July 2006

Surveillance Survey for the Guide to Community Preventive Services

Prepared for

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The Guide to Community Preventive Services
Coordinating Center for Health Information and Service (CCHIS)
Centers for Disease Control and Prevention
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*RTI International is a trade name of Research Triangle Institute.

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EXECUTIVE SUMMARY

Title: **Surveillance Survey for the Guide to Community Preventive Services**

Contract No: 200-2001-00123, Task 15

Sponsor: **Centers for Disease Control and Prevention**
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1. Statement of the Problem

As part of the Centers for Disease Control and Prevention's (CDC's) responsibilities for providing credible information to enhance health decisions, CDC maintains the *Guide to Community Preventive Services*, also known as the *Community Guide*. The *Community Guide* provides public health practitioners and decision makers with recommendations regarding population-based interventions to promote health and to prevent disease, injury, disability, and premature death, appropriate for use by communities and health care systems.

2. Evaluation Objectives

The key objectives of this evaluation were to (1) obtain information on awareness, use, and appraisal of information related to the *Community Guide*; and (2) explore dissemination of information about the Guide to state and local public health leaders. Information collected through this initial effort will serve as a benchmark for assessing changes in patterns of use and in customer satisfaction among public health decision makers, as the Guide refines its products and expands its dissemination. Future surveillance questionnaires will assess changes over time in how, when, and by whom the *Community Guide* is being used in public health decision making.

3. Methodology

Survey questions were developed by CDC and RTI International (RTI) staff and tested using a cognitive testing strategy with public health professionals. The questionnaire was implemented through a Web-based methodology, complemented by a paper-and-pencil questionnaire for those who preferred this optional data collection strategy. The questionnaire was administered to a census of State Health Directors, State Chronic Disease Directors, and Healthy People 2010 Coordinators, and to a random sample of 503 Local/County Health Directors stratified by public health or U.S. Department of Health and Human Services region. Data collection began on March 8, 2005, and was completed on June 24, 2005. The overall response rate for the survey was calculated at 71%.

Survey respondents were typically experienced in their positions. Ninety percent of respondents had been in their current position for at least 1 year, and 74% had been at their organization for at least 5 years. Respondents' job responsibilities corresponded with opportunities to influence public health decision making. Eighty-seven percent of respondents worked in program or policy planning, and 58% worked in developing grant proposals.

4. Major Findings and Recommendations

4.1 Major Findings

Familiarity with the Community Guide

- More than half (53%) of the decision makers surveyed were familiar with the *Community Guide*.
- State-level decision makers were more likely than local-level decision makers to be familiar with the Guide. State Chronic Disease Directors were most likely to be familiar with the *Community Guide* (86%), followed by State Health Directors (80%) and Healthy People 2010 Coordinators (70%). Awareness of the *Community Guide* was lowest among Local/County Health Directors (41%). Familiarity with the Guide did not appear to differ based on public health region.
- The most commonly reported way state respondents became familiar with the Guide was by visiting the Guide-specific Web site (59%). For local decision makers, the most common route to familiarity was through peer-reviewed publications (37%). Local decision makers (15%) were less likely than state decision makers (59%) to report learning about the Guide by visiting the Guide-specific Web site.

Public Health Decision-Making Process

- Questions were included to better understand how evidence-based data are used in the decision-making process. Results suggest that when making decisions about program planning, policy development, and funding, state respondents rely on funding guidance from a legislative or federal authority and systematic reviews, whereas local respondents rely on funding guidance and peers (systematic reviews of the body of scientific literature on a particular topic were ranked third). State respondents (45%) preferred decision-making resources that are evidence-based and from a credible source, whereas local respondents (44%) emphasized local relevance in valuing decision-making resources.

Use of the Community Guide

- Respondents who reported being aware of the *Community Guide* were asked about their use of it. Approximately 32% of all respondents reported using the *Community Guide* for their work (58% of state-level respondents and 20% of local-level respondents). Of those familiar with the Guide, 61% had personally used it. State-level decision makers (73%) were significantly more likely than local-level decision makers (50%) to have used the Guide ($p < .05$). State decision makers (53%) mentioned lack of familiarity as the primary reason for not using the Guide. Among local decision makers, lack of staff or financial resources was mentioned most frequently (by 27%), followed by lack of familiarity (19%). Respondents whose organizations had used the Guide reported using it for a variety of health topics; more than half reported using it for tobacco prevention and control, physical activity promotion, and diabetes.

- Decision makers who were familiar with the Guide tended to encourage others to use it (63%). Most who encouraged use of the Guide did so because “it shows what works” (85%). Other reasons for encouraging use of the Guide included that it is comprehensive and scientifically sound, objective, and helps decision makers use resources effectively.
- Among respondents reporting that their organizations had used the Guide, almost half (48%) indicated that the *Community Guide* had played a role in choosing to discuss or implement policy initiatives, programs, or research priorities.

Perceptions of the Community Guide and Recommendations for Improvement

- The questionnaire also sought to identify whether respondents correctly perceived the appropriate uses of the Community Guide. Most users (76%) correctly identified the Guide as “a tool to be used with data and best practices to support public health decision making.”
- Suggestions for making the Guide more useful included (1) adding descriptions of model programs, (2) increasing efforts to get information to users, and (3) including more information about promising practices (i.e., interventions that appear to be effective but for which conclusive evidence of effectiveness is not yet available).
- Respondents (71% overall, 82% state, 65% local) suggested conferences as the best vehicle for promoting the use of evidence-based findings. More than half of respondents also endorsed grant requirements (59% overall, 72% state, 53% local) and e-notices (59% overall, 56% state, 60% local) as useful vehicles for encouraging use of the *Community Guide*.

4.2 Recommendations for Future Action and Research

More than half of the respondents were at least familiar with the *Community Guide.* The large percentage of state-level respondents (79%) who reported familiarity with the Guide suggests that information about the Guide is reaching these important target audiences, as these respondents represent key decision makers for allocating state and federal dollars expended for public health. In addition, these individuals serve as key informational gatekeepers who can help to disseminate information and encourage use of the Guide to other state and local staff. Awareness and use was significantly lower among local health decision makers (41%) than among their state-level colleagues (79%), yet recent research (e.g., Thornton et al., 2004) suggests that local health department leaders want information about interventions with demonstrated effectiveness. Based on results from the present study, enhancing dissemination efforts for local public health decision makers may be useful for increasing awareness and use and ultimately may lead to greater implementation of evidence-based practices in local interventions. Given that local public health officials endorsed both peer-reviewed publications and conferences, these venues may provide useful dissemination strategies; targeting conferences attended by local public health officials, such as the annual meetings of the National Association of County and City Health Officials and the National Association of Local Boards of Health, may be a useful dissemination strategy.

The role of funding guidance should not be overlooked as an important mechanism to encourage use of the Guide inasmuch as respondents noted this was an important “driver” in their decision making. Motivating funders to include language that specifies inclusion of evidence-based recommendations could increase use of the Guide and ultimately potentially increase development of interventions based on evidence-based “best practices.”

The overall importance given to systematic reviews in making public health decisions, coupled with the reported use of the Guide, underscores the need for Guide staff to continue to develop new reviews and to update existing ones. More globally, the importance of evidence-based public health decision making may underscore the need for more rigorous evaluation of public health strategies, which will provide the underpinning upon which future reviews to assess the evidence can be developed.

This research provides important baseline data, but subsequent studies will be needed to build on this base for assessing changes in awareness and use of the Guide. Further research that explores in more depth how individuals have used the Community Guide and solicits specific examples relating Guide use to implementation of specific evidence-based best practice interventions could be important extensions for this research.

1. INTRODUCTION

As part of the Centers for Disease Control and Prevention's (CDC's) responsibilities for providing credible information to enhance health decisions, CDC offers the *Guide to Community Preventive Services*, also known as the *Community Guide*. The *Community Guide* provides public health practitioners and decision makers with recommendations regarding population-based interventions to promote health and to prevent disease, injury, disability, and premature death, appropriate for use by communities and health care systems.

To develop more effective strategies for promoting and disseminating *Community Guide* recommendations, CDC needs information on awareness, use, and appraisal of information related to the *Community Guide*. To help gather this information, CDC contracted with RTI International (RTI) to develop and conduct the *Surveillance Survey for the Guide to Community Preventive Services.* The goal of this initial questionnaire was to collect information that can be used as a benchmark for assessing changes in patterns of use and in customer satisfaction among public health decision makers, as the Guide refines its products and expands its dissemination. Future surveillance questionnaires will assess changes over time in how, when, and by whom the *Community Guide* is being used in public health decision making.

Data collection began on March 8, 2005, and was completed on June 24, 2005. The questionnaire was administered to a census of State Health Directors, State Chronic Disease Directors, and Healthy People 2010 Coordinators, and to a random sample of Local/County Health Directors stratified by public health or U.S. Department of Health and Human Services (DHHS) region. The questionnaire used a Web-based data collection method, complemented by a paper-and-pencil questionnaire for those who preferred this optional data collection strategy.

In Section 2, we provide more detailed information about the methods used. In Section 3, we present study results and conclusions and recommendations.

2. METHODS

In this section, we describe the data collection methods, including sample design, survey instrument, participant contact and follow-up methods, and the final response rate and disposition codes.

2.1 Sample Design

The sample design was developed in collaboration with CDC and finalized in August 2004. The design included a census of 58 State Health Directors that included representation from each of the 50 states and the District of Columbia. In addition, all U.S. territories and possessions with their own Health Directors were included: American Samoa, Federated States of Micronesia (a U.N. Trust Territory under U.S. administration), Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

The sample also included 59 State Chronic Disease Directors, including one individual from each of the 50 states and one each from the District of Columbia, American Samoa, Federated States of Micronesia, Guam, Northern Mariana Islands, Puerto Rico, Republic of Palau, Republic of the Marshall Islands, and the U.S. Virgin Islands.

The sample included 57 State Healthy People 2010 Coordinators, a census developed by including one individual from each state and one from each of the following: District of Columbia, American Samoa, Federated States of Micronesia, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

The local-level contribution to the sample came by sampling Local/County Health Directors. A sampling frame of 3,228 Local/County Health Directors was created by first identifying substate (e.g., county or region) areas within each of the 50 states. The primary sources for the frame were state Web pages and the directory of Local/County Health Directors compiled by the National Association of County and City Health Officials (NACCHO).

In some states, all counties were included in mutually exclusive health regions. In these states, the Health Directors for these regions were included in the sampling frame. In states without health regions, all counties with Health Directors were included in the sampling frame. Some states had health regions, but their regions did not include all counties. In those states, the Health Directors for the regions *and* for the individual counties (outside the regions) were included in the sampling frame.

Some states in New England have city and town governments but not county governments. In these states, health regions consisted of combinations of contiguous cities or towns. These health regions were included in the sampling frame. Counties that were not in any health region and that did not have a Local/County Health Director were not included in the sampling frame because their health services were provided by the state. In addition, if a territory/possession had health regions, it was treated as a county and included in the sampling frame. For example, the Federated States of Micronesia has four states (Chuuk, Kosrae, Pohnpei, and Yap) that were included in the sampling frame.

The Local/County Health Director sampling frame was stratified according to three variables:

- 10 U.S. Department of Health and Human Services regions identified by DHHS
- Metro/rural: A county was coded as metropolitan if it is categorized as a Metropolitan Statistical Area (MSA) by the U.S. Census Bureau. Otherwise, the county was coded as rural.
- Diversity level: A county was categorized as “high” when non-Hispanic Whites constituted less than 70% of the population. Otherwise, it was coded as “low.”

The sampling frame was divided into 39 mutually exclusive strata. The sample of 335 Local/County Health Directors was allocated to strata in proportion to total estimated strata population estimates. A total of 334 Local/County Health Directors were randomly selected with independent samples selected from the strata in proportion to the county population.

The sample design was submitted to the Office of Management and Budget (OMB) in August 2004 for approval prior to beginning data collection. The OMB package also contained the questionnaire and contact/follow-up methods that are described below. OMB approved the package in February 2005, without requiring any amendments.

