HEALTHY PEOPLE 2010 TOOLKIT

A Field Guide to Health Planning

PHF Public Health Foundation

Washington, DC

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Acknowledgments

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Explanation and Overview of the Toolkit

"If the only tool you have is a hammer, all of your problems will look like nails."

—Mark Twain

Welcome to the Healthy People Toolkit! The Toolkit provides guidance, technical tools, and resources to help states, territories, and tribes develop and promote successful state-specific Healthy People 2010 plans.[1] It can also serve as a resource for communities and other entities embarking on similar health planning endeavors.

This Toolkit is organized around seven major "action areas," which were derived from national and state Healthy People initiatives.[2] With the assistance and guidance of the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services (HHS), the Public Health Foundation reviewed both year 2000 and year 2010 initiatives and identified these seven areas as common elements of most health planning and improvement efforts. The seven action areas are:

- Building the Foundation: Leadership and Structure
- Identifying and Securing Resources
- Identifying and Engaging Community Partners
- Setting Health Priorities and Establishing Objectives
- Obtaining Baseline Measures, Setting Targets, and Measuring Progress
- Managing and Sustaining the Process
- Communicating Health Goals and Objectives

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[1] The term "state plan" will be used throughout the Toolkit to indicate "state-, territory-, or tribal-specific Healthy People 2010 plan."

[2] The hundreds of local health planning initiatives could fill a separate volume and were not reviewed for inclusion in the Toolkit. However, a small selection of local resources is included for local Toolkit users.

Each action area includes:

- a brief explanation and rationale
- a checklist of major activities, which are taken from the comprehensive planning checklist tool in "Managing and Sustaining the Process"
- tips for success
- national and state examples to illustrate Healthy People processes in action
- recommended "hot picks" of resources for further information, designated by a star ✪
- planning tools that can be easily adapted to state or local needs, designated by a tool 🔧

The suggested processes, tools, and resources in the seven action areas can help states build on past successes and round out their approaches to planning and developing year 2010 objectives. An effective planning initiative should reflect the state's unique needs, resources, and buy-in from a broad constituency.

Attached as appendices are comprehensive listings of resources; State, Territorial, and Tribal Action Contacts; and state and national Healthy People web sites.[3]

A web-based version of the Toolkit offers users enhanced access, navigation, and search capabilities and is available at: http://www.health.gov/healthypeople/state/toolkit. The web version contains direct links to state Healthy People web pages, up-to-date listings of state Healthy People action contacts, Healthy People 2010 lead agency content experts, and HHS Regional Health Administrators.

Because this Toolkit is in the public domain, we encourage you to copy the Toolkit to share with your state and local partners.

The Public Health Foundation would like to hear about your year 2010 initiative, how you are using the Toolkit, and what additional resources or examples would be helpful to you. Please contact us at:

<div align="center">

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[3] The Public Health Foundation made every reasonable effort to confirm the accuracy of all web site addresses, resource listings, and contact information as of February 2002. PHF apologizes for any inconvenience caused by inaccurate listings.

HEALTHY PEOPLE 2010 TOOLKIT

Building the Foundation: Leadership and Structure

"All 'players' need to be involved in the process from its inception. Top leadership needs to constantly reinforce support for the process."

—*Utah Department of Health*, Utah Tomorrow

Involvement of and support from the state health officer, other agency heads, top political leaders, and key policy makers in a state significantly improves and strengthens the state planning process. Effective leadership is necessary to inspire a shared vision and enlist appropriate partners and staff in the development process. Once leaders' commitments and buy-in are secured, planning structures, resources, and other essential elements often fall into place more easily. The suggestions and tools in this section can help you build a strong foundation for planning. Implementation will, of course, depend on the unique characteristics of each state.

Action Checklist:
Leadership & Structure

(See page 113 for a complete planning and development checklist.)
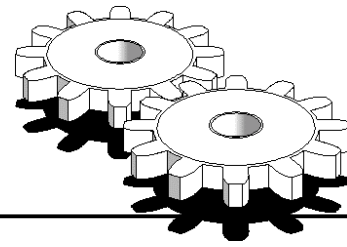
❑ Secure commitment from senior health department staff

❑ Form preparation team to identify goals and guide early stages of development

❑ Create a planning structure

❑ Examine policy/political environment

❑ Engage partners early and maintain their involvement

❑ Identify potential barriers and facilitators to success

❑ Present state plan development process to political leaders for support

❑ Identify related initiatives to integrate or consider coordination with state plan

❑ Define functions and composition of advisory and/or steering group

Tips
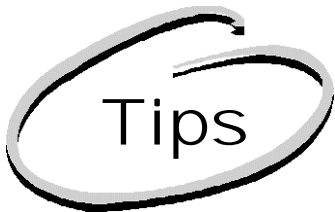
**Don't pass GO before gaining leadership support.
Enlisted leaders can:**

► Influence public opinion

► Mobilize support and engage partners

► Inspire action to get things done

► Facilitate finding, obtaining, and allotting resources

► Guide decision making

► Advocate for the state plan's goals and objectives

► Set policy and ensure that objectives are monitored and considered in policy matters

Begin within your own agency

► State health officer

► Senior health department staff and program managers (e.g., women's health, minority health, long term care)

Include the governor and key legislative leaders

► Governor's health policy advisors, advisory councils, cabinet members

► Political and policy leaders, including legislators on health and human services and fiscal subcommittees

► Key health supporters as well as potential adversaries

Enlist heads of other state agencies

► Mental health, substance abuse, environmental, social services, children and families, aging, disabilities, education, agriculture, transportation, and other agencies

► Work with the governor and cabinet members to determine which office(s) will officially issue the plan, and bring those leaders in early

Know the playing field

► Conduct a SWOT (strengths, weaknesses, opportunities, and threats) analysis (see page 19)

► Know how your state plan activities will align with other planning and improvement efforts

► Learn from past successes and mistakes

► Define how the state plan can support and advance leaders' current policies and priorities

Be explicit about what you are requesting from others

► Identify shared values and common goals

► Identify specific roles and responsibilities

► Share responsibilities and decision making

► Establish accountability mechanisms

Below are examples of how the nation and states have made connections with leadership to develop health objectives and establish planning structures.

From the National Initiative

Secretary's Council

The Secretary's Council on National Health Promotion and Disease Prevention Objectives for 2010 is the advisory structure for Healthy People 2010. The membership of the Council promotes leadership commitment and involvement in the development process. The Council, which meets annually, is comprised of former Assistant Secretaries for Health and the current heads of operating divisions in HHS. The Secretary of HHS serves as the chair, and the current Assistant Secretary for Health and Surgeon General is the vice chair.

The Council is charged to do the following, according to the Healthy People 2010 Charter:

- Provide to the Secretary advice and consultation to facilitate the process of developing national health promotion and disease prevention goals and objectives;

- Provide links with the private sector to ensure their involvement in the process of developing national health promotion and disease prevention objectives;

- Through those links with the private sector, enhance the prospects of tying together similar health promotion and disease prevention efforts throughout the private and voluntary sectors.

Healthy People Steering Committee and Work Groups

The Steering Committee is comprised of representatives of all operating divisions of HHS. The members are joined in these discussions by work group coordinators from the lead agencies in the Public Health Service which have been designated to be responsible for the achievement of the Healthy People targets. A list of the Healthy People 2010 Work Group Coordinators can be found in Appendix E of Healthy People 2010, Volume II at: http://www.health.gov/healthypeople/Publications.

The report, *Stakeholders Revisit Healthy People 2000 to Maximize the Impact of 2010,* describes the Steering Committee retreat proceedings which began the 2010 development process. The report includes summaries of the five Consortium member breakout groups and is available at: http://www.health.gov/HPcomments/Stakeholder.

From State Initiatives

Governor's office leads planning process

By Executive Order, **North Carolina's** governor
established the Task Force on Health Objectives
for the year 2000. The governor's Task Force
engaged 25 North Carolina leaders representing
health care providers, consumer organizations, and
public representatives. This broad coalition
helped to foster public and private sector
ownership of the state's health objectives. A state-level Office of Healthy North
Carolinians offered assistance to local community leaders and involved the majority of
counties in Healthy Carolinians activities. In April of 1999, the governor signed a
second executive order, establishing and expanding a successor Task Force for year
2010 health objectives. The goal is to review the national objectives for year 2010 and
involve North Carolina counties in establishing the state's 2010 objectives. North
Carolina believes that the state's "decentralized" public health system will lead to
success with this approach.
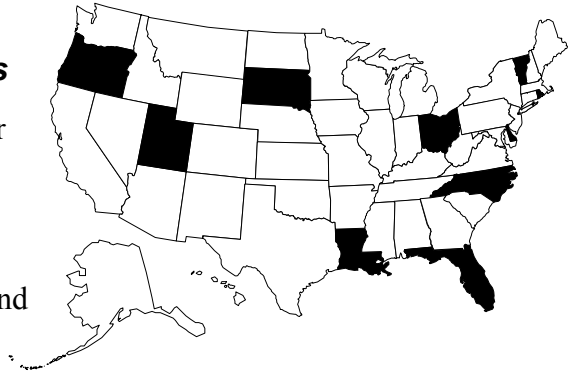
The **Louisiana** legislature passed a bill to create the Louisiana Healthy People 2010
Planning Council in the Department of Health and Hospitals. The task of the Council
will be to design a process for developing a state plan. The bill states that the Council
shall be composed of a variety of public, private, professional, educational, trade,
volunteer and advocacy organizations to ensure that all citizens are represented. It also
requires that a paid staff person assist the activities of the Council.

In 1996 **South Dakota's** governor signed an Executive Order establishing the Governor's
Health Advisory Committee to provide recommendations and advise the Secretary of
Health on health priorities. The Health Advisory Committee serves as a think tank on
emerging and priority health issues and helps to foster partnerships to improve geographic
and financial access to health care. The Committee uses the Healthy People objectives
when applicable. Included in the advisory committee are key members of the healthcare
community including providers, administrators, educators, and consumers.

In 1993 the **Utah** Legislature enacted legislation to create a statewide strategic plan with
performance measurements. State legislators, local government representatives, state
agency heads, other governor-appointed members, and a state coordinator participated in
the *Utah Tomorrow* strategic planning committee. By centralizing planning through the
governor's office, Utah achieved among various state agencies a common planning
language for performance measures and objectives. The governor's Office of Planning and
Budget provided technical assistance and hands-on skills training to state agencies, which
were asked to participate voluntarily in planning and performance measurement efforts.

Leadership and Structure

Incorporating health objectives into other strategic planning and evaluation efforts, such as performance-based budgeting

Florida's year 2000 planning occurred in the context of the state's 1992 Health Care Reform Act. This Act requires the state to develop biennial health plans that include population health status data, specific health status objectives, and outcome measures. These responsibilities were transferred to the Department of Health when the Department was created in 1997 and resulted in the development of the Florida State Health Plan. In addition, since Florida statutes mandated implementation of performance-based program budgeting, the Florida Department of Health integrated performance-based budgeting into the planning process for its Agency Strategic Plan, which is updated annually with five-year forecasts.

The 1993 **Oregon** legislature directed all state agencies to develop performance measures with ties to the state's indicators of well being, called Oregon Benchmarks. A Progress Board presents biennial progress reports to the legislature and public. The benchmarks and progress reports help to keep state agencies focused on results and help leaders evaluate and reset priorities. Many Oregon local governments have initiated their own benchmark planning systems.

In **Ohio**, the director of the Department of Health initiated a strategic planning process designed to strengthen Ohio's public health system. It was called Ohio's Public Health Plan. The plan targeted five initiatives, one of which was Healthy People Ohio. Ohio Department of Health senior staff and representatives of public health associations guided the planning process with a Work Group on Healthy People Ohio.

Using strategic plans and progress reports to evaluate proposed policies and funding allocations

Utah's annual budget cites relevant *Utah Tomorrow* goals, and state agencies must reference relevant performance standards for their department proposals. The Utah Legislature's Appropriations Subcommittees annually receive reports detailing updated objectives and performance measures for relevant subject areas. Utah legislators are encouraged, but not required, to correlate legislation with the state's strategic plan and to use *Utah Tomorrow* to evaluate proposed legislation.

Influencing health legislation

Vermont, Delaware, Guam, and **Utah** attribute state success in passing clean indoor air legislation to the state health objectives. In addition to clean indoor air laws, Vermont's legislative successes have been numerous, including passage of bills related to lead abatement, immunizations, and seat belt usage.

The **Rhode Island** Department of Health was successful in using year 2000 objectives to win legislative approval for new requirements related to automobile and boat safety and radon control, as well as new minority health programs funded by a tobacco tax.

Creating a Structure for Success

1. Preparation

A carefully organized and well-defined planning structure will position the 2010 planning process for success. There are several options for developing steering committees, advisory committees, and other structures to carry out planning work and involve people in the process. This tool can be used to structure government leadership or community involvement. (See the action area, "Identifying and Engaging Community Partners.")

This tool will give you ideas on how to structure your process, identify participants, and delineate participant roles and responsibilities. A small group, or 2010 preparation team, can help make structural decisions before the official steering group is formed. In just one or two meetings, this team can ensure that invitations are sent to the right people and their charge is clear from the beginning.

An existing health advisory group or public health management team can serve as a preparation team.

2. Align the planning structure with state goals

Consider first what the desired results of the 2010 process are, then build a planning structure around those goals. For example, if the state's goal is for policy makers to use the 2010 plan to propose legislation, a planning structure involving the legislative branch or the governor's office may be desirable. If state goals emphasize local use of the plan, a planning structure with local involvement would be ideal.
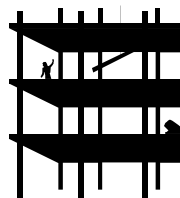
Know what you want to build before bringing in the crew.

3. Write down what the state wants to achieve, then consider the structural issues and options on the following pages by asking, "Which option will give us these results?"

In any planning structure, participants should know:

Who has an advisory role? Persons in an advisory role may provide informed input on topics such as the 2010 planning process, priority or focal areas, target populations, scope of objectives, marketing, and other aspects of the 2010 plan.

Who has a steering role? Persons in a steering role navigate the course of the planning process, establish work groups, determine input processes, and make decisions about the content of the state plan.

Who makes final decisions, weighing all input?

Who will be held accountable for the plan and see the plan through?

Advisory Structure Options

❑ Single, state-wide advisory group that meets throughout the process

❑ Two or more advisory groups to ensure input from specific constituencies (e.g., geographic areas, racial and ethnic populations, or local health officers), periodically convened

❑ Consortium of various advisory groups, (e.g., maternal and child health, mental health, substance abuse)

❑ No formal advisory group, but planned events or activities to gain input from key constituencies (see options in "Public Input and Involvement," page 10)

> **How can advisory and steering structures fit together?**
>
> *For a visual overview of potential relationships among various structures, see the four sample organizational charts on pages 13-14.*

Steering Structure Options

❑ Steering group with full authority to develop and adopt the 2010 plan

❑ Steering group with significant authority to develop the 2010 plan, subject to the final approval of the governor, state health officer, or others

❑ Steering group with specific authority over certain tasks (such as the development of objectives), with other tasks (such as marketing and publication of the plan) under the authority of the state health agency or governor's office

Leadership Options

❑ Chaired by the governor or his/her designee

❑ Chaired by an official or appointed by the legislature

❑ Chair elected by the group

❑ Chaired or co-chaired by state public health, mental health, substance abuse, or environmental health director(s)

❑ Co-chaired by the state health officer and a community representative (appointed or elected)

❑ Rotating chair

❑ No chair—group received direction and guidance from staff

Membership Options

❑ State agency staff only

❑ State and local public agencies staff

❑ Members of the private, public, and voluntary sectors — e.g., academia (schools of public health, social work, nursing, medicine), community health and social organizations, business, legislatures, etc.

❑ Community members excluding state agencies and academia

Issue 2:	*Distributing the Work*

The options below may apply to distributing the work of advisory groups, as well as steering groups, according to the planning structure in your state. (See "Participant Roles and Responsibilities," page 15, for additional ideas on ways to coordinate the work of developing the state plan.)

Delegation Options

❑ The steering group does all the work in steering group meetings

❑ The steering group divides its members into work groups or subcommittees

❑ The steering group establishes work groups to be chaired by a steering group member, with work group membership open to non-steering group members who have expertise or interest

❑ The steering group charges the state health agency with forming work groups as needed

Work Group Options

Number

❑ Limited number of work groups

❑ Unlimited number of work groups

Organization

❑ <u>By focal areas</u> (e.g., tobacco, infectious diseases, infrastructure), so that work groups are responsible for all aspects of developing the plan for their areas of expertise

❑ <u>By functions</u> (e.g., objectives, strategies, marketing, public input), so that work groups oversee one aspect of the process for all focal areas

❑ <u>By populations</u> (e.g., grouped by life stage, gender, race/ethnicity, people with disabilities)

❑ <u>By target audience</u> (e.g., business, government, community organizations)

❑ <u>Combination</u> of work group types

Communication

❑ Work groups operate independently, reporting only to the steering group

❑ All work groups are periodically convened with steering and advisory groups, sharing progress and discussing priorities of common concern

❑ Certain, related work groups periodically meet

❑ Staff, materials, web site, or electronic newsletters facilitate communication among groups

Staffing Options

❑ Members, or their respective staffs, do all the work

❑ Public agencies jointly support the process

❑ State health agency shares technical support (e.g., data, program expertise, or references) and administrative support responsibilities with members.

❑ State health agency provides unlimited technical and administrative support, as delegated by the group

❑ State hires contractual staff for administrative or technical support, funded by state or private grants

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Issue 3:   Public Input and Involvement

Options

❑ Public meetings with formal testimony

❑ Public meetings with informal discussion with steering committee members

❑ Public meetings with break out rooms for structured input or activities

❑ Dissemination (via e-mail, web site, fax, or mail) of requests for specific input or comment

❑ Surveys

❑ Focus groups

❑ Internet discussion group

Scheduling public input

❑ One location (such as the state capital)
❑ Multiple locations (meetings in every region)
❑ Single point in the process
❑ Multiple points in the process (see options below)

Potential opportunities for public input in the 2010 planning process

Beginning the 2010 process		Setting objectives		Comment on final draft plan

| | Determining focal areas and priorities | | Identify strate-gies & resources to include in plan | | Kick-off events or action meetings to monitor plans |
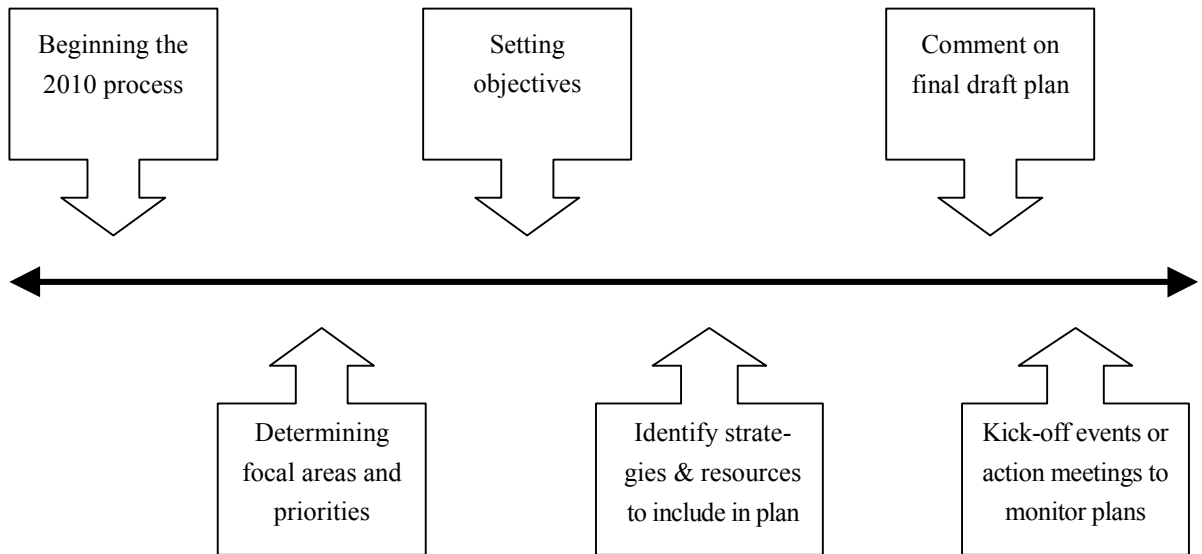
Adapted from: Healthy Delaware 2010 Project. Public Health Foundation, 1999.

General questions to consider for 2010 planning groups:

1. *How many members do you want, and what type of skills do they need to have?*
2. *What will be their time commitment? (How many hours per month for how long?)*
3. *How will member travel arrangements and expenses be handled?*
4. *Where, when, and how often will they meet?*
5. *Will the meetings be open or closed? (Check state regulations.)*
6. *What rules of order will be followed?*
7. *Will the members be expected to represent their agencies, community, or constituencies?*
8. *Which population groups should be represented?*
9. *Will the group sustain itself once the plan is developed? If so, how? What will the role of members be after the release of the state plan?*
10. *How will you evaluate the effectiveness of the groups?*
11. *How will you reward great efforts?*

Leadership and Structure

Sample State Statutes

State legislation may help to establish planning authority and build policy makers' support for the development and implementation of a state plan. Under the two sample statutes below, the Florida Department of Health has been given specific responsibility for the development of a state health plan. *Building Healthy Communities: Florida's Public Health Plan* is the Florida Department of Health's state health plan for 1998-2000.

SECTION 408.601, FLORIDA STATUTES:

"The Department of Health and Rehabilitative Services [now the Department of Health or DOH] shall develop a biennial Healthy Communities, Healthy People Plan that shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 31 of each even-numbered year.

"The plan must include data on the health status of the state's population, health status objectives and outcome measures, and public health strategies, including health promotion strategies. The plan must also provide an overall conceptual framework for the state's health promotion programs that considers available information on mortality, morbidity, disability and behavioral risk factors associated with chronic disease and conditions; proposals for public and private health insurance reforms needed to fully realize the state's health promotion initiative; the best health promotion practices of the county health departments and other states; and proposed educational reforms needed to promote healthy behaviors among the state's school-age children."

SECTION 20.43 (1) (L), FLORIDA STATUTES:

The Department of Health is required to "biennially publish, and annually update, a state health plan that assesses current health programs, systems, and costs; makes projections of future problems and opportunities; and recommends changes needed in the health care system to improve the public health."

Sample 2010 Planning Structures

1

State Agency Steering Group
- Final decisions
- Establishes and staffs state 2010 work groups
- Focal point for all input

Advisory Committee
- Recommendations on 2010 process & priorities
- Includes public and private members
- Non-state agency chair or co-chair

| Work Group | Work Group | Work Group | Work Group |

2

State Agency Support Team
- Coordinates and staffs work groups
- Provides technical and administrative support to the steering group

Steering Group
- Makes final decisions
- Includes public and private members
- Establishes work groups
- Public or private; potentially honorary chair

| Work Group | Work Group | Work Group | Work Group |

3

Governor's Steering Committee

- Final decisions
- Guides and manages process
- Engages cabinet leaders
- Establishes work groups

State Agency Support Team

- Technical support
- Coordinate and staff work groups under Steering Committee

Work Group

Work Group

Work Group

4

Work Group

Work Group

State Agency Steering Committee

- Makes decisions
- Establishes work groups of staff or mix of public and private members

Work Group

Work Group

Work Group

Work Group

KEY

→ Reports to

↔ Reports to, receives guidance from

········ Support role

Adapted from: Healthy Delaware 2010 Project. Public Health Foundation, 1999.

Participant Roles & Responsibilities (Sample) 🔧

All participants' responsibilities

- Contribute personal and professional experience and expertise to the group.
- Speak up for and faithfully represent community, professional, or constituency perspectives.
- Identify work group decisions that may present a conflict of interest and abstain from committee votes on these matters.

Steering Group

Composition
- ❑ Comprised of approximately 20-30 private and public sector leaders, community members, and experts. Includes 5-10 members from state agencies.
- ❑ Co-chaired by the state health officer and a private sector leader.
- ❑ All members have an equal say in decisions and an equal vote in the plan's adoption.

Roles
- ❑ Develop and adopt the state's 2010 plan.
- ❑ Guide a well-coordinated, sound, inclusive, and efficient process to develop the plan.
- ❑ Determine a process to select priority or focal areas, decide priorities, set the parameters, and choose a format for objectives.
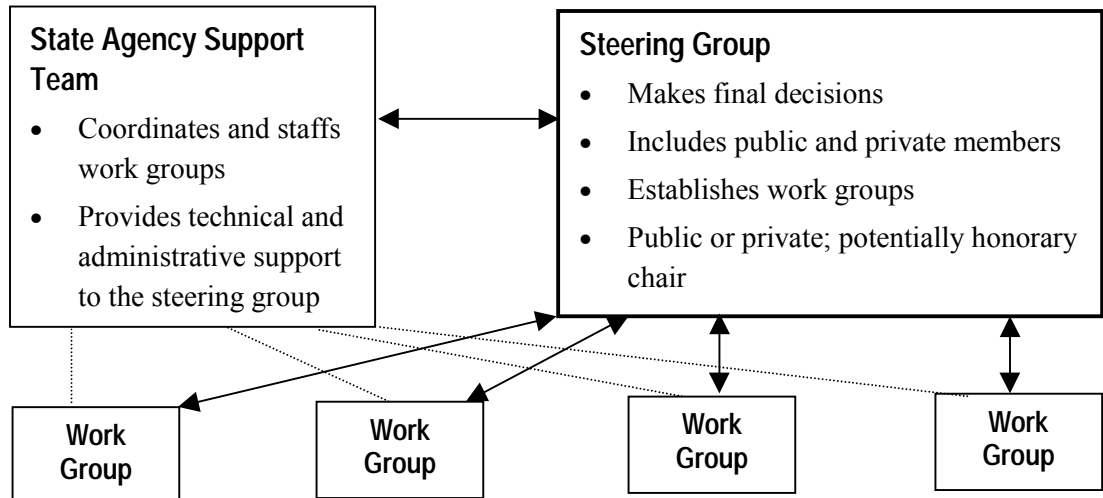- ❑ Establish work groups, delegate tasks, and approve work group recommendations.
- ❑ Identify technical assistance and data needs for the steering group.
- ❑ Serve as the focal point for all community input and review data needed to make decisions.
- ❑ Help secure commitments from community partners needed to oversee the plan.
- ❑ Plan ways to sustain and monitor the state 2010 plan.

Member responsibilities
- ❑ Participate in steering group meetings (meeting frequency to be established by the group).
- ❑ Participate in at least one work group.

Leadership and Structure

Executive Committee of the Steering Group

Composition

❑ Comprised of the steering group co-chairs and work group chairs.

Roles

❑ Ensure the steering group and work groups accomplish tasks on schedule.

❑ Make decisions and manage details between meetings, as referred by the steering group.

❑ Help the co-chairs plan an agenda and methods to accomplish group goals.

❑ Identify ways to improve the process and resolve problems.

❑ Plan an evaluation of the process.

Member responsibilities

❑ Participate in teleconference meetings monthly, or as needed.

❑ Communicate with work groups, staff, and others to fulfill the Executive Committee's coordination function.

Work Groups

Composition

❑ Comprised of the steering group members and others who have interest or expertise in the subject.

❑ Chaired by a steering group member.

Roles

❑ Develop objectives, recommend strategies, and draft other components of the plan as assigned by the steering group.

❑ Gather and review detailed information needed to develop priority areas of the plan.

❑ Help ensure the plan is a practical guide for community action.

❑ Identify technical assistance needs of members and communicate these to the state Healthy People Coordinator or work group staff.

Member responsibilities

❑ Participate in meetings by teleconference or in person as determined by the work group.

State Healthy People 2010 Coordinator

(The state's designated representative to the national Healthy People 2010 process)

Roles

❑ Serves as lead state health agency (SHA) staff support to the steering group.

❑ Provides guidance and helpful national, state, or local resources to the steering group.

❑ Serves as link to SHA management team (see roles below).

❑ Coordinates requests and feedback to state plan contractors, if any (e.g. data experts, consultants, marketing companies, graphic designers, printers).

❑ Manages SHA resource contributions to support the 2010 process.

❑ Edits and prepares the plan and any companion documents for publication.

❑ Manages the time line for 2010 planning.

❑ Organizes steering group meetings and mailings. Ensures meetings are open and accessible.

Responsibilities

❑ Attends steering group meetings as lead state agency staff support (not as a voting member).

❑ Updates agency management team and the governor on the state plan.

State Health Agency (SHA) Management Team

Composition

❑ Comprised of senior SHA staff and section chiefs.

Roles

❑ Coordinate SHA staff technical support to the steering group, including data analysis and expertise.

❑ Assign one SHA staff member, who is not a member of the steering group, to provide technical support to each work group.

❑ Coordinate administrative support for the steering group and fill administrative support gaps in work groups.

❑ Coordinate efforts to identify and secure resources for state plan.

❑ Facilitate involvement of leaders.

❑ Develop and handle details of the marketing plan, with input from the steering group.

State Health Agency Support Staff

<u>Roles</u>

❑ Assist the steering group or work groups as assigned.

❑ Ensure that members have the information they need to make decisions.

❑ Compile and analyze data, offer expert opinion, present options, and draft text based on group suggestions, as requested.

❑ Assess whether the chair or co-chair requires administrative or technical assistance to prepare for each meeting.

<u>Responsibilities</u>

❑ Regularly attend meetings as assigned.

❑ Respond to technical assistance requests and communicate additional requests to the SHA Healthy People Coordinator.

❑ Allow members to fully discuss and vote on priorities. Offer members input and information when requested or essential.

Adapted from: Healthy Delaware 2010 Project. Public Health Foundation, 1999.

SWOT Worksheet

SWOT is an examination of a group's internal strengths and weaknesses, as well as the environment's opportunities and threats. It should be used in the beginning stages of decision making and strategic planning.

Strengths   What are your state's particular strengths? Do you do something particularly unique? What could be an asset in developing objectives for your state plan?

Weaknesses   Where is your state lacking? What do others seem to accomplish that you cannot? What could limit your state planning efforts?

Potential Internal Strengths	Potential Internal Weaknesses
1.	1.
2.	2.
3.	3.
4.	4.

Opportunities   What is happening in your state that could provide opportunities?

Threats   What is happening that could pose threats to the process or your goals?

Potential External Opportunities	Potential External Threats
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Adapted from: Balamuralikrishna R., Dugger J.C. "SWOT Analysis: A Management Tool for Initiating New Programs in Vocational Schools." *Scholarly Communications Project, University Libraries, Virginia Tech.* http://borg.lib.vt.edu/ejournals/JVTE/v12n1/Balamuralikrishna.html

HOT picks

Resources for Building the Foundation: Leadership and Structure

✪ **Williams-Crowe S.M., Aultman T.V. "State Health Agencies and the Legislative Policy Process."** *Public Health Reports,* **109(3):361-7, 1994.**

Provides specific strategies for dealing with state legislatures based on the experiences of state legislative liaison officers. Organized into five key areas—agency organization, staff skills, communications, negotiation, and active ongoing involvement.

