

Success Measures® Health Tools

Field Test Summary Report

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Introduction

As more community development practitioners embrace the important linkages between community development and individual, family and community health, the need for tools to measure these health-related outcomes has become increasingly clear. In response, Success Measures[®], an evaluation resource group based at NeighborWorks[®] America, developed an evaluation framework and set of data collection tools for community development practitioners interested in documenting the health outcomes of a wide range of affordable housing, neighborhood revitalization, workforce development, supportive service and community engagement programs. Drawing on social determinants of health research and using a health equity lens, the project, supported by NeighborWorks America, Wells Fargo Housing Foundation and Morgan Stanley, focused on the evaluation support needs of community development practitioners, and complements efforts by leading funders, researchers and others to identify core measurement issues at the intersection of health and community development.

Based on a literature review, stakeholder engagement, and the input of an expert working group¹ drawn from the health care, public health, community development and public policy fields, the final products of this effort are:

- An evaluation framework that arrays the health-associated outcomes of the spectrum of housing and community development programs in three main categories:
 1. Healthy People: Measures about the status and change in health-related conditions, activities, attitudes and behaviors for individuals and households, as well as measures of inclusion, community engagement and social cohesion.
 2. Healthy Places: Measures about the condition, availability and quality of homes, work places, neighborhoods and other aspects of the physical environment;
 3. Healthy Organizational Relationships: Measures to assess the types, strengths and efficacy of organizational partnerships and cross-sector collaborations to address social determinants of health, health care access and use of health services.
- A set of 65 data collection tools to measure the outcomes from the first two categories – healthy people and health places. Data collection tools include: surveys, key informant interview guides, templates for collecting existing data, and observations. The data collection tools were field-tested and completed as of October 2015.
- A set of categories and draft tools for the third category, healthy organizational relationships, has been drafted and we are seeking funding to field-test them in 2016.

The underlying challenge for the development of the Success Measures Health Tools² was twofold. First, to articulate the intersections between the housing, community development and health fields and to develop content, in the form of data collection tools, enabling practitioners to collect information about outcomes in a way that is relevant for both fields. And second, to ensure that the questions reflected the way that real people talk about health and related issues.

¹ The list of working group participants is Appendix A, p.23.

² The tools were originally referred to as Health and Community Development Outcome Measurement Tools.

The working group took the first steps by finalizing a coherent framework for thinking about health-related outcomes of community development work. The final phases of the project – Success Measures’ work translating the framework into data collection tools relevant to both respondents and practitioners from the community development and health fields – are the focus of this paper.

Based on existing research on the health equity outcomes associated with comprehensive community development programs, strategies and investments, we set out to explore the ways in which community development practitioners could explicitly articulate and track health-related outcomes in order to:

1. Clarify the direct intersections between community development and health to enhance health outcomes for people in low- and moderate- income communities.
2. More clearly articulate the health outcomes resulting from existing community development work so that community development practitioners can gather information needed to make better decisions about health-focused programs which they might implement on their own or with health partners.
3. Support more effective partnerships between community development and health practitioners through an integrative evaluation framework, common language and shared measures.

With these issues in mind, the challenge was to create data collection tools that evaluate the social determinants of health, meaning a set of tools focused on the health-related outcomes of community development work. We also realized that community development organizations are already successfully working with health partners to deliver direct health programming on-site as part of resident and supportive services. Our tool set needed to address both of these.

Tools to evaluate the social determinants of health need to make the link between health and an array of affordable housing, community engagement, human service, and financial capability programming. Outcomes in this category are generally upstream and long term. The connections are based on existing research. For example, community development organizations often build and rehabilitate quality affordable housing. In the 1990s, research focused on the cost savings and resulting increase in disposable income that could then be used for health care.³ Recent research has extended that concept to link psycho-social benefits, decreases in stress, stability of the household, and improved quality of life from living in a safe home in good repair to improved health outcomes in the long term⁴.

Tools to measure the medium- and short- term benefits of health programming done onsite with health partners as part of resident services and supportive services are needed to help organizations understand how that health programming is related to their ongoing community development work. For example, physical fitness programs are “health” programs. However, within a community development context,

³ Rohe, William M., Shannon Van Zandt, and George McCarthy. "The social benefits and costs of homeownership: A critical assessment of the research." *The affordable housing reader* 40 (2013): 00-01.

⁴ Maqbool, Nabihah, Janet Viveiros, and Mindy Ault. *The Impacts of Affordable Housing on Health: A Research Summary Insights for Housing Policy Research* 2015

practitioners are interested in residents' attitudes, behaviors and physical changes in addition to their increased engagement and bonding with other community members.⁵

By making the links in both directions explicit, we hope to contribute to the growing movement to include an array of health promotion, health care and health access programming as part of broader neighborhood revitalization and other strategies carried out by community development organizations. This goal was integrated into the development of the data collection tools in the following ways:

- Question content: Combining the perspectives of the health and community development fields to ensure that both perspectives are reflected in the issues addressed by the question content.
- Nature and number of questions: Balancing the data needs of health providers and policymakers with those of community development practitioners.
- Question wording: Focusing on diverse low-income communities in both urban and rural areas to allow for customization of language and terminology.

In summary, we approached the development of the health tools as one step toward helping community development and health practitioners develop a common language for the shared outcomes both fields are working to achieve. This document highlights key learning from the field test phase of the project. We present them to contribute to the broad range of measurement efforts in this emergent space.