2.2 Survey Instrument

Questionnaire development was iterative and collaborative between CDC and RTI, with emphasis given to addressing CDC’s priority information needs. Invitations to participate, instructions, questions, skip patterns, and response options (including open-ended response options) were developed collaboratively by staff at CDC and RTI. The questionnaire was designed to identify and track the degree of familiarity with the *Community Guide* among public health decision makers and the degree to which they are using the *Community Guide* in their decision making and planning. Information was also collected on ways to improve the *Community Guide* to enhance user satisfaction and ultimately improve public health. The data collected through this questionnaire ideally will help CDC assess the value of the *Community Guide* to key public health professionals at the state and local levels. The questionnaire addressed the following specific topics:

- job title, tenure, and responsibilities
- resources used in public health decision making
- familiarity with and use of the *Community Guide*
- reasons for not using the *Community Guide*

- recommending the *Community Guide* to others
- improving the effectiveness of the *Community Guide*

A copy of the questionnaire is included in Appendix A.

Data were collected using a Web-based survey, a method that is becoming increasingly employed over telephone and mail data collection for many different types of surveys. Establishment surveys of business, university, and other organizations, where computer and Internet access are widely available, have been found to be the best suited for using the Web data collection mode (Dillman, 2000). Web data collection was particularly well-suited to the needs of the *Community Guide* surveillance survey for a number of reasons:

- Ready access and use of a computer. Most state and local health department staff have access to and use a business computer on a daily basis.
- Readily available e-mail addresses. Because the sample was derived from government public health officials, their e-mail addresses are generally publicly available and accessible.

Furthermore, use of a Web-based strategy offered a number of key advantages, including the following:

- Faster and less expensive. E-mail communication was faster and less costly than telephone or standard mail communication with all respondents would have been. The Web survey could be sent via e-mail and completed at the respondent's convenience, initiated simply by clicking on a link in the e-mail.
- Better access to respondents. The Web-based data collection strategy was especially appropriate for contacting and interviewing public health officials who tend to be overextended and work in multiple environments (e.g., at their desks, in clinics, in the field). E-mail access typically follows them as they change locations. Further, Web data collection could be affordably enhanced with targeted telephone follow-up to realize the advantages of mixed mode data collection.
- Easy access to the *Community Guide*. The *Community Guide* is a tool available on the Web; the survey could provide users with a link to the Guide as needed. Although there was some discussion in the planning stages as to the appropriateness of including a link from the Survey to the *Community Guide* Web site, the decision was made to include the link to help educate potential users about the Guide as they completed the survey. (Analysis later suggested that no significant bias resulted from allowing respondents to link to the *Community Guide* Web site.)
- Less burdensome to complete. Automated skip patterns simplified the number of steps needed to complete the survey. Furthermore, the automated skip patterns and range checks enabled instant validation of data, thus improving data quality relative to a mail survey.
- Greater understanding of the survey response process. Better data about respondents' survey completion behavior could be collected by the Web survey, including measures of time spent on a particular screen, completing the entire survey, revising answers, and clicking on external links (including the *Community Guide* Web site).

- Better detection of administration problems. Early identification of questionnaire problems from the field was possible because data were saved into the database immediately after the respondent completed the interview.
- Lower analysis costs. The Web-based format allowed the development of an electronic database on an ongoing basis, providing regular updates and reports virtually immediately as data became available.
- Development of an electronic directory of state and local public health officials for use in periodic resurveys and potential new applications. Although it was developed for the ongoing evaluation of the use and dissemination of the *Community Guide*, the sample could also be used as a readily accessible mechanism for contacting the population of key state health officials (State Health Directors, State Chronic Disease Directors, and State Healthy People 2010 Coordinators) together with a random and representative sample of Local/County Health Directors.

To pretest the questionnaire, four public health officials, identified by CDC, were asked to complete a draft questionnaire in summer 2004. RTI staff conducted telephone debriefings with these individuals to assess usability of the questionnaire and clarity of the questions. These individuals provided detailed qualitative comments, for example, about question meanings and applicability of response options to the intended audience. Feedback from these reviewers was summarized for CDC, and the questionnaire was modified as needed.

The questionnaire content was finalized by August 2004 for the OMB package, and programming began the next month. The program was tested, revised, and retested for functionality and format by CDC staff before it was launched for data collection. Frequencies for each question were maintained in a dynamic Web page made accessible to CDC, as was other documentation, such as Web questionnaire specifications.

2.3 Participant Contact and Follow-Up

The first invitation to participate was sent on March 8, 2005. This invitation contained a link to the questionnaire to complete via the Web. In addition, on that same date, a paper questionnaire was mailed to seven sample members who did not have e-mail addresses. On March 11, e-mail follow-up reminders were sent to nonresponders. A second follow-up e-mail was sent on March 17. The final e-mail reminder was sent on March 30, and a hard copy letter, including a paper version of the questionnaire, was mailed to all nonrespondents on April 7 as a last attempt at inviting participation.

Follow-up telephone calls were conducted from May 9 through June 3 (after allowing the month of April for respondents to complete the questionnaire without prompting). Telephone interviewers reminded respondents that they could still participate via the Web and offered to fax or mail a hard copy questionnaire. As part of the follow-up telephone calls, respondents were offered the option of completing the questionnaire immediately, by telephone. A total of 34 respondents completed paper versions of the survey. There were no telephone completes.

The sampling protocol allowed for substitution of respondents. That is, it was the job position (i.e., State Health Director, State Chronic Disease Director, State Healthy People 2010 Coordinator, and Local/County Health Director) rather than any particular person fulfilling the role that comprised the sample unit at the time of selection. Open-ended text remarks and e-mail communication with some respondents indicated that substitution did occur, although no mechanism was in place to track how often. In one case, the selected person had left the position and had not yet been replaced. This case was given a final disposition of ineligible.

Although not explicitly addressed in the sampling or data collection protocol, it appears that, in some cases, Directors requested assistance from other staff in completing the questionnaire. The questionnaire did not explicitly ask whether the respondent was the person addressed in the e-mail invitations nor did it assess whether the individual was currently functioning in a given role. Future waves of data collection may benefit from including mechanisms for monitoring who is completing the questionnaire and more about their current roles for tracking substitution, delegation, and possible turnover in a given position.

2.4 Final Response Rate and Disposition Codes

Table 1 presents cumulative questionnaire results by type of respondent (i.e., State Health Director, State Chronic Disease Director, Healthy People 2010 Coordinator, or Local/County Health Director). Overall, the four types of respondents responded to the questionnaire at about the same rate (chi-square = 1.162, *df* = 3, *p* = .7622).

The original sample is dividable into the 10 DHHS regions that were used as sampling strata for Local/County Health Directors. Their response rates by region are shown in Table 2. Regional response rates varied from 56% for the West Coast to 78% for the Southeast. In general, the lowest completion rates were in the West, Southwest, and Northeast, and the highest completion rates were in the Southeast and Midwest. These response patterns are typical for survey research.

Table 1. Questionnaire Response Rate, by Respondent Type (*n* = 503)

Type of Respondent	Invited	Completed	Response Rate (%)
State Health Director	57	39	68.4
State Chronic Disease Director	59	38	64.4
Healthy People 2010 Coordinator	53	37	69.8
Local/County Health Director	334	237	71.0
Total	**503**	**351**	**69.8**

Table 2. Questionnaire Completion Results, by Region (*n* = 503)

Region	Area	Invited	Completed	Response Rate (%)
1	New England	29	18	62.1
2	New York	41	31	75.6
3	Mid-Atlantic	57	39	68.4
4	Southeast	85	66	77.6
5	Upper Midwest	76	57	75.0
6	Southwest	48	31	64.6
7	Lower Midwest	28	21	75.0
8	Mountain	31	23	74.2
9	West Coast	79	44	55.7
10	Pacific Northwest	29	21	72.4
Total		**503**	**351**	**69.8**

Table 3 lists the final disposition codes, which were used to calculate the final response rate. One of the 503 invited cases was deemed ineligible because no one was in the position to serve as the respondent. Therefore, the final calculated response rate for the study is 71%. This number is based on a total of 502 eligible respondents. The calculation was based on the overall response rate formula used for the Behavioral Risk Factor Surveillance System (BRFSS), a state-based telephone survey conducted by CDC. This same formula is the standard overall response rate calculation preferred by the American Association for Public Opinion Research (AAPOR) (AAPOR, 2004; National Center for Chronic Disease Prevention and Health Promotion, 2004).

Table 3. Final Disposition Codes (*n* = 503)

Final Disposition Code	Total Number of Cases	Percentage of Cases (%)
Completed Interview	351	70.2
Refusal	1	0.0
Eligible Noninterview	128	25.0
Ineligible	1	0.0
Uncertain if E-mail Belongs to Sample Member	22	4.4
Total Sample	**503**	100.0
Number Eligible	**502**	99.8

Overall response rate is a more conservative calculation than a simple survey completion rate. In a household survey (the version of the formula that the BRFSS uses), the overall response rate assumes that 90% of likely households are in fact actual households and that 98% of these households contain an adult who uses the phone number. The BRFSS response rate formula is based on the AAPOR Response Rate 3. AAPOR is the foremost organization for survey research standards. Our assumptions in adapting the BRFSS overall response rate formula for this surveillance survey are that 90% of the sample e-mail addresses belong to the sampled staff person and that 98% of those 90% are owned by someone who uses their e-mail account. The response rate is calculated as follows:

$$RR = COMP / [.98\ (COMP + TERE + ELNO + INEL) + .90\ (UNCE)]$$

where

RR = response rate,
COMP = completed interviews,
TERE = terminations and refusals/breakoffs,
ELNO = eligible noninterviews,
INEL = ineligibles, and
UNCE = uncertain if e-mail belongs to sample member.

Interviews were counted as complete if the respondent completed through question 10 in the survey. The one explicit refusal was recorded when a sample member was contacted for a telephone follow-up and told the contactor that he did not want to participate in the survey. (No respondents returned e-mails saying they did not want to participate.) Nonrespondents whose e-mails were not returned as undeliverable were counted as eligible noninterviews. This comprised the largest group of nonrespondents to the survey. One case was counted ineligible because the person selected had vacated the position and had not been replaced. Cases fell into the “uncertain if e-mail belongs to sample member” category when a follow-up phone call reached a person or a recording that did not confirm the correct sample member name or position. (With no such information, cases were assumed to be eligible noninterviews.)

3. RESULTS

This section presents survey results. Specifically, we present details on respondents' characteristics (Section 3.1), familiarity with the *Community Guide* (Section 3.2), and use of the *Community Guide* (Section 3.3). Results are presented for all respondents and broken out by state and local respondents when differences occur. Appendix A contains the complete survey questionnaire. Appendix B contains respondents' remarks to open-ended questions that are not readily codable.

In reviewing the results, it is important to note several points regarding the sample. First, because of skip patterns and item nonresponse, the total number of respondents reported in this section for any given question is less than the total number of completed interviews (351) reported in Tables 1 through 3. With regard to skip patterns, not every respondent was eligible for every question. For example, respondents who reported little or no familiarity with the Guide skipped all detailed questions about use of the Guide. These skip patterns ensured a logical set of questions for each respondent and a smooth flow throughout the questionnaire.

Second, with regard to item nonresponse, minimal restrictions on the way respondents could enter data in the survey allowed for blank answer fields. Early in the design process, the CDC and RTI survey design team agreed not to force respondents to answer every question, although blank answer fields were probed one time with a request to complete the question. However, respondents who elected to leave certain fields blank could move through the questionnaire without answering all questions.

Third, for questions that asked respondents to "check all that apply" and then rank a subset of them (e.g., the top 3), the selection of a single element automatically assigned a default rank of "0" by the Web application. Those were re-coded to equal "1" on the assumption that a sole checked item by definition would be the first ranked item.

Unless otherwise noted, percentages reported are valid percentages, based on a denominator that counted the number of nonmissing answers for any given question.