✪ **Civic Practices Network–Community Section.**
http://www.cpn.org/sections/topics/community/index.html

Provides information on community building through "community organizing, social capital, and urban democracy." It also provides information on the Consensus Organizing Model, which explains ways one can bring together all the players in a community.

✪ **Civic Practices Network–Health Section.**
http://www.cpn.org/sections/topics/health/index.html

Provides perspectives on building community involvement, as well as "how to put health reform on more solid civic foundations."

✪ **Public Health Resources on the Internet – Legislative and Regulatory Resources.**
http://www.lib.berkeley.edu/PUBL/regs.html

Links to California, federal, and other legislative and regulatory resources that can be helpful.

Please see Appendix A for more resources on building the foundation: leadership and structure.

HEALTHY PEOPLE 2010 TOOLKIT

Identifying and Securing Resources

"It takes a village to raise a child (or develop a state plan)."

—adaptation of African proverb

In This Section

Identifying and securing resources for state planning is a constant challenge. Yet as the examples in this section show, there are many creative options for ensuring adequate resources. Having dedicated resources helps facilitate a successful state planning initiative. A helpful strategy is to identify how the goals of the state plan may be aligned with the goals of potential resource contributors. In addition, a detailed budget for planning activities facilitates securing both public and private resources. The budget should cover all aspects of the development process, including resources needed to carry out each of the seven action areas outlined in this Toolkit.

Action Checklist:
Identifying and Securing Resources

(See page 113 for a complete planning and development checklist.)
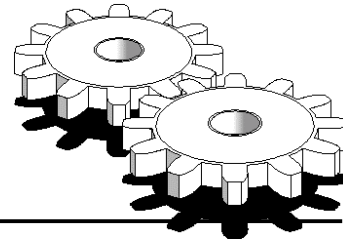
❑ Identify resources needed to develop state plan

❑ Develop budget

❑ Plan to integrate the plan into state planning, budgeting, and programming processes

❑ Identify existing internal resources

❑ Identify potential external resources, including potential donated resources

❑ Develop staff and technical support plan

❑ Secure identified resources and develop alternative resources if necessary

Tips
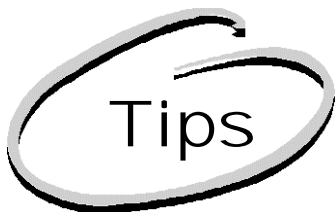
Ask the right questions early

► What is the scope of the state planning process?

► What does the state want to accomplish through this process?

► Why should taxpayers or others fund the development of the state plan?

► What will it take to support the planning initiative?

Recognize up front that planning takes money

► Find examples of what other state initiatives have included and required in funding

► Develop a plan for supporting the process, identifying both people and dollars

► Think about developing a separate budget for state plan development

► Be realistic — do not underestimate your costs (think through the potential budget items, page 31)

Capitalize on what you have

► Investigate the uses of available resources such as the Prevention Block Grant or categorical funding

► Negotiate reallocation of existing agency staff

► Identify and secure assistance from internal development experts (e.g., grant writers)

You can't get it if you don't ask for it

► Investigate availability of new state-based funding sources, such as tobacco settlement money and hospital conversion foundations

► Research potential external funding sources, such as the federal government, private foundations, hospitals, governor-funded initiatives, and other public or private sources whose purposes may be aligned with state plan

► Consider self-sustaining funding sources, such as forming a Healthy People coalition and collecting dues from its members or creating a non-profit organization to raise and distribute funds for Healthy People initiatives

► Ask businesses or community groups to donate services or other non-financial resources (check state regulations first!)

Don't forget to plan for the future—it's not over when the plan is released

► Identify resource needs to carry out a ten-year plan to monitor progress, publish periodic reviews, and sustain activities

► Keep a wish list ready for future funding (e.g., resources for a business companion document, a special health disparities consortium, or other ideas generated during 2010 planning)

Coordinate your resources with local initiatives

► Identify local Healthy People initiatives and ways to include them in resource proposals

► Assist local public health agencies in identifying resources

Process in Action: Examples from the Field

Below are examples of how the nation and states identified and secured resources for assessment, development, and implementation of a Healthy People plan.

From the National Initiative

Federal statutes

Many federal funding streams can be utilized for development of state plans. HHS grant announcements reference the relevant Healthy People 2000 priority areas and encourage applicants to obtain the document. In addition, the Indian Health Care Improvement Act requires reporting on progress toward Healthy People objectives.

Preventive Health and Health Services Block Grant

Commonly known as Prevention Block Grants, these grants are allocated by the Centers for Disease Control and Prevention (CDC) and give states wide discretion in fund distribution to ensure the best use of resources. States are mandated to show how the funds are aligned with Healthy People Objectives. States are also directed to use the block grants in areas of greatest need, which can mean developing a state plan.

Maternal and Child Health Services Block Grants

The Maternal and Child Health Bureau, HHS, distributes Maternal and Child Health Services Block Grants. Money from these block grants is directed toward improving the health of mothers and children. This grant application requests funds from Title V of the Social Security Act. Program goals are to be linked to the nation's Healthy People goals. There is also an extensive set of reporting requirements that states must follow for their annual reports.

Resource Development Guide

In 1991 ODPHP published the reference, *Locating Resources for Healthy People 2000 Health Promotion Projects.* This 46-page guide helps make the connection between Healthy People 2000 objectives and searching for funding and other assistance. It is available from the U.S. Government Printing Office, Superintendent of Documents, Mail Stop SSOP, Washington, DC 20402-9328. ISBN # 0-16-035928-7.

From State Initiatives

Allocate Prevention Block Grant funds

Alabama, Colorado, Maine, Kentucky, Illinois, and **West Virginia** are among several states that have used their Prevention Block Grants to fund initiatives tied to their state objectives. These states require state and local jurisdictions to specify which of the Healthy People objectives will be addressed with grant funds.
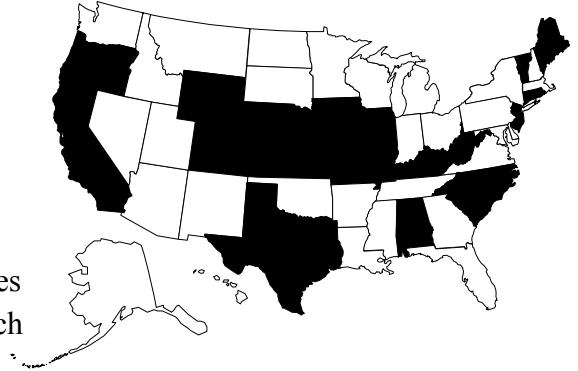
For year 2000, the **Colorado** Department of Public Health and Environment allocated Prevention Block Grant funds to help local health departments, county nursing services, and local sanitarians develop strategic plans based upon the year 2000 objectives.

In **Maine** private community agencies under contract to deliver public health services must base program funding requests on the state's objectives, similar to the requirements of health department applicants for Prevention Block Grant funds.

Illinois used a portion of its Prevention Block Grant to fund the Illinois Project for the Local Assessment of Needs (IPLAN) initiative. The state set aside funds to actualize local needs assessment projects, including a statewide, computerized data system and training workshops to support local planning. The IPLAN process allows local public health jurisdictions to set priorities and monitor interventions related to year 2000 and year 2010 objectives.

Develop new sources of funding

Iowa's Barn Raising II, held in June 1999, promoted the state's 2010 plan with over 700 participants. With an anticipated budget of approximately $100,000 for the two-day event, fundraising efforts to support this event started early in the year. The governor, lieutenant governor, and Iowa Department of Public Health Director signed a letter requesting organizations to partner with the state by providing assistance or financial support. The major benefit to the organizations was the opportunity to showcase their organizations' activities and to network. Iowa received commitments for support ranging from $50 to $11,500. The Wellmark Foundation awarded Iowa a grant for $40,000. In order to assist local agency participation, registration costs were kept low. The $40 registration fee covered the cost of food. However, the fee did not cover most other costs, including materials and promotion.

The **Rhode Island** Prevention Coalition has leveraged over $550,000 in public and private resources to address physical activity through grants programs. The Coalition's focus on physical activity resulted from a careful review of Rhode Island's year 2000 health objectives. The Department of Health initiated the Coalition in 1995 in partnership with Rhode Island HMOs, health insurers, hospitals, and voluntary health agencies. A private organization, the

Rhode Island Public Health Foundation, serves as the Coalition's fiscal agent. The Coalition issues requests for proposals (RFPs) to stimulate local programs promoting physical activity. Coalition-funded programs have additionally contributed over $225,000 worth of local in-kind resources to address physical activity. In-kind resources include staff resources from various agencies, as well as materials and public relations services.

A **South Carolina** coalition became an independent 501(c) 3 organization, providing the umbrella for single purpose coalitions and linking their activities. This coalition has now become an important component of a hospital-supported partnership in the community with continued staff and linkage support.

Oregon secured external state and local private funders, such as the Oregon Community Foundation and the Portland Area United Way, by using its benchmarks to focus grantmaking priorities.

Reallocate other types of existing resources

Missouri, New Jersey, and **Wyoming** identified and categorized existing resources that were being used to address health objectives. These resource assessments provided a basis for reallocating resources to priority areas. For example, Wyoming supplemented carryover funds and human resources for planning, with some redirection of discretionary funds to oversee some of the priority areas.

For both year 2000 and year 2010 plans, the **Connecticut** Department of Health has committed funds for internal staff resources and production costs. The Department of Health dedicated two full-time staff to the year 2000 planning process, who were funded by the agency budget.

Kansas used grant funds awarded by the Kansas Health Foundation to help support its Healthy Kansans 2000 process. There is no funding set aside for Healthy Kansans 2010, however enough funds remain from year 2000 planning to start the 2010 plan. The state also plans to help other organizations better utilize their funding by incorporating Healthy Kansans 2010 objectives into their workplace objectives.

The **Nebraska** State Department of Health reallocated existing resources to develop its year 2000 plan. The Director adopted the plan as a high priority and strongly advocated using the objectives for local planning efforts. The objectives were used to structure the guidance for grant applications as well.

Texas Healthy People 2000 planning activities were supported primarily through existing program budgets. In 1992, the Texas Department of Health was one of six states awarded a five-year grant by the CDC to assess progress toward achieving Healthy People 2000 objectives.

Assist local public health agencies in identifying resources

North Carolina has established two foundations that provide money to counties to implement Healthy Carolinians projects. The Office of Healthy Carolinians alerts counties to requests for proposals (RFPs) and other available money.

In **California** the Office of County Health Services (OCHS) administers the Health Incentive Program, which provides funding to local health agencies for disease prevention and health promotion programs and services in priority areas designated by the federal Healthy People 2000 initiative. OCHS also provides approximately $300 million in federal, state, and private funding for these services and related administrative activities, as well as technical assistance to local health programs.

Generate in-kind support

Vermont did not have specific budget for either development of a year 2000 plan or year 2010 planning. Although there is no coordinator or other personnel specifically designated for this job, the state's publicity campaign pulls in enough human resources to sustain the Healthy Vermonters project.

Sample Budget Line Items ⚒

Line Item	Internal Resources (new agency budget allocation)	Internal In-kind (reallocation of existing agency staff, shared budgets, or resources)	External Resources (grants or financial resources: public or private sources)	External In-kind (donated services or non-financial resources)
Personnel (Staff or Contractors)				
Coordinator *Data manager* *Administrative support staff* *Technical support/consultants* *Subject matter experts* *Meeting facilitators* *Graphic designer* *Marketing/PR specialist* *Copy writer/editor* *Web site designer* *Fringe benefits*				
Services (Non-Personnel)				

Duplication and Printing
   Steering/advisory group materials
   State plan publication
   Companion documents
   Letterhead
   Press kits, marketing materials				

Rental
   Conference and meeting rooms
   Conference booth rental
   Computer equipment rental				

Equipment and Maintenance
   Audio equipment
   Presentation equipment
   Other equipment purchase
   Computer/copier maintenance				

Line Item	Internal Resources	Internal In-kind	External Resources	External In-kind

Advertising
   Public meeting notices
   Promotion of state plan in
      small media (newsletters,
      conference programs)
   General media placement
      (radio, print, web,
      television)				

Postage
   Steering/advisory group
      mailings
   Overnight delivery services
   Meeting announcements
   Circulation of drafts
   Correspondence to partners
   Dissemination of plan and
      companion documents
   Marketing materials				

Utilities, Telecommunications
   Conference call services
   Long distance services
   Web site service
   Electric				

Supplies				
Office supplies *Meeting supplies* *Computer supplies* *Graphic design software* *Data software* *Plaques or certificates of thanks* *for steering group members*				
Travel				
Staff meeting travel, lodging, and *per diem* *Steering group travel and lodging*				

Line Item	Internal Resources	Internal In-kind	External Resources	External In-kind
Other Direct Costs				
Meeting refreshments *Literature search/retrieval fees* *Incentives for focus group participation*				
Indirect Costs				
TOTAL				

Identifying Resources

Finding Other Resources 🔧

Important to Explore (✓)	Responsible Party	Potential Strategies to Ensure Resources for Planning and/or Implementation
		Request legislators to appropriate additional funds to implement priority activities based upon state-plan objectives.
		Private and public partners create a non-profit organization to raise and distribute funds for Healthy People initiatives.
		Ask public agencies to voluntarily adopt policies to focus their current human and financial resources on priorities or certain objectives.
		Ask private groups to voluntarily redirect current program resources to address health objectives.
		Encourage legislators to evaluate budgets against the plan's priorities.
		Use policy and regulation to focus private sector and public sector efforts on priorities in the plan.
		Ask private foundations to consider state public health priorities when developing grant making programs and awarding funds.
		Request private organizations to provide technical assistance, leadership, administrative support, and donated services to planning efforts, programs, and policy initiatives.
		Require local health departments or community agencies to address health objectives as a condition of using certain public funds. (Recipients choose which objectives to address.)
		Earmark state funding for particular Healthy People activities, objectives, or strategies in the plan, in order to ensure certain priorities are addressed.
		Request local and state health agencies contribute in-kind resources such as personnel to planning efforts.
		Set aside state funding and technical assistance resources to help local jurisdictions with planning efforts.
		Charge dues to organizational members of the state Healthy People coalition.
		Apply for private or public grants to support Healthy People efforts.

HOT picks

Resources for Identifying and Securing Resources

✪ **U.S. Department of Health and Human Services, Public Health Service, Office of Disease Prevention and Health Promotion.** *Locating Resources for Healthy People 2000 Health Promotion Projects,* **1991.** Available from Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (202) 512-1800.

This publication is a guide to locating financial assistance for projects related to the Healthy People 2000 goals. It reviews principles and procedures of grant seeking and discusses ways to locate potential funding through local, state, and federal agencies, as well as the private sector.

✪ **Department of Health and Human Services – GrantsNet.** http://www.hhs.gov/grantsnet/

GrantsNet is a tool for finding and exchanging information about HHS and other selected federal grant programs. This site provides access to up-to-date government resources available to the general public.

✪ **Office of Minority Health Resource Center.** *Funding Guide.* **Available at** http://www.omhrc.gov/omhrc/publications/publications5.htm

This guide was developed to assist grantseekers in their search for funding sources for health-related activities. It includes resources to enhance knowledge of public funding, private funding, and the basics of getting started in the search for funding sources.

✪ **National Library of Medicine HSRProj -** http://www.nlm.nih.gov/nichsr/db.html#hsrp

HSRProj is one of the information products developed by the National Information Center on Health Services Research and Health Care Technology (NICHSR), a component of the National Library of Medicine. HRSProj contains descriptions of research in progress funded by federal and private grants and contracts for use by policy makers, managers, clinicians, and other decision-makers. It provides access to information about health services research in progress before results are available in a published form.

✪ **Robert Wood Johnson Foundation. http://www.rwjf.org/index.jsp**

The Robert Wood Johnson Foundation's mission is "to improve the health and health care of all Americans." To stay up-to-date about RWJF program developments —- new ideas and recent calls for proposals, subscribe to the Foundation's free quarterly newsletter, ADVANCES®, read their annual report, or regularly visit their web site where all new publications and requests for proposals are posted.

✪ **W. K. Kellogg Foundation. http://www.wkkf.org/**

The mission of the W. K. Kellogg Foundation is "to help people help themselves through the practical application of knowledge and resources to improve their quality of life and that of future generations." The searchable grants database is organized around the W. K. Kellogg Foundation's programming interests.

✪ **Grantmakers in Health. http://www.gih.org/**

"This is a non-profit organization serving funders throughout the country who make grants in health and related human services. Grantmakers in Health serves these constituents through convening, publishing, providing education/training, conducting research, developing and making accessible databases and other information resources, providing technical assistance and consultation, making referrals, and helping grantmakers build professional relationships."

Please see Appendix A for other links to funding sources and references for identifying resources for developing a state plan.

HEALTHY PEOPLE 2010 TOOLKIT

Identifying & Engaging Community Partners

"Never doubt that a small group of committed citizens can change the world; indeed it is the only thing that ever has!"

—Margaret Mead

The health status of community residents is not the sole responsibility of the public health agency or health service providers. While public health agencies may bear responsibility for leading community health improvement efforts, their success hinges on their ability to establish and maintain effective partnerships throughout the state. The public health agency needs to identify and work with all entities that influence community health—from other government agencies to businesses to not-for-profit organizations to the general citizenry. Healthy People initiatives should begin with a commitment to collaboration among diverse constituencies so that everyone feels a sense of ownership in the state plan.

Action Checklist:
Identifying and Engaging
Community Partners

(See page 113 for a complete planning and development checklist.)
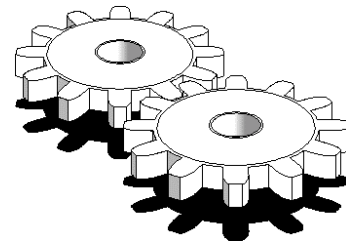
- ❑ Define target audiences
- ❑ Identify key individuals and organizations
- ❑ Design strategies for engaging partners
- ❑ Identify roles for partners and assign responsibilities
- ❑ Establish formal partnership agreements where appropriate

- ❑ Develop accountability and evaluation plans
- ❑ Develop a communication vehicle to highlight partner activities
- ❑ Reassess and evaluate partner involvement and satisfaction

Tips
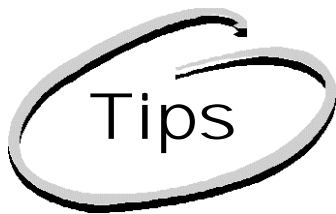
There is strength in numbers—community input does not burden, but strengthens, the planning process. Community partners can:

► Advocate for the goals and objectives of the state plan in the community and recruit other partners

► Contribute particular skills and talents

► Help monitor progress and achieve objectives

Be inclusive, not exclusive (Don't invite just your friends!)

► Strive for broad representation, and regularly assess gaps

► Identify individuals and organizations who look at problems and solutions differently

► Look for partners who have a stake in healthy communities, will contribute to the process, and help achieve objectives

Create and define useful roles for partners

► Confirm commitments—in writing where possible

► Give credit where credit is due

► Accept that some partners will have different levels of commitment

Don't just meet for the sake of meeting

▶ Be clear about the purpose and desired results of meetings

▶ Choose an effective facilitator (not always the chair)

▶ Show respect for other people's time

▶ Plan the meeting from the participants' perspective

Nobody likes to be a rubber stamp

▶ Provide a continual feedback mechanism and consider all feedback received

▶ Report back to partners how comments were addressed

▶ Give people a voice before priorities are set

▶ Ensure that groups have options and understand their implications before making big decisions

▶ Strive to understand all parties' concerns and perspectives

▶ Allow time for meaningful discussion

▶ Establish ground rules that are fair to all

▶ Establish partners' sense of ownership of the process

Re-visit lessons learned from your year 2000 planning process

▶ Assess partner contributions and gaps in the 2000 initiative

▶ Share how year 2000 plans did and did not lead to action

▶ Be candid with partners to establish trust and share responsibilities for improvement

Find creative and flexible ways to engage partners and community members

▶ Consider rotating meeting places and times to accommodate different schedules and give participants a chance to see other regions and communities

▶ Offer meeting options that accommodate different preferences and levels of comfort with groups, such as: informal discussions, conference calls, anonymous surveys, provider forums, focus groups, independent work groups, and kick-off events with kiosks or small break-out groups

▶ Use electronic communications, list servers, and web sites

Below are examples of approaches that the nation and states used to identify and involve partners in the Healthy People planning process.

From the National Initiative

Healthy People Consortium

Established in 1987, the Healthy People Consortium is comprised of more than 350 national membership organizations and the state public health, mental health, substance abuse, and environmental health agencies. The Consortium includes organizations that are national in scope and whose members (individuals, institutions, or affiliates) are interested in improving health and well being for all. Consortium member organizations represent older adults, racial and ethnic coalitions, educators, businesses, providers, scientists, and many others.

The Consortium uses the Internet, quarterly newsletters, and annual meetings to support ongoing communication and collaboration. In the initial stages of the Healthy People 2010 development process, Consortium members were asked to renew their commitment to Healthy People and to the development of year 2010 objectives. See page 48 for a copy of the pledge. Visit the Consortium website for how to join, as well as the most current listing of members, newsletters, and summaries of annual meetings: http://odphp.osophs.dhhs.gov/pubs/hp2000/consort.htm.

Activities

Consortium members engage in a broad range of activities that support achievement of the national health objectives. Nearly all members have publicized the objectives to their members; and many have used their newsletters and journals to solicit comments on the draft Healthy People 2000 and 2010 objectives. Many others have highlighted the objectives at their annual conferences or devoted sessions to discuss how the organization and individuals can help achieve the objectives.

Focus Groups

In 1996, the Consortium used professionally facilitated focus group sessions with key partners to examine the perceived value and functions of Healthy People objectives, both current and future. The findings from the Consortium focus groups can be found in Chapter Two of the report, *Stakeholders Revisit Healthy People 2000 to Maximize the Impact of 2010* at the following web site: http://www.health.gov/HPComments/Stakeholder.

Clear themes and suggestions emerged from the analysis of the focus groups. Consortium members were unanimous in valuing the Healthy People 2000 document as a "voice for public health." The value of the document was not debated, only the extent and nature of

revisions to be made for the next version. Although most Consortium members did not want major changes in the structure and content of the document, they did want to take advantage of new information and communication technology to create not only a single "reference" document, but also a flexible "database" that would permit multiple versions of the document to be produced.

Healthy People State Action Contacts

The Healthy People State Action Contacts are the states' representatives to the Healthy People Consortium. They receive national Healthy People resources and communicate to the nation information about state activities. An updated list is available in Appendix B and at the following web site: http://www.health.gov/healthypeople/Contact/StateContact.htm.

Business Advisory Council

In 1997, with funding from the Robert Wood Johnson Foundation, the Partnership for Prevention (a Healthy People Consortium member) created a Healthy People Business Advisory Council. This Council is engaging the leaders of America's businesses, both large and small, in evaluating Healthy People as a tool for both worksite based and general community health promotion. The Council also participated in Healthy People 2010 development. For information on Council activities, visit: http://www.prevent.org.

From State Initiatives

Form a statewide coalition of partners

In 1991 **South Carolina** formed the Healthy People Coalition as an independent organization with members elected to a governing council. The Coalition's mission is to promote an environment where all South Carolinians have the ability to achieve and maintain maximum health and well being. The Coalition's strategies included raising public awareness of the national health objectives, identifying the focus for action in communities throughout the state, and focusing attention on reducing health status disparities among population groups. The Coalition worked with the Department of Health and Environmental Control and other organizations to track changes in health status, behaviors, and other indicators against the national Healthy People objectives and promoted their findings. Local communities also formed their own coalitions, which meet annually to learn about activities in other localities.

Engaging Partners
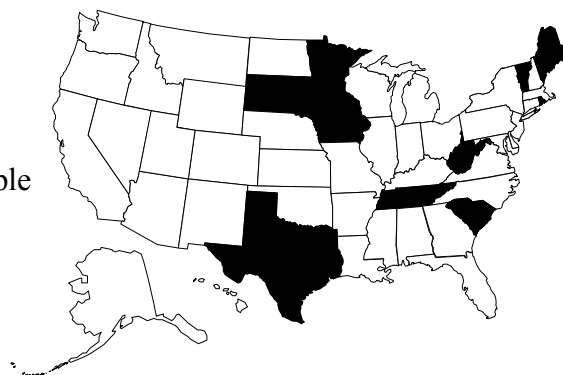
Formed in 1990, the Healthy **West Virginia** Coalition is comprised of 18 organizations representing public health, health care providers, school health programs, universities, worksites, and networks. The Coalition fosters collaboration among various sectors to help advance the goals of Healthy People 2000 and 2010 in West Virginia. West Virginia also planned a two-day Summit, scheduled for summer 1999, to bring together hundreds of West Virginians for a meeting on the Healthy People goals and objectives. Another instrumental group for pulling together key partners has been the State Health Education Council, founded in 1977, an organization of more than 300 individuals working in the areas of health promotion and health education in the state of West Virginia.

To achieve its year 2000 objectives, the **Rhode Island** Department of Health initiated the Worksite Wellness Council of Rhode Island. Rhode Island focused on increasing health promotion and disease prevention activities in work sites, where most adults spend the majority of their time. The state Wellness Council entered into an agreement with the Wellness Council of America (WELCOA) to make Rhode Island the first Well State in the U.S. Through this agreement, Rhode Island aims to have 20 percent of its workforce in WELCOA-certified Work Well Sites. The Wellness Council obtained a non-profit tax status and is governed by its own Board of Directors. While the Council works toward financial independence, the Council is staffed by the Department of Health and supported by financial and in-kind contributions of its business members. The Council will continue to be involved in Rhode Island's year 2010 activities.

Develop multiple levels of participation

Iowa organized multiple levels of participation in the development of year 2000 objectives. Iowa's governor appointed a 19-member Healthy Iowans Task Force, comprised of state agencies, academic institutions, voluntary agencies, consumers, health professional associations, and the state board of health. Iowa's governor assured gender and political party balanced the group. A consortium of 80 professional and voluntary organizations assisted in the development of sections and action steps. The state mailed several hundred copies of the draft *Healthy Iowans 2000* to interested groups and individuals for comment. Written comments, as well as testimony at public meetings, informed the Task Force's final deliberations with the governor over the objectives.

According to the Iowa Department of Health, the private and voluntary sector has or shares major responsibility for 20 percent of the 338 action steps in *Healthy Iowans 2000*. The state's year 2000 plan designated specific state agencies, voluntary organizations, and companies that would be involved in the realization of each objective.

In 1995 **Vermont** adjusted Vermont's health status objectives to the community level. This created a more meaningful document to local organizations and helped to further engage the people at the community level.

In the spring of 1996, the **Texas** Department of Health, the Texas Health Foundation, and the CDC sponsored a two and a half-day conference entitled "Mobilizing for Health: The ABCs of Community Assessment." Over 700 persons attended the conference. The conference goal was to provide communities with the planning, data collection, community organizing, and policy analysis tools needed to successfully undertake the community assessment process. It attracted a wide variety of private, public, and nonprofit organizations and encouraged them to work together to improve the overall health of Texas communities.

Minnesota formed the Minnesota Health Improvement Partnership, a group of individuals representing a broad sector of both public and private organizations, including members from local departments of health. This group was charged with the responsibility to develop *Healthy Minnesotans: Public Health Improvement Goals for 2004*.
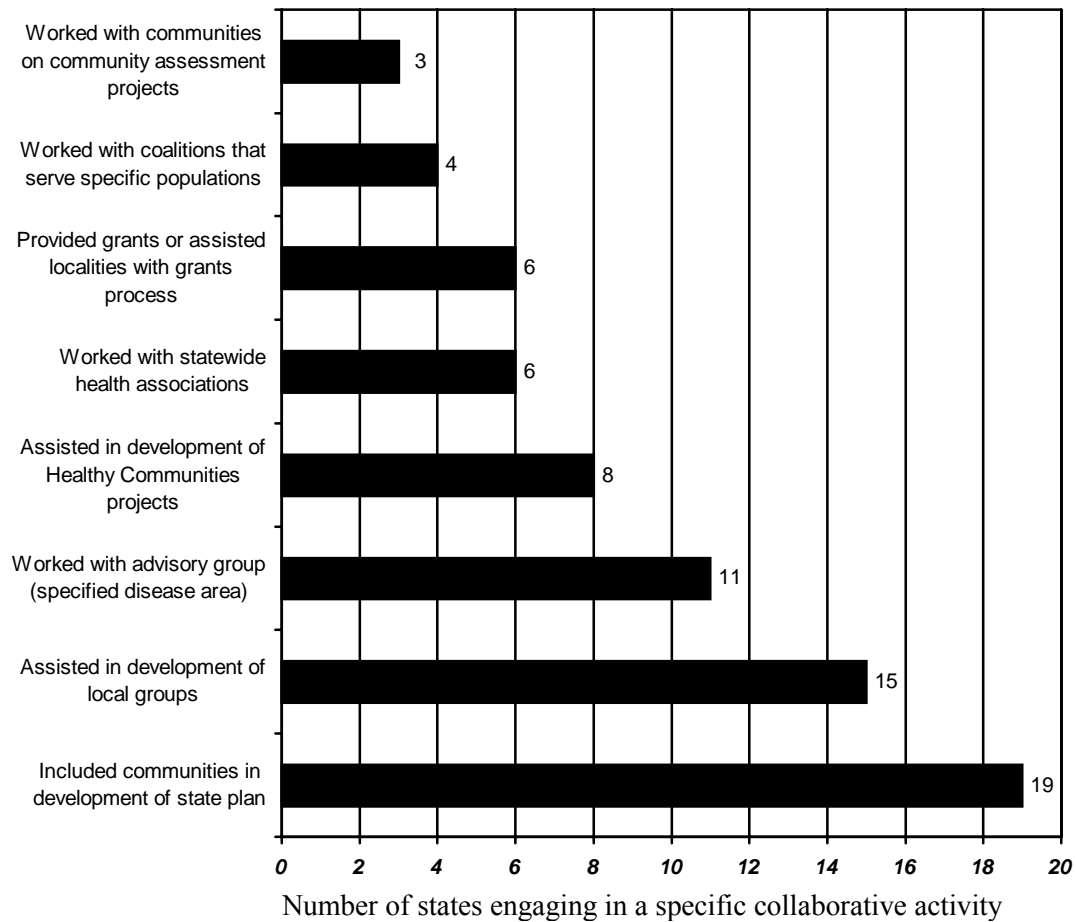
Influence strategic plans of external community organizations, both private and public

Maine and **Tennessee** were among several states whose year 2000 objectives influenced the planning and activities of private health organizations. As examples, the American Cancer Society in Maine redesigned their core activities to reflect the state's health objectives. Tennessee's Health Facilities Commission incorporated the state's objectives into its Certificate of Need Process.