⁵ Lachance, Laurie , Laurie Carpenter , Martha Quinn , Margaret K. Wilkin , Edward Green , Kazumi Tsuchiya , Belinda Nelson , Cleopatra Caldwell , Linda Jo Doctor , Noreen M. Clark Food & Community: the cross-site evaluation of the W.K. Kellogg Food & Fitness community partnerships. *Community Development*. Vol. 45, Issue 3, 2014

Methods

The field test was designed to assess the validity and reliability of survey questions directed at individuals, whether community residents or program participants. It was specifically designed to evaluate (1) the extent to which the questions would actually measure what was intended and (2) the degree to which they generated consistent results.⁶ Following a series of question revisions, based on learning and feedback from the field test, the survey tools directed toward individuals were then incorporated into the Success Measures Data System (www.successmeasures.org), in both English and Spanish. For a complete list of the health tools, please see Appendix B, p.26.

Conducted in four phases between June and September of 2015, the multi-phase field test involved nine community-based organizations. Organizations with interest in the field test and with active programs bridging community development and health were invited to participate. They were selected to represent a diversity of locations, different types of programming, and both rural and urban settings. Each organization played a specific role in testing and participated in only one of four phases. A complete list of participating organizations and their locations can be found in Appendix C, p.28.

Each organization received a small stipend for its participation, a project orientation, and tasks specific to a single phase of the field test. In the first three phases, Success Measures staff traveled to the participating sites to conduct the field-testing. For the last phase, organizations received a larger stipend to collect two rounds of data using the same survey tools. Their efforts were supported by remote assistance from Success Measures. Survey data were entered into the Success Measures Data System by the participating organizations and analyzed by Success Measures.

Because the 47 tools which were survey tools (out of a total of 65 tools) each consisted of multiple questions, not all could be field-tested. We chose a subset of questions from each tool based on several criteria:

1. Questions that had not been previously field-tested were given top priority.
2. Uncertain terminology was tested with at least one question that contained the word or expression.
3. Questions representing new concepts were tested, often in multiple phases.
4. Sets of questions with the same wording and response categories were represented by a single question.

Each phase focused on a different aspect of question validation and required the participation of organizations in different ways. In phases two to four, selected questions from the draft survey tools were combined into several different instruments that were used with respondents. Descriptions of the four phases follow:

PHASE 1 - Focus Groups: For each organization participating in this phase, two focus groups of approximately 10 people each were convened and facilitated by Success Measures during a one-day site visit. Lasting 1.5 hours each, the Phase 1 focus groups helped us understand how community residents think about health and health-related issues, as well as the terminology they use in talking

⁶ Additional data collection tools developed for this project include observation and assessment instruments that primarily employ questions from existing tools along with tracking and reporting templates for recording secondary data over time.

about these subjects. The focus group discussions drilled down on key concepts in health and explored participants' interpretation of and comfort with health-related language. They also addressed, from the participants' perspective, how aspects of culture, environment, diet, and activity connect to health.

PHASE 2 - Cognitive Interviews: We conducted 10 one-on-one resident interviews during a two-day site visit at organizations participating in this phase. Success Measures staff conducted five interviews per day, each lasting approximately 1.5 hours. Phase 2 focused on residents' interpretation of and answers to specific questions on the data collection instruments. Respondents were encouraged to talk about what they thought about when they heard a question and how they came to the answer they chose. This phase also allowed Success Measures staff to engage in discussion that would help to address contextual differences, including intergenerational and multicultural households and caregiving in the home.

PHASE 3 - Self-Administered Questionnaires (English & Spanish): For each organization participating in this phase (two English-speaking and one Spanish-speaking), 10 one-on-one sessions between a resident and a Success Measures staff member were scheduled for 1.5 hours during a two-day site visit. At each session, the resident independently completed a self-administered questionnaire. This was followed by a debriefing conducted by Success Measures. Phase 3 focused on studying the overall ease of navigating the questionnaire, including interpretation of instructions and use of skip patterns. The debriefing discussions also served to confirm and build on findings from both Phases 1 and 2.

PHASE 4 - Test-Retest: The same self-administered questionnaire was administered by the two participating organizations to the same 25 people twice in a one-month period⁷. Phase 4 focused on test-retest reliability and included questions for which consistent answers would be expected over time. This protocol allowed for the comparison of results at two points in time for individual respondents and could be used to identify questions that did not produce similar measurements.

All participants were provided with some form of compensation for their time and participation, although not all were aware that they would receive remuneration until the conclusion of the session they attended. The respondent incentives were paid for out of the stipend given to each organization. The amount and type of incentive was determined by the organization and ranged from gift certificates to check cards.

Questions for each phase were selected for testing based on feedback and revisions from the prior phase. Between each phase, the Success Measures team modified both the tool framework and the questions as indicated. Phases 1 and 2 relied on qualitative analyses to assess respondent feedback. Special attention was given to understanding how residents spoke about health and what they feel is related to health (e.g., housing conditions, work environment, amenities, and finances). Key topics such as health care use, foodways⁸ and managing chronic illness were also explored. Success Measures also analyzed the data that

⁷ Both field test organizations in Phase 4 collected data from 30 participants to ensure that we would have a total of 50 respondents.

⁸ Foodways, refers to the cultural, social and economic practices related to the production and consumption of food. It often refers to the intersection of food, culture, traditions and history. Definition taken from Darton, Julia. "Foodways: When food meets culture and history", Michigan State Extension

were collected to study the dispersion of responses to individual questions, thereby identifying those questions that do not produce sufficient variability⁹.

Discussion of Key Findings

An underlying goal of the field test was to improve our understanding of how to ask people about their individual status, attitudes, behaviors, influences and cultures related to health; about their access to and use of health care services; about their physical environment, and about their housing conditions related to health. The health tools include self-administered survey tools and interview guides; observation and assessment tools; and data tracking and reporting templates. At the start of the field test, our team had completed drafts of the 47 survey tools that covered the topics identified in the health, housing and community development evaluation framework.