3.1 Respondent Characteristics

The first five items in the *Community Guide* questionnaire asked respondents about key personal characteristics related to their job. The first question asked respondents to report their job titles. Responses were coded for reporting purposes, and results are presented in Table 4, with overall results as well as state and local results. The largest categories were

Table 4. Q1: Job Titles Reported by Respondents (*n* = 351)

Job Title	State (%) (n)	Local (%) (n)	Overall (%) (n)
Director	36.0 (41)	45.1 (107)	42.2 (148)
Health Officer	6.1 (7)	17.3 (41)	13.7 (48)
Administrator	7.0 (8)	15.6 (37)	12.8 (45)
Coordinator/Manager	10.5 (12)	5.1 (12)	6.8 (24)
Commissioner	7.0 (8)	5.9 (14)	6.3 (22)
Chief	15.8 (18)	0.0 (1)	5.4 (19)
Nurse/Doctor	0.1 (1)	5.1 (12)	3.7 (13)
Deputy Director	7.9 (9)	0.1 (2)	3.1 (11)
Epidemiologist	2.6 (3)	0.1 (1)	1.1 (4)
Deputy Commissioner	2.6 (3)	0.1 (1)	1.1 (4)
Other	2.6 (3)	1.7 (4)	2.0 (7)
Not answered/Unknown	0.1 (1)	2.1 (5)	1.7 (6)
	98.3 (114)[a]	**98.2 (237)**	**99.9 (351)**

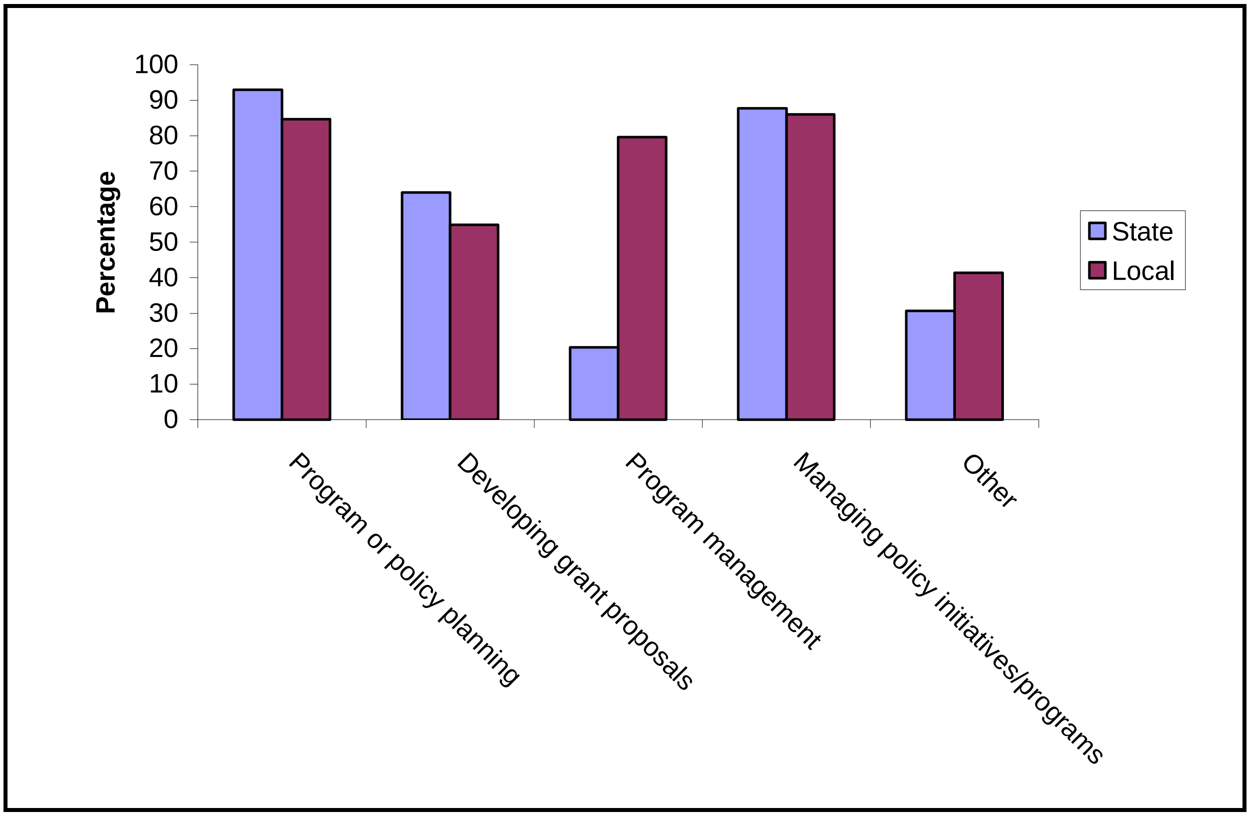
[a] Percentages may not total 100% because of rounding.

Director, Health Officer, and Administrator. Respondents who reported their title as “Assistant” were coded as Administrator.

Question 2 asked respondents to report tenure in their current job/role. The majority of respondents (68%) reported being in their current position for more than 3 years; 22% had been in their current position for 1 to 3 years, and 10% had been in their current position less than 1 year. Question 3 asked respondents about their organizational tenure. Nearly three fourths of respondents (74%) had been with their agency/organization for more than 5 years; 21% had worked at their agency for 1 to 5 years, and 5% had worked at their agency less than 1 year. Neither time in position nor organizational tenure differed significantly for state or local respondents.

Respondents were also asked about the kinds of work they do (Question 4). Figure 1 presents results of this question, a “mark all that apply” item. Responses suggest that most respondents were involved in the types of activities that are informed by evidence-based decision-making tools, such as the *Community Guide*, including program or policy planning, planning and managing policy initiatives or programs, managing programs, and developing grant proposals. Thirty-eight percent (31% of state respondents and 41% of local respondents) reported having “other” work responsibilities, which were specified and subsequently coded. “Other” work responsibilities included administration (*n* = 40), budgeting (*n* = 22), clinical or patient care (*n* = 21), staff supervision (*n* = 9), legislation

Figure 1. Q4: Kinds of Work Respondent Does (*n* = 349)



(*n* = 4), epidemiology or community health (*n* = 4), and statistical or other research (*n* = 3). Another 19 respondents reported "other" job responsibilities that were not readily codable (see Appendix B). Ten checked "other" but did not describe their "other" job responsibilities. Among the responses to Question 4, only one—working in program or policy planning—differed significantly for state and local respondents (chi-square = 4.80, *df* = 1, *p* = .03).

Question 5 asked respondents to rank six elements according to their importance in making decisions about program planning, policy development, or funding, where "1" indicated the most important element, "2" indicated the second most important element, "3" indicated the third most important element, and so on. Table 5 summarizes these rankings for the 349 respondents to this question. Overall results are shown, as are state and local results.

Table 5. Q5: Rankings of Resources for Making Decisions about Programs, Policies, or Funding, Where 1 = Most Important and 6 = Least Important (*n* = 349)[a]

	Percentage Endorsing Rank (%)						
	1	2	3	4	5	6	Total (%)[b]
Success stories and lessons learned from peers							
State	11.4	15.8	22.8	24.6	23.7	1.75	100.1
Local	24.7	18.7	18.3	17.9	15.3	5.11	100.0
Overall	20.3	17.8	19.8	20.1	18.1	4.0	100.1
Funding guidance (either from legislative authority or federal funding sources)							
State	36.0	29.0	18.4	9.7	5.3	1.8	100.2
Local	37.9	19.2	17.0	14.0	8.9	3.0	100.0
Overall	37.3	22.4	17.5	12.6	7.7	2.6	100.1
A single study or a review article on a specific topic							
State	2.6	3.5	6.1	7.0	23.7	57.0	99.9
Local	6.4	2.6	9.8	12.8	22.1	46.4	100.1
Overall	5.2	2.9	8.6	10.9	22.6	49.9	100.1
Systematic reviews of the body of scientific literature or scientific reports (e.g., IOM reports, Surgeon General reports, Guide to Community Preventive Services)							
State	36.8	18.4	17.5	15.8	9.7	1.8	100.0
Local	21.7	19.6	19.6	20.4	14.5	4.3	100.1
Overall	26.7	19.2	18.9	18.9	12.9	3.4	100.0
Health planning tools (e.g., MAPP or Healthy People 2010)							
State	10.5	18.4	20.2	26.3	17.5	7.0	99.9
Local	14.9	23.8	19.2	19.2	17.0	6.0	100.1
Overall	13.5	22.1	19.5	21.5	17.2	6.3	100.1
Other (e.g., perspectives or priorities of organization leadership)							
State	17.5	15.8	16.7	8.8	15.8	25.4	100.0
Local	20.9	15.7	13.6	12.3	13.2	24.3	100.0
Overall	19.8	15.8	14.6	11.2	14.0	24.6	100.0

[a] Two respondents did not answer this question.

[b] Percentages may not total 100% because of rounding.

For all respondents reporting, funding guidance was clearly important to public health professionals, with 77% of respondents ranking it as “1,” “2,” or “3.” Similarly, systematic reviews of scientific results were consistently ranked highly. Conversely, 50% of respondents ranked a single study or review as *least* important. When state and local respondents are isolated, systematic reviews of the body of scientific literature and funding guidance were the top resources for state respondents; local respondents ranked funding guidance highest, followed by success stories and lessons learned from peers, and systematic reviews. Table 6 shows the result of collapsing the rankings for Question 5 into “important” for items ranked 1, 2, or 3 and “not important” for items ranked 4, 5, and 6, overall and by state and local.

Table 6. Q5: Rankings of Elements for Making Decisions about Programs, Policies, or Funding (*n* = 349)[a]

	Percentage Ranking “Important” [b]			Percentage Ranking “Not Important”		
	State	**Local**	**Overall**	**State**	**Local**	**Overall**
Success stories and lessons learned from peers	50.0	61.7	57.9	50.0	38.3	42.2
Funding guidance (either from legislative authority or federal funding sources)	83.4	74.1	77.2	16.8	25.9	22.9
A single study or a review article on a specific topic	12.2	18.8	16.7	87.7	81.3	83.4
Systematic reviews of the body of scientific literature or scientific reports (e.g., IOM reports, Surgeon General reports, Guide to Community Preventive Services)	72.7	60.9	64.8	27.3	39.2	35.2
Health planning tools (e.g., MAPP or Healthy People 2010)	49.1	57.9	55.1	50.8	42.2	45.0
Other (e.g., perspectives or priorities of organization leadership)	50.0	50.2	50.2	50.0	49.8	49.8

[a] Two respondents did not answer this question.

[b] Rankings of 1, 2, and 3 were coded as “Important.” Rankings of 4, 5, and 6 were coded as “Not Important.”

To summarize the respondent characteristics data, the typical respondent to the *Community Guide* questionnaire was a director of a state, county, or local health department or program; had worked at his/her current position 3 years or longer; and had worked at his/her agency 5 years or longer. Almost all respondents worked in program and policy planning and management, and most were engaged in multiple types of activities in their positions. When making decisions about program planning, policy development, and funding, state respondents reported relying on funding guidance from a legislative or federal authority and systematic reviews, whereas local respondents relied on funding guidance and peers, with systematic reviews of the body of scientific literature on a particular topic ranked as third most important.

3.2 Familiarity with the *Community Guide*

Fifty-three percent of decision makers surveyed were familiar with the Guide. Among these respondents, 15% said they were very familiar, 39% said they were somewhat familiar, and 47% reported knowing little or nothing about the Guide (Question 6). Familiarity with the Guide was not associated with length of time in current job (Spearman's rho = –0.09, p = 0.107). Only among those tenured more than 5 years was a majority (55%) at least somewhat familiar with the Guide (Table 7).

Table 7. Q6: Familiarity with the *Community Guide*, by Tenure in Organization (n = 344)

Familiarity with Guide	Less than 1 Year (%) (n)	1–5 Years (%) (n)	More than 5 Years (%) (n)
Very familiar	6.3 (1)	12.7 (9)	15.6 (40)
Somewhat familiar	31.3 (5)	36.6 (26)	39.7 (102)
Little or no familiarity	62.5 (10)	50.7 (36)	44.8 (115)
Total[a]	100.1 (16)	100.0 (71)	100.1 (257)

[a] Percentages may not total 100% because of rounding.