Since 1995 **Minnesota** law has required managed care organizations to submit Collaboration Plans to the state's Commissioner of Health. Plans must describe actions that the health maintenance organizations or community-integrated networks have taken or intend to take to achieve public health goals. The Minnesota legislation helps communities utilize the combined efforts of the public and private sectors to address priority health problems of shared concern.

In **South Dakota** individual programs seek input from partners within and outside state government. The state's Public Health Alliance Program is a cooperative effort involving the Department of Health, local health care providers, and county government. These entities work together to ensure the delivery of public health services. Through this project, community councils are formed and actively participate in program planning and implementation. County-specific health indicators are presented to community health councils. During these presentations, the county-specific indicators are compared to statewide indicators, national measures, and relevant Healthy People objectives.

Methods of Community Input in the Development of State-Specific Healthy People 2000 Plans
(N=43)

Activity	Number of states
Worked with communities on community assessment projects	3
Worked with coalitions that serve specific populations	4
Provided grants or assisted localities with grants process	6
Worked with statewide health associations	6
Assisted in development of Healthy Communities projects	8
Worked with advisory group (specified disease area)	11
Assisted in development of local groups	15
Included communities in development of state plan	19

Number of states engaging in a specific collaborative activity

Note: States may be counted more than once since some provide more than one type of assistance in objectives planning, development, and tracking.

Source: Public Health Foundation. *Measuring Health Objectives and Indicators: 1997 State and Local Capacity Survey.* March 1998.

How Do You Define Meaningful Citizen Participation?

◆ Power to make decisions and affect outcomes

◆ Citizen driven; from the community up, not top down

◆ Proactive, not reactive

◆ Encourages and facilitates broad community involvement

◆ Inclusive, not exclusive; accessible to all

◆ Balanced representation in the participation process; not just major "partners"

◆ Consensus-oriented decision making

◆ Compromise; give and take

◆ Opportunities for involvement in all levels of activity, which include creating a vision, planning, prioritizing, deciding, evaluating

Source: Dever, G.E.A. Improving Outcomes in Public Health Practice: Strategy and Methods. Aspen Publishers, Inc., Maryland, 1997.

Engaging Partners

Potential Partners

Below is a partial listing of the many public, private, and voluntary sector partners that states have engaged in Healthy People initiatives. Which are most important to you?

Health
- [ ] Prevention Research Centers
- [ ] Coroner, medical examiner
- [ ] Emergency medical system
- [ ] Health departments – city, county, state
- [ ] Health professional associations
- [ ] Hospitals
- [ ] Health maintenance organizations
- [ ] Medical societies
- [ ] Mental health organizations
- [ ] Substance abuse agencies
- [ ] Primary Care Associations
- [ ] Community Health Centers
- [ ] Nursing homes, home health agencies
- [ ] Nutrition centers
- [ ] Red Cross chapters-local, state

Funding Resources
- [ ] Philanthropic institutions
- [ ] United Way, foundations

Select Populations
- [ ] Area Agency on Aging
- [ ] Corrections
- [ ] Day care facilities/Head Start
- [ ] Disabled citizens' alliance
- [ ] Health department clients
- [ ] Multicultural community centers
- [ ] Shelters/soup kitchens/bars
- [ ] Youth coalitions/teen centers
- [ ] Migrant worker groups
- [ ] Minority and gay/lesbian organizations

Planning/ Regulatory Agencies
- [ ] Area Health Education Center
- [ ] Human resources council
- [ ] Regional Planning Councils

Voluntary Groups
- [ ] American Association of Retired Persons
- [ ] Faith communities and organizations
- [ ] Civic groups
- [ ] Fire and rescue service
- [ ] Interagency coalitions and councils
- [ ] Service providers
- [ ] Water Patrol

Business
- [ ] Private businesses
- [ ] Chamber of Commerce
- [ ] Economic development directors
- [ ] Insurance companies

Education
- [ ] Colleges and universities
- [ ] Public schools - elementary, secondary
- [ ] Teachers and administrators
- [ ] Parent organizations

Communication
- [ ] Health advocacy newsletters
- [ ] Media (TV, radio, print)
- [ ] State/local web sites

Government
- [ ] Army Corps of Engineers
- [ ] Dept. of Environmental Protection
- [ ] Military installations
- [ ] Mayor's office
- [ ] Empowerment Zone/Enterprise Community office
- [ ] Law enforcement agency
- [ ] State legislators
- [ ] HHS Regional Health Administrators

Forming Partnership Agreements

How can partnerships effectively assist the development and implementation of the state plan? The following provides factors to consider when delineating the roles and responsibilities of partners.

What are partnership agreements?

► Memoranda of understanding and/or informal agreements between state agencies and public or private partners that establish relationships or formalize existing relationships of benefit to both partners

What are essential components of partnership agreements?

► Mutually agreed upon, clearly defined purpose

► Clearly defined roles, responsibilities, and operating procedures

► Shaped by mutual respect and trust

What are potential roles for partners?

► Link and consult with civic groups, health organizations, planning councils, and other groups to address community health issues

► Lead community initiatives, including fundraising and policy development

► Facilitate community input through meetings, events, or advisory groups

► Provide technical assistance and guidance for program planning and policy development

► Collect and analyze data; conduct literature reviews, research, or assessments

► Develop and present education and training programs

► Educate elected officials and policy makers on health issues

► Market the plan

► Publish companion documents or midcourse review

► Provide resources (for ideas, see sample budget line items, page 31)

► Monitor/analyze health-related legislation

► Evaluate components of state plan

► Provide long-term support to sustain health initiatives

Consortium Pledge

▶

Healthy People 2010 Pledge

Recognizing that 50% of premature deaths in the United States can be prevented through clinical and other preventive services as well as behavior change, and that prevention is integral to the general health and well-being of all Americans,
_____ *pledges to support Healthy People an Initiative of*
    (Organization Name)
the Surgeon General, as it moves into the next century.

Specifically, we promise to:

1) Engage our membership in the development of the objectives for Healthy People 2010.

2) Work towards the achievement of health for all Americans by developing health promotion and other programs that utilize Healthy People goals and objectives.

3) Have our organization listed as a member of the Healthy People Consortium in *Healthy People* publications.

4) Be an active participant in the Healthy People Initiative.

Signed:

_____
(Organization)

_____   _____
(Name Printed)   (Title)

_____   _____
(Name Signed)   (Date)

Resources for Engaging Community Partners

✪ **National Association of County Health Officials.** *Assessment Protocol for Excellence in Public Health (APEXPH)*, 1991.

The tool is an eight-step process for assessing community health status and planning for improvement. It is based on the principles of environmental justice, community collaboration, and locally appropriate decision making. Guidance is designed to be easily accessible and flexible enough to meet the needs of a variety of communities with differing health concerns. For more information, see **http://www.naccho.org.**

✪ **Coalition for Healthier Cities and Communities, Norris T. & Howell L.** *Healthy People in Healthy Communities: A Dialogue Guide*. 1999.

This guide assists communities in hosting dialogues leading to action and policy on what makes healthier communities. It is a part of the Healthy Communities Agenda, the 1999 – 2000 campaign of the Coalition for Healthier Cities and Communities and its partners. For more information contact the Healthy Communities Agenda "Dialogue Coach" at 1-800-803-6516 or contact the Coalition for Healthier Cities and Communities, One North Franklin, Chicago, IL 60606. **http://www.healthycommunities.org**

✪ **Community Tool Box, http://ctb.lsi.ukans.edu/**

The mission of the Community Tool Box is to promote community health and development by connecting people, ideas, and resources. The website provides tools needed to build healthier and stronger communities. The web site also provides information for those interested in a variety of community health and development issues and connects individuals to personalized assistance for improving community change efforts.

✪ **Institute of Medicine (Committee on Public Health).** *Healthy Communities: New Partnerships for the Future of Public Health.* National Academy Press, Washington, D.C., 1996. **http://www.nap.edu/catalog/5475.html**

"The Committee's analysis [concludes that] the public's health depends on the interaction of many factors; thus, the health of a community is a shared responsibility of many entities, organizations, and interests in the community, including health delivery organizations, public health agencies, other public and private entities, and the people of a community."

✪ **U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC/ATSDR Committee on Community Engagement).** *Principles of Community Engagement.* Atlanta, Georgia, 1997.

Principles of Community Engagement provides public health professionals and community leaders with a science base and practical guidelines for engaging the public in community decision-making and action for health promotion, health protection, and disease prevention.

✪ **Civic Practices Network. http://www.cpn.org/sections/topics/community/index.html**

The community section of this web site provides information on community building through "community organizing, social capital, and urban democracy." It also provides information on the Consensus Organizing Model, which explains some ways one can bring together all the players in a community.

Please see Appendix A for other resources about engaging community partners.

HEALTHY PEOPLE 2010 TOOLKIT

Setting Health Priorities and Establishing Objectives

"Put first things first."

—Stephen Covey

Determining health priorities helps direct resources to the areas that matter most to community partners and that will have the greatest impact on community health status. With so many competing needs, selecting priorities and establishing objectives may seem like an arduous task. However, there are numerous models and resources to use to identify state priorities. Develop consensus among steering group members on what models will be used, and how qualitative data, quantitative data, assets, community opinion, political agendas, or other factors will inform the priority setting process. Striking an effective balance among these sources of information will make for a smoother process. When well publicized, documented, and endorsed by communities, a sound priority setting process helps achieve widespread support for the plan.

Action Checklist:
Setting Health Priorities and
Establishing Objectives
(See page 113 for a complete planning and development checklist.)
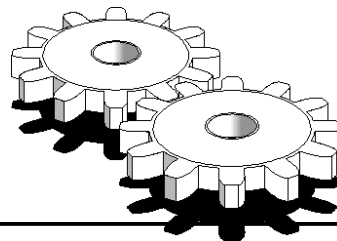
❑ Evaluate input from community partners and experts

❑ Collect and review previous health needs and assets assessments

❑ Conduct assessments of health needs and assets, if necessary

❑ Plan for transitions from year 2000 to year 2010 health objectives

❑ Decide where changes from year 2000 are needed and what should be retained

❑ Define the scope of the state plan

❑ Set criteria for establishing potential priority or focus areas

❑ Establish a process for final determination of priorities

❑ Identify and obtain information to evaluate areas according to criteria

❑ Select final priority or focus areas

❑ Determine types of objectives desired and establish criteria for adopting them

❑ Outline standard information to include with all priority areas and objectives

❑ Specify intervention points; identify potential topics and indicators for objectives

❑ Develop draft objectives

Tips
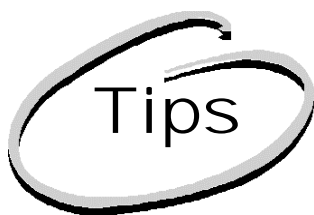
Perception is reality for many people

► Learn what the community and key partners see as important health issues (see action area, "Communicating Health Goals and Objectives," for ideas on learning from target audiences)

► Review comments your state residents submitted on the draft *Healthy People 2010* focal areas and objectives (see page 54)

► Obtain qualitative data, where possible, to assess and describe community perceptions

► Build on perceptions to gain broader support for priorities

Define the "rules of the game" up front—before trying to establish priorities and objectives

► Make sure everyone understands and accepts the process for recommending and adopting final priorities

► Set a cut off date for proposing changes to the "rules"

► Determine what other plans and objectives should be explicitly considered or incorporated into the state plan (e.g., national Healthy People 2010 draft objectives, state performance plans, existing tobacco or HIV/AIDS plans)

► Determine how priority areas should be related to the agreed vision and scope of your plan

Be clear about your criteria for determining priorities and establishing objectives

► Communicate important characteristics of objectives (e.g., feasibility, effectiveness, short-term/long-term, measurability) to work groups

► Make simple worksheets or checklists to help planning group members consistently consider criteria and see relevant information at a glance

► Strive for measurable objectives, but don't neglect important health areas where measures need to be developed and objectives may drive new data sources

You're not starting from scratch—build on your assets, not just your needs

► Align priorities, objectives and strategies with your state's strengths, assets, and opportunities where possible

► Look to other sources for information such as leading causes of death, Basic Priority Rating or other ranking systems, surveillance systems, or outcomes from your state's Healthy People 2000 plan

► Show respect for what already has been accomplished to address priorities

Below are examples of how the nation and states have identified priorities and set the parameters for health objectives.

From the National Initiative

Regional meetings

Six public hearings were held to provide opportunities for the public to comment on the draft of the Healthy People 2010 objectives. For more information on where these meetings were held and a summary of the critical issues discussed, visit the following web site: http://www.health.gov/hpcomments/default.htm.

Leading Indicators for Healthy People 2010

This report from the Health and Human Services Working Group on Sentinel Objectives includes potential models, candidate sets of leading health indicators, available data sources, and considerations for implementation. Information on the Leading Health Indicators can be found at: http://www.health.gov/healthypeople/LHI.

In 1999, the Institute of Medicine (IOM) Committee on Leading Health Indicators for Healthy People 2010 released the "Leading Health Indicators for Healthy People 2010: Final Report." It is currently available through the Division of Health Promotion and Disease Prevention and IOM at: http://books.nap.edu/catalog/9436.html.

Internet

In 1997 the consultation on the Healthy People 2010 framework took place on the Internet. Individuals from 46 of the 50 states "let their voices be heard." New focus areas on public health infrastructure, health communication, and disability and secondary conditions were added to the existing framework. Many additional areas of focus were suggested and provided the background for further discussions.

In 1998 more than 11,000 comments were received from people in every state, the District of Columbia, and Puerto Rico. While 43 percent of the comments were placed electronically, all the paper comments and regional testimony were scanned into the Healthy People web site. This makes the Internet the complete repository of all comments. They are available for use in setting state priorities and are searchable by key words and zip codes of persons commenting: http://www.health.gov/hpcomments/.

Other public forums

Presentations on Healthy People 2010 have been made at numerous conferences, symposia, and meetings sponsored by Consortium members and other groups. These speaking engagements offered an opportunity to describe the Healthy People 2010 development process to thousands of people in the public health community. Questions from the audience provided opportunities for exchanging ideas, which have helped refined the process, concepts, and content of the initiative.

From State Initiatives

### Develop and use standardized methodology or formulae

Delaware used a formula to identify its *Healthy Delaware 2000* priorities, based on the size of a health problem (A), the seriousness the problem (B), and the potential for interventions to impact the public's health (C). The seriousness of the health problem was weighted as twice the importance of its size. Planners used several questions to determine the seriousness of a problem. The most important criterion was the effectiveness of available interventions according to a review of the scientific literature. To calculate the formula $[(A + 2B) C]$, Delaware assigned numeric scores to each defined criteria. Finally, the Governor's Advisory Committee on Public Health categorized health problems as having the "most opportunity," "some opportunity," or "less opportunity" to intervene.

Maryland developed a matrix (see pages 67-69) to rank priorities (1 to 5) that compared state-specific health indicators to national health indicators as "better than," "same as," or "worse than" for both trends and average ratings. Priorities were examined for each local jurisdiction as well, comparing counties to Maryland. While this matrix was used internally to set year 2000 priorities, the year 2010 process will incorporate much wider input from the community in how to translate the priorities into objectives.

Utilize several resources for input

Kansas determined priority health issues through its Healthy Kansas 2000 Steering Committee, who evaluated health data, sought expert opinions, invited public comments, and conducted an opinion survey of residents. Kansas used a consensus method to limit the scope of its objectives to seven priority health areas and four disease risk factors. The seven priority health areas included alcohol and drug abuse, cancer, heart disease, HIV and other STDs, infectious diseases and immunizations, injuries and violence, and maternal and infant health. The focal risk factors were lack of access to preventative care, tobacco
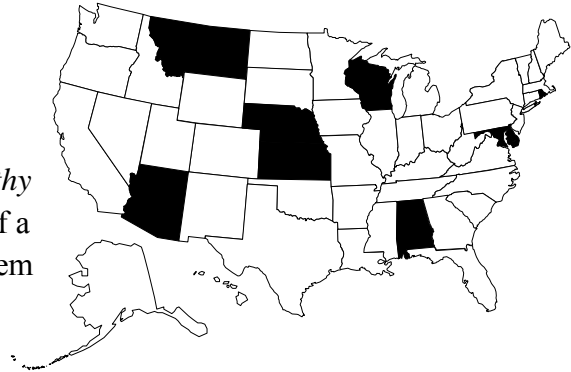
use, poor nutrition, and lack of physical activity. Work groups recommended strategies to achieve most objectives. Where work group recommendations differed from the Kansas Department of Health and Environment policy, the Kansas plan identified the source of strategy recommendations.

For year 2010 plans Kansas is using input from committees and groups that were formed during year 2000 implementation. For example, Kansas intends to use the objectives from the state's Injury Plan and Tobacco Control Plan. The state plans to incorporate objectives developed through the state Cancer Plan funding into the Healthy Kansans 2010 plan.

The **Montana** Department of Public Health and Human Services completed the prioritization process in order to allocate block grant dollars. For this process, methodologies delineated in *Public Health Administration and Practice* by G.E. Pickett and J.J. Hanlon, and the *Assessment Protocol for Excellence in Public Health Manual*, published and distributed by the National Association of County and City Health Officials, were used. The first method takes into account major diseases/conditions in terms of mortality, morbidity, years of potential life lost, economic burden, proportion of the population affected and other measures.

In 1997 and 1998, Montana also developed and published a state health plan, *The Montana Health Agenda.* This plan served as a "road map" to identify and prioritize health needs in Montana, provide health services, and direct program activities. The next publication of *The Montana Health Agenda* will be January 2000. It will provide an update and progress report on each of the priority issues. Plans are in place to expand the health objectives to include issues of environmental health, mental health, the elderly population, and disabilities.

Two **Native American Tribes in Wisconsin** went through the APEX*PH* process by forming committees consisting of Tribal health clinic staff, teachers, Tribal community leaders, and others. The results gave each of them the starting point for setting priorities. Each committee identified priority issues and used the *Healthy People 2000* document to formulate their objectives. Experts from the field also came to talk to the committees about activities that were already taking place and made suggestions on how to proceed.

Solicit input from community

Alabama involved more than 2,000 organizations and individuals in the development of Healthy Alabama 2000. Testimony from seven public meetings throughout the state guided the selection of priority areas for Alabama's health objectives. Alabama convened a statewide conference to further define the state's health needs and priorities. State conference planners secured co-sponsorship from over 60 organizations and attracted over 700 participants. A task force drafted specific health objectives for final review by all conference co-sponsors. Alabama limited its state health objectives to 60, organized under four broad headings.

Nebraska involved only government program staff in the development of objectives and strategies for the first version in 1989. But in 1992, the state held public forums with speakers and presented their data findings to involve the community in the final version. The Health Policy and Planning Office in the state Department of Health worked with community action agencies and with local health departments. One of their lessons learned was to make a better effort to include the rural area health departments.

Solicit input from key leaders

Arizona convened a technologically innovative gathering of leaders to determine their 10 priority health areas for the year 2000. Twenty-five state health leaders reached consensus on the 10 priorities after a one-day meeting, the Arizona Year 2000 Town Hall. A computer-equipped meeting room with terminals for each person enabled leaders to anonymously brainstorm health priorities for the group's master list. Arizona credits the computer-based method of input with a more honest identification of the state's priority needs and the ability to reach consensus quickly. However, one lesson learned was that roundtable discussions in addition to the computer-based input method were needed to help foster collaboration. Another lesson learned was that the one-day process left out a few important areas such as environmental and behavioral health.

Divide up tasks among different groups

To set priorities for year 2000 objectives, **Rhode Island's** task force first analyzed and discussed available baseline data in each of the nation's priority areas. The task force identified health issues that had the greatest impact on the state's population, then established five issue-specific committees: 1) Disease Control, 2) Environmental Health, 3) Family Health, 4) Disability Prevention, and 5) Injury Prevention. Each committee identified achievable objectives and specified target populations by age group, gender, socioeconomic status, race/ethnicity, or other at-risk categories.

Number of Year 2000 Objectives and Sub-Objectives Among States (N=39)

Total objective/sub-objectives*	**4,397**
Range	**20 to 308**
Mean	**113**
Median	**103**

Number of Objectives by State

Alabama	103	Iowa		Nevada	61	Tennessee	120
Alaska	308	Kansas	214	New Hampshire	93	Texas	110
Arizona	50	Kentucky	185	New Jersey	120	Utah	35
Arkansas	144	Louisiana	74	New York	40	Vermont	61
California	110	Maryland	93	North Carolina	54	Virginia	30
Connecticut	161	Massachusetts	90	Ohio	119	Washington	38
Delaware	101	Minnesota	121	Oklahoma	199	West Virginia	59
Florida	86	Mississippi	288	Oregon	47	Wisconsin	253
Hawaii	122	Montana	64	Rhode Island	74	Wyoming	164
Indiana	20	Nebraska	107	South Carolina	141	**Total:**	**4,397**

*Illinois was unusual with 790 objectives/sub-objectives and was excluded from this analysis.

Source: Public Health Foundation. *Measuring Health Objectives and Indicators: 1997 State and Local Capacity Survey.* March 1998.

Number of States with and without Year 2000 Objectives/Sub-Objectives or Implementation Plans for Mental Health, Substance Abuse, Environmental Health, or Occupational Health (N=47)
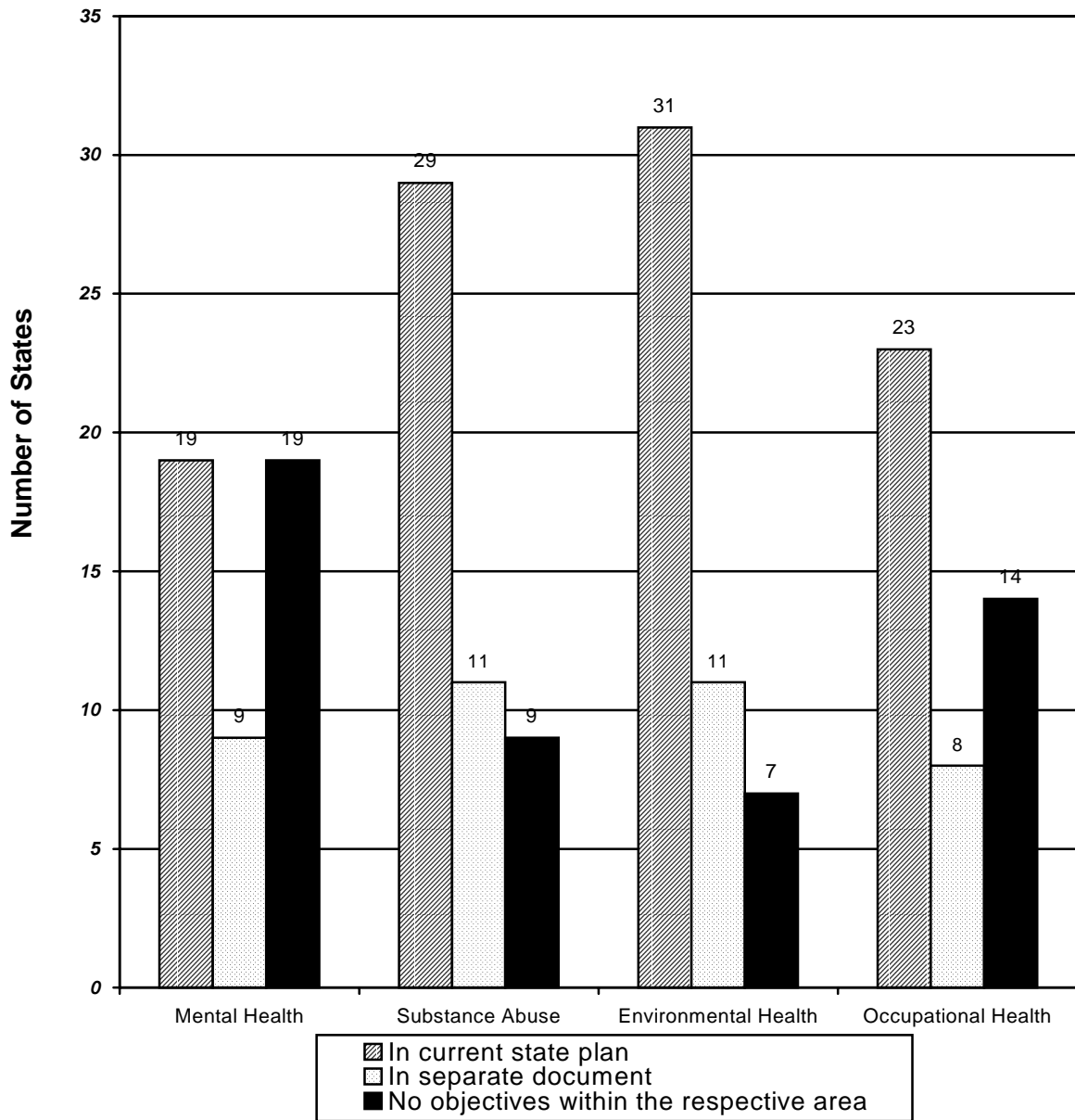
Note: Some states may include objectives in their year 2000 plan and in a separate document and may be counted twice.

Source: Public Health Foundation. *Measuring Health Objectives and Indicators: 1997 State and Local Capacity Survey.* March 1998.

Defining the Terms

Before beginning work on setting priorities, it is a good idea to develop a common understanding of terms. The terms *vision, goals, objectives, baselines, and targets* often are used differently by participants in planning processes.

Vision	**Why is a plan being established?**
Examples	*(describes the overall goal of the state plan, a common purpose and shared values)*
Create healthy people in healthy communities through shared responsibility	Tips
Provide citizens and leaders with opportunities to impact and measure the health of the state	• To begin crafting a vision ask, "what would a healthy state be like?" or "what would make this plan a success?"
Create a sustainable structure for coordinated, interdisciplinary health planning	• Publish the vision at outset of document with vision statement or guiding principles.
	• Use the vision to guide choices in the planning process and to communicate priorities.
Goal	**What do you want to happen?**
Examples	*(broad and lofty statement of general purpose to guide planning around a health issue)*
Increase regular exercise among older adults	Tips
Ensure all children have access to health care	• Use goals to clarify what is important within a priority area, before drafting objectives.
Eliminate second hand smoke in public places	• Begin with action words such as *reduce, increase, eliminate, ensure, establish, etc.*
	• Focus on the end result of the community's work
	• Consider whether the goal is community-wide or if specific to a particular population (by age, race, gender, ability, etc.).

Objectives

Examples

By 2010, increase the use of safety belts and child restraints to at least 93% of motor vehicle occupants. (Baseline: 69% in 1997)

By 2010, increase to at least 95% the proportion of people who have a specific source of ongoing primary care. (Baseline: 84% of adults 18 years and over in 1994.)

By 2005, increase to 100% the proportion of health plans that offer treatment of nicotine addiction. (Potential data source: state managed care survey)

How will we know if we reached the goal?

(offers specific and measurable milestones, or targets; sets a deadline; narrows the goal by adding "who, what, when, and where;" clarifies by how much, how many, or how often)

Tips

- Consider a wide range of things that could indicate state progress toward achieving health goals. Among these are individual behaviors, professional practices, service availability, community attitudes and intentions, insurance status, service enrollment, policy enactment, voluntary participation in employer programs, organizations that offer particular programs, policy compliance/enforcement findings, results of population screening or environmental testing, or the occurrence of events that suggest breakdowns in the public health system.

- Be specific. What is to be achieved? (e.g., What behavior or what outcome? Who is expected to change, by how much, and by when)?

- Get ideas for objectives from year 2000 objectives or other state plans, other state objectives, and the nation's draft year 2010 objectives and comments.

- Set short-term as well as long-term objectives as a motivational strategy.

- Be clear with numbers and percentages (e.g., know your denominator). There is a big difference in increasing enrollment <u>by</u> 20 percent, <u>to</u> 20 percent, or <u>by 20 people</u>.

- Throughout drafting of objectives, ask are they relevant to the goal and vision? Do they show what the state hopes to accomplish and why? Are they timed? Do they include a time line by which they will be achieved? Who is held accountable for meeting and updating the time line? Are they challenging? Do they stretch the public health agency to set its aims on significant improvement of importance to the community?

Baseline and Target	- Objectives need a **target** (the desired end point amount of change, reflected by a number or percentage) and a **baseline** (where the community is now, or the first data point in the tracking continuum). Exceptions include policy or organizational objectives that can be measured simply by being established. - If data are not available about a particular priority area, determine if there are alternative types of data available or ones that realistically can be developed.
Strategy Examples *Increase tax on cigarettes by at least 75 cents.* *Provide skills training to physicians on effective physical activity counseling* *Enforce laws prohibiting tobacco sales to minors* *Expand sites promoting CHIP and application assistance to employers, neighborhood agencies, parish nursing, YWCA, and others* .	***How will the objective be reached?*** *(specifies the type of activities that must be planned, by whom, and for whom)* Tips - Generate a list of strategies that gives various sectors a job to do (e.g., businesses, voluntary organizations, government, health care organizations, social services, faith communities, and citizens). Consider strategies that require sectors to work together. - Consider the specific assets of the state to choose strategies that are achievable. - Ask whether the strategy addresses known risk factors and how it will reduce risk and/or increase health factors. - Provide known effective (efficacious and possible) interventions and strategies. - Seek individuals affected directly or indirectly by the health threat. Enlist their support in responding to getting policy maker or partner support for strategies. - Seek guidance from those who may carry out strategies on the most effective, efficient, and "doable" activities. - Consider strategies recommended in year 2000 state plan and by other groups (such as PATCH, Planning Councils, HIV Prevention Community Planning Groups, and the Tobacco Prevention Coalition). - Provide examples of state or local programs that work. See HRSA's "Models that Work," http://bphc.hrsa.gov/mtw

	• Ask external consultants for technical assistance if you need more information on strategies that have worked around the country to address objectives. Effective strategies may include:
	
	    • targeted economic development
	    • health education
	    • social marketing
	    • assessment and referral
	    • policy (legislation, regulation, program policy)
	    • enforcement
	    • capacity building (new or improved systems)
	    • coordination of services
	    • changing the social or physical environment
	    • employer programs
	
	• Determine if the strategy is likely to reach the target population.
	
	• Work with evaluation in mind. Is the strategy set up in a way in which its effectiveness in reaching the state objectives can be evaluated?

Worksheet 1

Initial Assessment

A tool as simple as a questionnaire completed by partners will help clarify priorities and potential strategies. As an initial step after reviewing needs assessment data, ask members of the planning group to describe the three most important health areas of concern for the state in the next decade. For each issue, list the primary goal and the primary strategy that has been or could be used to approach it. After consensus on the priorities has been achieved, consider this input in ranking potential goals and issues to address.