Our aim during the field test was to test the questionnaires for a variety of factors that would affect validity and/or reliability, including cultural relevance, potential bias, question interpretation, and ability to respond. Below we have compiled key findings that emerged from this endeavor and that best describe what we learned from the field test. These findings have been grouped into the following categories which mirror our areas for consideration for the overall field test:

1. *Question content:* Ensuring that questions operationalize key concepts in ways that are relevant to both community development and health practitioners.
2. *Nature and number of questions:* Finding the “right” level of information to collect that meets the needs of both community development and health practitioners.
3. *Question wording:* Finding language that conveys key concepts and ideas that translate across rural and urban communities.

CATEGORY 1: QUESTION CONTENT

Content revisions: What respondents were willing to talk about

While there are some community development organizations offering health-related programming, community residents participating in that organization’s programming may not be accustomed to thinking about their work in relationship to their health. As mentioned earlier, an important part of the field test was to help us begin to understand health and health-related topics that respondents would feel comfortable addressing in a questionnaire. We were keen on ensuring that the tools developed would not be perceived by respondents as too personal or intrusive which, we thought, would lead to missing or inaccurate responses as well as a negative experience for the respondent. For the most part, we found that focus group, interview and survey respondents were more than willing to be very open in discussion about their health and health-related issues, even suggesting other issues we might consider addressing. However, there was one topic we had originally included in the health and community development framework that we ultimately chose not to explore in the tool development phase based on practitioners’ and field-test respondents’ feedback: this was the issue of disciplining children.

⁹ Variability in the case indicates situations in which the variability in responses obtained were sufficient to distinguish among respondents on a particular variable(question)

What we removed – disciplining children

Originally, the working group identified the issue of discipline as a component of household and family dynamics that may influence health. To explore the feasibility of incorporating this issue into our tool development process, Phase 1 focus group respondents were asked the following question:

The next topic is about parenting. How someone raises his or her children is a very individual matter. Different people take different approaches to parenting.

What are your thoughts about parents disciplining their children?

Respondents' feedback indicated that discipline was a highly individual matter that varied by family and sometimes among adults within the same family. Furthermore, we are undoubtedly living in a time where parenting has become both increasingly private and yet highly public. At the same time, recent media reports have demonstrated the level of scrutiny parents today are facing and public "shaming" of parenting behavior is an emerging phenomenon. Parenting norms have changed over time making what was acceptable a generation ago now inconceivable to some parents, and vice versa.

In addition, even though the issue of discipline was raised in discussions in the working group, practitioners indicated that their organizations' programs were not likely to focus on the issue. Thus, understanding that while discipline is in fact an important factor that can influence health – particularly from the perspective of the connection to violence and safety – addressing it in the community development context may not be appropriate. Given that we felt respondents may either be reluctant to or uncomfortable with sharing their opinions and that this set of questions would likely not yield useful information for community development organizations, we decided not to pursue this subject matter past the field test's second phase.

In this case, respondents' feedback resulted in removing content we had originally intended to include. More often than not, however, respondents' feedback helped inform us of content they felt should be added to the health and community development tools and even expressed that participation in the survey had been a positive and beneficial experience that they enjoyed.

Make it about "me"

Research shows that family and peer relationships strongly affect one's own health-related behaviors.¹⁰ We developed a line of questions that asked respondents to reflect on the views, attitudes and/or behaviors of their friends or family members on health and health-related issues. Our reasoning for embarking on these types of questions was based on the sizable body of research that has found that family and peer influences can be a significant factor in individual beliefs and behaviors regarding health. We wanted to develop a set of questions that might help an organization understand the extent to which this was true for the individuals and communities they serve. In a community development context,

¹⁰ Umberson, Debra and Jennifer Karas Montez Social Relationships and Health: A Flashpoint for Health Policy. Journal of Health and Social Behavior November 2010 vol. 51 no. 1

programming related to community engagement, health promotion and *promotora*¹¹ models would benefit from understanding this aspect.

One set of Phase 2 interview included a number of questions about the behaviors of the respondent's friends, as in these three examples:

A. In general, how much alcohol would you say your friends drink?

- A great deal
- A fair amount
- Some
- A little or none

Other Phase 2 interview questions asked respondents to compare themselves to their friends, for example:

B. When you compare your level of interest in eating balanced meals to that of your friends, would you say that you are ...?

- More interested
- Less interested
- Have about the same level of interest

Another set of questions included several asking respondents to assess the influence their friends had on their attitudes and behaviors, for example:

C. From your perspective, to what extent do your friends influence what you eat?

- A great deal
- A fair amount
- Somewhat
- A little or not at all

We found that interview respondents reacted very differently to these three question types. When asked to think about the opinions or behaviors of their friends, some respondents first asked why we wanted to know about their friends at all, or stated that they did not feel they could confidently answer for their friends. In talking with respondents, we came to understand that they did not feel comfortable speaking on behalf of others or felt that they could really know, with certainty, what their friends thought.

In addition, a number of respondents said that they did not have any friends and could not answer the question, while others were unsure of which friend groups we were referring to (e.g., life-long friends, current acquaintances). To address this issue, we subsequently used the phrase "close friends," which conveyed a more consistent meaning in later phases of the field test. We discuss these types of changes to question wording related to respondents' needs later in this report on page 14.

¹¹ A *promotora* is a lay Hispanic/Latino community member who receives specialized training to provide basic health education in the community without being a professional health care worker.
<https://en.wikipedia.org/wiki/Promotora>

When using the questions that asked respondents to compare themselves to their friends, such as question B, we did not experience the same type of hesitation; respondents often answered these questions with ease. While question A proved difficult because respondents felt they had to guess, B seemed more within their reach because it specified that we wanted to know their perspective or opinion about themselves in comparison to their friends. Similarly, respondents felt they could answer question C, which asked specifically for a respondent's perspective of the influence friends had on their (the respondent's) attitudes and behaviors.