Familiarity with the *Community Guide* differed across job titles (Table 8). Note that job titles correspond with working at either a state or local level. State Chronic Disease Directors were more likely to report being *very* familiar with the Guide (43%) compared with Healthy People 2010 Coordinators, a state-level position (28%); State Health Directors (18%); or Local/County Health Directors (7%). Analysis by the 10 public health regions revealed no significant differences (chi-square = 26.84, df = 18, p = .08).

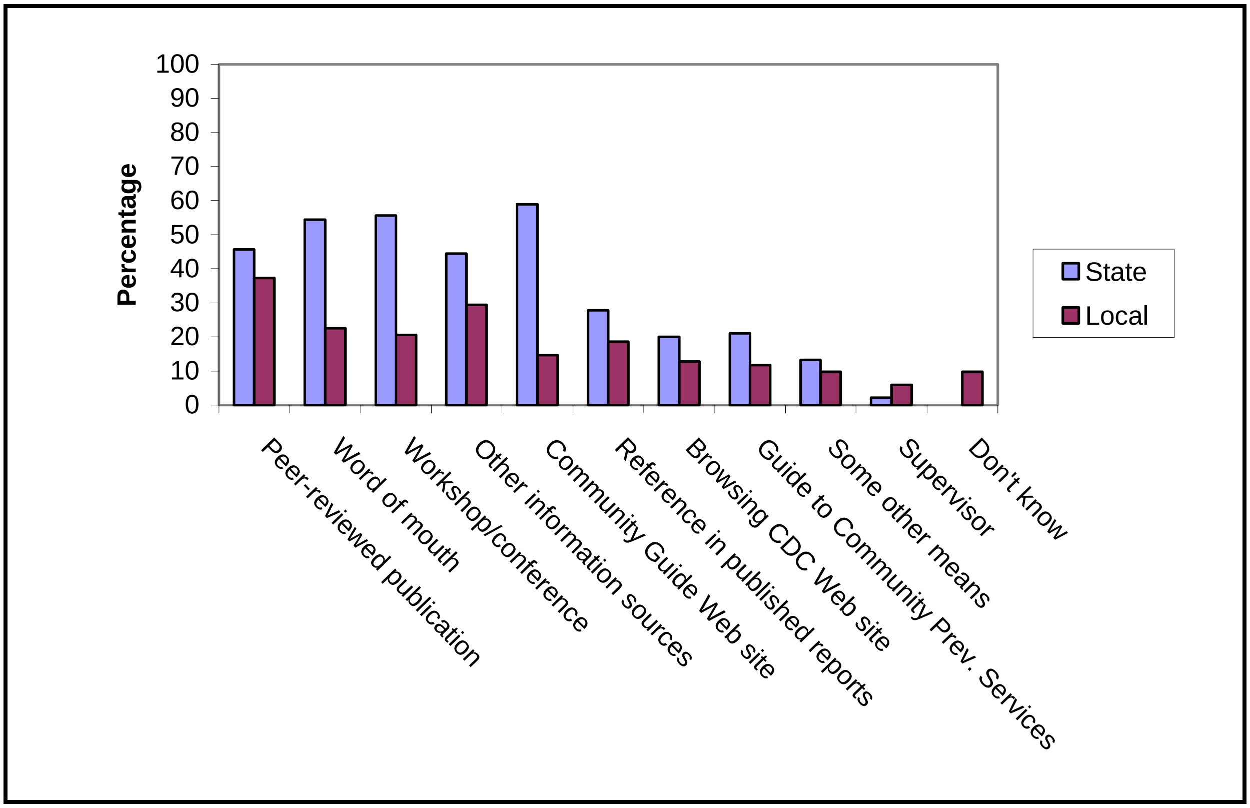
When combining reports of "very familiar" and "somewhat familiar" into a single class of "familiar with Guide," the pattern is similar, although not identical. State Chronic Disease Directors were most likely to report being familiar with the Guide (86%), followed by State Health Directors (80%) and Healthy People 2010 Coordinators (70%). Local/County Health Directors were least likely to report being familiar with the Guide (41%). Analysis of familiarity by job category was statistically significant (chi-square = 65.0, df = 6, p < .001).

Table 8. Q6: Familiarity with the *Community Guide*, by Precoded Job Title (*n* = 344)

Job Title	Very Familiar (%) (n)	Somewhat Familiar (%) (n)	Little or No Familiarity (%) (n)	Total (%) (n)
State Chronic Disease Director	43.2 (16)	43.2 (16)	13.5 (5)	99.9 (37)
Healthy People 2010 Coordinator	27.8 (10)	41.7 (15)	30.6 (11)	100.1 (36)
State Health Director	18.0 (7)	61.5 (24)	20.5 (8)	100.0 (39)
Local/County Health Director	7.3 (17)	33.6 (78)	59.1 (137)	100.0 (232)

Question 7 asked how respondents became aware of the *Community Guide* (Figure 2), with a series of choices and an "other" option provided. Note that this question was only asked of respondents who were very familiar or somewhat familiar with the Guide. Respondents who were unfamiliar with the Guide were skipped to the final four survey questions (Questions 16 through 19). Therefore, the percentages are calculated from the total eligible and not from the total 351 survey respondents.

Figure 2. Q7: How Respondents Became Aware of the *Community Guide*



Respondents were allowed to report more than one mechanism by which they become aware of the Guide. The most common way state respondents learned about the Guide was by visiting the Guide-specific Web site (59%, compared with only 15% for local respondents). On the other hand, for local respondents, the most common method of learning about the Guide was through references in peer-reviewed publications (37%, compared with 46% for state respondents). Five of the 11 response options generated statistically significant differences between state and local respondents ($p < .05$): workshops/training or conference presentations, visiting the Guide-specific Web site, other information sources, word of mouth, and “don’t know” how became aware. A cluster analysis was performed to assess more about how respondents learned about the Guide, but no clusters emerged.

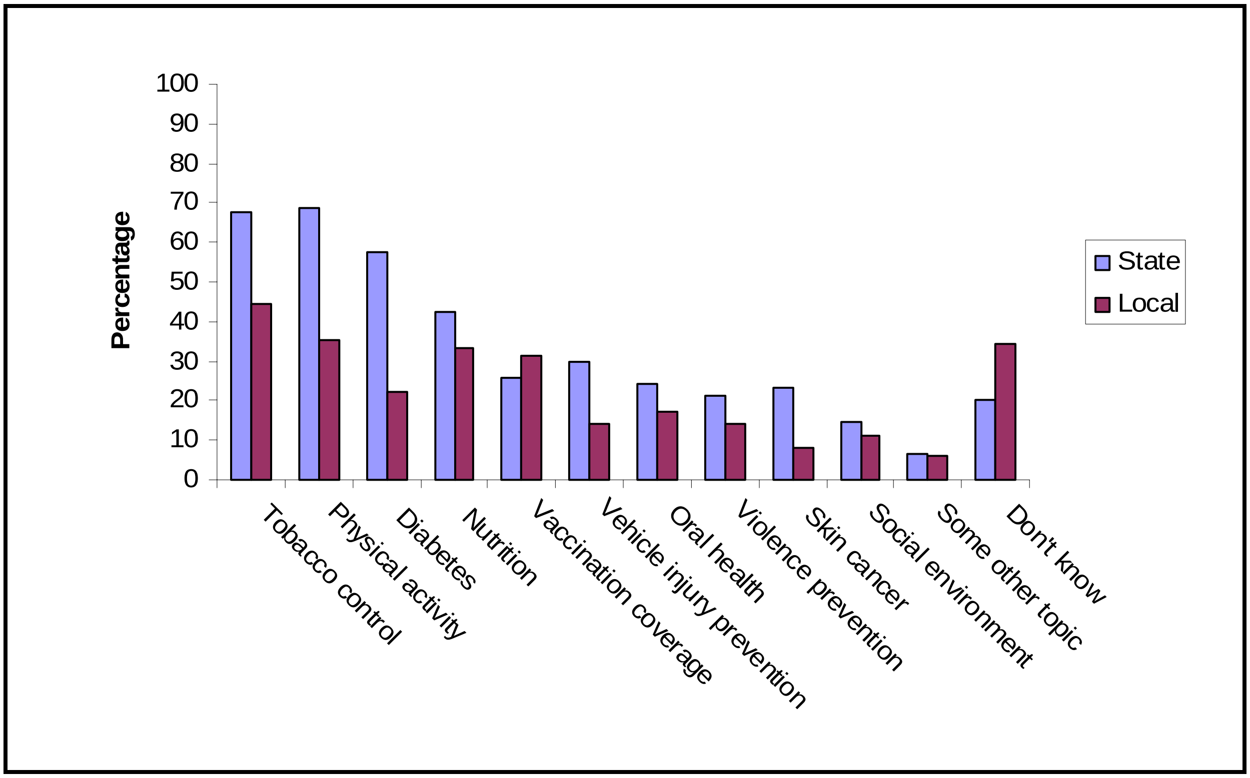
In summary, a majority of State Health Directors, State Chronic Disease Directors, and State Healthy People 2010 Directors were at least somewhat familiar with the Guide. Among those who were familiar with it, the predominant means of learning about the Guide were through peer-reviewed publications, word of mouth, conference presentations and workshops, other information sources, and the *Community Guide* Web site. Local respondents were less likely to report becoming aware of the Guide through the Guide-specific Web site.

3.3 How Respondents and Their Organizations Use the *Community Guide*

Question 8 assessed how public health decision makers and their organizations used the Guide to address various health topics. Results are presented in Figure 3. The three most common uses of the *Community Guide* findings were tobacco prevention and control (68% for state respondents, and 44% for local respondents), physical activity promotion (69% for state, and 35% for local), and diabetes (58% for state, and 22% for local). However, more than a quarter of respondents overall did not know how their organizations used the Guide. This was observed much more frequently among local respondents. Six of the 12 response options generated statistically significant differences between state and local respondents ($p < .05$): tobacco prevention and control, physical activity promotion, motor vehicle occupant injury prevention, diabetes, skin cancer, and “don’t know.”

Respondents who reported being aware of the *Community Guide* were asked about their personal use of the *Community Guide* findings in their work (Question 9). In Question 9, 61% of respondents reported having personally used the *Community Guide* in their work. Results indicate that significantly more state-level decision makers (73%) than local decision makers (50%) had used the Guide (chi-square = 10.66, $df = 1$, $p = .0011$).

Figure 3. Q8: How Organizations Have Used *Community Guide* Findings



Among respondents who had not used the *Community Guide*, 73 identified various barriers to use in Question 10 (Table 9). Most frequently mentioned by respondents overall (36%) and by state respondents (53.4%) was lack of familiarity with the Guide. Most frequently mentioned by local respondents was lack of staff or financial resources (27%), with lack of familiarity with the Guide the second most frequently mentioned reason (19%). State respondents' results were heavily concentrated in their number one mention, whereas local respondents' results were spread out across several different responses.