1) Issue: _____

   _____

   Primary Goal: _____

   _____

   Strategy: _____

   _____

2) Issue: _____

   _____

   Primary Goal: _____

   _____

   Strategy: _____

   _____

3) Issue: _____

   _____

   Primary Goal: _____

   _____

   Strategy: _____

   _____

WORKSHEET 2
Writing Objectives

Priority Area: _____

Goal	
Available Data Sources	
Potential Objectives	A.
	B.
	C.
Potential Strategies	➤
	➤
	➤

Priority Setting Worksheet 🔧

Potential criteria and methods to weigh the importance of a health event
(e.g., cancer, HIV, substance abuse)

Health Event: _____

To Use ✔	Sample Criteria (tailor to ensure criteria can be applied to all health issues being weighed)	Measure (cite specific measure and data source if available)	Score (score data, assign points, or rank using identified method)	Weight* (assign value to criteria if desired)	Weighted Score (score multiplied by weight)
	Prevalence				
	Mortality rate				
	Community concern				
	Lost productivity, e.g., bed-disability days				
	Premature mortality, e.g., years of potential life lost				
	Medical costs to treat (or community economic costs)				
	Feasibility to prevent				
	Other:				
	Other:				
	Other:				
				Priority Score (sum of weighted scores for each criterion used)	

*A weight ensures that certain characteristics have a greater influence than others have in the final priority ranking. A sample formula might be: 2(Prevalence Score) + Community Concern Score + 3(Medical Cost Score) = Priority Score. In this example, the weight for prevalence is 2 and medical cost is 3. Users might enter data or assign scores (such as 1-5) for each criterion and use the formula to calculate a total score for the health event.

Note: These criteria work only for health events. Separate criteria and methods may be needed to weigh the importance of process or system issues (e.g., transportation, workforce development, business participation in health promotion), particularly to compare across many types of health issues.

Priority-Setting in Maryland 🔧

In Maryland, the 2010 initiative will attempt to build on its year 2000 process. The focus of Healthy People efforts will be on eliminating health disparities for minority populations as well as on improving the public health system's infrastructure. Maryland's Health Pledge to its citizens is the basis for outlining shared goals and vision for health care delivery in Maryland. The Department's Health Pledge addresses three focal areas: 1) creating healthy communities; 2) strengthening and expanding partnerships; and 3) creating a world class organization, including an infrastructure that supports quality, access, efficiency, and cultural sensitivity.
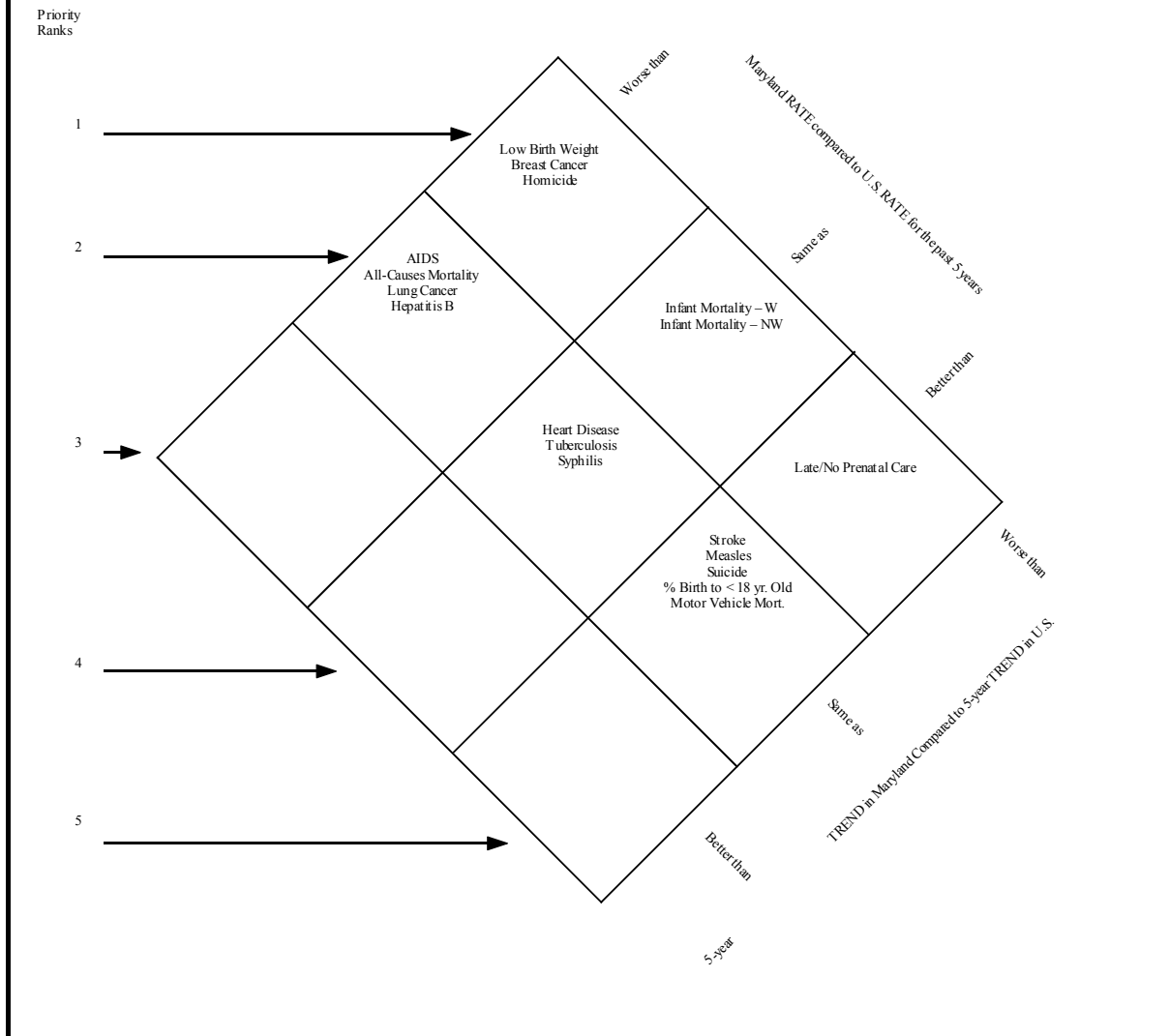
Maryland is in the process of determining community-based priorities in partnership with its 24 local jurisdictions. The state and local collaboration and network of resources has allowed monitoring of the population health needs by using centrally organized data collection and analysis. In addition, many Maryland counties and Baltimore have completed the Assessment Protocol for Excellence in Public Health (APEX*PH*) and/or Planned Approach to Community Health (PATCH) process, and have produced strategic plans, with the help of local health planning councils.

Maryland has assessed the needs of the population and set priorities, both at the state and local levels, using a consensus set of health indicators. The basis for these indicators is behavioral and preventive service data from the Behavioral Risk Factor Surveillance System (BRFSS), mortality and natality data from vital statistics, and morbidity data such as STDs and AIDS from the Infectious Disease Reporting System.

Maryland developed a set of indicators derived from a report of consensus indicators by Maryland's "Committee 22.1" (named for its charge to address the Healthy People 2000 objective 22.1). Maryland used the indicators in a model referred to as the "golden diamond." This diamond model (see page 68) allows the Department of Health and Mental Hygiene (DHMH) to examine morbidity and mortality rates and trends to determine high priority areas at the state and local levels. These comparative analyses, along with review of state and local information and input by local health officers, are used to help assess where state and local resources should go. Information on local resources and services is used and factored into the final determination of how funds and other resources will be utilized.

Two documents that communicate and clarify what Maryland has accomplished in the development of goals and objectives are *Healthy Maryland,* Volumes I and II. Volume I focuses on benchmarking the health status of Maryland as compared to national measures. Volume II focuses on specific objectives for both the state and local areas and includes details about the local programs in operation.

Consensus Set of Disease Indicators by Comparisons of Rate and Trend, and Priority Ranks for Maryland and the U.S., 1989-1994

Priority
Ranks

1 →

2 →

3 →

4 →

5 →

Worse than

Maryland RATE compared to U.S. RATE for the past 5 years

Same as

Better than

Worse than

Same as

Better than

5-year

TREND in Maryland Compared to 5-year TREND in U.S.

Low Birth Weight
Breast Cancer
Homicide

AIDS
All-Causes Mortality
Lung Cancer
Hepatitis B

Infant Mortality – W
Infant Mortality – NW

Heart Disease
Tuberculosis
Syphilis

Late/No Prenatal Care

Stroke
Measles
Suicide
% Birth to < 18 yr. Old
Motor Vehicle Mort.

A Local Example in Maryland Using the PEARL Framework

The Cecil County Community Health Advisory Committee (Committee) was formed to assess the health status of Cecil County and develop a Community Health Plan for improving health status. Task forces, which drew from beyond the Committee membership, were formed to analyze and plan interventions for each of seven priority health problems. The task forces identified factors important to Cecil County through existing data, quick surveys, focus groups, and background community familiarity. The involvement of other agencies made available much more data and information than the Cecil County Health Department usually had accessible. The task forces also reviewed goals and objectives from Healthy Communities

2000 and chose those appropriate to the priority health problems and local contributing factors. They then modified each for Cecil County. Locally appropriate interventions were developed by the task forces using an evaluation framework known as PEARL (Vilnius and Dandoy): a socio-economic, legality, and political viability tool.

P = **propriety**; is an intervention suitable?

E = **economics**; does it make economic sense to address this problem?

A = **acceptability**; will this community accept an emphasis on this problem and will they accept the proposed intervention?

R = **resources**; are funding and other resources available or potentially available?

L = **legality**; do the current laws allow the intervention to be implemented, and if not, is it worthwhile to expend time, energy, and resources working for legislative or regulatory change?

The results of the task forces were specific plans for each of the seven priority health areas. These plans were combined into an overall summary plan that recognized interventions that would address more than one problem. Priority interventions were grouped by the level of community involvement in the spectrum of prevention: individual knowledge, community education, provider education, meeting treatment needs, building coalitions and networks, and changing organizational practices, policy, and legislation.

Source: Vilnius D., Dandoy S. "A Priority Rating System for Public Health Programs." *Public Health Reports*, 105(5):463-470, 1990.

Criteria for Objectives Development

♦ The result to be achieved should be **important and understandable** to a broad audience and relate to the Healthy People 2010 goals and focus areas.

♦ Objectives should be **prevention oriented** and should address health improvements that can be achieved through population-based and health-service interventions.

♦ Objectives should **drive action** and suggest a set of interim steps that will achieve the proposed targets within the specified timeframe.

♦ Objectives should be **useful and relevant**. States, localities, and the private sector should be able to use them to target efforts in schools, communities, work sites, health practices, and other settings.

♦ Objectives should be **measurable** and include a range of measures–health outcomes, behavioral and health service interventions, and community capacity–directed toward improving health outcomes and quality of life. They should count assets and achievements and look to the positive.

♦ **Continuity and comparability** are important. Whenever possible, objectives should build upon Healthy People 2000 and those goals and performance measures already adopted.

♦ There must be sound **scientific evidence** to support the objectives.

Source: U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. *Developing Objectives for Healthy People 2010*, 1997.

Defining Assets

Defining your assets and capacities will help with the efficiency of your planning efforts. It will assist in setting the criteria for your objectives as well as prevent duplicate efforts. It will also identify strengths that may be used to your advantage and weaknesses that may need addressed.

PRIMARY BUILDING BLOCKS

Individual Assets
Skills, talents, and experience of residents
Individual businesses
Home-based enterprises
Personal income
Gifts of labeled people (handicapped, mentally ill, etc.)

Organizational Assets
Associations of businesses
Citizens associations
Cultural organizations
Communications organizations
Religious organizations

SECONDARY BUILDING BLOCKS

Private and Non-profit Organizations
Higher education institutions
Hospitals
Social services agencies

Public Institutions and Services
Public schools
Police
Libraries
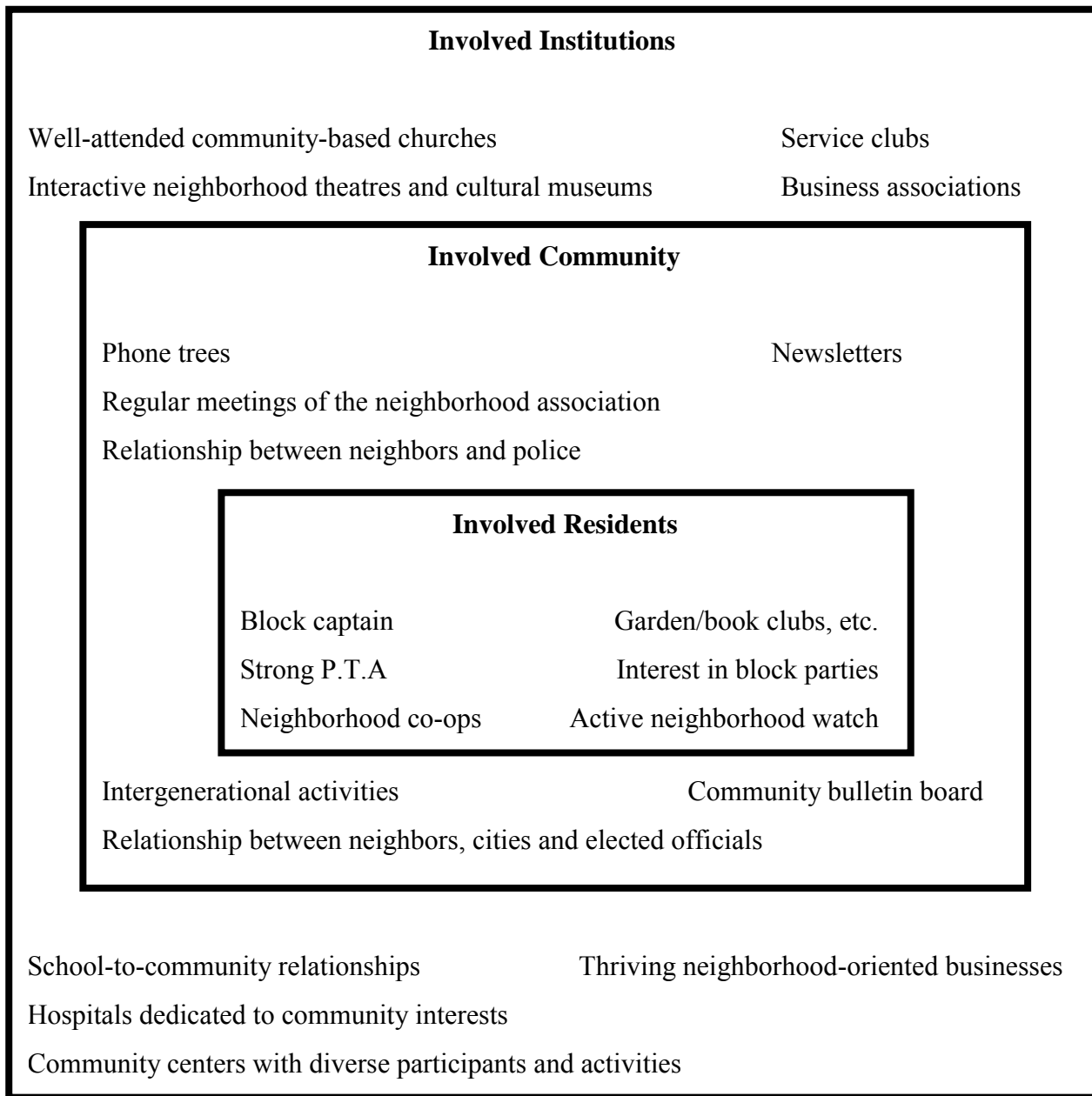Fire departments
Parks

Physical Resources
Vacant land
Commercial and industrial structures
Housing
Energy and waste resources

POTENTIAL BUILDING BLOCKS

Welfare expenditures
Public capital improvement expenditures
Public information

Source: McKnight J.L., Kretzmann J.P. *Mapping Community Capacity*. The Asset-Based Community Development Institute, Institute for Policy Research, Northwestern University, 1996.

Examples of Assets

Involved Institutions

Well-attended community-based churches   Service clubs

Interactive neighborhood theatres and cultural museums   Business associations

Involved Community

Phone trees   Newsletters

Regular meetings of the neighborhood association

Relationship between neighbors and police

Involved Residents

Block captain	Garden/book clubs, etc.
Strong P.T.A	Interest in block parties
Neighborhood co-ops	Active neighborhood watch

Intergenerational activities   Community bulletin board

Relationship between neighbors, cities and elected officials

School-to-community relationships   Thriving neighborhood-oriented businesses

Hospitals dedicated to community interests

Community centers with diverse participants and activities

Source: The Neighborhood Resource Center of Metropolitan Denver. *What Makes a Community Healthy? Principles and Ideas for Building Strong Neighborhoods.* Doug Likhart, Executive Director.

Leading Health Indicators ⚙

A short list of leading health indicators can help focus attention on a small number of key issues, define measures that indicate overall progress toward achieving health objectives, and communicate priorities to communities and leaders.

The indicator sets proposed by the Institute of Medicine Committee on Leading Health Indicators for Healthy People 2010 are:

1. **Health Determinants and Health Outcomes Set** – multifaceted
2. **Life Course Determinants Set** – at every age there are measures of good health and means to achieve it
3. **Prevention Oriented Set** – prevention is the goal

Criteria Guiding Selection of Leading Health Indicators

1. **Worth Measuring -** the indicators represent an important and salient aspect of the public's health

2. **Can be Measured for Diverse Populations -** the indicators are valid and reliable for the general population and diverse population groups

3. **Understood by People Who Need to Act -** people who need to act on their own behalf or that of others should be able to readily comprehend the indicators and what can be done to improve the status of those indicators

4. **Information Will Galvanize Action -** the indicators are of such a nature that action can be taken at the national, state, local and community levels by individuals as well as organized groups and public and private agencies

5. **Actions That Can Lead to Improvement Are Known and Feasible -** there are proven actions (e.g., personal behaviors, implementation of new policies, etc.) that can alter the course of the indicators when widely applied

6. **Measurement Over Time Will Reflect Results of Action -** if action is taken, tangible results will be seen indicating improvements in various aspects of the nation's health

Source: Committee on Leading Health Indicators for Healthy People 2010. *Leading Health Indicators for Healthy People 2010: Final Report.* Division of Health Promotion and Disease Prevention, Institute of Medicine, 1999.

Developing Priority Areas 🔧

SAMPLE GUIDANCE TO WORK GROUPS

Healthy Iowans 2010: A Guide to Chapter Team Discussion

The following information has been prepared as a guide for teams as discussion of each [*Healthy Iowans 2010*] chapter's contents begins. Use this information to guide your teamwork today and at future meetings as consensus is reached regarding the final content for your team's chapter. As work progresses, your team will want to concentrate on several components that are expected from each team for the "finished product" chapter narrative. These components include an introduction followed by goals with a trend line where appropriate, and a rationale and action steps for each goal.

I.   **Dimensions of the Problem – The following questions can be used to open the discussion of the problem:**

- What are the compelling public health reasons for people to be concerned about the problem?

- How can the problem be documented with supporting data?

- What interventions are effective in solving the problem?

- Why is common action important?

- Who needs to be involved in the action?

- What system do we have in place now to prevent the problem and promote health?

- What stages within the health system need to be mobilized? (for example, health promotion, disease prevention, acute treatment, aftercare)

- What health disparity and quality of life issues need to be considered?

- What will happen if the problem is not addressed? What are the societal costs?

II.   **Goals and Action Steps – The goals and action steps are the outline of what needs to be done to address the problem. When making an assessment of the need, consider the following:**

- Prevalence (the number of proportion of cases or events or conditions in a given population; often further distinguished as point prevalence–a single point in time or period prevalence–over a period of time.)

- Frequency (the number of times an event occurs within a stated period of time) Examples: rate of children immunized, facilities to be inspected, food-borne outbreaks, requests for assistance, results of screening)

- Incidence Rate (a measure of the frequency with which an event, such as a new case of illness, occurs in a population over a period of time)

- Seriousness

  - High risk exposure or environmental conditions
  - Urgency
  - Severity of disability/disease
  - Survival rate after exposure
  - Case fatality rate
  - Direct impact on others (likely or not and to what degree)
  - Comparative risk information

- Any other information to demonstrate the importance of the problem

In setting goals and action steps, consider these questions:

- What are the expected outcomes?

- What are the cost and time to accomplish the goals and take action?

- Is there any research demonstrating that interventions are effective?

- Are there baseline data so the goals and action steps can be tracked?

- If there are no data available for tracking, is a developmental goal needed at the outset to establish baseline information? (This goal will be addressed immediately.)

- What agency or group is willing to assume responsibility for achieving the goal or taking action?

- What kinds of communication in social marketing strategies as well as in technology will be needed to reach the goals of take action?

- To insure a broad-based document, identify the targeted populations and the channels for reaching them. Are there populations experiencing disparities in health status?

III.   Writing the Goals and Action Steps for the Chapter

The goal statement. The goal statement includes **the level** to which a health problem should be reduced or maintained within a **specified time period of 10 years.** Set a baseline for each goal so progress can be tracked. (We will follow the federal decision to do age adjustment based on the 1940 census and readjust the baseline to our year 2000 population in 2001.) List the national objective reference. In some cases, Iowa will set goals which are unique to this state with no national equivalent. This should be noted.

The rationale for the goal statement. The rationale provides answers to why the goal needs to be achieved and what needs to happen. What regulatory or policy requirements apply? Who is the target audience and why? What resources will it take to achieve the goal? What are the internal strengths and weaknesses and the external opportunities and threats (SWOT analysis)?

A trend line chart. Where possible, using the baseline and the 2010 goal, develop a trend line.

The action step. The action step explains what will be done to achieve the goal, **who or what agency** will be responsible for taking the action, and when the action will be taken. The action should be taken **within the first five years** of the decade. (This will require a midcourse review in 2005 with new action steps for the next five years of the decade.)

Source: Iowa Department of Public Health and Healthy Iowans. Contact: Louise Lex, 515-281-4348, llex@idph.state.ia.us.

Resources for Setting Health Priorities and Establishing Objectives

✪ **CDC WONDER – The CDC Prevention Guidelines Database.**
http://wonder.cdc.gov/wonder/prevguid/prevguid.shtml

The database is a comprehensive compendium of all of the official guidelines and recommendations published by the Centers for Disease Control and Prevention (CDC) for the prevention of diseases, injuries, and disabilities. This compendium was developed to allow public health practitioners and others to quickly access the full set of CDC's guidelines from a single point, regardless of where they were originally published.

✪ **Maiese D, Fox C.E. "Laying the Foundation for Healthy People 2010."** *Public Health Reports, January 1998.*

This article summarizes activities implemented to gain input from people on Healthy People 2010, with hopes that these efforts would be duplicated by states and communities in their own planning processes. Available at: http://www.health.gov/hpcomments/2010article.htm.

✪ **Committee on Leading Health Indicators for Healthy People 2010.** *Leading Health Indicators for Healthy People 2010: Final Report.* **Division of Health Promotion and Disease Prevention, Institute of Medicine, 1999.**

This report is a compilation of the committee's efforts to establish leading health indicator sets that could "focus on health and social issues as well as evoke response and action from the general public and the traditional audiences for *Healthy People*." Available at: http://books.nap.edu/catalog/9436.html.

✪ **U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. "Developing Objectives for Healthy People 2010." 1997.**

Provides information on the process for developing the Nation's third set of disease prevention and health promotion objectives and includes a 1997 Summary List of Objectives. It describes how to get involved. Also available at:
http://www.health.gov/healthypeople/publications/hppublist.htm

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Please see Appendix A for other resources for setting health priorities and establishing objectives.

HEALTHY PEOPLE 2010 TOOLKIT

Obtaining Baseline Measures, Setting Targets, and Measuring Progress

*"What gets measured, gets done."*

—Unknown

Data are the foundation of any effective objectives-setting or benchmarking initiative. As shown in the previous section, the collection and analysis of both quantitative and qualitative data are critical for setting health priorities. Once a state identifies the priority health areas and potential indicators, a baseline must be set (may require collecting new data) to determine where the state or community currently is on a given problem or indicator and set the stage for determining where it wants to be by the turn of the next decade (target). Setting targets (determining the desired amount of change over a given time interval) is the next critical step. Finally, monitoring progress toward meeting objectives, through collection and analysis of tracking data, should be done on a scheduled basis. Regular reporting and analysis of progress can help state planning groups and leaders refocus resources where they are needed most.

Action Checklist:
Obtaining Baseline Measures, Setting Targets, and Measuring Progress
(See page 113 for a complete planning and development checklist.)
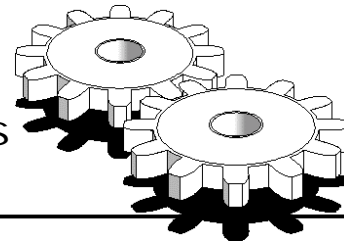
❑ Consult with state experts on census, age-adjustment, ICD-10, and other data changes

❑ Set criteria for evaluating existing public and private data sources

❑ Inventory relevant public and private data sources to measure objectives

❑ Review progress in achieving state Healthy People 2000 objectives

❑ Develop targets with appropriate baselines and measures and finalize objectives

❑ Develop methods for measuring objectives without existing data sources

❑ Gather and evaluate other data and information to include in state plan

❑ Plan regular intervals to measure and track achievement of targets

Tips
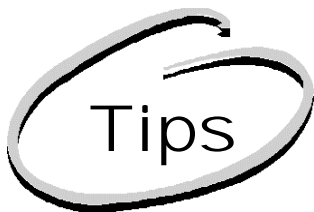
Look out your front door for help with your data needs; there are many able and willing partners

► State center for health statistics

► Health information unit

► Health department statisticians, epidemiologists, and program directors

► Health data analysts at the local, state, and national levels

► Other local and state government agencies

► Academic partners

Address major data issues up front, and be prepared to explain impact of data changes

► Age-adjustment to the year 2000 standard

► Census classification changes (stay tuned)

► New International Classification of Diseases, 10th Edition (ICD-10)

► Need for and creation of new data sources

► Standards for the quality of information sources

► Analysis of trends

► Year 2000 computer problems

► Measurement of incidence/prevalence of health problem

Use a variety of sources for baseline measures

► Healthy People 2010 draft

► National, state, and local surveys, surveillance systems, and registries

► Private community partners with their own databases (e.g., hospitals)

Set challenging, yet realistic, targets for your objectives

► Identify lessons learned from the year 2000 targets (e.g., how many were too ambitious or not ambitious enough, how many had to be reset and why)

► Use previously identified statewide performance measurements

► Use existing state agency or program-specific benchmarks

► Set targets to eliminate population health status disparities

► Use applicable national Healthy People 2010 targets

► Use other statistical methods (see page 93)

Plan your approach to track the progress of your objectives

► Maintain consistency of terms and data definitions

► Produce progress reports focusing on: racial and ethnic populations, geographic areas, stages of life, and/or priority issues

► Incorporate objectives in regular reports (e.g., HMO report cards)

► Plan an annual Healthy People 2010 update

► Coordinate press releases with other reports and updates

Process in Action: Examples from the Field

Below are examples of how the nation and states addressed data issues.

From the National Initiative

Obtaining Baseline Measures and Identifying Data Needs

Monitoring data

In 1991, the Health Promotion Statistics Division was established at CDC/National Center for Health Statistics (NCHS) to monitor Healthy People 2000. Staff in this unit coordinate with the HHS lead agencies in collecting and reporting on the national Healthy People objectives. This division produces the *Healthy People 2000 Review*, available at: http://www.cdc.gov/nchswww/products/pubs/pubd/hp2k/hp2k.htm.

Developing new data

Healthy People 2000 spearheaded the development of new data throughout the past decade. In 1991, nearly one-third of the national objectives had no baselines when they were initially set. By 1998, 82 of these 91 objectives had measures. These include areas such as school health, health provider activities, and work-site health.

Selecting indicators, setting targets, and tracking progress

Promoting continuity between plans

The initial draft of Healthy People 2010 disseminated for public comment continued many of the objectives from Healthy People 2000. In fact, 138 objectives were maintained from Healthy People 2000, while 96 objectives were revised and 297 new objectives were introduced. The continuity between the plans helps to confirm trends and promotes long-term analysis of the same subjects.

Setting targets that are challenging, but necessary

The Healthy People 2010 draft proposed a goal of eliminating health disparities resulting in one target for all population groups to achieve. In fact, for behaviors, risk factors, and services objectives, the target is better than the best population group. For most outcomes, national averages were used with explicit recognition that all groups should improve.

Healthy People 2000 Newsletters: **Statistical Notes** *and* **Statistics and Surveillance**

Two NCHS newsletters address technical issues related to assessing progress toward the year 2000 objectives. Visit: http://www.cdc.gov/nchswww/products/pubs/pubd/hp2k/hp2k.htm.

From State Initiatives

Obtaining Baseline Measures and Identifying Data Needs

Assessing data and data needs in order to set objectives

The **Connecticut** Department of Public Health responded to the year 2000 national initiative with a coordinated, internal data-oriented review of *Healthy People 2000* and development of state objectives. In 1992, the Department of Public Health produced *Healthy Connecticut 2000 Baseline Assessment Report*, as a framework for program planning, evaluation, policy development, and assurance activities. The report originally contained 112 objectives in 18 priority areas that focused on health status and risk reduction. The Department of Public Health updated the *Baseline Assessment Report* in 1997 with 42 service and protection objectives. The objectives set targets for the services needed to address the health status and risk reduction objectives.
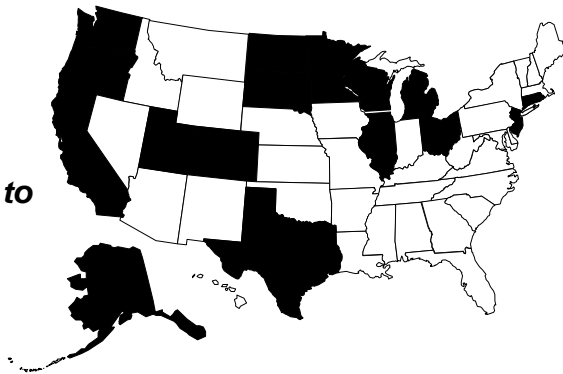
In the **District of Columbia**, the State Center for Health Statistics was given the task of working with Program Administrators and staff to produce a comprehensive review of progress from 1993 to 1998 toward meeting Healthy Residents Year 2000 Objectives. In January of 1999, the Progress Review was completed and released. Following the evaluation and documentation of progress, program administrators and staff working with their Advisory Board members, community-based contacts, and collaborating federal agencies developed the draft year 2010 objectives for both internal review and public comment.

