

## **Standards and Measures Documentation: Tips for Success: Requirements for the Collection of Primary Data: October-November 2019**

*This is the fifth in a series of columns in which PHAB staff share tips for successfully demonstrating conformity with various PHAB Standards and Measures. Here, PHAB Chief Program Officer Robin Wilcox addresses the requirements for the collection of primary data.*

Initial Accreditation Measure 1.2.3 and Reaccreditation Measure 1.2, Requirement 3, both require examples of primary data. Some health departments express concern about collecting data. Isn't it complicated? Isn't it expensive? Isn't time consuming?

Primary data is defined in PHAB's glossary as "data observed or collected from original sources, ranging from more scientifically rigorous approaches such as randomized controlled trials to less rigorous approaches such as case studies."

Health departments start by looking at broad, high level, secondary data. Secondary data, such as the Behavioral Risk Factor Surveillance System data, the county health rankings, or census data can provide a wealth of information concerning the population's health. Those data can raise red flags and point the health department to where it needs to understand more about its community and more about an issue in its community. Data at the county level will not tell the community about the reality of the population's experience, what the population's perspectives and priorities are, or what community resources or resilience can be mobilized to address situations that cause poor health. The purpose of the collection of primary data is to create an increasingly robust, accurate, in-depth, and precise understanding about the complexities of the community. Primary data are required to better understand causes or contributing factors, specific situations, and potential solutions.

Because Initial Accreditation Measure 1.2.3 and Reaccreditation Measure 1.2, Requirement 3, are about the health department's capacity to collect primary data to better understand its community, surveillance data is not accepted as documentation for this measure. Also, data collected for the evaluation of a program or intervention is also not accepted for this measure. The data for this measure are intended to better understand the population, not the effectiveness of a program.

The collection of primary data provides an excellent opportunity to better understand social conditions that have an impact on the health of the population served; for example, unemployment, poverty, education level, homelessness, and physical activities. Primary data can provide information about the community, such as location of liquor stores, lack of access to fresh foods, lack of accessible facilities for physical activity, old housing stock, and limited transportation systems.

Primary quantitative data can be obtained from surveys or observational counts of target groups, such as teenagers, the jobless, the homeless, or residents of a neighborhood with higher risks of poor health outcomes. Primary qualitative data may be gathered, for example, from open-ended survey questions, forums, listening sessions, focus groups, storytelling, group interviews, stakeholder interviews, and key informant interviews.

While every data collection effort provides more information and a deeper understanding, it will also raise additional questions. As more and more questions are asked and more and more data are collected, an increasingly multidimensional understanding of the community's issues and resources is developed. And, knowing the community is a basic element of an effective health department.