Question 10 also asked respondents to rank the top three barriers to using the Guide (Table 10). If only two barriers were identified, only two were ranked. If a respondent selected only one barrier, the Web questionnaire did not provide an option for ranking. Table 10 presents results for Question 10 for overall respondents and for state and local respondents. Of the 73 respondents who identified at least one barrier to using the Guide, 39 selected only one barrier, 25 selected and ranked two barriers, and 9 selected and ranked three barriers. Lack of staff or financial resources was identified as the most important barrier by 75% of respondents (60% of state respondents and 80% of local respondents). Despite the fact that only respondents who previously reported being at least somewhat familiar with the Guide received this question, 69% of respondents (64% of state

Table 9. Q10: Barriers to Using the *Community Guide* (n = 73)[a]

Barrier	Barrier Selection					
	State		Local		Overall[b]	
	n	%	n	%	n	%
Lack of familiarity or understanding about the *Community Guide*	31	53.4	11	18.6	42	35.9
Low demand in my organization for systematic reviews	2	3.4	7	11.9	9	7.7
Skepticism about methodology used to develop findings	0	0.0	1	1.7	1	0.0
Uncertainty over what makes the *Community Guide* findings any more useful than existing “best practices” documents, guidelines, or meta-analyses	2	3.4	10	16.9	12	10.3
Uncertainty about what to do with “insufficient evidence” findings	0	0.0	0	0.0	0	0.0
Lack of staff or financial resources	5	8.6	16	27.1	21	17.9
Lack of “how to” information in the *Community Guide* about how to carry out recommended strategies	1	1.7	1	1.7	2	1.7
Not enough information in the *Community Guide* about the cost of implementing recommended interventions or about their cost effectiveness	4	6.9	5	8.5	9	7.8
Other (Please specify)	13	22.4	8	13.6	21	17.9

[a] Seventy-three respondents identified barriers in Question 10. Table total is higher than 73 because respondents were allowed to select more than one barrier.

[b] Percentages may not total 100% because of rounding.

respondents and 71% of local respondents) ranked lack of familiarity as the most serious barrier.

Among those at least somewhat familiar with the Guide, 120 respondents (63%) had encouraged others to use it (Question 11). Those who benefited from their encouragement included subordinates (82% overall, 82% state, 80% local), colleagues (72% overall, 80% state, and 59% local), practitioners (43% overall, 47% state, and 14% local), the general community (36% overall, 36% state, and 35% local), grantees (31% overall, 43% state, and 11% local), students (26% overall, 21% state, and 35% local), and supervisors (22% overall, 26% state, and 15% local). Two of these response options, colleagues and grantees, generated statistically significant differences between state and local respondents ($p < .05$). In Question 12, respondents gave various reasons for encouraging use of the Guide. Eighty-five percent reported recommending this resource because it shows what

Table 10. Q10: Rankings of Barriers to Using the *Community Guide* (*n* = 73)[a]

Barrier	Rank Endorsement						Total Ranked[b]	
	1		2		3			
	n	%	n	%	n	%	n	%
Lack of familiarity or understanding about the *Community Guide*								
State	7	63.6	4	36.4	0	0.0	11	100
Local	22	71.0	9	29.0	0	0.0	31	100
Overall	29	69.0	13	31.0	0	0.0	42	100
Low demand in my organization for systematic reviews								
State	1	50.0	0	0.0	1	50.0	2	100
Local	3	42.9	3	42.9	1	14.3	7	100.1
Overall	4	44.4	3	33.3	2	22.2	9	99.9
Skepticism about methodology used to develop findings								
State	0	0.0	0	0.0	0	0.0	0	0
Local	0	0.0	1	100.0	0	0.0	1	100
Overall	0	0.0	1	100.0	0	0.0	1	100
Uncertainty over what makes the *Community Guide* findings any more useful than existing "best practices" documents, guidelines, or meta-analyses								
State	2	100.0	0	0.0	0	0.0	2	100
Local	5	50.0	4	40.0	1	10.0	10	100
Overall	7	58.3	4	33.3	1	8.3	12	99.9
Uncertainty about what to do with "insufficient evidence" findings								
State	0	0.0	0	0.0	0	0.0	0	0
Local	0	0.0	0	0.0	0	0.0	0	0
Overall	0	0.0	0	0.0	0	0.0	0	0
Lack of staff or financial resources								
State	3	60.0	0	0.0	2	40.0	5	100
Local	12	80.0	1	6.6	2	13.3	15	99.9
Overall	15	75.0	1	5.0	4	20.0	20	100
Lack of "how to" information in the *Community Guide* about how to carry out recommended strategies								
State	0	0.0	0	0.0	1	100	1	100
Local	0	0.0	1	100.0	0	0.0	1	100
Overall	0	0.0	1	50.0	1	50.0	2	100
Not enough information in the *Community Guide* about the cost of implementing recommended interventions or about their cost effectiveness								
State	1	20.0	4	80.0	0	0.0	5	100
Local	1	25.0	2	50.0	1	25.0	4	100
Overall	2	22.2	6	66.7	1	11.1	9	100

(continued)

Table 10. Q10: Rankings of Barriers to Using the *Community Guide* (n = 73)[a] (continued)

Barrier	Rank Endorsement 1 n	1 %	2 n	2 %	3 n	3 %	Total Ranked[b] n	Total Ranked[b] %
Other (Please specify)								
State	11	84.6	2	15.4	0	0.0	13	100
Local	5	62.5	3	37.5	0	0.0	8	100
Overall	16	76.2	5	23.8	0	0.0	21	100

[a] When a respondent checked only one barrier, the ranking was recoded to equal “1.” When two or more barriers were checked, the respondent explicitly ranked the barriers.

[b] Percentages may not total 100% because of rounding.

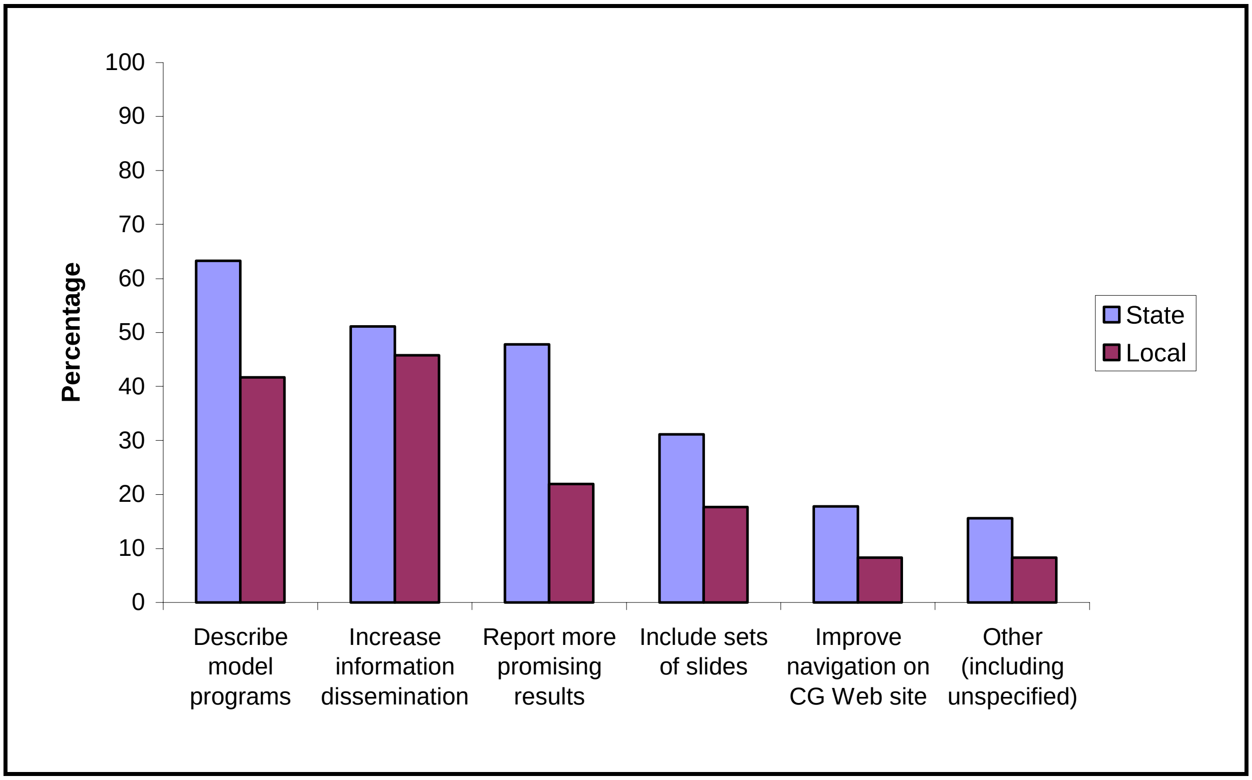
works. More than half reported that the Guide is comprehensive and scientifically sound (63% overall, 66% state, and 59% local), is objective (55% overall, 54% state, and 57% local), and helps use resources effectively (54% overall, 68% state, and 33% local). State respondents (68%) were significantly more likely than local respondents (33%) to promote using the Guide to ensure that resources were used effectively (p < .05).

In Question 13, 48% of respondents (88 out of 184 administered the question) answered “yes” to the question, “Within your organization, have *Community Guide* findings played a role in choosing to discuss or implement policy initiatives, programs, or research priorities?” These results were statistically different between state respondents (63%) and local respondents (34%) (p < .05). Thirty-six percent of respondents (29% state, 42% local) answered “don’t know,” and 16% (8% state, 24% local) answered “no.”

When asked how the Guide was best described (Question 14), 76% of all respondents agreed that it was a tool to support decisions and 4% described it as a “cookbook” that provided start-to-finish details.

However, many respondents had ideas about ways to make the Guide more useful (Question 15). The most common suggestions included describing model programs reflecting recommended interventions, increasing efforts to get information to users, and providing information about promising results (even when there were insufficient data for the Task Force to recommend implementation) (Figure 4). Other ideas for improving its usefulness are listed in Appendix B.

Figure 4. Q15: Ways to Make the *Community Guide* More Useful



We also cross-tabulated the specified ways to make the *Community Guide* more useful by respondent job title and found several significant differences. One response option asked whether the *Community Guide* should report more promising results, even when there is insufficient evidence for the Task Force to recommend implementation. Sixty-four of 186 respondents who answered Question 15 endorsed this idea. State Chronic Disease Directors were most likely to endorse it (64%), compared with State Health Directors (39%), Healthy People 2010 Coordinators (38%), and Local/County Health Directors (22%). These findings were statistically significant (chi-square = 19.62, df = 3, $p < .001$). Reporting promising results was different for Local/County Health Directors than for Healthy People 2010 Coordinators ($t = 3.52$, $p = .0005$) and State Chronic Health Directors ($t = 5.44$, $p < .0001$).

Another response option suggested that the Guide could describe model programs that reflect recommended interventions. This option was endorsed by 97 respondents, but Local/County Health Directors (42%) were less likely to select this option than State Health Directors (65%), State Chronic Disease Directors (64%), and Healthy People 2010 Coordinators (62%). These differences were also statistically significant (chi-square 8.79, df = 3, $p = 0.032$). Local/County Health Directors also differed significantly from State

Chronic Disease Directors ($t = 2.15$, $p = .0329$) and State Health Directors ($t = 2.18$, $p = .0306$).

Offering sets of slides through the *Community Guide* was endorsed by just 45 respondents, but the highest level of endorsement came from Healthy People 2010 Coordinators (42%), followed by State Health Directors (32%), State Chronic Disease Directors (21%), and Local/County Health Directors (18%) (chi-square = 8.11, $df = 3$, $p = 0.044$).

Respondents were asked to select which of five resources (including "Other") they used to make decisions about programs, policies, or research (Question 16, Table 11). A total of 339 respondents made resource selections, and 323 of those selected multiple resources. A total of 1,109 selections were made across all 339 respondents, for an average of approximately 3 selections per respondent. Reports (289) and Web sites (290) were selected in about equal numbers, and each of those resources constituted 26% of all resource selections across all respondents. Peer-reviewed literature was selected somewhat frequently (22%), as were organization newsletters (19%). Respondents mentioned 31 other resources that were not easily categorized (see Appendix B). A number of respondents apparently were unclear about this question, because many ranked more than one element, or even all elements, "1" or "2." As previously described, the questionnaire was designed to allow respondents flexibility in their responses, and thus programming did not preclude using the same ranking for multiple elements. Respondents who assigned values of "1," "2," or "3" to multiple cases were excluded from the analysis.