In **Ohio**, as a part of Ohio's Public Health Plan, the Data System Work Group assisted the Healthy People Ohio (HP Ohio) Work Group by preparing a Data Inventory. The inventory specifies the data source and whether data are available for each HP Ohio objective. The Data System Work Group also identified baseline data for some of the HP Ohio objectives, and made recommendations for data collection for objectives with no data source. The HP Ohio objectives are included in the Ohio Department of Health's data warehouse.

The **Great Lakes Inter-Tribal Council of Wisconsin** and the **Inter-Tribal Council of Michigan** serve Tribes in both states through a Cooperative Agreement Epidemiology Project (The EpiCenter). The EpiCenter developed Tribal-specific community health profiles based on health indicators by making use of Indian Health Service's Base Line Measures, a needs assessment, and Healthy People 2000. Data in the community health profiles serve as baseline measures and descriptions of changing health status for the Tribes in the project service area.

In **South Dakota**, data activities begin at the program level with programs following the grant proposal/reporting process for developing baseline measures, setting targets, and determining methods for progress measurement. Many grants, such as the Maternal and Child Health Block Grant, use Healthy People performance measures, grant-specific performance measures, and state-specific performance measures.

In 1995 **Minnesota** developed objectives to improve its data systems' ability to measure progress toward the year 2000 objectives. Among these objectives, Minnesota sought to collect and disseminate data from state agencies, local agencies, health plan companies, and other health care providers. The state planned to identify significant gaps in disease prevention and health promotion data, as well as establish methods to collect and analyze health status indicators.

Identifying and communicating data sources and data needs specific to the measurement of each objective in the plan

Healthy New Jersey 2000 details state data needs for each goal and corresponding objectives. New Jersey expanded its list of relevant data needs beyond health status objectives. As examples, the plan calls for better patient socioeconomic and clinical outcome data, standardized definitions of certain conditions, evaluation data on prevention interventions, and economic impact data.

In **Texas**, through a grant from the CDC, the department received staff assistance to develop a series of on-going reports tracking state progress according to the 18 Health Status Indicators recommended by CDC in conjunction with the Healthy People 2000 initiative. The preparation of this series of reports was institutionalized within the department and is continued as an important component of its ongoing assessment of the state's health status.

The **Illinois** Project for Local Assessment of Needs (IPLAN) was developed to assist local health departments to complete community health needs assessments. The system utilizes Healthy People 2000 and Healthy People 2010 objectives as reference points, where applicable, and provides over 100 state- and county-level population-based health indicators. For some indicators, community-level data are available. Originally designed as a stand-alone PC-based data system, the current IPLAN system is available through the Internet and can be viewed at: http://app.idph.state.il.us/index.htm.

Selecting indicators, setting targets, and tracking progress

Selecting indicators based upon previously identified performance measures or benchmarks

The **Colorado** Statewide Outcomes/Indicators Task Force established a defined set of measures to rate the performance of the Colorado Department of Public Health and Environment (CDPHE). Performance was measured in terms of outcomes (e.g., heart

disease death rates), rather than processes (e.g., number of adults who have had their blood pressure checked). Task Force members represented public health agencies, managed care organizations, academia, and philanthropic organizations. Population-based objectives were developed to reflect the Healthy People 2000 national plan and the CDPHE budget requests.

Rhode Island's Minority Health Information Improvement Project aimed to strengthen the state's ability to assess and respond to the health needs of its diverse population. The project developed methods to use existing data sources to measure progress toward year 2000 objectives for racial and ethnic minority populations. Through a collaboration between the Rhode Island Health Department and the Minority Health Advisory Committee, the project published a minority health status sourcebook that established baselines and identified data gaps for minority populations.

To provide continuity with earlier statewide health improvement plans, **Washington** based its primary health indicators on existing "performance measures" in six public health areas. Each indicator has a primary measure (e.g., the mortality rate) followed by other measures of impact and burden (e.g., hospitalization, years of potential life lost). To assist a wide range of audiences engaged in local planning and implementation, Washington compiled for each health area existing data on population risk factors, protective factors, and intervention effectiveness from research and practice.

The **Oregon** Legislature directed all state agencies to develop performance measures with ties to the state's indicators of well being, called Oregon Benchmarks. From 1992 through 1997, Oregon used funding from a CDC grant (Assessment Initiative) to compile valid existing data and measure their benchmarks. These results were submitted to the legislature in an annual progress report.

Tracking and communicating progress toward objectives

For its 1996 and 1999 updates to the state's year 2000 objectives, **New Jersey's** statistical and program staff assessed progress and analyzed trends. Based on their trend analysis, staff categorized each objective and sub-objective as "likely to be achieved," "unlikely to be achieved," or "uncertain."

Washington analyzed data from local, county, state, and national sources in its 1996 statewide assessment of health status, health risks, and health systems. The state used a standard format to present data on its progress in each priority area, including analyses of time trends, geographical variation (including numerous objectives tracked at the county level), variation by age, gender, race, ethnicity, income, and education (where available).

California created individual county health status profile tables, containing 26 Healthy People health status indicators. Data for the profiles are provided by the state Center for Health Statistics, the Division of Communicable Disease Control, and the Office of

AIDS of the Department of Health Services. The Demographic Research Unit and the Census Data Center of the Department of Finance provided the 1990 census data and the 1996 race/ethnic population estimates, by county, with age and sex detail.

In addition, as part of its strategy for addressing data needs, **California** has the Health Information and Strategic Planning Division (HISP) of the California Department of Health Services (DHS). This division takes the lead in making the DHS health data systems more integrated, accessible, and useful for policy development and program management. It also develops uniform health data systems to promote the collection of information on health status outcomes, provides technical assistance and support to local health agencies, organizes strategic planning and special initiatives in support of DHS priorities, and builds strong relationships with public health organizations and schools of public health.

In 1992 the **Michigan** Department of Community Health (MDCH) established a strategic planning process, which linked state-level health assessment to the identification of priorities, goals, objectives, and strategies to improve health. *Healthy Michigan 2000*, issued in 1993, provided a guide for improving health by the year 2000. The foundation of the plan was an assessment of not only health status and health system trends, but also the economic, demographic, public perception, and management trends likely to influence the public's health. In 1996 *Healthy Michigan 2000, Second Edition*, re-affirmed the goals documented in the first edition and streamlined the objectives to reflect the areas most in need of significant emphasis or change in order to reach the goals.

Between 1992 and 1996, MDCH created an agency-wide Surveillance and Data Strategic Work Group to promote greater use of surveillance data in policy and program decision-making and to determine the data needed to monitor progress toward reaching Healthy Michigan 2000 objectives. The work group drafted a "Health Surveillance Plan" to enhance the capacity for the collection, analysis, interpretation and dissemination of information on health status, health risks, and health systems. The "Health Surveillance Plan" established variables for monitoring objectives contained in Healthy Michigan 2000, identified gaps in data and potential problems, and suggested possibility for new and enhanced data sources. The plan also recommended a set of critical health indicators as a means of communicating the overall health of the state's population. Based on the "Health Surveillance Plan," the state initiated annual reporting on selected critical health indicators in 1996. *Michigan Critical Health Indicators* are linked to both key *Healthy Michigan 2000* objectives and related interventions.

In **Utah** the governor's Office of Planning and Budget coordinates data collection and monitoring of performance measures for all state agencies, as specified in the *Utah Tomorrow* strategic plan. The governor's office maintains performance measurement data in their information base. In 1995, with funding from the CDC, the Utah
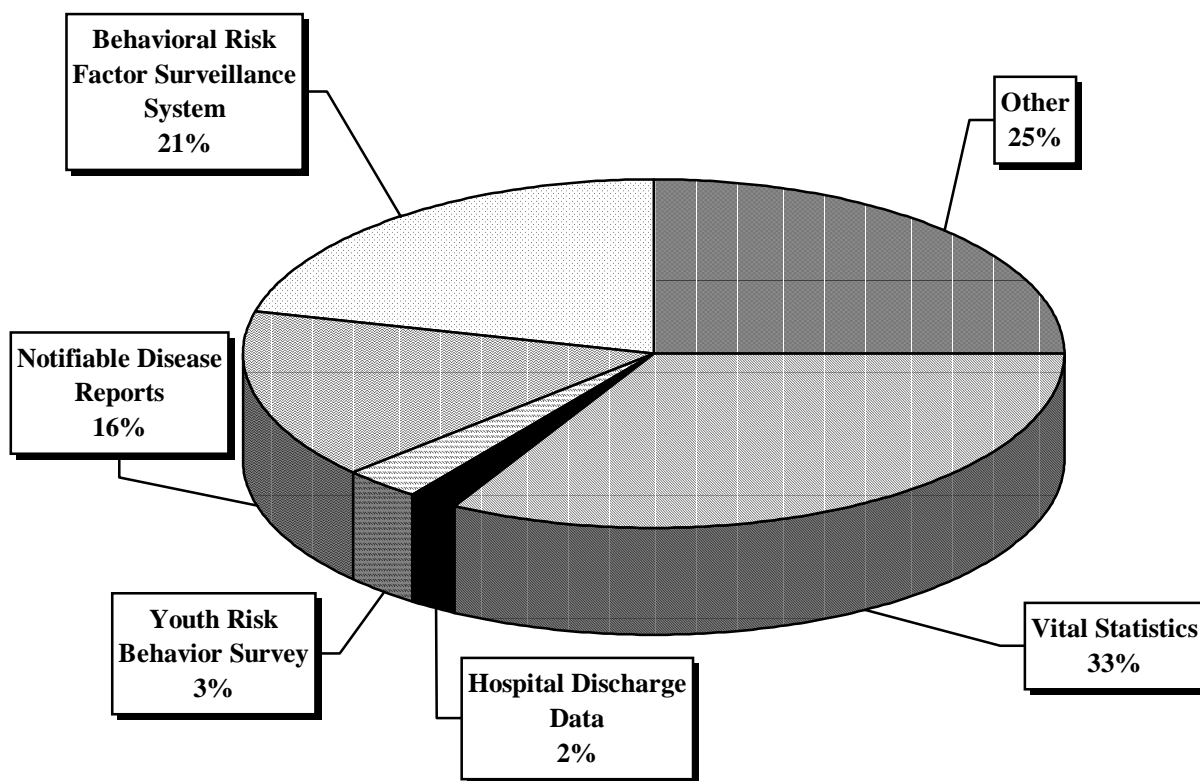
Department of Health, Office of Public Health Data published data to track the 18 Healthy People 2000 health status indicators by local health department district.

On July 1, 1993, the **North Dakota** Department of Health began to assess the state's progress toward meeting the year 2000 objectives. A point-in-time study was conducted from July 1, 1993, through March 11, 1994. The report was published in June 1994 and helped the state health department and local communities to identify high priority needs. Some of the findings included: 22 percent of the Healthy People 2000 objectives had been met, 23 percent were unmet, 5 percent were moving away from the HP 2000 target, and 49 percent had no data available.

Alaska completed two *Healthy Alaskans 2000* data reports. One report was released in March 1997 which updated the health status objectives for *Healthy People 2000* objective 22.1. The second report was released in December 1998 which was a complete update on all *Healthy Alaskans 20*00 objectives. The December 1998 report also emphasizes that data collection is the first step in public health planning and an interim step in developing a comprehensive review of *Healthy Alaskans 2000.*

**Percentage of State Year 2000 Objectives/Sub-Objectives Tracked Using States' Identified "Top Five" Data Sources**

Total Objectives/Sub-Objectives Using "Top Five" Sources = 3,130
(N=36)

Behavioral Risk Factor Surveillance System 21%

Other 25%

Notifiable Disease Reports 16%

Youth Risk Behavior Survey 3%

Hospital Discharge Data 2%

Vital Statistics 33%

Note: Each state was asked to identify its "top five" data sources used for tracking objectives and to identify the number of objectives/sub-objectives tracked by those five data sources. Data sources not appearing in a state's "top five" list were captured in the "other" category.
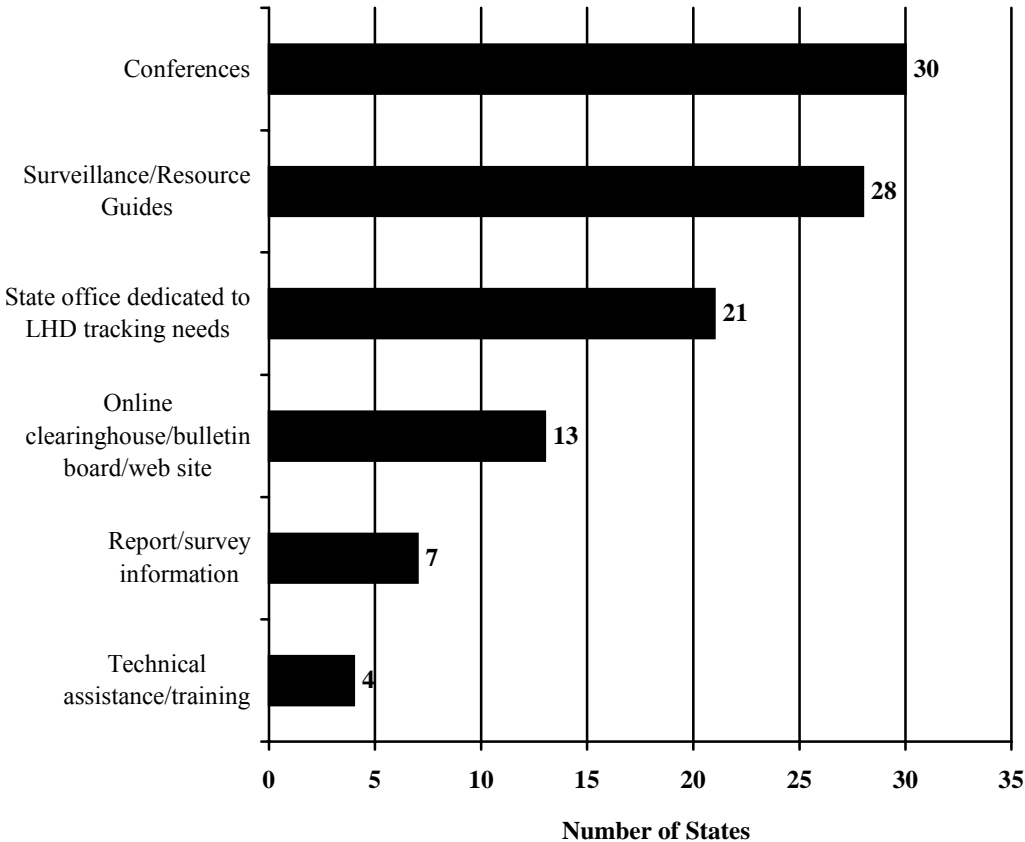
Source: Public Health Foundation. *Measuring Health Objectives and Indicators: 1997 State and Local Capacity Survey.* March 1998.

Extent that Availability of Baseline Data Influenced the Selection of States' Year 2000 Objectives/Sub-Objectives
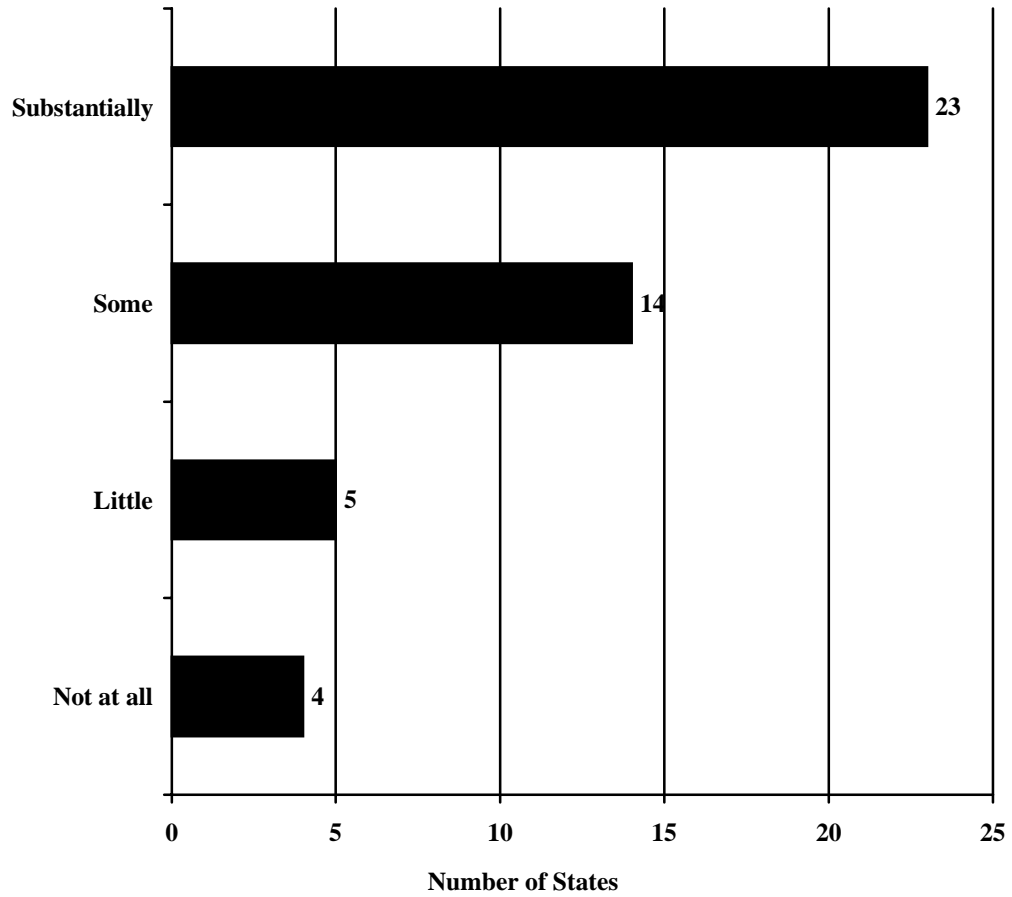
Category	Value
Substantially	23
Some	14
Little	5
Not at all	4

Number of States

Source: Public Health Foundation. *Measuring Health Objectives and Indicators: 1997 State and Local Capacity Survey.* March 1998.

Number of States that Provided Assistance to Local Health Departments for Year 2000 Initiatives, by Type of Assistance

Type of Assistance	Number of States
Conferences	30
Surveillance/Resource Guides	28
State office dedicated to LHD tracking needs	21
Online clearinghouse/bulletin board/web site	13
Report/survey information	7
Technical assistance/training	4

Number of States

Note: States may have been counted more than once because some provided more than one type of assistance.

Source: Public Health Foundation. *Measuring Health Objectives and Indicators: 1997 State and Local Capacity Survey.* March 1998.

Potential Health Measures

The following is intended to assist you in identifying different types of measures for your state's health plan. It is not meant to be an exhaustive list, but provides types of measures many communities have found beneficial in developing and monitoring health objectives.

COMMUNITY MANAGEMENT
Interagency networks
Open city council meetings
Planning - economic development, social
    planning council
Policy environment
Readiness - fire escape plans, CPR training,
    retirement preparation
Representation in community groups
Responsiveness - emergencies
Volunteerism level
Voter turnout

DEMOGRAPHICS
Age distribution
Education levels
Median income
Occupations
Population stability
Poverty levels
Unemployment rates

GROWTH AND NUTRITION
Breastfeeding prevalence
Developmentally delayed children
Fruit and vegetable consumption
Disability prevalence
Enrollment in entitlement programs
Elders who participate in fitness programs
Life expectancy
Self-reported health status
Women, Infants and Children (WIC)

HEALTH BEHAVIORS
Exercise levels
Overweight prevalence
Tobacco use
Alcohol use/abuse prevalence
Substance abuse treatment need

HEALTH CARE RESOURCES
Insurance status
Medicaid/Medicare providers
Managed care penetration

HEALTH CARE UTILIZATION
Hospital use rate
Preventable hospitalizations rate

HEALTH OF EMPLOYEES
Sick days used
Workmen's compensation claims
Worksite injuries and deaths

HEALTH OF MOTHERS AND CHILDREN
Contraceptive services and need
Low birth weight babies percent
Prematurity prevalence
Prenatal care percent
Teen parenting prevalence

MORBIDITY
Dental caries among children
Communicable diseases rates
Vaccine preventable disease/deaths
Mental illness prevalence

MORTALITY

Infant mortality - neonatal, post-neonatal
Major killers - CHD, cancer, stroke, homicide,
    suicide, motor vehicle injuries,
    unintentional injuries, diabetes,
    COPD, AIDS
Overall and age-level

PHYSICAL ENVIRONMENT

Environmental conditions - air, water,
    recreational water site quality
Environmental hazards
Epidemics
Household smoke detectors
Households on water and sewage treatment
    systems, septic systems
Household fuel efficiency
Household recycling
Industrial waste recycling
Lead paint housing vulnerability, soil
Natural disasters
Nuisance index - noise, dirt, odors

PREVENTIVE MEASURES

Blood pressure checks
Childhood immunization rates
Cholesterol checks
Colon cancer screening prevalence
Diabetic eye and foot exams
Flu vaccine use among the elderly
Mammography screening prevalence
Pap test prevalence

SOCIAL SUPPORT MEASURES

Bike path mileage
Recreation center use
Child abuse investigations
Domestic violence services
Family and friend support networks
Religious center use
Law enforcement
Neighborhood Watch Programs
Self help group participation
Suicide prevention services
Transportation services

Source: Empowerment Zone/Enterprise Community Health Benchmarking Project. Public Health Foundation, 1998-1999.

Setting Targets for Objectives

One of the central issues many states struggle with when developing objectives is how to set achievable, realistic targets for outcome, performance, and process objectives. The guidance below focuses primarily on setting targets for health outcomes and performance.

➢ *Using an absolute percent decline*

Some Healthy People 2000 objectives used an **absolute percent decline** based on "best guesses"/expert opinion. Calculations can be made based on the percent of the target population reached and change expected. For example, a decline in mortality of 30 percent expected in two-thirds of the women with breast cancer.

[Start Amount x (1-.30) x 2/3] + [Start Amount x 1/3] = End Amount

Example: Breast cancer rate of 33/100,000

[33 x (1 - .30) x 2/3] + [33 x 1/3] = 15.4 + 11 = 26.4/100,000

➢ *Using peer communities*

You can set targets by comparing your community to others like it. Age and poverty distribution and population size and diversity may define peer communities. The following may be used to describe one's peers: typical values for a specific objective, means or medians, or the variation among peers. Visit the Public Health Foundation web site for more information on the Community Health Status Indicators Project, which is utilizing this strategy: http://www.phf.org/data-infra.htm#Community.

➢ *Using the pared-mean method to set data driven benchmarks*

The pared-mean method determines "top performance." This is defined as the best outcome accomplished for at least 10 percent of the population.

Steps to Compute the Pared-Mean (The article cited below uses an example of mammography screenings)

1. Rank order providers or other units of analysis (e.g., health departments, jurisdictions) in descending order of adherence. In this example, metropolitan statistical areas were ranked according to average mammography rates.

2. Order providers in descending sequence until you have a subset that equals or exceeds 10 percent of all patients in the survey. In this example it was 10 percent of women over the age of 50 in the survey.

3. Calculate the benchmark based on the subset of units analyzed, dividing the total number of patients in the subset receiving the recommended intervention (e.g., mammography screenings by the population).

In the example of the mammography screenings, a benchmark rate of 71 percent was found, exceeding the Healthy People 2000 target of 60 percent.

Data sources to use for the pared-mean method include vital statistics and the Behavioral Risk Factor Surveillance System.

This method is not feasible for all Healthy People objectives. Data may not be available for some objectives, or the nature of the objective may not lend itself to using the pared-mean method. For example, access to preventive care should be available for 100 percent of the population, regardless of what the data show.

Source: Allison J., Kiefe C.I., Weissman N.W. "Can Data-Driven Benchmarks be Used to Set the Goals of Healthy People 2010?" *American Journal of Public Health,* 89(1):61-5, 1999.

➢ *What if areas in the state have already achieved or surpassed the national Healthy People target for an objective?*

You can calculate a new, higher state target that will be challenging for local areas that have achieved or surpassed the national target. You also may wish to note in your plan the jurisdictions that have not achieved your previous targets and redouble your efforts in these areas as well as set equally ambitious targets for year 2010.

➢ *Setting targets for process objectives*

Many process objectives, particularly those that pertain to infrastructure (data systems, workforce, and research), are new this year in Healthy People 2010. These should be examined carefully by states to determine their applicability to the state plan. Setting measurable targets for process objectives requires judgment and is not an exact science. To set process targets, planners should consider the current status (baseline) of the state's public health infrastructure, seek stakeholder input on the desired level of improvement, and make a realistic assessment of what can be accomplished given the state's experience, resources, political opportunities, and partner commitment.

➢ *Using performance measures*

"**Performance measurement** responds to the need to ensure efficient and effective use of resources, particularly financial resources. It links the use of resources with health improvements and the accountability of individual partners." (*Prevention Report,* Winter 1997) This is of particular importance since the inception of the Government Performance and Results Act of 1993, which aims at holding Federal agencies accountable for spending public dollars. This extends to states, local jurisdictions, and other organizations that receive Federal funding. Performance measures can be incorporated into or based upon Healthy People objectives. Please see the following pages for a detailed description of setting performance measures.

Setting Performance Measures Step by Step

These examples are based on the State of Maryland's Healthy Maryland 2000 *document*

STEP	EXAMPLE
1. Relate the performance measure to an important national, state, or local health priority area.	Maryland has undertaken work related to the national health objective to reduce coronary heart disease deaths to no more than 100 per 100,000 people.
2. Measure a result that can be achieved in 5 years or less.	Maryland has identified an achievable result that is linked scientifically to the Healthy People 2000 Heart Disease and Stroke priority area: Increase the proportion of people who engage in light to moderate physical activity to at least 30 percent of the population.
3. Ensure that the result is meaningful to a wide audience of partners.	Target partners are essentially all Marylanders, with an emphasis on school-age children and people at high risk for diseases and medical conditions associated with physical inactivity (for example, persons with hypertension and high cholesterol). Partners include principals, teachers, students, parent-teacher associations, the state education department, state and local health and recreational agencies, public health and medical professionals, and others.
4. Define the strategy that will be used to reach a result.	The state of Maryland has selected four strategies: 1. Implement a combination of strategies that include consumer education and skills development, health assessment, professional training, and environmental changes. 2. Reinforce risk reduction messages and promote programs and policies in schools, work-sites, faith communities, and other settings. 3. Focus on youth and families so that healthy habits are started early and nurtured in the family. 4. Use a health promotion approach tailored to reach diverse ethnic and socioeconomic groups.

| --- | --- |
| **5. Define the accountable entities.** | The accountable entities depend upon the strategies selected and the way in which a particular community is organized. For Maryland's strategy 2, these entities include schools, work sites, and community centers. For example, the Cecil County Public Schools have agreed to be accountable for specific tasks related to strategy 2 and are working in partnership with the Cecil County Health Department to offer healthy lifestyle programs to elementary school children. The programs, such as the **Heart Challenge Course**, bring teachers and food service workers together to promote healthy eating habits and physical fitness through educational games, classroom projects, and other activities that appeal to children. |
| **6. Draft measures that meet statistical requirements of validity and reliability and have an existing source of data.** | In consultation with biostatisticians and epidemiologists, organizations can draft measures that are statistically sound. One of Maryland's performance measures might be "Increase to 30 percent the proportion of students in each Cecil County elementary school who engage in light to moderate physical activity for 30 minutes or longer every school day by participating in school physical fitness activities." |

Source: U.S. Department of Health and Human Services. **"**Improving the Nation's Health with Performance Measurement." *Prevention Report,* 12(1):1-5, 1997.
http://odphp.osophs.dhhs.gov/pubs/prevrpt/97winfoc.HTM.

Measuring Progress

Annual Percent Change

This measure can be used to track whether progress is on course and determine if the 2010 objectives will be reached. It provides the amount of decline each year that is needed to reach the target.

Formula:

$$\left\{ \left(\text{Target rate} \div \text{Baseline rate} \right)^{[1/ (\text{Target year-Baseline year})]} - 1 \right\} \times 100 = \text{Annual Percent Change}$$

Example Data Showing
Percentage Change Needed to
Reach Healthy People Goal

	Year	Rate
Target	2010	7/1,000
Baseline	2000	10/1,000

Calculations:

$$\left(\text{Target rate} \div \text{Baseline rate} \right) = 7/1{,}000 \div 10/1{,}000 = 0.700$$

$$^{[1/ (\text{Target year-Baseline year})]} = 1/ (2010\text{-}2000) = 1/10 = 0.100$$

$$\left(\text{Target rate} \div \text{Baseline rate} \right)^{[1/ (\text{Target year-Baseline year})]} = 0.70^{\,0.10} = 0.965$$

$$\left\{ \left(\text{Target rate} \div \text{Baseline rate} \right)^{[1/ (\text{Target year-Baseline year})]} - 1 \right\} = 0.965 - 1 = -0.035$$

$$\left\{ \left(\text{Target rate} \div \text{Baseline rate} \right)^{[1/ (\text{Target year-Baseline year})]} - 1 \right\} \times 100 = 0.035 \times 100 = -3.5\%$$

A decline of 3.5% per year between year 2000 and 2010 is needed to reach the target.

Measuring Progress

This equation is used in measuring progress for each objective, adapted from *Healthy People 2000 Midcourse Review and 1995 Revisions*:

$$\frac{(\text{Current Status} - \text{Baseline})}{(\text{Year 2000 Target} - \text{Baseline})} \times 100 = \text{Percentage of Target Achieved}$$

Note: You will get a negative percentage when the baseline has gotten worse.

Evaluating Data:
Data Issues and Uses

What are some general data issues that you may want to address?

✔ **Data Quality** – When using new data collection systems, be sure to check for standardization of data collection and recording, data management and analysis, and structure and content of questions.

✔ **Limitations of Self-Reported Data** – When relying on self-reported data such as income level, exercise frequency, or health screening behaviors, be aware of self-reporting bias. Measures will vary based on the type of data collection alone (written survey, telephone interview, direct observation, etc.).

✔ **Data Validity and Reliability** – Revision of survey questions and the development of new data collection systems will require careful validity and reliability testing. In monitoring efforts, the validity of responses over time may also become an issue.

✔ **Periodicity of Data Availability** – Data collection efforts are not always performed on a regular basis. Take this into consideration when planning your dissemination and communication efforts.

✔ **Timeliness of Data Availability** – As previously stated, this is not always possible, but still important. It helps to be able to regularly identify progress and areas that may need additional efforts.

✔ **Representativeness of Data** – Special considerations need to be made when collecting data for specific population groups or local communities. Do responses collected represent those individuals of interest?

✔ **Small-Area Analysis** – Take into account the limitations of applying national data to the state, local and community levels. This pertains to using small numbers in one's statistics. Poisson distribution, non-parametric statistics, and standardized mortality rates/ratios (SMRs) may be appropriate methodologies.