Though subtle, the difference was between making the question primarily about the respondent rather than their friends, and removing the pressure for respondents to feel that they needed to be "right" or provide a fact-based answer. Moving forward, we eliminated the approach which focused solely on a respondent's assessment of their friends, and kept the questions that focus on a respondent's description of themselves compared to their friends or on their own perspective or opinion.

Frequency over quantity

There were a number of questions used during the field test that required respondents to estimate the quantity or length of time that they did a certain activity. Two types of problems emerged regarding respondents' estimation. One was that respondents struggled to recall their habits and behaviors if the time period involved was too long. The second was that respondents found it most difficult to estimate the number or length of time that they did something if it was something they did routinely, regardless of the time period involved (for example, even within a single day).

One of the Phase 2 interview questionnaires included the following questions:

On average, how many servings of fruits and vegetables do you eat each day?

How many raw or whole fruits did you eat yesterday?

How many raw or cooked vegetables (not fried) did you eat yesterday?

Respondents often struggled to recall the number of fruits and vegetables they consumed over a period of one day, particularly among individuals who reported eating fruits and vegetables often. They also did not necessarily understand what amount constituted a single serving. When instead, they were asked how many *times* in a single day they eat fruit, not the quantity of fruit in terms of servings, respondents were able to give more specific answers. Similarly, when asked, not how many vegetables they consumed over a given period of time, but rather the *number of times* they used vegetables in their meals, respondents were better able to answer the question with some certainty. It was a small but important distinction we made to convert the questions to address frequency rather than quantity.

As a result, we revised this set of questions in Phase 3 to instead read as follows:

On a typical day, how many times do you eat fruit (not including juice)?

Never

Less than once a day

About once a day

About twice a day

Three or more times a day

On a typical day, how often do you include vegetables of any type in the meals you eat (both cooked and raw)?

- Never
- Less than once a day
- About once a day
- About twice a day
- Three or more times a day

With these revisions, we switched from asking respondents about “yesterday” to asking about “a typical day”, eliminating error or inaccuracies that might arise if the prior day was in some way unusual. Additionally, we created grouped-data categories, rather than asking respondents to provide a specific number, which better communicated the range of possible responses to the respondent.

CATEGORY 2: NATURE AND NUMBER OF QUESTIONS

Asking for the right level of detail

We began with some questions that were adopted from already existing health data collection tools and tested them as part of the field test. In the process, we learned that the level of detail required in data collection tools for health went beyond what would be useful in a community development context. In many cases, we needed to shift the way in which key concepts were experienced in context. For example, when focusing on “physical activity”, a strictly health perspective might address the change in an individual’s fitness level with data such as heart rate and minutes of exercise. The same focus on “physical activity” within a community development context might address behaviors related to overall fitness and recreation, as well as participation in activities and programs.

Originally, we asked the following:

In a typical week do you do any vigorous-intensity sports, fitness, or recreational activities that cause large increases in breathing or heart rate like running or basketball for at least 10 minutes continuously?

- Yes
- No

[If yes] In a typical week, on how many days do you do vigorous-intensity sports, fitness, or recreational activities? _____ days

[If one or more days] How much time do you spend doing vigorous-intensity sports, fitness, or recreational activities on a typical day? _____ minutes

The same set of questions was repeated for “moderate-intensity sports, fitness, or recreational activities” and “exercises to strengthen or tone your muscles”. In discussion with Phase 2 interviewees, it quickly became clear that this set of questions did not take into account different levels of physical ability. Some respondents indicated that there were various factors that limited their physical ability to do vigorous-intensity sports, for example a recent injury or surgery, a chronic condition such as arthritis, or other physical differences and/or constraints, such as using a wheelchair or walker. However, this did not necessarily mean that these respondents did not exercise. Surely, some simply did not, but others did in fact exercise in various ways fitting for their ability or condition and we wanted to be able to capture that

in our line of questioning. Revising our assumptions about physical activity, we developed a new set of questions to reflect our new understanding. We adjusted this set of questions as follows:

Some people are able to get a lot of physical exercise while others have limitations on how physically active they can be. Do you have a diagnosed medical condition that limits your physical activity?

- Yes
- No

[If Yes:] How often do you exercise in ways that are appropriate to your level of ability?

- Often
- Sometimes
- Rarely
- Never

How often do you deliberately get physical exercise that goes beyond your typical day-to-day activities?

- Often
- Sometimes
- Rarely
- Never

While these changes to the question addressed chronic illnesses and conditions, they did not address acute conditions or temporary physical injuries. Focusing on what community development practitioners needed to know, the new set focused on collecting those data and shortened the survey experience for respondents. We came to understand that it was not so much the level of exercise respondents were getting that was important but, rather, whether respondents were exercising at all. For this reason, the adjustment to asking respondents about exercise, within their level of ability, regardless of what that level was, yielded a more inclusive set of questions that provided the pertinent information.

Integrate qualifying statements

At times, we discovered that the way we had phrased a question was influencing how respondents answered. We realized that we were inadvertently influencing respondents' answers with our questions on physical activity and how friends and family relate to attitudes and behavior. The Phase 2 interviews included the following questions on the influence of friends:

How similar or different are your attitudes about health and health-related topics compared to those of your friends?

- Very similar
- Somewhat similar
- Somewhat different
- Very different

When you compare how accepting you are of drinking alcohol to how accepting your friends are, would you say you are ...?