Table 11. Q16: Resources for Making Decisions About Programs, Policies, or Funding ($n = 305$)

	Resources Selection					
	State		**Local**		**Overall**	
Barrier	**n**	**%**	**n**	**%**	**n**	**%**
Reports (e.g., Surgeon General, IOM)	107	29.0	182	24.6	289	26.1
Web sites (e.g., www.cdc.gov, others)	94	25.4	196	26.5	290	26.1
Organization newsletters (e.g., NACCHO, ASTHO, others)	60	16.3	153	20.7	213	19.2
Peer-reviewed literature (e.g., AJPH, Health Affairs, others)	88	23.8	154	20.8	242	21.8
Other (Please specify)[a]	20	5.4	55	7.4	75	6.8

[a] Three hundred five respondents selected resources for Question 16. Table total is higher than 305 because respondents were allowed to select more than one resource.

Table 12 shows respondents' rankings of resources they reported using, for all respondents overall and for state and local respondents only. Reports (such as those from the Surgeon General) were ranked most important for decision making by 45% of respondents overall (60% state and 35% local). Web sites (such as CDC's and others) were ranked as most important by 35% of respondents overall (24% state and 41% local).

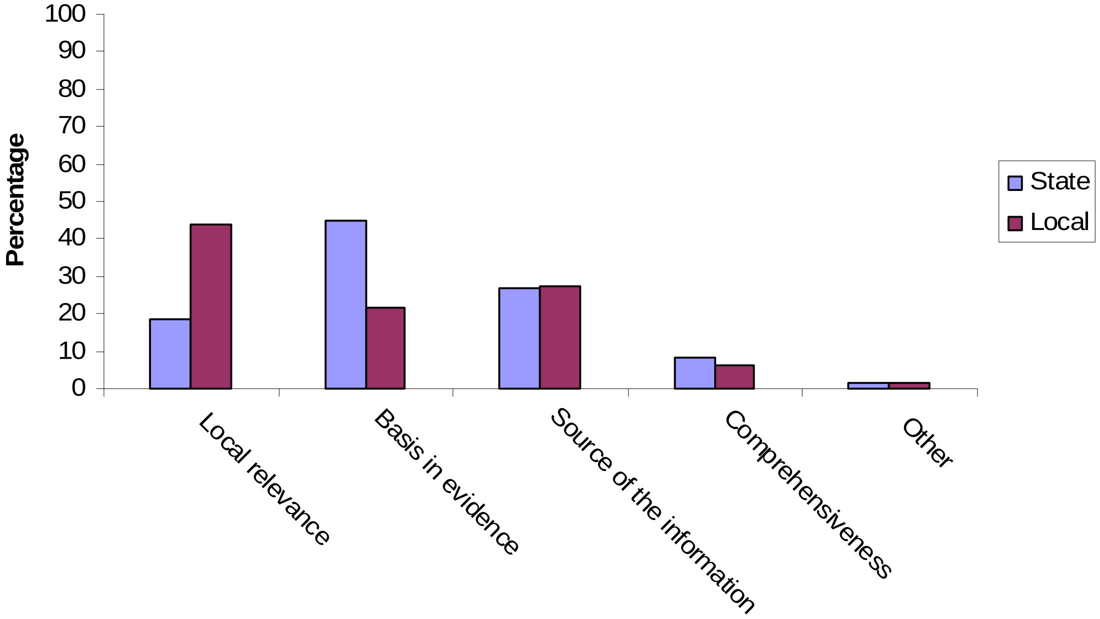
Table 12. Q16: Rankings of Resources for Making Decisions about Programs, Policies, or Funding (*n* = 305)

	Rank Endorsement						Total Ranked[a]	
	1		2		3			
Resource	**N**	**%**	**N**	**%**	**N**	**%**	**n**	**%**
Reports (e.g., Surgeon General, IOM)								
State	61	60.3	31	30.7	9	8.9	101	99.9
Local	53	35.3	64	42.7	33	22.0	150	100
Overall	114	45.4	95	37.8	42	16.7	251	99.9
Web sites (e.g., www.cdc.gov, others)								
State	20	24.4	27	32.9	35	42.7	82	100
Local	64	41.0	56	35.9	36	23.1	156	100
Overall	84	35.3	83	34.9	71	29.8	238	100
Organization newsletters (e.g., NACCHO, ASTHO, others)								
State	2	6.1	7	21.2	24	72.7	33	100
Local	20	20.2	37	37.3	42	42.4	99	99.9
Overall	22	16.7	44	33.3	66	50.0	132	100
Peer-reviewed literature (e.g., AJPH, Health Affairs, others)								
State	11	15.7	35	50.0	24	34.3	70	100
Local	27	23.9	40	35.4	46	40.7	113	100
Overall	38	20.8	75	41.0	70	38.3	183	100.1
Other								
State	9	64.3	3	21.4	2	14.3	14	100
Local	36	85.7	3	7.1	3	7.1	42	99.9
Overall	45	80.4	6	10.7	5	8.9	56	100

[a] Percentages may not total 100% because of rounding.

Question 17 presented five aspects of resources used for decision making and asked respondents to select the most important one (Figure 5). The most commonly selected response was local relevance (35% overall, 19% of state respondents, and 44% of local respondents), followed by basis in evidence (29% overall, 45% of state respondents, and 21% of local respondents), information source (27% for state and 28% for local respondents), and comprehensiveness (7% overall, 8% of state respondents, and 6% of local respondents). Another five altogether (1% overall, 2% of state respondents, and 1% of local respondents) answered some “other” aspect but did not describe what that was. Results were statistically different for state and local respondents ($p < .05$).

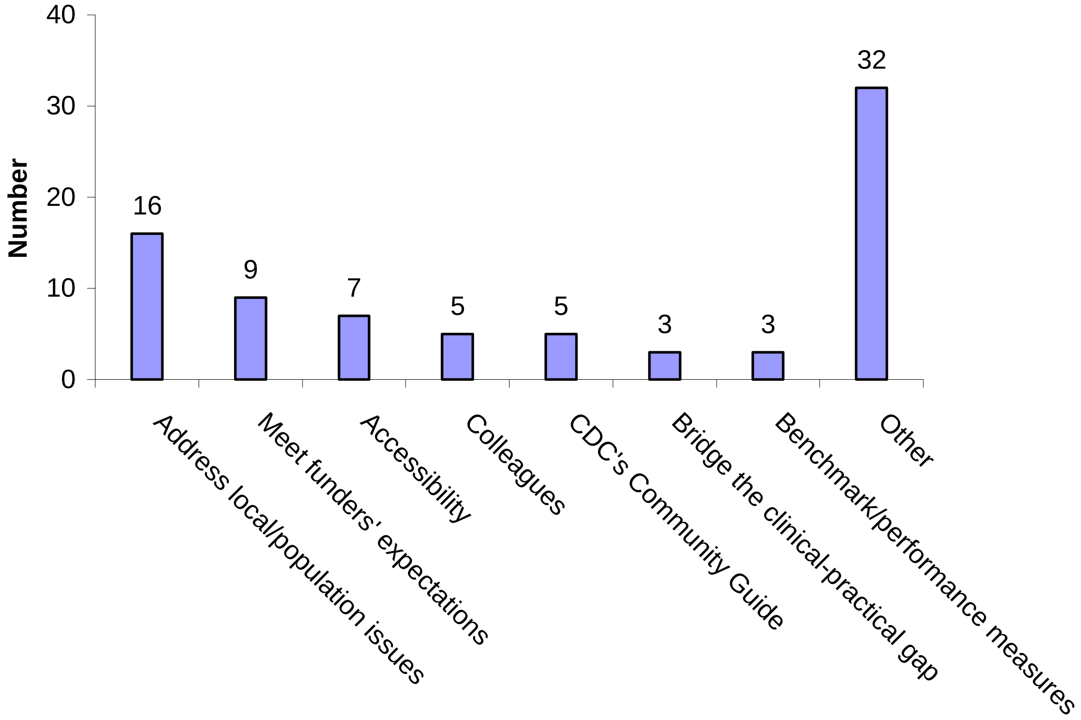
Figure 5. Q17: Important Aspects of Resources Used for Decision Making



Question 18 asked how a federal agency can effectively promote the use of evidence-based findings and provided a series of response options. Presentations at professional conferences were most often endorsed (71% overall, 82% state, and 65% local), followed by almost equal numbers endorsing grant requirements (59% overall, 72% state, and 53% local) or electronic notices (59% overall, 56% state, and 60% local). Another 53% overall (51% state, 55% local) endorsed using notices in professional newsletters, and 9% overall (11% state, 9% local) offered “other” means of promotion. Those included state or professional organizations (*n* = 8), Web or electronic modes (*n* = 5), workshops/Continuing Education Units (*n* = 3), agency structures (*n* = 2), Healthy People (*n* = 2), foundations (*n* = 1), proof of relevance (*n* = 1), and other responses (*n* = 8) (see Appendix C). Two respondents checked "other" but did not specify a response.

The questionnaire concluded with an open-ended question asking for any other comments on resources used in decision making (Question 19). Figure 6 summarizes the 94 responses received to this question. Some respondents noted that resources need to address local or population-specific issues (*n* = 16). Others said that their budgets are so limited that any decisions are based on funders' interests or expectations (*n* = 9). Other responses included accessibility (*n* = 7), colleagues (*n* = 5), and the *Community Guide* itself (*n* = 5). A few wanted their information resources to bridge the gap between clinical and practical worlds or to provide performance/evaluation measures (*n* = 3 each). Thirty-two respondents offered unique comments that are presented in Appendix B; 14 others made no substantive remarks.

Figure 6. Q19: Open-Ended Comments About Resources Used for Decision Making (*n* = 94)



3.3.1 Limitations

One significant potential limitation to interpreting results of this study is the fact that respondents were provided with a link to the *Community Guide* within the survey framework itself. The potential bias such a link could create by providing ready access for users to become “aware of” and “use” the survey during the questionnaire completion phase of the study was discussed by the CDC and RTI planning team members during the instrument development stage. The team decided that the potential benefits derived from providing access to public health professionals outweighed the risk of potential bias from enhancing access to the *Community Guide* Web site through clickable access. We did, however, measure the number of individuals accessing the Web site through the link. We found that 28 respondents actually clicked on the link and, of these, 1 did not return to complete the survey. The breakout for individuals using this link option is as follows:

- 2 State Health Directors
- 1 State Chronic Disease Director
- 3 Healthy People 2010 Coordinators
- 22 Local/County Health Directors (including the 1 individual who did not return to the questionnaire)

Two individuals left the questionnaire and did not come back for more than a day after clicking on the CDC Guide link. If we remove these two outliers and include only those completing the survey, the average time these individuals spent at the Web site was 3 minutes, 19 seconds, with the longest time being about 23 minutes. Because less than 10% of respondents actually used the click link in responding, we believe that the potential bias created from this option is minimal and should not adversely affect the overall interpretation of results.

A second limitation stems from the development of the sample. It is possible that various health agencies, particularly in remote areas, may have combined organizationally in ways that were not appropriately represented. Similarly, we sampled individuals by e-mail, but the unit of analysis was the position; thus, it is possible that individuals were no longer in the positions for which they were responding. Finally, we do not know how many times the person in the position delegated responsibility for completing the survey to their staff. Future surveys could include strategies for capturing this information.

3.3.2 Summary

The following summarizes key highlights from the study results:

- Participant Characteristics
  - Survey respondents were typically experienced in their positions. Ninety percent of respondents had been in their current position at least 1 year, and 74% had been in their organization for at least 5 years.

