of information could be even more valuable. Last, understanding which areas are *not* of public concern could be very instructive. For example, if health departments were aware that unintentional injury was not a major concern for the public, it might choose to begin some public awareness efforts, in light of the fact that the seven-county motor vehicle fatality rate is twice that of the state.

From a socioecological perspective, the lack of high-quality public survey data limits what health departments learn about how the community is thinking on health and about the ways it may be willing to collaborate. For example, from the high rating of concern about obesity and physical inactivity, combined with the high proportions of respondents indicating a willingness to be contacted with further information, suggests that the media and other message sources that have been focusing on obesity may be influencing community views. Furthermore, from a participatory health perspective, it would seem that health departments have some obligation to place issues that are high priorities with the public among their top priorities as well.

### **Limitations**

There are several limitations that must be acknowledged with this study. Because the data are of three different types, the comparability has some limitations. For example, we cannot be sure that although health departments identified *Access to quality health care* as a top priority, they are focusing on health care cost specifically. In addition, the use of local disease prevalence (and other indicators) compared to state prevalence is an admittedly rough indication of the severity of a health problem. Although this type of comparison is widely used, it must be acknowledged that some important problems may be quite severe all across the state and thus not be identified through this process. The inherent differences between different types of health problems may make simple quantitative comparisons insufficient, meaning that more subjective judgments by knowledgeable health department leadership are necessary. Also, looking at health department priorities without further study of their CHA documents limits what can be said about their aims and processes. This study is intended as an initial look at an area that has not been explored before: the correspondence between two objective sources of planning data and the priorities that result. Furthermore, more comprehensive study is needed to fully elucidate the local planning process.

### **► CONCLUSION**

Health department priorities were consistent with community views on the leading issue, *Access to quality health care* (which includes cost of health care/health insurance), although the local area does not appear to be performing notably worse than the rest of the state with regard to access. The second leading issue for communities, *Obesity*, was only partially present among county priorities, even though health indicator data suggest that it is particularly severe problem in the study region. If county health departments had the data showing the high level of public concern over obesity and willingness to learn more about the topic, obesity might have been a top priority among more counties. There are many practical benefits to health departments of having high-quality, systematically collected public opinion data along with health indicator data when doing strategic planning: community views are more accurately represented, it can assist the entire process in becoming more systematic and can provide an important tool for health departments to understand their communities better.

## NOTE

1. The term *prevalence* is used here for brevity; however, indicators included incidence, mortality, and other types of measures.

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