Evaluate your existing data collection methods using these guidelines:

✔ Simplicity   ✔ Predictive value positive   ✔ Representativeness
✔ Sensitivity   ✔ Flexibility   ✔ Acceptability
✔ Timeliness

Source: Klaucke D.N., Buehler J.W., Thacker S.B., Parrish R.G., Trowbridge F.L., Berkelman R.L., and the Surveillance Coordination Group. "Guidelines for Evaluating Surveillance Systems." *Morbidity and Mortality Weekly Report.* 37(S-5):1-18, 1988.

Characteristics of High-Quality and Effective Data for Policy Making

Technical Characteristics	
Content	Cover one or more major health policy or program concerns with sufficient detail to clarify the implications of alternative policy choices.
Currency (Timeliness)	Appear on a sufficiently timely basis and with the appropriate frequencies that they provide a relatively current profile and can be credibly used.
Completeness	Achieve sufficiently high submissions, reporting, or response rates and item completion, to limit biases leading to distorted conclusions.
Reliability	Provide classification and coding consistency to enhance interpretability and reduce confusion.
Analytical Flexibility	Support both routine and special analyses, particularly on an interactive or real-time basis.
Strategic Characteristics	
Cross-System Flexibility	Allow users to merge, compare, or jointly use data from complementary systems; include compatible and consistent variable definitions, coding categories, and a linkage mechanism.
Adaptability	Allow data content and/or reporting to be readily modified to address changing needs.
Accessibility	Provide clear reports to a non-technical audience; make available diverse reports or information tailored to different decision needs or users, and provide access to public-use data sets at a reasonable cost so they can be independently analyzed.
Translation and Policy Applicability	Effectively translate technical data to policy-relevant information.
Dissemination	Accurately and fully inform potential users or decision-makers about the resources and how to access it effectively.

Source: Feldman P., Gold M., Chu K. "Enhancing Information for State Health Policy." *Health Affairs,* 13(3):238, 1994.

Explaining Data Changes 🔧

Age-Adjusting to Year 2000:
State and Local Age-Adjusted Rates Will Increase

Explanation of Age-Adjustment: *Age-standardization* is a practice of adjusting for differing age composition of populations. Age-standardization is useful when comparing disease outcomes across time, place, or populations. Prior to 1998, the conventional standard population used for adjustment was the U.S.1940 population. As of 1998, the National Center for Health Statistics (NCHS) will use and has recommended that others use the year 2000 standard. [The year 2000 standard resembles the current population structure and for many geographic areas is close to the crude (unadjusted) disease rate.] *Healthy People 2010* uses the year 2000 adjusted rate for baselines and target rates.

Impact of Changes: For most disease categories, especially where disease rates increase with increasing age, year 2000 adjusted rates will increase substantially. Diseases that occur among young people, such as homicide, will decline while others which affect the age extremes will stay the same using the new age standard. Users of the year 2000 standardized rates will not be able to readily compare them to prior years' statistics that were calculated using the 1940 standard.

Resources: The year 2000 population standard and a brief explanation of the age-adjustment issues are found at http://www.cdc.gov/nchs/data/nvsr47_3.pdf and in the NCHS publication, NVSS (Vol 47, number 3, 10/7/98). The web site also provides examples of how this change affects the size of rates, relative to rates adjusted to the former 1940 standard.

Changing from ICD-9 to ICD-10:
Comparability of Data Will Be Impacted

Explanation of Disease Classification: International Classification of Diseases (ICD) codes are used for vital statistics, hospital discharge, and a variety of other health services data sets (including data sets used to measure Healthy People objectives). The World Health Organization maintains and revises disease codes used widely in the health care field. Revisions are necessary when new diseases are identified and old diseases redefined.

Impact of Changes: A new 10th edition (ICD-10) has been released and will produce non-comparability between some statistics aggregated based on ICD-9 and the new ICD-10. Users are cautioned that some differences in disease statistics calculated using one version and then the other may reflect merely the change in rubrics. As causes of mortality, Alzheimer's Disease is expected to increase and pneumonia decrease as a result of the change in coding.

Resources: For more information about the ICD, revisions, training resources, and publications, visit the following site: http://www.who.int/whosis/icd10/. See also the National Center for Health Statistics: http://www.cdc.gov/nchs/data/20manual.pdf.

Race and Ethnicity for Year 2000 Census:
Individuals Can Select More than One Race

Explanation of Race and Ethnicity Data Standards: The Office of Management and Budget (OMB) issues standards for data collection, including race and ethnicity data. These standards have been developed to provide a common language for the collection and use of data on race and ethnicity by federal agencies. To be consistent with national race and ethnicity data, many researchers, businesses, and other units of government may also use the standards.

Impact of Changes: The year 2000 U.S. Census will use new Office of Management and Budget (OMB) categories for capturing the self-report of race by Americans. In addition to being able to choose among five race categories and Hispanic ethnicity, persons who report being of more than one racial group may specify their racial heritage and be counted in a "more than one race" category. Interpretation of race distribution will be complicated by the fact that persons reporting any one race can be included in the "more than one race" category. For example, persons who report white and Asian background will be counted in each category or in a broad group called "multiracial."

Resources: A discussion of the change and concepts of race and ethnicity are found at the American Anthropological Association site: http://www.aaanet.org/gvt/ombdraft.htm and the Association of MultiEthnic Americans, Inc. site http://ameasite.org/classification/omb15v97.asp. "Provisional Guidance on the Implementation of the 1997 Standards for the Collection of Federal Data on Race and Ethnicity (12/15/00)" may be found at http://www.whitehouse.gov/omb/inforeg/r&e_guidance2000update.pdf.

Existing Data Systems

Data are the foundation of Healthy People objectives. While the national Healthy People initiative has stimulated the development of new data systems, there are still areas where information is missing. These areas constitute the developmental objectives, where efforts are being made over the next decade to measure these indicators. In the meantime, how do you manage the data presently available? There are approximately 200 data sources used to track the national Healthy People objectives.

Health and Human Services Data Systems and Sets
Most Critical to Monitoring *Healthy People*

✓ Vital Statistics*

✓ National Health and Nutrition Examination Survey***

✓ National Health Interview Survey***

✓ Youth Risk Behavior Survey***

✓ National Survey of Worksite Health Promotion Activities

✓ National Survey of Family Growth

✓ Behavioral Risk Factor Surveillance System**

✓ National Household Survey on Drug Abuse***

✓ National Hospital Discharge Survey***

✓ National Notifiable Disease Surveillance System*

✓ Census Data*

KEY:

*   Measures are available at state and local levels

**   Provides state and possibly local measures

***   May provide state or local measures

Source: Leading Indicators for Healthy People 2010. A Report from the HHS Working Group on Sentinel Objectives. U.S. Department of Health and Human Services, March 1998. http://odphp.osophs.dhhs.gov/pubs/LeadingIndicators/ldgindtoc.html

Resources for Obtaining Baseline Measures, Setting Targets, and Measuring Progress

✪ **Committee on Leading Health Indicators for Healthy People 2010.** *Leading Health Indicators for Healthy People 2010: Final Report.* **Division of Health Promotion and Disease Prevention, Institute of Medicine, 1999.**

This report includes the criteria for selection of leading health indicators, as well as proposed indicator sets for Healthy People 2010. Available at: http://books.nap.edu/catalog/9436.html.

✪ **ICD-10 – The following sights provide information on the ICD-10.**

http://www.healthmkt.com

http://www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm

✪ **National Association of Health Data Organizations. http://www.nahdo.org**

The National Association of Health Data Organizations (NAHDO) is the "premier national health information organization dedicated to improving health care through the collection, analysis, dissemination, and use of health care data."

✪ **National Center for Health Statistics. http://www.cdc.gov/nchs/products.htm**

Publications and information products with links to Healthy People 2000 Reviews (in PDF format). The home page for the National Center for Health Statistics is available at http://www.cdc.gov/nchs/.

✪ **Morbidity and Mortality Weekly Report. http://www.cdc.gov/mmwr/**

"The Morbidity and Mortality Weekly Report (MMWR) Series is prepared by the Centers for Disease Control and Prevention (CDC). The data in the weekly MMWR are provisional, based on weekly reports to CDC by state health departments."

✪ **U.S. Census Bureau.** **http://www.census.gov**

Under the Department of Commerce, The Census Bureau's mission is to be the preeminent collector and provider of timely, relevant, and quality data about the people and economy of the United States. Their Goal is to provide the best mix of timeliness, relevancy, quality, and cost for the data they collect and services they provide.

Please see Appendix A for other resources for obtaining baseline measures, setting targets, and measuring progress.

Managing and Sustaining the Process

"Even if you're on the right track, you'll get run over if you just sit there."

—Will Rogers

The success of a Healthy People initiative (national, state, or local) depends on sustaining the process, particularly as leadership, administrations, and policy makers change. Initial commitment and energy of community partners in identifying needs and setting objectives or targets is only the beginning of the process. Sustainability and institutionalization of Healthy People in day-to-day activities of many people in diverse organizations is necessary in order to achieve objectives. Commitment is not a one-time event, but must grow throughout the next decade.

Action Checklist:

Managing and Sustaining the Process

(See page 113 for a complete planning and development checklist.)
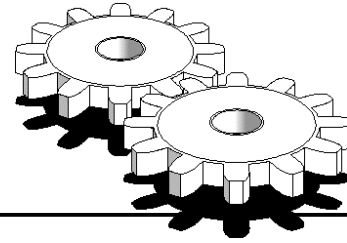
❑ Designate staff and organizational unit for coordinating state plan development

❑ Create a work plan and time line to develop and release the plan

❑ Coordinate expertise and staff support

❑ Assign development tasks to teams or individuals

❑ Establish and implement processes for ongoing input

❑ Market development process (see the action area, "Communicate Health Goals and Objectives")

❑ Plan periodic reviews

❑ Integrate state plan into ongoing planning, budgeting, programming, and legislative processes

❑ Develop a ten-year monitoring and implementation plan

Tips
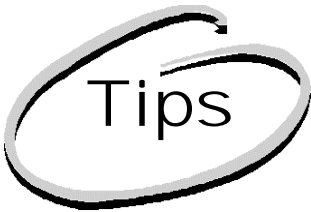
A car without a driver can't go anywhere

► Identify a person (single point of contact) to manage the process and ensure that things get done

► Consider establishing an office, with an annual budget, dedicated to the Healthy People initiative

► Designate a state contact to liaison with the national Healthy People 2010 initiative

Let everyone know the final destination and stops along the way

► Develop a time line and designate responsible parties

► Distribute the time line and tasks to all partners

► Establish a means of continuous communication to report progress among those involved (consider electronic possibilities)

► Display the relevant time line tasks at each meeting

► Make sure major partners see tasks on the time line for them

► Share management responsibilities across agencies and possibly with the private sector

Integrate the state plan initiative into many ongoing activities

- ► Incorporate in strategic and annual plans of agencies, (e.g., objectives, performance measures, data collection plans)

- ► Encourage agencies to use the state's Healthy People logo in their documents that refer to the state plan

- ► Tie to agency policies and legislative initiatives

- ► Link to funding proposals and allocations (e.g., foundations, state grant funds, legislative budgeting)

Schedule internal, interagency, and public reviews of the state plan and progress

- ► Monitor progress toward objectives, legislative actions, and organizational commitments in the plan

- ► Time opportunities to review plan with new leaders and after elections for new terms in office

- ► Use reviews to revitalize or redirect the initiative

- ► Identify successes and areas of focus for public and private audiences

- ► Convene periodic summits or conferences around the state plan to maintain momentum

Remember to celebrate milestones, and recognize groups and individuals for their contributions

- ► Use kick-off events to showcase community, government, and business partners and their commitments

- ► Find time and resources for certificates of recognition, plaques, and personal notes

- ► Invite the governor, respected state leaders, and national leaders to participate in milestone events (kick-off, announcement of priorities, draft objectives, etc.)

Be prepared for "postpartum" blues

- ► Plan activities to follow the "labor and delivery" of the plan

- ► Redefine roles of the steering group, work groups, and others in phases following the release of the plan

- ► Bring in new partners for a boost of energy

Below are examples of how the nation and states have managed and sustained the development and implementation process for Healthy People plans.

From the National Initiative

Dedicated staff

The Office of Disease Prevention and Health Promotion (ODPHP) is designated as the coordinator of the Healthy People initiative. A staff office reporting to the Assistant Secretary for Health and Surgeon General, ODPHP supports the Secretary's Council on National Health Promotion and Disease Prevention Objectives for 2010, Healthy People Steering Committee, and the Healthy People Consortium.

Steering Committee

The Healthy People Steering Committee, which meets quarterly, is composed of representatives from all HHS operating divisions. The group is responsible for overseeing the drafting, revisions, and final modifications of the Healthy People document. A list of the Healthy People 2000 Steering Committee members is available at the following web site: http://www.health.gov/hpcomments/Guide/Steering.htm.

Lead agencies

The Assistant Secretary for Health has designated lead agencies in HHS to be accountable for the achievement of Healthy People targets. Each lead agency is responsible for monitoring, tracking, and reporting the nation's progress on the objectives in its focus area. For some areas, two agencies act as co-leads. HHS agency heads in turn have designated work group coordinators to assume day-to-day responsibilities for the objectives.

Broad participation and mobilization

ODPHP staff attribute much of the sustained interest in Healthy People 2010 to the widespread year 2000 participation and buy-in, particularly among public sector partners and private non-profit groups. With virtually all states and 70 percent of local communities participating in the year 2000 initiative, vested communities create a strong demand for continuing the 2010 objectives. A critical mass of participation and positive peer pressure fuel partners' continued desire to be "on board" this popular initiative.

Another reason for the sustainability of the Healthy People Initiative is the many Consortium members from the private and voluntary sectors who have used and promoted the objectives as a framework for their constituents' action. As an example, the American Hospital Association developed *Healthy People 2000: America's Hospitals Respond*, a

resource kit for hospital administrators to help mobilize health promotion initiatives. The American Dietetic Association (ADA) developed *Call to Action* to inspire its more than 64,000 members to pursue the nutrition objectives. These and other initiatives of Consortium members continue to sustain Healthy People at multiple levels.

From State Initiatives

Identify key staff to manage the state plan

All states and territories identify Healthy People state action contacts. Among these, four have appointed staff solely devoted to Healthy People coordination. These four state action contacts have been instrumental in establishing a development plan early and sustaining the effort throughout the decade. A current listing of the state action contacts is included in the Toolkit and available at: http://www.health.gov/healthypeople/Contact/StateContact.htm.
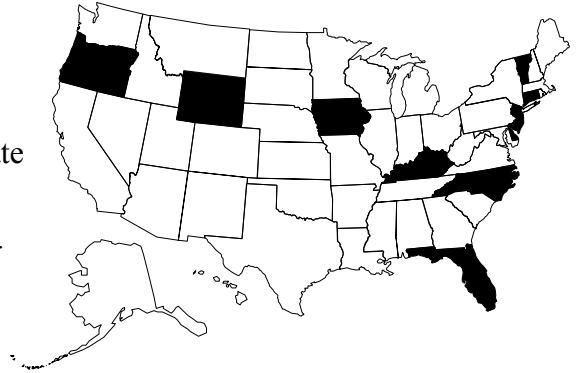
As another example, **North Carolina** has established an Office of Healthy Carolinians that is responsible for keeping the initiative on track. Staff are available to North Carolina counties for support and training, particularly coalition building. There is also a governor's task force that certifies counties in the Healthy Carolinians project. The counties do an assessment and then implement an action plan.

The **Connecticut** Department of Health kept year 2000 planning on track with the help of two staff assigned to the process and an internal advisory committee. The year 2000 process was expanded with the development of *Looking Toward 2000 – An Assessment of Health Status and Health Services*. Connecticut formed the state health planning coordinating committee responsible for analyzing health status data, service data, program plans, and objectives for the *Assessment*. The committee reconvened to review and coordinate the Department's response to *Healthy People 2010 – Draft for Public Comment*.

Although desirable, an official coordinator is not imperative to success. Because of funding deficiencies, **Wyoming** lost its Healthy People 2000 coordinator. However, due to individual efforts from key personnel who had "bought into" the process, Wyoming was able to carry on with year 2000 activities.

The **Delaware** Division of Public Health used a combination of state and grant funds to hire a private consulting group to help manage the development of *Healthy Delaware 2010*. The Division of Public Health retained responsibilities for convening and leading the steering group, as well as providing technical and administrative support to work groups. The consultants will assist by managing the time line, identifying technical tasks for staff, developing a marketing plan, coordinating community meetings, and preparing the plan for publication.

Managing the Process

Maintain communications among partners

The **Iowa** State Department of Health is working with the Hardin Library for the Health Sciences and College of Medicine at the University of Iowa in establishing listservers by teams, by team leaders and facilitators, and for all chapter team members with e-mail addresses, so they can interact via the Internet. This is a key component in the communication process. (See "Communicating Health Goals and Objectives.")

Since June 1998, **Kentucky** has been working on their year 2010 plans. The state has assigned 26 team leaders to form committees around each year 2010 chapter, with a key contact appointed to oversee each committee's progress. Monthly meetings are held with most of the team leaders with regular phone contact in between. A majority of the team leaders hold monthly meetings with their committees as well.

Share management responsibilities across departments

New Jersey's health department formed an Interdepartmental Steering Committee to oversee development of the year 2010 public health agenda. The committee established a work plan with specific target dates for each step required to complete the document. The committee consists of key staff from within the health department as well as other state departments such as Human Services, Environmental Protection, Education, and Law and Public Safety.

Vermont began with work groups for its identified priority areas. These groups consisted of both Department of Health employees and other agency people. However, these formal groups did not work effectively, and the state discovered that more informal meetings and discussion with these groups worked better.

Integrate Healthy People initiative with other key projects

The Benchmarks Project was a part of **Oregon's** strategic plan and is therefore supported by the governor. State Healthy People objectives influenced the selection of Oregon benchmarks. The Oregon Progress Board monitors the benchmarks and reports on progress toward long term performance targets. Oregon Benchmarks are part of the biennial budget process. Agencies must identify benchmark links and report on progress toward achieving the performance targets. Results are reported in a biennial report to the legislature.

By combining the planning processes for the Agency Strategic Plan, mandated performance-based program budgeting, and the State Health Plan, the **Florida** Department of Health was able to create an ongoing planning process that encompasses both long- and short-range program planning. Through performance based program budgeting, specific outcomes were linked to resource requirements in budgets submitted to the state legislature.

(See also state examples, page 5)

Planning and Development Checklist

The Planning and Development Checklist is a tool for organizing and tracking the development of a state health plan. The Checklist outlines potential tasks under each of seven critical action areas to develop, manage, and promote a successful state plan. The seven action areas were identified as the common threads found in the national and state Healthy People processes. This list serves as a menu of activities and processes from the beginning of the development process through the final evaluation of the plan in the next decade, as well as a tool for monitoring progress of plan development.

Individual activities listed for each component should be evaluated and adapted for use in a way that best fits the needs of the state. Additional activities may be added in the space at the end of each section's checklist.

Because many activities run well concurrently, skillful integration of these components will lead to an efficient and effective process. For example, identification and engagement of partners can help in engaging leaders and securing resources. Refer to the sample time line page 126, which illustrates concurrent activities.

> Tasks for which tools are available in the Toolkit are identified by page number and with the tool icon.

	Activity Deemed Relevant	Process Initiated	Process Completed	Comments
Build the Foundation: Leadership and Structure				
➢ Secure buy-in and commitment to develop state plan from senior health department staff (including state health official, state epidemiologist, vital statistics director, chronic disease coordinator, and the Healthy People 2010 Coordinator)				
➢ Meet internally and form preparation team to identify goals and guide early stages of development				
➢ Create a structure for the planning process 🔧 page 7 🔧 page 13				
➢ Examine policy/political environment (e.g., current policies, governor's priorities, legislative agenda, legislative mandates)				
➢ Define functions and composition of an advisory group and/or steering committee 🔧 page 15				

	Activity Deemed Relevant	Process Initiated	Process Completed	Comments
➢ Identify potential barriers and facilitators to success, including lessons learned from year 2000 activities 🔧 page 19				
➢ Present state plan development process to political leaders (executive and legislative) and leadership of other agencies for support 🔧 page 12				
➢ Identify related initiatives to integrate or consider coordination with state plan				
➢ Engage partners early in process and maintain involvement as appropriate 🔧 page 46				
➢ Other activities:				
Identify and Secure Resources				
➢ Identify staff, financial, and technical resources needed to develop state plan				
➢ Develop budget to plan, publish, market, and (if desired) support implementation of state plan 🔧 page 31				

	Activity Deemed Relevant	Process Initiated	Process Completed	Comments
➢ Plan to integrate the plan into state planning, budgeting, and programming processes				
➢ Identify existing resources (e.g., block grants) that could be used to support proposed tasks page 34				
➢ Develop staff and technical support plan				
➢ Identify potential external funding sources and organizations or businesses that can offer printing, supplies, other donated services, and/or dollars page 34				
➢ Secure identified resources, (including staff expertise in other agencies, organiza- tions, foundations, etc.) and develop alternative resources, if necessary (See resource listings in Appendix A, page A-3.)				
➢ Other activities:				

	Activity Deemed Relevant	Process Initiated	Process Completed	Comments
Identify and Engage Community Partners				
➢ Define target audiences 🔧 page 145				
➢ Identify key individuals and organizations that can provide connections to the community or specific expertise 🔧 page 46				
➢ Design strategies for engaging <u>all</u> partners in development and implementation processes				
➢ Identify roles for partners and assign responsibilities				
➢ Establish formal partnership agreements where appropriate to sustain activities and involve partners 🔧 page 47 🔧 page 48				
➢ Develop accountability and evaluation plans, including identification of specific persons or groups of people responsible for each action item with target dates				
➢ Develop a communication vehicle to highlight partner activities as they relate to the state plan				

Managing the Process

	Activity Deemed Relevant	Process Initiated	Process Completed	Comments
➢ Reassess and evaluate partner involvement and satisfaction in plan development				
➢ Other activities:				

Set Health Priorities and Establish Objectives

	Activity Deemed Relevant	Process Initiated	Process Completed	Comments
➢ Evaluate input received from community partners and expert advisors page 64 page 143				
➢ Collect and review information from previous community/state health needs and assets assessments and determine if new ones are needed				
➢ Conduct assessments of health needs and assets, if necessary page 71				
➢ Examine and plan for transitions from year 2000 to year 2010 health objectives (e.g., updates, integration, progress reviews)				

	Activity Deemed Relevant	Process Initiated	Process Completed	Comments
➢ From previous activity, decide where changes from year 2000 plans need to be made and what should be retained. Identify specific health priorities, contributing factors, and other issues that have emerged and should be addressed.				
➢ Define the scope of the state plan, (e.g., racial disparities, public health infrastructure, mental health, environmental health, substance abuse, and behavioral factors)				
➢ Set criteria for establishing potential priority areas or focus areas 🔧 page 66 🔧 page 67 🔧 page 73				
➢ Establish a process for final determination of priorities				
➢ Identify and obtain information to evaluate areas according to criteria				
➢ Select final priority or focus areas				

Managing the Process

	Activity Deemed Relevant	Process Initiated	Process Completed	Comments
➢ Determine types of objectives desired [e.g., measurable vs. in need of data (developmental), qualitative vs. quantitative, process vs. outcome] for each area and establish criteria for adopting them 🔧 page 70				
➢ Outline standard information to include with all priority areas and objectives, (e.g., trend data, targets, accountable or committed partners, policy and regulation issues, populations to target, standards or guidelines, intervention strategies, exemplary programs) 🔧 page 74				
➢ Specify intervention points; identify potential topics and indicators for objectives (what you want to measure, such as health status, behaviors, or interventions) 🔧 page 91				
➢ Develop draft objectives 🔧 page 60 🔧 page 65				
➢ Other activities:				

	Activity Deemed Relevant	Process Initiated	Process Completed	Comments
Obtain Baseline Measures, Set Targets, and Measure Progress				
➢ Consult with state vital statistics division, or other appropriate agencies to provide information on census changes, data changes/requirements for age-adjustment, ICD-10, and other data changes page 101				
➢ Set criteria for evaluating the quality and appropriateness of existing public and private data sources page 99				
➢ Inventory relevant public and private data sources to support measurement of objectives page 91 page 103				
➢ Review progress and successes in achieving state Healthy People 2000 objectives page 97				

	Activity Deemed Relevant	Process Initiated	Process Completed	Comments
➢ Develop targets with appropriate baselines and measures (i.e., determine the desired amount of change for each objective), and finalize objectives ⚒ page 93				
➢ Develop methods for measuring objectives without existing data sources (e.g., new data sources, estimation techniques, attainable proxies)				
➢ Gather and evaluate other data and information to include in state plan				
➢ Plan regular intervals to measure and track achievement of targets via identified data sources (e.g., annual progress reviews) ⚒ page 97				
➢ Other activities:				

Manage and Sustain the Process

	Activity Deemed Relevant	Process Initiated	Process Completed	Comments
➢ Designate staff and organizational unit for coordinating state plan development				

	Activity Deemed Relevant	Process Initiated	Process Completed	Comments
➤ Create a work plan and time line to develop and release the plan 🔧 page 113 🔧 page 126				
➤ Coordinate expertise and staff support to carry out identified tasks in work plan 🔧 page 15				
➤ Assign development tasks to teams or individuals				
➤ Establish and implement meaningful, ongoing processes for input from key staff, partners, stake-holders, and communities 🔧 page 45				
➤ Market development process and time line both internally and externally (see "Communicate Health Goals and Objectives")				
➤ Plan reviews to update baselines and targets, add objectives to meet emerging issues, and report on progress				
➤ Plan to integrate state plan into ongoing planning, budgeting, programming, and legislative processes				

	Activity Deemed Relevant	Process Initiated	Process Completed	Comments
➢ Develop a ten-year plan and time line to release, implement, and monitor the plan				
➢ Other activities:				

Communicate Health Goals and Objectives

	Activity Deemed Relevant	Process Initiated	Process Completed	Comments
➢ Establish marketing and communication goals and objectives page 145				
➢ Conduct target audience research page 143				
➢ Develop a publication and dissemination plan				
➢ Design state-specific Healthy People identity (e.g., logo, color scheme, web site, spokesperson)				
➢ Develop and implement marketing and communication plan (e.g., strategies for using the media and other available resources to engage the community and influence actions or beliefs) page 145				
➢ Prepare state plan for publication and dissemination				

	Activity Deemed Relevant	Process Initiated	Process Completed	Comments
➢ Develop supporting companion documents that target specific audiences, focus areas, or strategies				
➢ Manage document review process				
➢ Publish and release state plan				
➢ Collect and disseminate to community partners exemplary practices from local plans throughout state				
➢ Continue to promote interest in meeting targets and health improvement (e.g., web sites, press releases, newsletters, TV spots, speeches, etc.)				
➢ Periodically report progress to partners, policy makers, and community partners				
➢ Evaluate marketing plan page 147				
➢ Other activities:				

Sample Time Line—Overview

ACTION AREA	Percent Time Elapsed (tailor to your project period)											
			25%			50%			75%			100%
Build the Foundation: Leadership and Structure…	X	X	X	X								
Identify and Secure Resources…	X	X	X	X								
Identify and Engage Community Partners…	X	X	X	X	X	X	X	X				
Set Health Priorities and Establish Objectives…				X	X	X	X	X	X			
Obtain Baseline Measures, Set Targets, and Measure Progress…						X	X	X	X	X	X	
Manage and Sustain the Process…	X	X	X	X	X	X	X	X	X	X	X	X
Communicate Health Goals and Objectives…		X	X	X	X	X	X	X	X	X	X	X

Sample Time Line—Detailed View

ACTION AREA	Percent Time Elapsed (tailor to your project period)											
			25%			50%			75%			100%
Build the Foundation: Leadership and Structure												
Secure senior staff commitment to develop state plan	X											
Meet internally and form preparation team to identify goals and guide early stages of development	X	X										
Create a structure for the planning process	X	X										
Examine policy/political environment		X	X									
Identify potential barriers to success, including lessons learned from 2000		X	X									
Determine composition and function of advisory/steering groups		X	X									
Present process to leaders and agency colleagues for support		X	X									
Identify initiatives to integrate with state plan			X	X								
Identify and Secure Resources												
Identify staff, financial, and technical resources needed to develop the state plan	X	X										
Develop budget to plan, publish, market, and (if desired) support implementation of state plan	X	X										
Develop staff and technical support plan	X	X										
Identify potential funding sources aligned with goals of planning and implementation		X	X									
Secure or develop alternative resources		X	X	X	X							

Sample Time Line—Detailed View

ACTION AREA			25%			50%			75%			100%
Identify and Engage Community Partners												
Define target audiences	X	X										
Identify key individuals and organizations		X	X									
Design strategies to engage partners		X	X	X								
Establish partnerships and clarify roles			X	X	X	X	X	X				
Develop a plan to evaluate partner involvement			X									
Set Health Priorities and Establish Objectives												
Evaluate input from partners				X	X	X	X	X	X			
Review available needs assessments and data sources. Conduct needs and assets assessment, if needed				X	X							
Examine and plan for transitions from year 2000 to year 2010 objectives				X								
Describe scope of state plan				X	X							
Set criteria for determining priority or focus areas				X	X							
Identify and obtain information to evaluate areas according to criteria					X	X						
Determine types of objectives desired for each area and objectives for adopting them					X	X	X					
Outline standard information to include with all priority areas and objectives, such as trend data, strategies, and model programs						X	X					
Select priority or focal areas							X					
Develop draft objectives							X	X				
Draft final text for each priority area										X	X	

Percent Time Elapsed (tailor to your project period)

Sample Time Line—Detailed View

ACTION AREA	Percent Time Elapsed (tailor to your project period)											
			25%			50%			75%			100%
Build the Foundation: Leadership and Structure												
Partner with vital statistics or others for technical assistance on data issues						X	X	X				
Set criteria to evaluate public and private data sources						X	X					
Inventory public and private data sources to support measurement of objectives						X	X	X				
Review progress in achieving state Healthy People 2000 objectives						X						
Develop final objectives with appropriate baselines, targets, and measures									X	X	X	
Develop methods to measure objectives without existing data sources, as needed									X	X		
Gather and evaluate other information to include with objectives in state plan						X	X	X	X			
Manage and Sustain the Process												
Designate staff and organizational unit to coordinate state plan activities	X											
Create a work plan for planning process, release, and monitoring of plan			X									
Assign development tasks to teams or individuals					X	X	X	X	X	X		
Establish and implement processes for input from key staff, partners, and community members		X	X	X	X	X	X	X	X	X	X	X
Market the development process			X	X	X	X	X	X	X	X		
Plan to integrate 2010 objectives into strategic plans and the evaluation of proposed programs, policies, and funding allocations						X	X	X	X			
Develop a 10-year plan to implement, evaluate, and revise the state plan									X	X		

Sample Time Line—Detailed View

ACTION AREA			25%			50%			75%			100%
Communicate Health Goals and Objectives												
Establish marketing goals and objectives		X										
Conduct audience research			X	X								
Develop a publication or dissemination plan				X	X							
Design state-specific Healthy People identity and logo				X	X	X						
Develop a marketing plan					X	X						
Draft state plan publication									X	X		
Develop supporting companion documents that target specific audiences									X	X	X	
Manage the document review process									X	X		
Develop a plan to report progress and promote interest in meeting targets											X	X
Publish and release state plan												X
Implement and evaluate marketing plan					X	X	X	X	X	X	X	X

Percent Time Elapsed (tailor to your project period)

Resources for Managing and Sustaining the Process

HOT picks

✪ **Change Project. http://www.well.com/user/bbear**

From this main page, follow the link to Healthy Communities, then to "How to create one," then to "Sustaining the Effort." This will take you to the article, "Sustaining The Effort: Building a Learning Community" from the healthcare forum. The table of contents includes areas such as governance, structure, and leadership; process; maintaining participation and inclusion; resources; staff support; measurement; and celebration.