  - Respondents' job responsibilities corresponded with opportunities to influence public health decision making. Eighty-seven percent of respondents worked in program or policy planning, and 58% worked in developing grant proposals.
- Public Health Decision Making in General
  - When making decisions about program planning, policy development, and funding, state respondents reported relying on funding guidance from a legislative or federal authority and systematic reviews, whereas local respondents reported relying on funding guidance and peers (systematic reviews of the body of scientific literature on a particular topic were ranked third).
  - State respondents (45%) preferred decision-making resources that are evidence-based and from a credible source, whereas local respondents (44%) emphasized local relevance in valuing decision-making resources.
- Familiarity with the *Community Guide*
  - More than half (53%) of the decision makers surveyed were familiar with the Guide.
  - State-level decision makers were more likely than local-level decision makers to be familiar with the Guide.
  - Familiarity with the Guide did not appear to differ based on public health region.
  - The most commonly reported way state respondents became familiar with the Guide was by visiting the Guide-specific Web site (59%). For local decision makers, the most common route to familiarity was through peer-reviewed publications (37%). Local decision makers (15%) were far less likely than state decision makers (59%) to report learning about the Guide by visiting the Guide-specific Web site.
- Use of the *Community Guide*
  - Approximately 32% of all respondents reported using the *Community Guide* for their work (58% of state-level respondents and 20% of local-level respondents).
  - Of those familiar with the Guide, 61% had personally used it.
  - State-level decision makers (73%) were significantly more likely than local-level decision makers (50%) to have used the Guide.
  - Among state decision makers who were not using the Guide, lack of familiarity was the barrier mentioned most frequently (by 53%). Among local decision makers, lack of staff or financial resources was mentioned most frequently (by 27%), followed by lack of familiarity (by 19%).
  - Respondents whose organizations had used the Guide reported using it for a variety of health topics; more than half reported using it for tobacco prevention and control, physical activity promotion, and diabetes.
  - Among those at least somewhat familiar with the Guide, 63% had encouraged others (e.g., subordinates, colleagues, practitioners, the general community, grantees, students, and supervisors) to use the Guide.
  - For respondents who recommended the Guide, 85% reported recommending it because it "shows what works" and 63% reported that the Guide is comprehensive and scientifically sound. Over half also reported that the Guide is objective and helps use resources effectively.

  - Among respondents reporting that their organizations had used the Guide, almost half (48%) indicated that the *Community Guide* had played a role in choosing to discuss or implement policy initiatives, programs, or research priorities.
- Perceptions of the *Community Guide*
  - Most users (76%) correctly identified the Guide as “a tool to be used with data and best practices to support public health decision making.”
- Suggestions for Improving the *Community Guide*
  - Suggestions for making the Guide more useful included (1) adding descriptions of model programs, (2) increasing efforts to get information to users, and (3) including more information about promising practices (i.e., interventions that appear to be effective but for which conclusive evidence of effectiveness is not yet available).
  - Respondents (71% overall, 82% state, 65% local) suggested conferences as the best vehicle for promoting the use of evidence-based findings. More than half of respondents also endorsed grant requirements (59% overall, 72% state, 53% local) and e-notices (59% overall, 56% state, 60% local) as useful vehicles for encouraging use of the *Community Guide*.

4. CONCLUSIONS AND RECOMMENDATIONS

4.1 Study Implications and Recommendations

More than half of the respondents were at least familiar with the *Community Guide*. The large percentage (86%) of State Chronic Disease Directors who reported being familiar with the Guide suggests that these individuals are in decision-making positions that include intervention development and implementation. State Health Directors (80%) and Healthy People 2010 Coordinators (approximately 70%) reported high levels of familiarity with the Guide, which suggests that information about the Guide is reaching important target audiences, as these individuals represent key decision makers for allocating state and federal dollars expended for public health funds. In addition, these individuals serve as key informational "gatekeepers" who can help to facilitate the dissemination of information and encourage use of the Guide to other state and local staff. As expected, based on the responsibilities associated with their positions, State Chronic Disease Directors and Healthy People 2010 Coordinators were most likely to use the Guide in their work. The fact that approximately 75% to 80% of state decision makers who were familiar with the Guide had told others about it suggests that these individuals, based either on familiarity or use, believe the Guide has value for public health decision makers.

It is also important to explore why Local/County Health Directors, representing key decision makers within the local community echelons of public health practice, are not yet familiar with the *Community Guide*. Recent research (Thornton et al., 2004) suggests that local public health leaders want information about interventions with demonstrated effectiveness, which the *Community Guide* addresses. However, the fact that less than half of Local/County Health Directors (41%) were familiar with the Guide suggests that either more or different types of dissemination activities are needed.

Thornton et al. (2004) also suggested that dissemination of information from state to local levels may not be an effective dissemination strategy, and the present study supports this finding. Despite the relatively high number of state decision makers who reported having told others about the Guide, the fact that local-level decision makers do not seem to be as familiar with the Guide suggests that information about the Guide is not being systematically diffused through the statewide public health system to local levels, but rather remains predominantly in the hands of state officials. It is possible that state-level staff, as well as decision makers in local communities who may be charged with implementing or sharing information about intervention development, may not be aware of the Guide as a resource.

Thus, although it appears that important information about the Guide has been relatively well disseminated to the state-level leadership, the overall value of the Guide has been tempered in cases where subordinates are responsible for public health planning and intervention development. Effective top-down communication could bring about a more comprehensive organizational use of the Guide. Recommendations in the *Community Guide* could be used to stimulate discussions between state and local entities focused on a positive, “what works” perspective.

Peer-reviewed publications, conference presentations, and workshops were the principal means of learning about the *Community Guide*. However, lack of familiarity with the Guide was the most frequently cited barrier, across all groups, to using the Guide. Thus, it may be useful to consider publications and conferences aimed specifically at local public health officials as opportunities for targeted dissemination, such as the annual meeting of the National Association of County and City Health Officials and the National Association of Local Boards of Health. Other mass dissemination techniques recommended by participants, such as e-notices and newsletters, are relatively low-cost dissemination channels.

In exploring ways to stimulate use of the Guide*,* CDC may want to investigate why more local public health decision makers do not use the *Community Guide* Web site. Future versions of the *Community Guide Surveillance Survey* could examine this issue. For example, the survey could determine if access to the *Community Guide* Web site is intuitive to users and if standard Web searches for evidence-based public health resources identify the *Community Guide* Web site.

The role of funding guidance should not be overlooked as an important mechanism to encourage use of the Guide inasmuch as respondents noted this was an important “driver” in their decision-making process. Encouraging funders (internal and external to CDC) to include language that fosters use of the *Community Guide* in intervention planning and development could increase use of the Guide and ultimately increase development of interventions based on evidence-based “best practices.”

The majority of respondents viewed the Guide as a tool to be used in concert with other data and best practices to support public health decision making, whereas only a small number viewed it as a “cookbook” approach to interventions. State-level respondents were more likely to consider the Guide as an essential resource, whereas local-level staff viewed it as a tool to support decision makers. In short, users’ expectations are in line with the intended purpose of the Guide, suggesting little need to educate users.

Frequently mentioned improvements include requests for new topics (particularly on nutrition) and more relevant information that can be adapted for local populations. Local relevance was an important criterion for evaluating the quality of informational resources, which is to be expected, as the majority of respondents were employed by county or local health departments. Respondents also indicated that they would like to see “promising practices” included in the Guide, which suggests that they view the options currently presented in the Guide as somewhat limited because such stringent standards are required to meet the Guide’s “bar.” Some public health decision makers, eager for a variety of interventions that can be tailored to their unique communities and populations, suggested they would appreciate a tiered approach in which the “gold standards” of the Guide recommendations are provided, but also information about promising options.

The overall importance of systematic reviews in making public health decisions endorses the necessity of ongoing efforts to develop evidence-based review through the *Community Guide.* The suggestion to include more “promising” practices, together with the importance of local relevance for decision-making, suggests the need to have more options to select from in terms of the recommendations included in the Guide. However, because recommendations are constrained by the quality of research on which they are based, a more global issue may be the need for more rigorous research and evaluation of public health practice to expand the knowledge base of “what works” for interventions in the field.

4.2 Methodological Implications and Recommendations

This initiative established a structure through which awareness, use, and appraisal of information about the *Community Guide* can be monitored over time through repeated surveys. The Web-based survey method allows for efficient administration and analyses, and it can be modified readily for clarification, although larger-scale changes would require an OMB amendment. The 71% response rate achieved through this survey suggests that a Web-based strategy is appropriate for communicating with busy public health officials; that is, most sample members were able to take the time to respond to the survey. To retain its effectiveness, however, the structure requires regular updates (perhaps annually) of e-mails and contact information.

Other applications of this Web-based respondent directory are also possible. For example, a targeted survey of key state- and local-level public health decision makers could be implemented and analyzed quickly in a national crisis (pending OMB approval or its waiver).

To maintain the completeness and accuracy of this respondent directory for routine follow-up and other potential applications, it will be necessary to update and maintain the survey structure. To do so, contact information will need to be updated at least annually. In addition, a small percentage of respondents at the local level will need to be replaced with each administration to ensure that the survey does not become overly burdensome and to retain its longitudinal nature. State-level respondents can only be replaced through turnover because the population of positions is included.

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APPENDIX A:

CDC *COMMUNITY GUIDE*
EVALUATION QUESTIONNAIRE

UserID__________

Surveillance Survey for Guide to Community Preventive Services

The Centers for Disease Control and Prevention (CDC) is conducting a survey to examine what information or resources people are using to make health planning decisions. As part of this process, we are asking public health leaders like you to complete this survey.

Your participation is entirely voluntary and you may decline to answer any question that you are not comfortable answering. Your responses will be kept private and all identifying materials collected through the process will be destroyed at the conclusion of the study.

If you have any questions about the study, please e-mail Peter A. Briss, MD, MPH, CDC *Community Guide* Branch Chief, at cdccommguide@rti.org. If you have any questions about your rights as a person in this study, or feel you have been harmed by this study, please call John Ward, MD, CDC's Human Subjects Contact, tracking number 1949, at 404-498-6040. Leave a message, including your name and phone number, and someone will call you back as soon as possible.

1. What is your job title? ____

2. How long have you held your current position?
   - ☐ Less than 1 year
   - ☐ 1 to 3 years
   - ☐ More than 3 years

3. How long have you been with this agency or organization?
   - ☐ Less than 1 year
   - ☐ 1 to 5 years
   - ☐ More than 5 years

4. Within your organization, what kinds of work do you do? Please check all that apply.
   - ☐ Program or policy planning
   - ☐ Developing grant proposals
   - ☐ Program management
   - ☐ Planning and managing policy initiatives or programs
   - ☐ Other (Please specify) ____

5. When you make decisions about program planning, policy development, or funding, how important are each of the following for you? Please rank each, with 1 being most important and 6 being least important.

    __ Success stories and lessons learned from peers
    __ Funding guidance (either from legislative authority or Federal funding source)
    __ A single study or a review article on a specific topic
    __ Systematic reviews of the body of scientific literature or scientific reports (e.g., IOM reports, Surgeon General reports, Guide to Community Preventive Services)
    __ Health planning tools (e.g., MAPP or Healthy People 2010)
    __ Other (e.g., perspectives or priorities of organization leadership)

6. How familiar are you with the *Guide to Community Preventive Services,* sometimes referred to as the *Community Guide (*www.thecommunityguide.org*)?*

    ☐ Very familiar
    ☐ Somewhat familiar
    ☐ Little or no familiarity ➜ SKIP TO QUESTION 16 (page 5)

7. How did you become aware of the *Community Guide*? Please check <u>all that apply</u>.

    ☐ Workshop/training, conference presentation
    ☐ Visiting the *Community Guide* Web site (www.thecommunityguide.org)
    ☐ Reference in peer-reviewed publication (e.g., CDC MMWR, *American Journal of Preventive Medicine*)
    ☐ Other information sources (e.g., professional association newsletters, *The Nation's Health*)
    ☐ References in published reports (e.g., IOM reports, mass media stories)
    ☐ Word of mouth
    ☐ Supervisor
    ☐ Browsing CDC Web site
    ☐ *Guide to Community Preventive Services: What Works to Promote Health* (book by Oxford University Press)
    ☐ Other (Please specify) ____
    ☐ Don't Know

8. Have *Community Guide* findings been used within your organization to address any of the following? Please check <u>all that apply</u>.

   ☐ Vaccination coverage
   ☐ Tobacco prevention and control
   ☐ Physical activity promotion
   ☐ Motor vehicle occupant injury prevention
   ☐ Oral health
   ☐ Diabetes
   ☐ Violence prevention
   ☐ Skin cancer; cancer screening
   ☐ Social environment (education and housing)
   ☐ Nutrition
   ☐ Other (Please specify) ______________________________
   ☐ Don't Know

9. Do you personally use *Community Guide* findings in your work?

   ☐ Yes

   If "yes," please indicate how you have used the findings. Please check all that apply.