- More accepting
- Less accepting
- At about the same level of acceptance

Most respondents felt they needed to qualify their answers by making clear that it depended upon the type of friend. Based on this feedback from the Phase 2 interviews, we surmised that the way the questions were worded – without any sort of qualifying phrase – confused respondents because the word “friend” was much too broad. We realized the questions needed rephrasing to focus on “close friends” as they would likely carry the most influence. As a result, we augmented the questions to read as follows:

How similar or different are your attitudes about health and health-related topics compared to those of your close friends?

- Very similar
- Somewhat similar
- Somewhat different
- Very different

When you compare how accepting you are of drinking alcohol to how accepting your close friends are, would you say you are...?

- More accepting
- Less accepting
- At about the same level of acceptance

In subsequent testing of these questions in the self-administered questionnaires used in Phase 3, we saw more variation in answers, which would be expected.

CATEGORY 3: QUESTION WORDING

Language and meaning – how we really talk about things

One of the difficulties in designing questionnaires that a respondent will answer without an interviewer present, is to identify terms that have the same meaning to many different people and that will be interpreted similarly despite many possible differences such as age, geography and cultural background. This is, of course, relevant to obtaining comparable information from a variety of respondents. Understanding this common language is also important to practitioners because, in our various lines of work, we may often use terms within the scope of our organizations’ programs and activities that may not be similarly understood by others. Community development and health are each already complex; working at the intersection of the two makes being deliberate and thoughtful about language we use even more essential to establishing a common ground for practitioners.

Some of what we learned during the field test may assist other community development groups with overall communication about health to community residents across the U.S. Finally, using language that

corresponds to respondents' worldview provides a more positive experience for the respondent. We are aware that we are asking respondents about potentially sensitive, and certainly personal topics, such as health, relationships with one's doctor, family, and finances. We are also asking them to think about health more broadly, connecting health to other aspects of their lives – their workplaces, how they move from one place to another, and services available to them. For these reasons, it was important to us that we develop questions that are clear, concise and phrased in a respectful manner. This all begins with the very broad concept of language and word choice.

What respondents said was important – chronic illness and disease

Feedback from respondents was very important as we learned from a line of questions on managing illness and disease. One of the Phase 3 questionnaires asked questions about whether or not respondents had been diagnosed with an illness or disease for which they were currently receiving medical care or taking medication. We developed these questions to address issues such as hypertension, diabetes, asthma, high cholesterol, and depression that, based on the literature, are leading indicators for vulnerable populations. However, through discussion with Phase 3 survey respondents, we learned that they felt it important to also include similar questions specifically about rheumatoid arthritis, lupus, fibromyalgia and other auto-immune diseases that they found to be prevalent in their communities. Low-income communities have a higher incidence of both disease and disability, so getting this kind of detail to customize the questionnaires is important. We subsequently expanded the set of questions on illness and disease to include their suggestions. Respondents reported that part of the reason they felt that these additions were important was because these types of illnesses often went undiagnosed in their communities. Individuals suffering from these illness often did not know what the problem was and, therefore, could not name it. Having these illnesses included and named in the questionnaire helped to legitimize their experience and acknowledged the prevalence of these illnesses in their communities.

Provide definitions only when necessary

One of the basic, but important, goals of the field test was to identify language or word choice that impeded respondents' understanding of what the questions were designed to ask. We originally addressed this issue by either providing a definition within the phrasing of the question, or simply using more commonly understood terminology. For example, many respondents were unfamiliar with the term "telemedicine"¹² in the following question:

How much do you trust the following sources for accurate information about health and health-related issues? [a great deal, a fair amount, a little, or not at all]

- Family members
- Close friends
- Co-workers
- Faith community members
- Celebrities
- Online resources, such as websites, social media, and blogs
- Telemedicine providers

¹² Telemedicine is the use of telecommunication and information technologies to provide clinical health care at a distance. It helps eliminate distance barriers and can improve access to medical services that would often not be consistently available in distant rural communities. <https://en.wikipedia.org/wiki/Telemedicine>

Since “telemedicine” was, in fact, the commonly accepted term for what we were asking, but not yet a widely available service in non-rural areas, rather than replacing the term, we provided a definition within the answer option, as follows:

How much do you trust the following sources for accurate information about health and health-related issues? [a great deal, a fair amount, a little, or not at all]

- Family members
- Close friends
- Co-workers
- Faith community members
- Celebrities
- Online resources, such as websites, social media, and blogs
- Remotely connecting via the internet to a health professional who is located someplace else for diagnosis and treatment information, sometimes called telemedicine

However, in other cases, we found that questions or answer options that included definitions were at times difficult or lengthy for respondents to read through and became an obstacle to completing questionnaire. Other definitions some respondents found humorous and/or distracting; for example, when we tested this question in Phase 2:

Marijuana, also called pot or weed, is usually smoked, either in cigarettes, called joints, or in a pipe. It is sometimes cooked in food. Hashish is a form of marijuana that is also called “hash.” It is usually smoked in a pipe. Do you think people can get addicted to using marijuana?

- Definitely yes
- Probably yes
- Probably no
- Definitely no

While this detailed definition of marijuana, from a different pre-existing question developed by the Center for Disease Control (CDC), may have been appropriate in context when originally developed, it now proved distracting and unnecessary for our purposes. We later, in Phase 3, simplified this question as follows:

Do you think people can get addicted to using marijuana?

- Definitely yes
- Probably yes
- Probably no
- Definitely no

Most often, rather than provide a definition, we simply reworded the question using terms more commonly known among respondents. Often, when respondents began noting a term that did not make sense, we explained what we were trying to say and solicit their input for a clearer word or phrase. We then tested those new terms in subsequent interactions with respondents, adopting those that had broad awareness across different demographics, and found that it improved comprehension. For example, we replaced the use of the term “food cupboard” with “food bank,” and the term “breadth”, as in “the

breadth of services my health insurance covers” with “variety”, as in “the variety of services my health insurance covers.”