✪ **National Civic League. *The Healthy Communities Handbook*. Available from National Civic League, 1445 Market Street, Suite 300, Denver, CO 80302. (303) 571-4343.**

This manual is intended for the use of community groups, business people, individuals, or local governments that are concerned with their communities. It incorporates the goals and objectives of the Healthy People 2000 initiative into a community-based health planning process. Appendices include listings of tools, models, definitions for health indicators, resources, and a bibliography."

✪ **Revisiting the Critical Elements of Comprehensive Community Initiatives. http://aspe.os.dhhs.gov/hsp/cci.htm**

The study focuses on lessons and insights gained through the experience of Comprehensive Community Initiatives. The study defines the characteristics of a good leader and staff, how to develop and maintain a sense of hope and momentum, and how planning and action can be blended and balance.

Please see Appendix A for other resources for managing and sustaining the process.

Communicating Health Goals and Objectives

"There is no acting or doing of any kind, till it be recognized that there is a thing to be done; the thing once recognized, doing in a thousand shapes becomes possible."

—Thomas Carlyle

In This Section

Developing a vision of healthy people in healthy communities, and establishing goals and objectives to meet that vision, can be nothing more than an academic exercise if the vision, goals, and objectives are not effectively communicated to and "owned by" the community. Identifying the target audiences, crafting clear messages, and effectively communicating these messages to the target audiences will increase the likelihood of the state plan being accepted and used by state and community partners. Enlisting key advocates, or "champions," early in the process is another important ingredient for success. (See "Building the Foundation: Leadership and Structure" and "Identifying and Engaging Community Partners.") Just as private sector companies conduct market research long before they try to produce or sell a product, state and community Healthy People initiatives should begin planning their marketing efforts in the earliest stages of development.

Action Checklist: Communicating Health Goals and Objectives

(See page 113 for a complete planning and development checklist.)
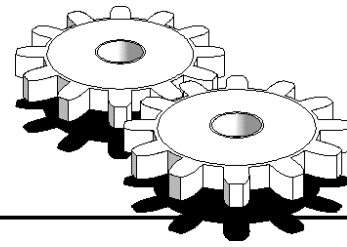
❑ Establish marketing and communication goals and objectives

❑ Conduct target audience research

❑ Develop publication/dissemination plan

❑ Design state-specific identity and logo

❑ Develop and implement marketing and communication plan

❑ Prepare state plan for publication and dissemination

❑ Develop companion documents that target specific audiences or focus areas

❑ Manage document review process

❑ Publish and release state plan

❑ Evaluate marketing plan

Tips
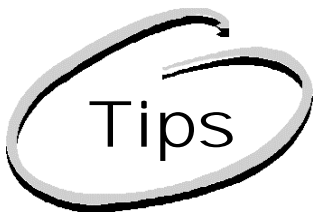
Clear messages begin with clear thinking

► Identify priority audiences—intended users of the plan

► Clearly define what you want people to do with the plan

► Identify the most important ideas to convey

Create a marketing plan

► Involve your public information officer or marketing director

► Consider asking or hiring an outside group to gather your marketing information and help you develop a marketing plan

► Write down your strategy—even if it's just one page

► Talk through the marketing steps at a steering committee meeting or assign to a new committee

Learn how to target your message

► Learn about the objectives important to individuals who are familiar and unfamiliar with Healthy People, the role of public health, and government planning efforts

► Learn about the objectives important to individuals with both favorable and unfavorable opinions about past planning efforts

► Look for the intersection of what you want to say and what people want to hear

► Recruit marketing partners to find the best "selling points" for different audiences

A picture is worth a thousand words

- ► State Healthy People logos and letterhead build recognition, generate excitement, and create a unique identity
- ► Make your logos and marketing materials available to partners

Don't leave your objectives hanging. Surround them with the information and inspiration your audiences need to act.

- ► Stories of real people that illustrate the issue
- ► Trend data
- ► Specific strategy and policy ideas
- ► Examples of state and local programs that work
- ► Contact persons
- ► Committed partners in the public and private sectors

One size rarely fits all

- ► Communicate your plan and messages in formats your different audiences prefer (e.g., print, web, conferences)
- ► Consider the "bang for the buck" in producing two or three targeted versions of the plan, compared to one plan for everyone
- ► Targeted executive summaries or "companion documents" can highlight or expand upon objectives and strategies for audiences such as policy makers, business leaders, or schools
- ► Get partners to distribute your plan to their members, highlighting in a cover letter the areas in which their members have a role

Below are examples of how the nation and states utilized communication to achieve sustained action, published plans, and marketed the initiative.

From the National Initiative

Sustained Action through Communication

Internet

All Healthy People materials published since 1995 are placed on the Healthy People web site: http://www.health.gov/healthypeople/Publications/hppublist.htm. Prior to the January 2000 release of the final Healthy People 2010 document, the web site will be redesigned. It will continue to be maintained throughout the implementation phase. In 1997 HHS launched the Healthy People 2010 web site: http://www.health.gov/hpcomments/. This web site is the complete repository of all public comments received during two Healthy People 2010 public comment periods in 1997 and 1998.

Consortium Exchange

ODPHP publishes a quarterly newsletter for Consortium members to share news about prevention activities related to achieving the nation's health objectives. http://www.health.gov/healthypeople/Implementation/Consortium/Newsletter/default.htm.

Consortium members spreading the word

Consortium members share news of Healthy People activities via their organizational newsletters, web sites, and list servers. For example, COSSMHO, the National Coalition of Hispanic Health and Human Services Organizations, used its newsletter to announce to its constituency the invitation to submit conference abstracts for the launch of Healthy People 2010, at the "*Partnerships for Health in the New Millennium.*" The 1998 Annual Report of the Asian and Pacific Islander American Health Forum highlighted their role in hosting the first Healthy People progress review held outside of Washington, D.C.

Progress review reports

The national initiative has produced two-page summaries to communicate progress on either a Healthy People focus area or crosscutting population objectives. These reports document data objectives, barriers, and successes in meeting the year 2000 objectives. http://www.health.gov/healthypeople/Publications/hppublist.htm

Midcourse Review and 1995 Revisions

This report communicated the progress made toward the year 2000 objectives at the mid-point of the decade. The report was a call to action, renewing the Healthy People effort. It assessed the challenges that remained and confirmed that the occasion for achieving a healthier America was at hand. The chapter on Consortium Action describes the efforts of both national and state organizations to achieve health improvement.

Publication Plans

Healthy People 2010 Objectives: Draft for Public Comment

This draft includes a background section on the Healthy People initiative, a description of the two overarching goals and an overview of the proposed objectives for Healthy People 2010. The draft also lists e-mail addresses, phone numbers, and fax numbers for all the individuals involved in the national development process. The final document will be released in January 2000 in Washington, DC. The draft for public comment is available on the Internet: http://www.health.gov/hpcomments/2010Draft/object.htm.

Healthy People 2010

Healthy People 2010 will be a three-volume set. Volume 1 is directed toward policy makers and will be short (approximately 50 pages). Volume 2 will contain the objectives and supporting text with scientific references. Volume 3 will contain information on tracking the objectives with operational definitions and data source information, so that states and localities can replicate the measures.

Companion documents

Several HHS agencies are planning to produce companion documents to Healthy People 2010 in partnership with private organizations. These companion documents will focus on specific populations or settings and will be released over the decade.

Marketing

Professional assistance

HHS has evaluated the *Healthy People* audiences with the assistance of communication professionals. Outreach to new constituencies continues with the Healthy People Consortium and is continuing to expand. In addition, the development of the Healthy People initiative has maintained a highly visible presence at all national and many local meetings throughout the past few years.

Surgeon General's Launch of Healthy People 2010 Conference, January 24 - 28, 2000

The Partnership for Health in the New Millenium is a joint conference sponsored by the Healthy People Consortium and the Partnerships for Networked Consumer Health Information, celebrating the launch of Healthy People objectives for 2010. For more information, visit the following web site: http://www.health.gov/partnerships.

Healthy People logo competition

The Department of Health and Human Services has initiated a public competition for a new Healthy People logo to use for the next set of Healthy People objectives. The goal of the graphical representation is to show progress, growth, and success.

From State Initiatives

Sustained Action through Communication

Delaware organized its publication, *Healthy Delaware 2000*, to offer a plan of action for many people and agencies throughout the state. The plan's chapters include Opportunities, Health Problems and Objectives (containing background information on each health problem with measurable objectives) and Strategies.
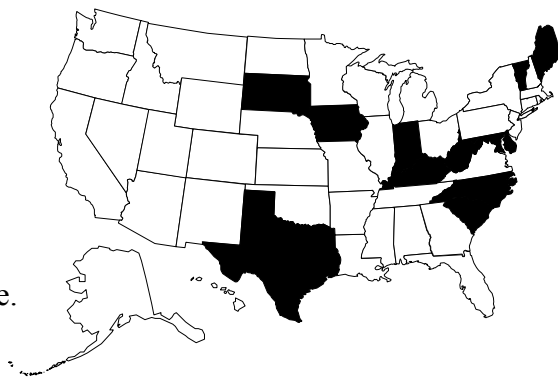
In its mid-decade review of *Healthy Kentuckians 2000*, the **Kentucky** Department for Health Services detailed implementation activities conducted by public health agencies, the Kentucky Legislature, voluntary organizations, universities, businesses, citizens, and other active partners. The 1996 publication also communicated to its partners additional action steps to achieve the year 2000 objectives.

To aid implementation of the *Healthy Iowans 2000* plan, **Iowa** state agencies responsible for priority activities are listed in each chapter. When the Iowa Department of Public Health conducted its mid-course review of all Iowa goals and action steps, groups with primary responsibility for implementation were asked to make an assessment of their progress.

The *Healthy Hoosiers 2000 (Indiana)* plan listed private and public agency partners, called Primary Implementers, to help the state achieve each section. To help communities link to key individuals, names and contact information for public and private sector contacts were also listed for each section.

Publication Plans

Design multiple documents or print sections of a single document for distribution to different target audiences.

In **Iowa,** all chapters of the *Healthy Iowans 2000* plan are available as separate publications available from the Department of Public Health. By distributing smaller sections, the Department of Public Health can focus audiences' attention on areas that interest them and can be used for action. While the Department saves resources, they also avoid overwhelming recipients with more information than they require.

Format a single document to appeal to a broad range of audiences, including the general population.

Texas formatted its brief *Healthy Texans 2000* publication to be easily understood by a wide range of audiences. Photographs, charts, and color enhance the publication's appeal. The content of the report was developed from background papers developed by workgroups, which were focused on specific health topic areas.

Maryland and **North Carolina** both produced brochures about the state plans that summarized the pertinent information for a more general audience. The brochures were distributed to audiences at various public health displays and meetings as a more portable version to take home and reference.

Marketing

Many states, including **Maine**, use the Department of Health's web site to inform professionals and the public about health objectives and progress toward achieving them. Users of the Maine web site can access graphs to track Maine's year 2000 objectives and compare the Maine Health Status Indicators to the U.S.

West Virginia developed and released a Healthy West Virginians 2010 logo and motto several months in advance of their planning process.

The **Delaware** Division of Public Health hired a private marketing subcontractor to develop a marketing plan and identity campaign for the state's 2010 objectives and plan.

The **District of Columbia** released its *Healthy People 2010 Objectives: Draft for Public Review and Comment* during National Public Health Week 1999.

The **South Dakota** Department of Health communicates its goals and objectives through periodic publications, news releases, a web page, presentations at health care conferences, and ongoing meetings with partners.

The **Iowa** Department of Public Health is using social marketing principles to help focus outreach. The Department of Public Health is also using its web site to publicize the Healthy Iowans 2010 time line, public comment period, staff contact information,

technical assistance opportunities, and summaries of progress toward each area in the state's year 2000 plan.

Two **South Carolina** Healthy People Coalitions used the Healthy People 2000 objectives for worksites as criteria for awards to businesses that were promoting health through their policies and activities. Annually, businesses qualifying for the Healthy People Worksite Awards are recognized at a ceremony and presented with Healthy People plaques. The local coalitions sent out press releases about the businesses and their awards. Newspapers in their areas have also reported these.

Another **South Carolina** coalition developed a partnership with the local NBC affiliate for one year. The television station produced three public service messages on health objectives each quarter and ran them during prime time at no cost to the coalition. They also highlighted the health issues in their newscasts, using the Healthy People logo and name.

Vermont continuously raised awareness of the Healthy Vermonters 2000 plan and its progress through a variety of mechanisms. Any event such as publishing an annual report, achieving a goal, or receiving a grant that was related to an objective was publicized. Vermont also created a logo that was used extensively. The state relied heavily on the media (newspaper, television, radio, etc.) for its promotional efforts. Through this public awareness, citizens came forth to volunteer their help. Vermont also publicized areas that were weaknesses, which recruited even more volunteers. In 1996, Vermont held a second kick-off meeting to re-energize the year 2000 process.

Number of States that Cited Methods for Disseminating Information About Year 2000 Objectives by Dissemination Method (N=44)

Method	Number of States
Published Report	39
Conference	25
Informal report/fax	23
On-line	18
CD ROM/disk	5
None	3

Number of States
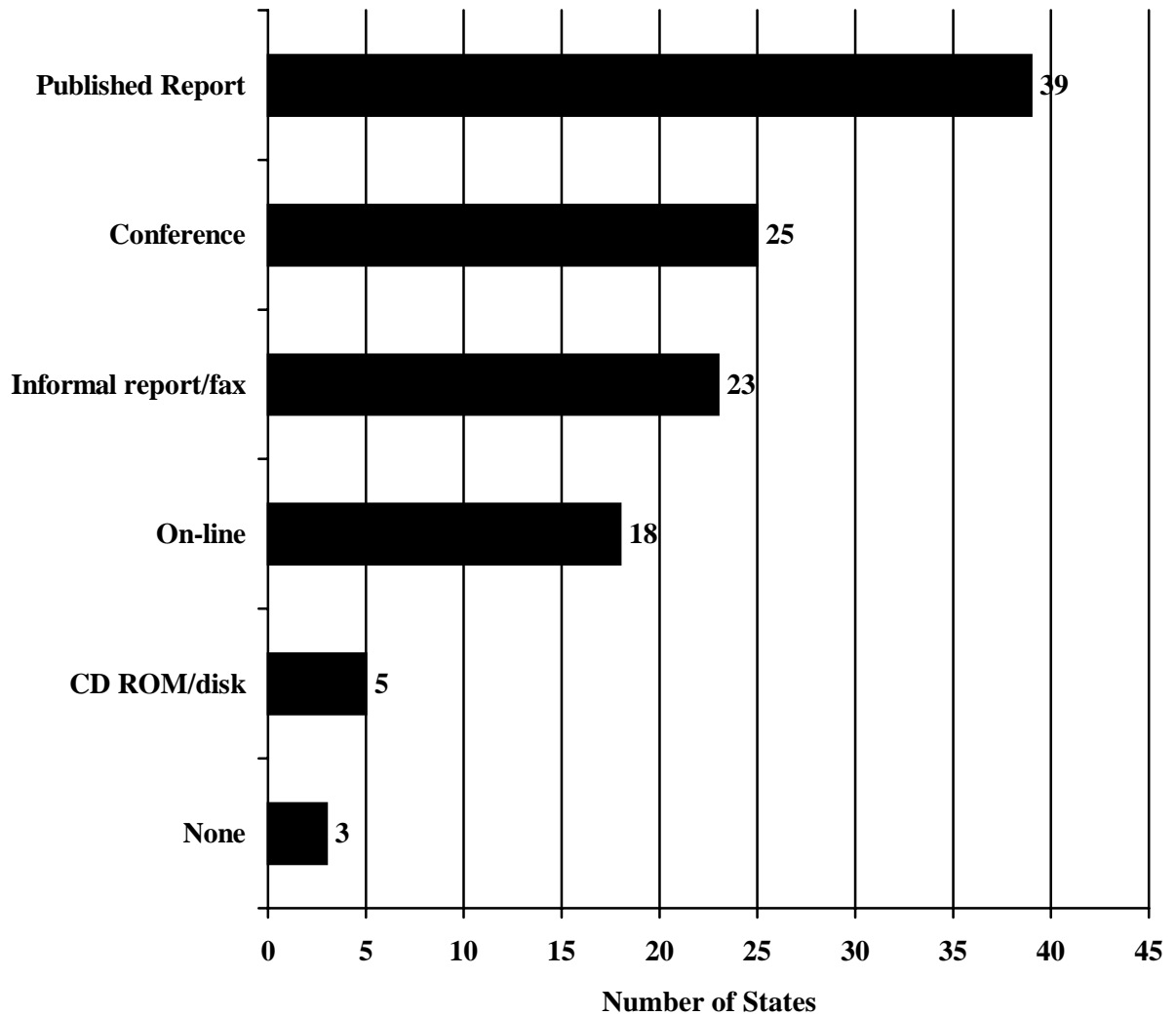
Note: States may have been counted more than once since some provided information by more than one method.

Source: Public Health Foundation. *Measuring Health Objectives and Indicators: 1997 State and Local Capacity Survey*. March 1998.

State Likelihood of Using Year 2000 Objectives
by Purpose (N=45)

Purpose	Value
Request resources	2.3
Develop/target health promotion campaigns	2.2
Collaborate with other agencies/associations	2.1
Develop performance measures	2
Develop policies or stimulate legislation	2
Develop/target direct intervention efforts	2
Develop/target disease awareness campaigns	1.9
Develop/target school health promotion programs	1.8
Formulate data collection and analyses plans	1.8
Allocate resources	1.7
Develop/target worksite health promotion programs	1.3
Other	0.3

0   0.5   1   1.5   2   2.5

<<Less Likely   More Likely>>

Note: The following conversion of frequency from words to numbers allowed for weighted averagin
Not at all=0, Infrequently=1, Somewhat=2, and Frequently=3.

Source: Public Health Foundation. *Measuring Health Objectives and Indicators: 1997 State and Local Capacity Survey*. March 1998.

Simple "Market Research" Strategies

Learning the needs, desires, and preferences of the target audiences does not need to be time consuming. Whether this learning takes place at the water cooler or from a marketing consultant, the point is to know your audience. Below are some of the many ways to learn from and about the people and organizations considered partners in state plan development, as well as those who will use and implement the plan.

Telephone Strategies	Face-to-Face Strategies	Electronic Strategies
Brief, informal calls to partners	Conduct face-to-face interviews with key partners	Email or post requests for ideas
Structured conference calls with groups or individuals	Hold structured discussions at scheduled association, staff, or community group meetings	Research known audience perspectives, exposure to similar initiatives, and communication preferences
Telephone surveys	Convene focus groups	Put draft materials or surveys on the web for feedback

Sample "Market Research" Questions

Carefully designed questions will help focus learning on the most important areas. The right questions will depend upon the audience, project goals, level of input desired and the stage in the 2010 planning process. For example, if the steering committee and work groups were already formed, planners would focus questions on how to develop and implement the plan rather than how to engage key partners and the community in the planning process.

Planning Process	Design and production
• How does your organization participate in planning processes? • What kinds of organizations have approached you to be a part of an advisory committee? How do you choose which ones you will join? • If you were inviting others (members of the target audience) to attend a work group meeting for this project, what would you say to get them to come? What would you avoid saying? • What was your impression of the state's year 2000 planning process? What worthwhile came out of it? • Tell me about a good experience that you have had working with public health.	• What makes a plan useful? What kinds of plans are not useful? • If you need detailed information about a topic, do you prefer to have it included at the back of a publication, in a separate publication, or on a web site? • Which of these formats is easy to use (present two or more visual formats)? • What do you think the people who wrote this page want you to do?
Marketing	**Implementation**
• Where do you get ideas for your work or community activities? • What kinds of published recommendations and plans have you seen from other state agencies? • What impression do you have of government planning efforts? • When you receive plans from other agencies, what do you do? • If you were in charge of marketing the state's health plan to others (members of the target audience), what would you do? • What do you read? • How do you like to get information about emerging objectives in public health?	• What makes a healthy community? • How do you contribute to your community's health? In what areas would you like to do more? • Have you ever used another agency's plan or objectives in your own work? What was the most important factor in your decision? • How important are goals and plans to your daily work? What would be an incentive to tie your program activities to the state health objectives? • What would it take for you to commit to help achieve a state health objective? • If your supervisor asked you about how you used the states' year 2000 objectives, what would you say?

How to Develop a
Marketing Plan

A marketing plan clarifies how a state can share the 2010 vision with others, promote the published plan, and "make things happen." To develop marketing goals and objectives, planners must determine priority audiences, desired results, key messages, strategies and tactics, and marketing partners.

1. Priority audiences

Whose opinions or actions are most important to the success of the 2010 process and the implementation of objectives? Identify potential target audiences and choose two to three of most importance.

Sample Target Audiences for 2010 Marketing Plans:

❑ policymakers, including elected officials
❑ private sector health organizations, including managed care organizations
❑ private sector employers
❑ medical societies and other health professional associations
❑ school and education leaders

❑ state voluntary organizations with local affiliates
❑ public health leaders and program managers
❑ front-line public health staff
❑ grass roots groups with the capacity to address health objectives
❑ potential community advocates for priorities

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2. Desired Results

What do you want each target audience to do or believe? Be specific! The final 2010 plan and marketing materials should, explicitly or subtly, be designed to achieve the desired outcome.

As examples, you might want the target audience to…

(*do*)
… use the state's 2010 objectives to develop policies to improve public health infrastructure
… use objectives and recommendations in the 2010 plan to evaluate proposed legislation relevant to focus areas
… incorporate components of the plan into agency strategic plans
… commit resources and staff to develop new data sources

(*believe*)
… be eager to work toward achieving objectives in their communities
… support the planning and evaluation role of public health
… believe the plan boosts accountability
… feel personal responsibility to be healthier for a healthy state
… think the 2010 priorities are fair
… believe that state and local resources should be tied to objectives

3. **Key Messages**

   For each audience, what are the main messages to communicate? Perhaps your main message is that this is a "people's plan," a governor's plan, a call to action, or a measure of the current path to success. Whatever your message, be sure to identify key words and phrases that support it. If your market research has identified that your target population responds favorably to "milestones," "action plans," and "steps to success"—but turns off when they hear "objectives" or "benchmarks"—include the preferred words in your key messages. Remember to be consistent with vocabulary. Key messages should be reinforced in all communications about the plan, including slogans, conference presentations, press releases, and executive summaries.

4. **Marketing Strategies and Tactics**

   How will you reach each audience?

   Strategies describe your general marketing approach. For some audiences and purposes, the best strategy may be to blanket the audience with messages about 2010 in a short period of time. For others, your strategy might be to selectively promote 2010 in connection with timely events (e.g., budget hearings) over several years.

   Tactics are the methods of communication, such as:
   - posters
   - television ads
   - newspaper articles, editorials
   - conference booths
   - training and presentations
   - letterhead
   - bumper stickers
   - fax or electronic newsletters
   - individual meetings
   - brochures
   - calendars
   - web sites

   Assess the communication environment of the target audience. The way to reach policy makers may be through their staff or targeted newsletters, whereas the way to reach public health program managers may be through an annual conference or posters at work.

   List marketing strategies with a budget in mind. However, a longer menu of marketing options can help identify marketing opportunities and resources in the future.

5. **Marketing Partners**

   General media, special interest media, advocacy organizations, public relations offices, health education units, graphics departments, private health care organizations, and professional organizations with newsletters or web sites may be excellent partners in promoting year 2010 objectives. Healthy People steering committees may include many potential marketing partners who have experience with campaigns and already have an interest in promoting the 2010 plan.

   Exclusive arrangements with a few marketing partners who are committed (e.g., "Channel 12 Cares") may sometimes be more effective than multiple, less focused partners. Explore options with marketing professionals and check your agency policies.

Evaluate Your Marketing Plan

Just as a marketing plan can clarify how a state can share the 2010 vision with others, the marketing evaluation plan can identify whether efforts were effective. The following factors can be used throughout the process internally as well as periodically be posed to the target audience throughout the decade.

❑ Was the planning process effective in preparing the marketing goals and action plan?

❑ Was there timely follow-through on marketing activities such as information requests?

❑ Is the marketing strategy a clear representation of the primary vision of the state plan?

❑ Is the marketing plan sensitive to the community's cultural dynamics?

❑ Did the development process include input from a diverse group of people?

❑ Were various media employed effectively to promote the state plan's goals, actions, and accomplishments? Was there media coverage (e.g., newspaper articles)? Did associations and other community partners use the logo, articles, or other marketing materials in their communications?

❑ How was input from partners used in developing and refining the marketing plan? Through what mechanisms was input collected (e.g., surveys, focus groups, consultants)?

❑ Has the marketing process assisted progress in meeting the state plan's specific objectives?

❑ How does the marketing plan mirror the goals and objectives of the overall state's plan?

❑ Has marketing generated funding or other resources for the initiative?

❑ Were messages designed to clarify what audiences should do with the state plan or what they should believe? Were marketing messages clear to targeted audiences?

❑ Did marketing efforts meet state objectives to influence the actions or beliefs of target audiences? (e.g., Did policy makers propose or pass legislation based on or using the state plan?)

HOT picks

Resources for Communicating Health Goals and Objectives

✪ **American Public Health Association, Model Standards Project. "Media Relations." Available from American Public Health Association, 800 Eye Street, NW, Washington, D.C. 20001-3710. (202) 777-2742. 1993.**

This manual provides local governments with strategies to obtain media coverage for their efforts to develop local health programs that integrate the "Healthy Communities 2000: Model Standards' Principles." It considers the interrelated needs of the local health departments for coverage and the local media for news of local interest. The manual provides strategies and tips for working with local media and reviews basic procedures for developing news releases.

✪ **National Cancer Institute. *Making Health Communication Programs Work: A Planners Guide.* 1992. http://oc.nci.nih.gov/services/HCPW/HOME.HTM**

The guide includes information on planning and strategy selection, determining target audiences, writing program plans and developing a timetable, selecting channels and materials, characteristics of mass media channels, developing materials and pre-testing. It also includes sections on implementing a program, establishing process evaluation measures, steps for involving intermediaries in a program, assessing effectiveness, evaluating outcomes, conducting impact studies, and revising the program.

✪ **Siege M., Doner L. *Marketing Public Health: Strategies to Promote Social Change.* Aspen Publications, Maryland. 1998.**

This book focuses on marketing principles for public health practice, including challenges and opportunities for marketing social change and public health. It also uses case studies and focuses on using marketing principles to design, implement, and evaluate public health interventions.

Please see Appendix A for other resources for communicating health goals and objectives.

Appendix A: Resources

Building the Foundation: Leadership and Structure

❑ Bryson J.M., Crosby B.C. <u>Leadership for the Common Good: Tackling Public Problems in a Shared-Power World.</u> Jossey Bass Publishers, Inc. San Francisco, CA, 1993.
Focuses on leadership in the public sector by explaining the dynamics of change in a shared-power world. It offers guidance for public leadership and decision-making when public problems are addressed.

✪ Civic Practices Network–Community Section.
http://www.cpn.org/sections/topics/community/index.html

Provides information on community building through "community organizing, social capital, and urban democracy." It also provides information on the Consensus Organizing Model, which explains how one can bring together all the players in a community.

✪ Civic Practices Network–Health Section. http://www.cpn.org/sections/topics/health/index.html

Provides perspectives on building community involvement, as well as "how to put health reform on more solid civic foundations."

❑ Education and Healthcare Policy: Perspectives on Goals 2000, IASA, IDEA and Healthy People 2000. http://www.ed.gov/databases/ERIC_Digests/ed390023.html
Addresses education and health care reform due to the unmet health needs of children reported in Healthy People 2000.

✪ Denotes a recommended "Hot Pick" resource

❑ Feldman P., Gold M., Chu K. "Enhancing Information for State Health Policy." *Health Affairs,* 13(3):236-250, 1994.
Essay on development of credible data, active policy champions, using data to gain the support of key constituencies, choosing staff with entrepreneurial and bridging skills, and taking advantage of short term policy windows.

❑ "Government and Private Sectors Join Forces for Food Safety." *Prevention Report,* Winter 1998. http://odphp.osophs.dhhs.gov/pubs/prevrpt/98winpr/98winfoc.htm
Summary of the 1997 Food Safety Initiative, which shows the collaboration between Federal, state and local agencies, and private organizations engaged in food production, marketing, preparation, and consumption.

❑ Healthy Policy – Idea Central. http://www.epn.org/ideacentral/health/
A virtual magazine of the electronic policy network.

❑ Marando V.L., Melchior A.C. "Public Health As A County Government Priority: Problems And Solutions For The Political Arena." *American Journal of Preventive Medicine,* 11(6 Suppl):17-23, 1995.
"This article addresses the priority issue given to public health by top county government officials. We determine that public health is generally a low priority issue for county government leaders. The low priority given to public health is, in part, linked to top county officials' lack of recognition of important public health problems and low levels of community group advocacy for public health issues."

❑ Najera A.P. "History of Successful Ballot Initiatives—California." *Cancer,* 83(12):2680-4, 1998.
This article gives a brief history of California's tobacco legislation.

✪ Public Health Resources on the Internet – Legislative and Regulatory Resources. http://www.lib.berkeley.edu/PUBL/regs.html

Links to California, Federal, and other legislative and regulatory resources.

❑ Shelton D.M., Alciati M.H., Chang M.M., Fishman J.A., Fues L.A., Michaels J., Bazile R.J., Bridgers J.C. Jr., Rosenthal J.L., Kutty L., et al. "State Laws on Tobacco Control—United States, 1995." *Morbidity and Mortality Weekly Report: CDC Surveillance Summary,* 44(6):1-28, 1995.