   ☐ Have read some of the *Community Guide*'s published work or visited Web site but have not used the findings in my work
   ☐ Have consulted the *Community Guide* Web site or publications when considering what programs, policies, or research to pursue
   ☐ Have used or intend to use in the next year, *Community Guide* findings to revise or implement programs, policies, or research priorities
   ☐ Other (Please specify)

   ☐ No ➜ SKIP TO QUESTION 10 (page 4)

10. If the answer to Question 9 is “no,” indicate what has kept you from using the *Community Guide*, by first checking all that apply and then ranking the top three where 1 is the greatest barrier and 3 is the least barrier.

Check	Rank	
☐	___	Lack of familiarity or understanding about the *Community Guide*
☐	___	Low demand within my organization for systematic reviews
☐	___	Skepticism about methodology used to develop findings
☐	___	Uncertainty over what makes the *Community Guide* findings any more useful than existing “best practices” documents, guidelines, or meta-analyses
☐	___	Uncertainty about what to do with “insufficient evidence” findings
☐	___	Lack of staff or financial resources
☐	___	Lack of “how to” information in the *Community Guide* about how to carry out recommended strategies
☐	___	Not enough information in the *Community Guide* about the cost of implementing recommended interventions or about their cost effectiveness
☐	___	Other (Please specify) ____

11. Have you encouraged others to use findings from the *Community Guide*?

☐ Yes

If “yes,” whom have you encouraged to use findings from the *Community Guide*? Please check <u>all that apply</u>.

☐ Supervisor
☐ Colleagues
☐ Practitioners in the field
☐ People who work for me
☐ Students
☐ Grantees
☐ General community

☐ No ➜ SKIP TO QUESTION 13 (page 5)

12. Why did you encourage others to use findings from the *Community Guide*? Please check <u>all that apply</u>.

☐ The *Community Guide* summarizes relevant studies to show what works
☐ The *Community Guide* helps ensure that resources are applied effectively
☐ The *Community Guide* is comprehensive and scientifically sound
☐ The *Community Guide* is objective
☐ Other (Please specify) ____

13. Within your organization, have *Community Guide* findings played a role in choosing to discuss or implement policy initiatives, programs, or research priorities?

☐ Yes
☐ No
☐ Don't Know

14. Overall, which of the following statements <u>best</u> describes the *Community Guide*? Please check <u>one</u>.

☐ A cookbook type of resource, which tells you how to build and implement policies and programs
☐ An essential resource to be consulted before making decisions about selecting interventions to address public health issues
☐ A tool to be used with data and best practices to support public health decision making

15. How could the *Community Guide* be made <u>more useful</u>? Please check <u>all that apply</u>.

☐ Improve navigation and/or content of the Web site
☐ Increase efforts to get information out to users (e.g., newsletter)
☐ Include information about practices that look promising, even when there is insufficient evidence for the Task Force to recommend implementation
☐ Model programs that reflect recommended interventions
☐ Include sets of slides
☐ Other (Please specify)
☐ Don't Know

16. What resources do you use to help you make decisions about programs, policies, or research priorities? First check all that apply and then rank the top three, where 1 is the most used resource and 3 is the least used resource.

Check	Rank	
☐	___	Reports (e.g., surgeon general, IOM)
☐	___	Web sites (e.g., www.cdc.gov, others)
☐	___	Organization newsletters (e.g., NACCHO or ASTHO, others)
☐	___	Peer-reviewed literature (e.g., JAPHA, Health Affairs, others)
☐	___	Other (please specify) ____

17. Which one of the following aspects of the resources you use in decision making is **most** important to you? Please check one.

☐ The source of the information (i.e., credibility)
☐ Local relevance (i.e., geographic or population characteristics)
☐ Degree to which it is evidence-based
☐ It's a "soup to nuts" resource (i.e., it tells you not only what to do but how to do it)
☐ Other (Please specify) ____

18. How can a Federal agency effectively promote the use of evidence-based findings? Please check all that apply.

☐ Notices in professional newsletters (e.g., *The Nation's Health*)
☐ A requirement within grant guidance
☐ Conference presentations at professional conferences
☐ Electronic notices (e.g., listservs or e-mail)
☐ Other (Please specify)
☐ Don't Know

19. Is there anything else you would like to say about resources that you use to make health planning decisions? Please describe here.

____

____

____

We sincerely appreciate your time and input. If you would like, we will send you the results from this survey. Please provide an e-mail address below where we can send you a PDF file of results.

____
Full e-mail address (e.g., John.Doe@domain.org)

Please mail your completed survey in the enclosed self-addressed envelope to:
RTI International
ATTN: Data Capture (08235.015.004)
PO BOX 12194
Research Triangle Park, NC 27709

APPENDIX B:

RESPONDENTS' DISTINCTIVE REMARKS NOT READILY CODABLE

Question 4. Respondent Work Description

- state public health functions
- please note I am not [NAME] but am responding at his request
- public health activities
- training and technical assistance around health promotion capacity
- community liaison
- assessment
- community health improvement activities
- facilitate hometown health coalition; run local health unit
- medical issues relating to public health
- community communication, press contact, agency advising, disease investigation monitoring, represent the county at functions
- outbreak investigations
- provision of program services, community education
- public education on WNV, SARS, code enforcement, inspections, complaint management, etc.
- medical direction
- training
- public information; Cmdr, ICS for emergency PH response, community service “boards”
- community health care needs assessments
- communicable disease control, environmental regulation
- field work (evaluations, inspections, complaints, education, etc.)

Question 7. How I Became Aware of *Community Guide*

- staff called my attention to it
- Healthy People 2010 work
- Guide distributed to medical directors
- was involved tangentially in setting it up
- exposure through MPH program

Question 8. Topics for Which My Agency Uses Guide

- physical activity (*n*one of the checked boxes have adequate suggestions)
- advise other organization's that do screening
- to initiate the MAPP process within the community
- as part of the overall information available
- probably used as a reinforcement of other sources of information
- no

Question 9. How I Have Personally Used *Community Guide*

- as new findings become available, we will use them. We are waiting for nutrition.

Question 10. Barriers to My Own Use of *Community Guide*

- have used other planning techniques
- new to my position
- too much of what this department does is dictated by funding sources
- very little health ed allocation, start, cv program

Question 12. Why I Encouraged Others to Use the Guide

- it provides a framework that fosters participatory thinking
- community partnerships request information on "best practices"
- additional resource offering sound perspectives
- has federal, CDC, HHS standing

Question 15. Ways to Make *Community Guide* More Useful

- provide evaluation tools that are user friendly in lack of financial resources
- send complimentary copies to all chronic disease directors
- have state health departments use and promote its use by counties
- work thru practice organizations like naccho and astho; use journal of public health management and practice
- funders should require applicants to consult the Guide when submitting proposals

Question 16. Resources that Help Me Make Decisions

- pilot projects
- experience from other states jurisdictions
- federal agency guidance
- the latest one is APCHOs program guidelines for the NDEP, AAPI group

- best practice findings
- I deal mostly in program and use programs that appear to have had some success
- politics
- funding sources
- information gathered by internal subject matter experts
- grant guidance, agency priorities
- HP2010, funding guidelines, state legislative direction, budget
- community input
- foundations, national gov assoc, national conf st legislators
- local priorities
- funding mandates guidelines
- updates from CDC, the state health department, and statewide professional organizations
- community needs
- local assessment information, state and local vital statistics
- internal reports and evaluations

Question 18. Ways a Federal Agency Can Promote Evidence-Based Findings

- from visiting consultants or referrals from other professionals that want to utilize our kind of epidemiologic information
- use in legislative mandates; program strategic planning
- Organized information at CDC about evidence-based PH and medical practice at CDC
- I'm a part time department head, severely under budgeted, do this as community service
- linkage to reimbursement
- package the evidence based findings as a group on a single topic. Most health departments have little time for "research"
- everything my agency does is already evidence-based, you are concerned about a problem that does not exist
- national healthcare information tech infrastructure with a superior GUI, data access and point of service EBM info

Question 19. Is There Anything Else You Would Like to Say about Resources You Use for Health Planning Decisions?

- Healthy People National Health Objectives should include BOTH objectives and evidenced-based interventions
- There is a real need for Federal data to be based on state data as with NCH's birth and death data. The next logical data sets for this to occur are the UB92 hospital inpatient; emergency department and outpatient databases.
- Please expand topic base for which strategies are suggested. Addressing disparities should be a chapter or how to address health disparities should be woven into each topic's chapter. We are desperately waiting for the report on nutrition.
- We look at needs identified through assessment process and then start looking for a program that seems to address those needs.
- I receive many publications and have state recourses available
- Unfortunately federal resources are losing credibility in the current political environment. It is hard to tell whether federal agencies are following a true evidence-based policy or an ideological one. They are not candid at all in letting us know the truth.
- We use the Planned Approached to Community Health and the Comprehensive Assessment for Tracking Community Health and share this information with the community to help guide policies. In addition Healthy People 2010 is also used.
- There are numerous resources available to us at the local level given the access to the Internet and the use of the Internet by national and state public health agencies and PH organizations. Sometimes difficult to know that you have found all the information that one is looking for. Clearinghouse at CDC that is marketed and useful would be a value-added service to local health departments.
- After we make our decision based on science and public health we are limited by financial and political constraints.
- Usually the resources that I have used are supported or recommended by the State Health Department personnel. Input from peers or those who may have used a source are very important.
- A comprehensive collection of evidence-based programs and curriculum that is updated on a regular basis would be helpful to use as a resource.
- It is truly a combination of resources that go into the decision making process with community based health education programs.
- Partner with other agencies to address health issues in the county (Board of Education, Lincoln County United Human Services Council, Lincoln County Adult Education Program, etc). This has been big plus in being able to work together to accomplish goals.
- funds available community support
- Health planning is heavily driven by data, funding sources and requirements.

- Need more templates guidance on good models of health planning tools
- Electronic templates that can be reconfigured for local use in record keeping decimation to support planning decisions.
- Resources often conflict in recommendations—i.e., CPSC refused to address ATV injuries. CDC makes other recommendations. EPA sometimes conflicts.
- HHS & CDC Publications including MMWR. US & NJ Census Data Community Health Profile NJ Public Health Practice Standards & National Pub Health Stds. NJ State Laws & Administrative Codes NJ Centers of Health Statistics Publications Other Public Health Textbooks & Journals
- A lot of my decision making comes from my leadership skills and knowledge of community resources, and populations
- Health planning decisions made by collective bodies (i.e., health councils) may have different material method needs than those of a Public Health Director responding as individual in position of leadership.
- We rely greatly on guidance from the New York State Department of Health.
- The area of environmental intervention to address physical activity and nutrition is still ???? in the *Community Guide* and ??? to be pulled and updated regularly as this is a critical and ??? area
- This questionnaire, contrary to the guidance at the beginning did NOT allow one to except questions and took a perverse dislike to certain numerical answers being duplicative but not others.
- We feel that one very important, yet underdeveloped (and now discontinued) resource for interpreting local data was the Community Health Status Report (HRSA)—last version July 2000.
- Local Health Directors Association Meetings Staff Input Community Health Assessments
- We use questionnaires such as the Ohio Adolescent behavioral risk questionnaire. We actually do some key informant questionnaires with our health assessment. CDC could play more of a role in analyzing the results of national and state questionnaire trends.
- Would be very helpful for federal agencies to better promote as identified in Q#18 above.
- In the health department system of my state, most policy is driven by the staff at the state level, not the local level.
- There are still many "gray" areas without adequate information available. It would be good to take common community health issues and identify those for which there is evidence and those which do not have sound evidence.
- Need local level data from state DPH that is comparable to state level data and other local jurisdictions—locals can't collect data that is useful always—need data to work with.

- I may be convinced or believe in a planning strategy, but I also have to get “buy in” from colleagues and staff for it to work. Issues that hit local or national media are generally easier to get support on.