Be direct, be specific

A core objective of the Phase 1 focus groups in particular was to test a number of words and phrases we hoped to use in the development of questions to see if they were understood by a diversity of individuals, but, moreover, whether they consistently conveyed the meaning we intended. For example, in Phase 1 focus groups, respondents were asked to express their thoughts about particular words, phrases, or concepts. This exercise helped us identify cases where a word or concept was unknown to respondents. For example, Phase 1 focus group respondents were asked:

When you hear the word “well-being,” what comes to mind?

We expected that “well-being” would be a fairly well-known term to represent an individual’s overall health or state of being. We were surprised to learn that the phrase “well-being” did not have a lot of meaning for many people. In fact, when asked, focus group respondents’ definitions of “well-being” ranged from self-awareness to being satisfied with life, but most said it didn’t mean anything, was too broad a term and, when probed, said that it simply wasn’t a word that they used. Through this exercise, we learned that focus group respondents divided their health status differently. They explained that it made more sense to ask specifically about their “physical health” or “mental health.” As a result, we formulated the questions to include these more specific references. For example:

Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health good? _____ days

Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health good? _____ days

Make it universal to make it relevant

An important component to ensuring that respondents feel that the questionnaire experience is positive and respectful is for questions to be phrased in an inclusive manner, that, to the extent possible, takes into account the various contexts or circumstances a respondent might bring to the table. Additionally, to ensure that the language and concepts used in the survey were familiar and understood by respondents, the field test was designed to help us understand the extent to which respondents might relate to these concepts and how this might change the meaning of a known concept among different people. Our goal was to develop questions that, despite different circumstances, would be interpreted by respondents consistently the same way.

A clear example of a word or term that was well known but whose meaning was different among respondents was “ethnic food, as posed to Phase 1 focus group respondents for discussion:

People from different cultures often eat different types of foods. What term would you use to refer to the food that your friends from other cultures eat? “Ethnic” food, “traditional” food, or “specialty” food?

We wanted to understand how people spoke about their own food and the foodways of others who may represent ethnic or cultural differences. Recognizing that one’s own food is what is normative, we looked

for words or phrases to describe other peoples' food, hoping we would then be able to ask questions about the availability of ingredients for the foods familiar to respondents across cultures. Access to affordable familiar ingredients impacts a household's ability and willingness to make meals at home and manage their diets. Additionally, we were interested in learning about the connection people have to their cultural traditions and how respondents can bring their interest in healthy eating to all the various types of foods they may eat.

When discussing health, clarifying an individual's relationship with food is key to understanding related attitudes and behaviors. If a cuisine differs from what is considered the norm it may impact people's feelings of belonging and identity, which then touches other aspects of health. How a person deals with food is complex and includes, at least, aspects of availability, affordability, and what one is used to; food deserts in both urban and rural areas can impact all three of these. We had developed questions to capture the first two dimensions, but not one for the third – what one is accustomed to.

In the Phase 1 focus groups, it became clear that the meaning of "ethnic food" shifted depending on an individual's background, but not in the way we had expected. It did not universally describe food beyond the traditional meals cooked at home. The term "ethnic food" excluded the foodways of white respondents who may not consider themselves part of an "ethnic group", yet have unique food traditions based on, for example, the region they are from rather than an ethnic culture. It also did not adequately articulate the differences between urban and rural food traditions among people of shared ethnicity.

We were fortunate to hold our first focus groups in New Orleans among respondents who represented multiple food traditions—rural, urban, Creole, and mainstream. During the conversation, one participant asked if what we were trying to understand was "the foods you grew up with". We ultimately found that this was a more encompassing term that would still get at different types of food that may not be prevalent in mainstream grocery stores, while also leaving room for a diversity of interpretation. For example, some respondents mentioned that the "food you grew up with", in their case, was TV dinners, while one participant responded with food purchased through the Schwan's home delivery grocery service. Asking the question this way also provided insight into their relationship with food.

Phrasing the question this way provides benefits to both respondents and practitioners using the data from the questionnaire. For respondents, it allows them to describe the food they grew up with and juxtapose that with what and how they currently prepare and eat food. For practitioners, it provides useful detail about the types of food program participants are used to and has implications for the development of farmers markets (e.g. making specialty vegetables available), cooking classes (e.g. making nutritional food with a pleasing array of flavors that reflect familiar tastes), and promoting grocery stores (e.g. encouraging stores to carry appropriate foods for the population).

We used the phrase "the food you grew up with" in a variety of questions to inquire about the primary type of food an individual had consumed during most of their upbringing, for example:

In your opinion, how healthy are the foods you grew up with?

- Very healthy
- Somewhat healthy
- Somewhat unhealthy
- Very unhealthy

[If “Somewhat unhealthy: or “Very” unhealthy:] What, if anything, do you think would make the foods you grew up with healthier to eat?

Similarly, we also discovered that the term “healthy living” did not carry the same connotations for everyone. In both focus group locations, respondents indicated that the term “healthy living” carried connotations of social class – for example, they considered “healthy living” as something only wealthier people could achieve because it involved the purchase of expensive foods (examples given by respondents included quinoa and kale) or gym memberships, which can be out of reach for lower income individuals and families. This told us that even though focus group respondents all understood what we meant by healthy living, they clearly didn’t relate to the concept in the same way. For some, it was something attainable if they put their mind to it, for others it was perceived as something exclusionary and unattainable without changing other more significant elements of one’s circumstance such as income and time.

In most cases, respondents understood and demonstrated a shared meaning of “healthy living” as correlated to eating well and staying active. Respondents already knew what healthy behaviors are; their reasons for not taking advantage of that knowledge related to constraints such as time, money and access. Respondents could recite the types of things we all might have learned in school or been told by doctors about what it meant to live a healthy lifestyle. For some focus group respondents, healthy living had to do with a series of deliberate decisions an individual made toward living a healthy lifestyle and wasn’t perceived as something that could naturally or casually occur. For this reason, we were careful not to use the phrase “healthy living” or “healthy lifestyle” in the tool development process. Instead, we focused on developing questions that asked more specifically about elements of health or whether or not something/someone was “healthy”, a term that was similarly understood across respondents without the conditional associations conjured by the term “lifestyle.”

Another concept known to respondents but carrying different meaning was “stress management and relaxation”. In this case, we were differentiating between the two concepts but learned that respondents interpreted them to be one and the same. We assumed that stress management would focus on punctuated moments of stress and the mechanisms to deal with them, while relaxation would reflect the incorporation of small habits in daily life that reflected an ongoing lifestyle choice. In Phase 2 interviews, respondents were asked one set of questions on managing stress (which we defined as “deliberately trying to reduce the level of tension, pressure, or anxiety a person might be feeling”) and another set of questions on what they did to relax (described as “taking time to rest, unwind, or slow down”) as part of daily life. For example, in the Phase 2 interviews, respondents were asked the following set of questions:

The next questions are about managing stress, that is, deliberately trying to reduce the level of tension, pressure, or anxiety a person might be feeling.

In your opinion, how much does reducing stress contribute to a person’s overall health?

- A great deal
- A fair amount
- Somewhat
- A little or nothing

The same set of questions were asked about relaxation (for example, “In your opinion, how much does relaxing contribute to a person’s overall health?” and so on). A number of interview respondents indicated

that they didn't feel there was a difference between the two – stress management and relaxation – and expressed that they found this line of questioning repetitive. For them, the two concepts were too closely related to be discussed separately. A set of respondents described relaxing as “taking time for yourself” or “taking a break,” which became a more useful set of terms for revising these questions. In revising this set of questions, we combined the sets of questions on stress management and relaxation into one tool and adopted respondents' language, as follows:

Different people do different things when they want to take time for themselves or take a break. Which of the following things, if any, would help you relax? *Check all that apply.*

- Socializing with others
- Talking with friends or family members
- Meditating, doing yoga, or engaging in some other quiet practice
- Engaging in artistic expression, such as drawing, painting, or playing a musical instrument
- Participating in religious or spiritual activities

Our aim was to develop and adapt our survey tools to reflect the ways real people talk with one another about health and issues related to health. The feedback from the field test confirmed that it was extremely important to be brief – for example, providing definitions only when necessary because they either made the questionnaires unnecessarily long or distracted from the more important content. In addition to making the questions as short as possible, we learned that it was equally important to be specific in our terminology and to simply say what we mean. Broad and generalizing terms such as “well-being” weren't meaningful to respondents and, therefore, were not useful in questions. If we honed in on we really wanted to ask about - for example, an individual's physical or mental health – we could easily get our meaning across.

Finally, we learned that the language used in the questions needed to be inclusive and universal in order to feel relevant to respondents. While the term “ethnic food” might be understood by many people, it may not necessarily be *relevant* to them depending, perhaps, on their own perception of ethnicity and their ethnic identity. However, asking individuals about “the food you grew up with” was a more inclusive approach because it was a question that would be relevant to everyone regardless of their racial or ethnic background.

Structuring questions to engage and empower

In addition to the language used, we knew that the structure of the questions themselves could influence an individual's experience with the survey. This was important as we were aiming to create an experience that was positive and empowering, despite tackling what could at times be considered difficult subject matter. In the context of community development practitioners, we knew they might use these data collection tools to strengthen relationships with community members and deepen residents' engagement in programs and initiatives that could create positive change for their families and communities. With that in mind, we set out to develop survey tools that might help respondents more deeply engage in conversations about health. It was important that the questionnaires feel like they were within respondents' knowledge to answer – which meant steering clear of the “knowledge test” or “trick question” tone that questionnaires can sometimes have. We didn't want respondents to feel there was a “right” or “wrong” answer and aimed to develop questions that would instead encourage individuals to actually reflect and provide an honest and thoughtful answer that was true for them and not simply what they thought we wanted to hear.

Conclusion & Next Steps

It is our hope that the findings shared in this field test summary report contribute to the sizable body of work currently underway that rests at the intersection of health and community development. Thanks to a knowledgeable and dedicated interdisciplinary group of individuals who participated in the working group, the hard work of organizations who helped to carry out the field test, and the openness and willingness of the respondents, we were able to develop and test a set of data collection tools that help illustrate the connection between community development efforts and associated health outcomes for individuals, families and communities. The field test also demonstrated the importance language can have in helping to establish a common ground across our many differences and how deliberate attention to the questionnaire content, structure and design can create an engaging, empowering and inclusive experience for individuals as they embark on an exploration of thinking and talking about health differently than they might have done before.

From the perspective of a community development organization, these findings illustrate the different ways that the health and community development evaluation tools can yield additional ancillary benefits we did not previously anticipate, such as opportunities for outreach, engagement, education and relationship building with community members, as well as improving understanding of the nuanced ways health and health-related issues affect the lives of the individuals, families and communities they serve. We observed that during and following the survey, respondents easily shared their thoughts and feelings about the subject matter and questions beyond what was required for the questionnaire. Often this feedback included that respondents felt the questions were unique; they commented that no one had ever asked them these types of questions before and that it felt good to be asked those questions. Many respondents used the questions and discussion with us as an opportunity to share personal stories about themselves, friends and family. Although these conversations were often about difficult topics, such as chronic illness, the loss of loved ones, poverty and homelessness, respondents nonetheless volunteered this additional information without prompting. We felt that the nature of the questions, and perhaps simply the process of setting aside a specific time, albeit brief, to focus on an individual's life experience (to the extent that is addressed in the questionnaires), brought a humanizing aspect to the discussion of health and health issues. These discussions, if nurtured by organizations administering the health and community development survey tools, can serve as a source of additional contextual information that can help shed light on some of the nuances of health and health-related issues in communities they serve. In addition, they can be a part of a broader strategy to ensure that resident voices are heard and that organizations are interested in residents' experiences.

The health and community development data collection tools are currently available on the Success Measures Data System (SMDS). We are currently seeking funding to develop a web publication that would provide the data collection tools in print so that organizations could access them at no cost. Moving forward, we will disseminate information about the tools more broadly, as we did at our recent conference presentations including the Grant Makers in Health and Association for Community Health Improvement. We are also working with metrics hubs such as The Build Healthy Places Network MeasureUp Portal. NeighborWorks has funded a small demonstration of the tools with 10 NeighborWorks organizations that will begin in April 2016. In addition, we are seeking partners for national and regional demonstration projects that would support community development organizations' use of the tools for longitudinal evaluations in their service areas. Success Measures is partnering with Enterprise Community Partners in the development of these demonstration projects.

Appendices

A- Success Measures Health Tools Working Group

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B- List of Success Measures Health Tools

SUCCESS MEASURES® HEALTH TOOLS

INDIVIDUAL AND COMMUNITY HEALTH STATUS

Individual Health Status

- Medical Conditions
- Disease Management
- Overall Health
- Health Metrics

Community Health Status

- Community Morbidity
- Community Mortality
- Medical Visit Metrics

INDIVIDUAL HEALTH BELIEFS AND ATTITUDES

Attitudes and Discussions about Health

- Views on Health
- Health Discussions with Household Members
- Health Discussions with Friends

Views on a Healthy Lifestyle

- Views on Eating
- Views on Physical Activity
- Views on Alcohol, Tobacco, and Drug Use
- Views on Relaxation and Stress Management

INDIVIDUAL HEALTH BEHAVIORS

Health Knowledge and Use of Health Care

- Health Care Knowledge
- Use of Health Care Services
- Health Insurance

Participation in a Healthy Lifestyle

- Eating Behavior
- Physical Activity Behavior
- Alcohol, Tobacco and Drug Use Behavior
- Relaxation and Stress Management Behavior

Care Giving and Receiving

- Caring for Others
- Receiving Care from Others

INDIVIDUAL FACTORS AND INFLUENCES RELATED TO HEALTH

Individual Factors

- Individual Demographics - Health
- Housing Costs
- Financial Stability
- Food Security
- Functional Status
- Interest in Education and Training
- Employment and Workforce Development
- Personal Traits
- Social Support and Safety
- Housing Stability

Use of Community Services and Amenities

- Use of Amenities
- Use of Community Services

Social and Cultural Contexts

- Social Connections
- Cultural Context

Influences on Individual

- Influences on Individual’s Views on Health
- Influences on Individual’s Eating
- Influences on Individual’s Physical Activity
- Influences on Individual’s Alcohol and Tobacco Use

COMMUNITY ENVIRONMENTAL FACTORS RELATED TO HEALTH

Housing Conditions

- Interior of Residence: Resident Perception
- Interior of Residence: Expert Assessment
- Exterior of Residence: Resident Perception
- Residential Building Exterior and Site: Expert Assessment
- Multifamily Common Areas: Resident Perception
- Multifamily Common Areas and Building Systems: Expert Assessment
- Housing in the Community

Land Use and Physical Features

- Design and Management
- Environmental Metrics
- Land Use and Maintenance
- Traffic and Pedestrian Safety

Community Services and Amenities

- Availability and Quality of Amenities
- Accessibility and Perception of Amenities
- Services and Trainings in the Community: Available Data
- Services and Trainings in the Community: Key Informant Perception
- Services and Trainings in the Community: Resident Perception

COMMUNITY DEMOGRAPHICS AND SOCIAL FACTORS RELATED TO HEALTH

Population Characteristics

- Community Demographics - Health

Social Factors

- Community Social Cohesion

AVAILABILITY, QUALITY, AND CULTURAL SENSITIVITY OF HEALTH CARE SERVICES

Availability and Quality of Health Care

- Availability of Hospital and Health Care Services
- Availability and Practices of Primary Care Services
- Features and Barriers in Health Care System
- Health Care Quality Metrics

Cultural Sensitivity and Interaction with Health Care Providers

- Accessibility of Health Care Services
- Cultural Sensitivity of Health Care Practices
- Interaction with Health Care Providers

Success Measures (successmeasures.org) operates as a social enterprise at NeighborWorks America, a national affordable housing and community development intermediary.

C – Health Tools Field Test Participating Organizations

Phase 1:

- Providence Community Housing, New Orleans, LA
- Westside Housing, Kansas City, MO

Phase 2:

- St. Joseph Carpenter Society Camden, NJ

Phase 3:

- Peoples' Self-Help Housing (San Luis Obispo, CA)
- Little Dixie (Hugo, OK)
- New Directions Housing Corporation (Louisville, KY)
- Chelsea Neighborhood Developers (CND) (Chelsea MA) *[SPANISH]*

Phase 4:

- Primavera Foundation (Tucson, AZ)
- East Bay Asian Local Development Corporation (EBALDC) (Oakland, CA)