❑ Stateline.org. http://www1.stateline.org/index.do)
"Stateline.org was founded in order to help journalists, policy makers and engaged citizens become better informed about innovative public policies." The web site covers welfare reform, healthcare especially as it relates to children and the right to die, and education especially the manner in which public schools are financed, among other issues.

❑ Wallack L., Dorfman L. "Media Advocacy: A Strategy for Advancing Policy and Promoting Health." *Health Education Quarterly*, 23(3):293-317, 1996.
"This article uses two case studies to illustrate key aspects of media advocacy. The first is a 5-year statewide violence prevention initiative for young people in California. The second focuses on the activities of a mothers' group working to improve public housing. The "new public health," with its focus on participation, policy development, and political processes could benefit from incorporating media advocacy."

❑ Weller J. "History of Successful Ballot Initiatives—Oregon." *Cancer,* 83(12):2693-6, 1998.
This article gives a brief history of Oregon's tobacco legislation.

✪ Williams-Crowe S.M., Aultman T.V. "State Health Agencies and the Legislative Policy Process." *Public Health Report,* 109(3):361-7, 1994.

"Based on the experiences of state legislative liaison officers, specific strategies for dealing with state legislatures have been identified and are organized into five key areas—agency organization, staff skills, communications, negotiation, and active ongoing involvement. A public health agency must be organized effectively to participate in the legislative policy process."

Identifying and Securing Resources

❑ Agency for Health Care Policy and Research. http://http://www.ahcpr.gov/fund
Links to funding opportunities, grant announcements, policy notices, and research training grants.

✪ Department of Health and Human Services – GrantsNet. http://www.hhs.gov/grantsnet

"Tool for finding and exchanging information about Federal grant programs."

✪ Grantmakers in Health. http://www.gih.org

"This is a non-profit organization serving funders throughout the country who make grants in health and related human services. Grantmakers in Health serves these constituents through convening, publishing, providing education/training, conducting research, developing and making accessible databases and other information resources, providing technical assistance and consultation, making referrals, and helping grantmakers build professional relationships."

❑ The Grantsmanship Center. http://www.tgci.com
Provides a list of links to funding sources.

❑ Meadows M. "Looking for Money: Common Mistakes People Make in the Search For Funding." *Closing the Gap.* April 1998. Available at http://www.omhrc.gov/ctg/money.pdf
A quick summary of mistakes people make in their search for funding and what to do to avoid those mistakes.

❑ Mickey's Place In the Sun. Grants and Grant Writing Resources.
http://Mickeys-Place-in-the-Sun.com/

Information and links for grants and grant writing, funding information on arts and humanities, children and youth, community development, crime, justice, law enforcement, disabled, education, environment, evaluation, and government. Information from grant-maker associations, health and medical organizations, philanthropy, research funding, rural funding, science, social services and welfare, substance abuse, telecommunications and technology, and training.

❑ Nonprofit Resources Catalog: Foundations.
http://www.fundsnetservices.com/index3.htm

Links to various foundations and funders.

✪ Office of Minority Health Resource Center. *Funding Guide*.
http://www.omhrc.gov/omhrc/publications/publications5.htm.

A guide to "assist grantseekers in their search for funding sources for health related activities. Includes resources to enhance one's knowledge of public funding, private funding, and the basics of getting started in the search for funding sources."

❑ Office of Minority Health Resource Center: Funding Materials Database.
http://www.omhrc.gov/OMH/fundingdb.htm
A searchable database of "funding resources that can help support minority health projects and other health related programs."

❑ Public Health Resources on the Internet. http://www.lib.berkeley.edu/PUBL/regs.html.
Links to California, Federal and other legislative and regulatory resources.

✪ Robert Wood Johnson Foundation. http://rwjf.org/index.jsp

"The Robert Wood Johnson Foundation's mission is to improve the health and health care of all Americans. Remaining faithful to our mission means keeping our commitment to the American People in everything we do from encouraging healthier living and the conditions that promote better health to promoting positive changes in the way health care is delivered in this country."

❑ Rural Health Services Funding: A Resource Guide. http://www.nalusda.gov/ric/richspub/ric41.htm
A revised edition of Rural Health Services Funding: Resource Guide. Additional directories and resources have been added along with an update of the section on Electronic Funding Resources. Publishers' information, listed in Section VIII, gives the reader the necessary information to purchase a publication.

❑ The Foundation Center. http://fdncenter.org/research/trends_analysis/pdf/health_hi.pdf)
Highlights of the 1998 Study: Health Policy Grant Making: A Report on Foundation Trends.

- University of Pittsburgh. http://www.hsls.pitt.edu/
Provides links to grant and funding information on the World Wide Web and print resources which are available at the Health Sciences Library System at the University of Pittsburgh.

- ✪ U.S. Department of Health and Human Services, Public Health Service, Office of Disease Prevention and Health Promotion. "Locating Resources for Healthy People 2000 Health Promotion Projects." Available from Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.   (202) 512-1800, 1991.

  "This publication is a guide to locating financial assistance for projects related to the Healthy People 2000 goals. It reviews principles and procedures of grant seeking, and discusses ways to locate specific groups in the private sector and local, state, and federal agencies that might provide funding. A list of information resources is included, along with a glossary, bibliography, and sample application form."

- ✪ W. K. Kellogg Foundation. http://www.wkkf.org

  The mission of the Kellogg Foundation is "to help people help themselves through the practical application of knowledge and resources to improve their quality of life and that of future generations." The Foundation was established 1930 and has "continuously focused on building the capacity of individuals, communities, and institutions to solve their own problems."

Identifying and Engaging Community Partners

- Adams C.F., ed. "Voices from America: Healthy Community Stories from Across the Nation." American Hospital Association, 1998.
http://www.healthycommunities.org/us_healthycities.cfm

  This is a collection of 10 case stories which highlight collaborations between local communities and neighborhoods which have defined health and quality of life for themselves, and designed initiatives to achieve these goals. Each community profile highlights lessons learned and outcomes.

- Assessment and Health Information: Planning and Community Partnerships. Columbus Health Department, Ohio. http://www.cmhhealth.org/communityhealthinfo/planning_community.html
"Planning and Community Partnerships focuses on coordination and collaboration in order to assess and assure the health of the community."

- Baker E.A., Brownson C.A. "Defining Characteristics of Community-Based Health Promotion Programs." *Journal of Public Health Management and Practice,* 4(2): 1-9, 1998.
This article examines some of the defining characteristics of community-based health promotion programs and the challenges faced by practitioners who wish to engage in this type of work.

✪ Civic Practices Network. http://www.cpn.org/sections/topics/community/index.html

Civic Practices Network–Community Section provides information on community building through "community organizing, social capital, and urban democracy." It also provides information on the Consensus Organizing Model, which explains how one can bring together all the players in a community.

❑ Coalition for Healthier Cities and Communities. c/o Health Research, Education, and Trust, One North Franklin, Chicago, Illinois 60606 (312) 422-2635
The coalition is a partnership of entities from the public, private and non-profit sectors collaborating to focus attention and resources on improving the health and quality of life of communities through community-based development.

✪ Coalition for Healthier Cities and Communities, Norris T. & Howell L. *Healthy People in Healthy Communities: A Dialogue Guide.* 1999.

This guide assists communities in hosting dialogues leading to action and policy on what makes healthier communities. It is a part of the Healthy Communities Agenda, the 1999 – 2000 campaign of the Coalition for Healthier Cities and Communities and its partners. For more information contact the Healthy Communities Agenda "Dialogue Coach" at 1-800-803-6516 or contact the Coalition for Healthier Cities and Communities, One North Franklin, Chicago, IL 60606. http://www.healthycommunities.org

✪ Community Tool Box, http://ctb.lsi.ukans.edu/

The Community Tool Box's mission is to promote community health and development by connecting people, ideas, and resources. The web site provides tools to build healthier and stronger communities. The web site also provides information for those interested in a variety of community health and development issues and connects individuals to personalized assistance for improving community change efforts. Sections of the web site include step-by-step guidelines, real-life examples, checklists of points to review, and training materials for practitioners. The Tool Box also includes success stories, innovative practices, trouble-shooting guides, and links.

❑ Chandler Center for Community Leadership. http://crs.uvm.edu/nnco/collab/wellness.html
"Community Based Collaboration – Community Wellness Multiplied"

"The Chandler Center for Community Leadership is concerned with the practical application of research, proven success, and action to solve community problems. Attention is centered on achieving positive community conditions, which include: helping communities to become vision and mission driven, tailoring services to fit the community, developing preventative solutions, emphasizing the value of citizen leadership, collaborative use of resources, and the democratic formation of public policy."

❑ Goodman R.M., Speers M.A., et al. "Identifying and Defining the Dimensions of Community Capacity to Provide a Basis for Measurement." *Health Education and Behavior,* 25(3): 258-278, 1998.
The article identifies dimensions of community capacity for program development, implementation and evaluation.

❑ Healthy Communities, "What Is Happening in My State?"
http://www.healthycommunities.org/us_healthycities.cfm
This web site is maintained by the State Network for Healthy Communities, a network of state and regional level initiatives that support the Coalition for Healthier Cities and Communities. Its two main objectives are to 1) encourage state-level collaboration between partners from various sectors; and 2) encourage state-level stake holders to make their presence and resources better known throughout their own state. The network has links to the following states and includes information from the healthy communities within them: Colorado, Florida, Louisiana, Massachusetts, Michigan, Missouri, Montana, New Mexico, Pennsylvania, Utah, Washington, and Wyoming.

✪ Institute of Medicine (Committee on Public Health). *Healthy Communities: New Partnerships for the Future of Public Health.* National Academy Press, Washington, D.C., 1996.
http://www.nap.edu/catalog/5475.html

"The Committee's analysis…the public's health depends on the interaction of many factors; thus, the health of a community is a shared responsibility of many entities, organizations, and interests in the community, including health delivery organizations, public health agencies, other public and private entities, and the people of a community."

❑ Kegler M.C., Steckler A. et al. "Factors That Contribute to Effective Community Health Promotion Coalitions: A Study of 10 Project ASSIST Coalitions in North Carolina." *Health Education and Behavior,* 25(3): 338-353, 1998.
"The results suggest that coalitions with good communication and skilled members had higher levels of member participation and member states. Coalitions with more staff time devoted to them and more complex structures had greater resource mobilization. Coalitions with more staff time, good communication, greater cohesion, and more complex structures had higher levels of implementation."

❑ Lasker R.D., and the Committee on Medicine and Public Health. Medicine and Public Health: The Power of Collaboration. The New York Academy of Medicine, New York, 1997.
Includes a history of relationships between medicine and public health and previous attempts to bridge the gap. Also includes models of medicine and public health collaboration as well as case studies.

❑ Milio, N. "Priorities and Strategies for Promoting Community-Based Prevention Policies." *Journal of Public Health Management and Practice,* 4(3): 14-28, 1998.
"Policy making requires a grasp of the interplay among stakeholders, policy makers, the press, and the public. A framework for gathering relevant information and guiding strategic action is a useful tool for participation in community, state, and national arenas in the interests of population health."

✪ National Association of County Health Officials. *Assessment Protocol for Excellence in Public Health* (APEX*PH*), 1991.

The tool is an eight-step process for assessing community health status and planning for improvement. It is based on the principles of environmental justice, community collaboration, and locally appropriate decision making. Guidance is designed to be easily accessible and flexible enough to meet the needs of a variety of communities with differing health concerns. For more information, see http://www.naccho.org.

❑ National Association of County and City Health Officials. *Protocol for Assessing Excellence in Environmental Health (PACE),* June 1997.
PACE's methodology consists of eight steps that are designed to walk a local health department through a process of engaging community residents in identifying environmental health priorities. Health departments working in concert with the community to design and direct the assessment from the earliest stage through completion is integral to the methodology of PACE. Only in this manner can the process accurately represent the needs and wishes of the people it will most directly affect. For more information, see http://www.naccho.org.

❑ Norris T. "Healthy Communities." *National Civic Review,* 86(1): 3-10, 1997.
The author suggests that what works best to create and sustain positive community change can ultimately be defined in a local context. Successful communities: recognize that the health and sustainability of a community are products of the whole community working, and not as a result of isolated interventions in any single sector. Instead, they engage everybody and build ownership and civic engagement; take a regional and a local approach simultaneously; know how they are performing; start with a shared vision and follow with a specific action plan and implementation strategy; build on existing resources; and look at systemic change.

❑ Ohioline: Community Organizing.
http://ohioline.osu.edu/lines/comun.html#comorg

Provides links to community organizing and coalition building fact sheets and bulletins.

❑ Revisiting the Critical Elements of Comprehensive Community Initiatives.
http://aspe.hhs.gov/hsp/cci.htm
The study focuses on lessons and insights gained by Comprehensive Community Initiatives. The study describes effective outreach, how to sustain involvement, how to address cultural issues, and how to address the challenges of collaboration.

❂ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC/ATSDR Committee on Community Engagement). *Principles of Community Engagement*, Atlanta, Georgia, 1997.

Principles of Community Engagement provides public health professionals and community leaders with a science base and practical guidelines for engaging the public in community decision-making and action for health promotion, health protection, and disease prevention.

❑ U.S. Department of Health and Human Services, Public Health Service, Office of Public Health and Science, Office of Disease Prevention and Health Promotion. *Healthy People 2000: Healthy People in Healthy Communities – A Guide for Community Leaders.* June 1998.
This publication provides information on defining healthy cities and communities, how to begin creating a healthy community, using Healthy People 2000 Objectives to set priorities, measure progress, and improve your community's health. It also provides a list of resources.

Setting Health Priorities and Establishing Objectives

❑ Brown W.J., Redman S. "Setting Targets: A Three-Stage Model for Determining Priorities for Health Promotion." *Australian Journal of Public Health,* 19(3):263-9, 1995.
Describes a three-stage model for setting targets for health promotion. The model enables "epidemiological data and views from the community to be synthesized and integrated with those of experts from health and social services, using a nominal group process."

❂ CDC WONDER – The CDC Prevention Guidelines Database.

http://wonder.cdc.gov/wonder/prevguid/prevguid.shtml

"Comprehensive compendium of all the official guidelines and recommendations published by the Centers for Disease Control and Prevention for the prevention of diseases, injuries, and disabilities. This compendium was developed to allow public health practitioners and others to quickly access the full set of CDC's guidelines using a single financial support from the Information Network for Public Health Officials project."

❂ Committee on Leading Health Indicators for Healthy People 2010. *Leading Health Indicators for Healthy People 2010: Final Report.* Division of Health Promotion and Disease Prevention, Institute of Medicine, 1999.

This report is a compilation of the committee's efforts to establish leading health indicator sets that could "focus on health and social issues as well as evoke response and action from the general public and the traditional audiences for *Healthy People*." http://books.nap.edu/catalog/9436.html

- Committee on Using Performance Monitoring to Improve Community Health. Division of Health Promotion and Disease Prevention, Institute of Medicine. "Improving Health in the Community: A Role for Performance Monitoring." 1997. http://books.nap.edu/books/0309055342/html/416.html.

- Conway T., Hu T.C., Harrington T. "Setting Health Priorities: Community Boards Accurately Reflect the Preferences of the Community's Residents." *Journal of Community Health,* 22(1):57-68, 1997.
  This article describes the process used to determine if the views of the District Health Councils (DHCs) members agreed with those of community members. The purpose was to determine the effectiveness of community advisory boards, which are often used as a vehicle for community input regarding health planning.

- Health Care Forum Outcomes Toolkit. http://www.act-toolkit.com
  "The Outcomes Toolkit provides a comprehensive approach to planning and evaluating collaborative, cross-sectoral efforts. The Toolkit integrates the process of defining mission and outcomes, setting performance goals over time, linking budget to performance, reporting results, and ensuring accountability." In particular, the toolkit establishes a process for setting priorities and tracking progress against strategic goals.

- Hertzman C., Torres E., Subida R., Martins J. "Identifying Environmental Health Priorities for A Whole Nation: The Use of Principal Environmental Exposure Pathways in the Philippines." *International Journal of Occupational Environmental Health,* 4(2):114-20, 1998.
  Summarizes an approach to establishing environmental health priorities based on the concept of principal environmental exposure pathways (PEEPs). This extends the concept of a causal pathway backward from the health outcome to the cause.

- ✪ Maiese D., Fox C.E. "Laying the Foundation for Healthy People 2010." *Public Health Reports,* January 1998.

  Summarizes activities implemented to gain input on Healthy People 2010, with the hopes that these efforts would be duplicated by states and communities in their own planning processes.

- McGinnis J.M., Foege W.H. "Actual Causes of Death in the United States." *Journal of the American Medical Association,* 270(18):2207-12, 1993.
  "The purpose of the study was to identify and quantify non-genetic factors that contribute to death in the United States. Approximately half of all deaths that occurred in 1990 could be attributed to the factors identified." They represent a major health burden on our society and their identification offers guidance for shaping health priorities.

❑ Robine J.M., Romieu I., Cambois E. "Health Expectancy Indicators." *Bulletin of the World Health Organization,* 77(2):181-5, 1999.
Summarizes the "progress in the development of health expectancy indicators, which are growing in importance as a means of assessing the health status of populations and determining public health priorities."

✪ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. "Developing Objectives for Healthy People 2010." 1997.

Provides information on the process for developing the Nation's third set of disease prevention and health promotion objectives and includes a 1997 Summary List of Objectives. It describes how to get involved. Also available at: http://www.health.gov/healthypeople/publications/hppublist.htm.

❑ U.S. Department of Health and Human Services, Public Health Service. "Healthy People 2000: State Action." 1992.
"The report reflects the diversity of ways in which states have used the Healthy People 2000 objectives as a guide for developing state-specific health objectives."

❑ U.S. Department of Health and Human Services "Healthy People 2010: What Next?" *Prevention Report,* 13(4), 1999.
Provides a summary of what has been done to date on the Healthy People 2010 Initiative. It also provides literature resources, online resources, in print resources, funding information resources, and educational aids resources.

❑ Vilnius D., Dandoy S. "A Priority Rating System for Public Health Programs." *Public Health Reports,* 105(5):463-70, 1990.
This article describes a priority rating system which ranks public health issues according to size, urgency, severity of the problem, economic loss, impact on others, effectiveness, propriety, economics, acceptability, legality of solutions, and availability of resources.

Obtaining Baseline Measures, Setting Targets, and Measuring Progress

❑ Agency for Health Care Policy and Research. http://www.ahcpr.gov/data/
Data page includes links to websites on data, surveys , and healthcare information standards.

❑ Allison J., Kiefe C.I., Weissman N.W. "Can Data-Driven Benchmarks be Used to Set the Goals of Healthy People 2010?" *American Journal of Public Health,* 89(1):61-5, 1999.
Provides an explanation of the "pared-mean" method, which helps identify from data the best health care practices. "For Healthy People 2010, benchmarks derived from data reflecting the best available care provide viable alternatives to consensus-derived targets."

❑ Baker E.L., Ross D. "Information and Surveillance Systems and Community Health: Building the Public Health Information Infrastructure." *Journal of Public Health Management Practice,* 2(4):58-60, 1996.
Discusses the purpose of public health surveillance and information systems, examples from states with strong public health information infrastructures, and the CDC INPHO initiative as a capacity building process. Identifies some future surveillance and information system challenges.

❑ Bengson C. "The Year 2000 Issue: Implications for Public Health Information and Surveillance Systems." *NACCHO NEWS*, January/February:11, 1998.
Highlights the basics of the "2000 date" hardware issue (Y2K) and provides essential contact information.

❑ Birkhead G.S. "Recognizing and Supporting the Role of Public Health Surveillance: Intensive Care for a Core Public Health Function." *Journal of Public Health Management Practice,* 2(4)vii-ix, 1996.
This editorial helps to define surveillance, the surveillance demands that have evolved, and the difficulty in recognizing and addressing public health surveillance needs.

❑ Bureau of Labor Statistics – Safety and Health Statistics. http://www.bls.gov/iif/
Links to data web sites, news releases, and documentation related to safety and health statistics.

❑ Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion. "Public Health and Managed Care: Data Sharing for Common Goals." *Chronic Disease Notes & Reports,* 10(1):1-8, 1997.
Describes benefits and barriers of data sharing, the intended effects of Kennedy-Kassebaum Legislation (HIPPA), and the HMO Research Network.

❑ CDC WONDER – Healthy People DATA2000 Request Screen. http://wonder.cdc.gov/health.shtml
"The DATA2000 System contains national baseline and monitoring data for each Healthy People 2000 objective. In WONDER the available baseline and updated data are shown for 520 objectives and sub-objectives. Output options include simple tables and graphs."

❑ Chin T.L. "Internets/Intranets: A New Public Health Tool." *Health Data Management*, February 1998.
Discusses the use of the Internet and intranets by health departments around the nation including a focus on the CDC Information Network for Public Health Officials (INPHO) initiative.

✪ Committee on Leading Health Indicators for Healthy People 2010. *Leading Health Indicators For Healthy People 2010: Final Report.* Division of Health Promotion and Disease Prevention, Institute of Medicine, 1999.

This report includes the selection criteria for leading health indicators, as well as proposed indicator sets for Healthy People 2010. Available at: http://books.nap.edu/catalog/9436.html.

❑ Committee on Using Performance Monitoring to Improve Community Health. Division of Health Promotion and Disease Prevention, Institute of Medicine. "Improving Health in the Community: A Role for Performance Monitoring." 1997. http://books.nap.edu/books/0309055342/html/416.html.

❑ Envirofacts Warehouse. http://www.epa.gov/enviro/index_java.html
Provides access to the Environmental Protection Agency's environment data.

❑ Feinleib M. "Setting and Monitoring Health Objectives for the Nation." *Public Health Reviews,* 23(2):127-38, 1995.
"Reviews the progress toward accomplishing the objectives of the Healthy People 2000 national disease prevention effort. The National Center for Health Statistics has the responsibility for gathering information needed to monitor the progress toward these targets. The NCHS does so by ensuring that timely and accurate data are available, by constant monitoring of the trends, and by efficient communication with those responsible for implementing the programs and those who provide the resources for supporting the programs. This is to enhance the likelihood of achieving national objectives."

❑ Feldman P., Gold M., Chu K. "Enhancing Information for State Health Policy." *Health Affairs,* 13(3):236-50, 1994.
Essay on development of credible data, active policy champions, using data to gain the support of key constituencies, choosing staff with entrepreneurial and bridging skills, and taking advantage of short term policy windows.

❑ Health Forum Outcomes Toolkit. http://www.act-toolkit.com/
The toolkit's data capabilities:

  ▪ Allows for the development of a community-wide database on health, quality of life, economic vitality and community capacity
  ▪ Supports multiple users and facilitates information sharing among users
  ▪ Provides charting and graphing capabilities
  ▪ Responds to public and private sector demands for demonstrating measurable results
  ▪ Browse through any database that is accessible online
  ▪ Cut-and-paste information into your own database from anywhere, including from other communities
  ▪ Customize reports about activities and results
  ▪ Equipped with the power to locate and use a vast array of relevant information, including secondary data, via Web access

✪ ICD-10 – The following sights provide information on the ICD-10.

http://www.healthmkt.com

http://www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm

❑ Information Clearinghouse (Health Care Financing Administration). http://www.hcfa.gov/stats/
Links to information on Medicare financing, public use data files, and national healthcare indicators and expenditures.

✪ Morbidity and Mortality Weekly Report. http://www.cdc.gov/mmwr/

"The Morbidity and Mortality Weekly Report (MMWR) Series is prepared by the Centers for Disease Control and Prevention (CDC). The data in the weekly MMWR are provisional, and are based on weekly reports to CDC by state health departments."

❑ National Association of County Health Officials. Assessment Protocol for Excellence in Public Health (APEX*PH*), 1991.
The tool is an eight-step process for assessing community health status and planning for improvement. It is based on the principles of environmental justice, community collaboration, and locally appropriate decision making. Guidance is designed to be easily accessible and flexible enough to meet the needs of a variety of communities with differing health concerns. For more information, see http://www.naccho.org.

✪ National Association of Health Data Organizations. http://www.nahdo.org

"The National Association of Health Data Organizations (NAHDO) is the premier national health information organization dedicated to improving health care through the collection, analysis, dissemination, and use of health care data."

❑ National Cancer Institute SEER Cancer Statistics.
http://www.seer.ims.nci.nih.gov/Publications/CSR7394/index.html
A review of cancer statistics from 1973-1995.

✪ National Center for Health Statistics. http://www.cdc.gov/nchs/products.htm

Publications and information products with links to Healthy People 2000 Reviews (in PDF format). The home page for the National Center for Health Statistics is available at http://www.cdc.gov/nchs/.

❑ Sondik E. "Healthy People 2000: Meshing National and Local Health Objectives." *Public Health Report,* 111(6):518-20, 1996.
Summarizes the successes and problems with data collection as it relates to the Healthy People initiative. Urges action on the national, state and local levels.

❑ Stevens P.E. "Focus Groups: Collecting Aggregate-Level Data to Understand Community Health Phenomena." *Public Health Nursing,* 13(3):170-6, 1996.
The article discusses the potential benefits of focus groups when studying community health. It explores the advantages and uses of a focus group as well as purposes and processes of focus group facilitation. It goes on to explain how to analyze focus group results, their limitations, and their implications for health planning.

❑ Torres I.M. "Assessing Health in an Urban Neighborhood: Community Process, Data Results and Implications for Practice." *Journal of Community Health,* 23(3):211-26, 1998.
Summarizes the development process of the Health Assessment Project (HAP). This was a health assessment conducted by the University of Massachusetts School of Public Health faculty, students and community organizations and residents. The article gives an overview of the community process, data results, and implications for public health practice.

❑ Turnock B., Handler A. "Measuring Effective Local Public Health Practice." Available from B.J. Turnock, Center for Public Health Practice, School of Public Health, University of Illinois at Chicago, Box 6998, Chicago, IL 60680. (312) 996-6620. 1994.
"This paper proposes a framework for describing and measuring local public health practice to track progress toward Objective 8.14 of Healthy People 2000. Performance measures consisting of performance expectations/standards and associated performance indicators for each of the 10 collective public health practices developed at the Centers for Disease Control in 1989 are included. The appendices include preliminary and revised standards and indicators. The effectiveness of local health departments in addressing the core functions of public health is discussed. Roles for local health liaisons in the surveillance of local public health practice and capacity building are also addressed."

✪ U.S. Census Bureau. http://www.census.gov

❑ U.S. Department of Health and Human Services. "Improving the Nation's Health with Performance Measurement." *Prevention Report.* http://odphp.osophs.dhhs.gov/pubs/prevrpt/97winfoc.HTM
This article looks at how the "U.S. Department of Health and Human Services and state and local communities are applying performance measurement. It describes and shows how states can develop performance measures based on Healthy People Objectives."

Managing and Sustaining the Process

❑ American Public Health Association, Model Standards Project. "Community Strategies for Health: Fitting in the Pieces." Available from the American Public Health Association, 800 Eye Street, N.W., Washington, D.C. 20001-3710. (202) 777-2742. 1993.
This manual indicates ways that local health agencies can reach out to organizations that are concerned with the health of their community. The principles contained in the "Healthy Communities 2000: Model Standards," are emphasized. The use of the Assessment Protocol for

Excellence in Public Health (APEXPH) and the Planned Approach to Community Health (PATCH) in reaching the goals of the model standards is considered. The manual highlights steps that local health departments, the medical community, community organizations, local employers, the academic community, and local media can take to obtain commitments from community members."

❑ American Public Health Association, Model Standards Project. "The Guide to Implementing Model Standards: Eleven Steps Toward a Healthy Community." Available from Jenne Glass, Model Standards Project, American Public Health Association, 800 Eye Street, N.W., Washington, D.C. 20001-3710. (202) 777-2742. 1993.
"This manual provides local health departments with 11 steps for implementing the "Healthy Communities 2000: Model Standards" within their programs to help achieve the goals of Healthy People 2000."

❑ Bronheim S.M., Keefe M.L., Morgan C.C. "Building Blocks of a Community-Based System of Care: The Communities can Campaign Experience." Available from Mary Deacon, Georgetown University Child Development Center, 3307 M Street, N.W., Suite 401, Washington, D.C. 20007. (202) 687-8635. 1993.
"This report is part of a series focused on the details of how individual communities can realize the vision of providing family-centered, community-based, coordinated care for children with special health needs and their families. Winning strategies included fostering interagency collaboration, establishing public/private partnerships, identifying non-monetary resources, promoting active participation by physicians and families in system development, building on existing programs, developing generic systems of care to serve all children, and developing cultural competence. This campaign was implemented as part of the Healthy People 2000 objectives for the nation, and funded by the Maternal and Child Health Bureau, U.S. Department of Health and Human Services, and by the American Academy of Pediatrics."

✪ Change Project. http://www.well.com/user/bbear

From this main page, follow the link to Healthy Communities, then to Sustaining the Effort. This will take you to the article, "Sustaining the effort: building a learning community from the healthcare forum." The table of contents includes areas such as governance, structure, and leadership; process; maintaining participation and inclusion; resources; staff support; measurement; and celebration.

❑ Committee on Using Performance Monitoring to Improve Community Health. Division of Health Promotion and Disease Prevention, Institute of Medicine. "Improving Health in the Community: A Role for Performance Monitoring." 1997. http://books.nap.edu/books/0309055342/html/416.html

❑ Johnson K. "Building Capacity Through Collaborative Leadership." *International Journal of Health Planning and Management,* 11(4):339-44, 1996.
"This paper is based upon material from the manuals and training program underpinnings of the 'Sustaining community-based initiatives' from the Healthcare Forum with the W.K.Kellogg

Foundation in the USA. The use of organizational management principles and practices in community involvement and strengthening community leadership is illustrated through practical examples."

✪ National Civic League. "The Healthy Communities Handbook." Available from National Civic League, 1445 Market Street, Suite 300, Denver, CO 80302. (303) 571-4343.

"This manual is intended for the use of community groups, business people, individuals, or local governments that are concerned with their communities. It incorporates the goals and objectives of the Healthy People 2000 initiative into a community-based health planning process. The manual notes the standards and principles from various programs to develop a baseline for planning local programs. "

✪ Revisiting the Critical Elements of Comprehensive Community Initiatives.
http://aspe.os.dhhs.gov/hsp/cci.htm

The study focuses on lessons and insights gained through the experience of Comprehensive Community Initiatives. The study defines the characteristics of a good leader and staff, how to develop and maintain a sense of hope and momentum, and how planning and action can be blended and balance.

❑ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. "Healthy People 2000: Turning Commitment into Action." 1993.
Provides activity ideas for mobilizing the Healthy People 2000 initiative.

Communicating Health Goals and Objectives

✪ American Public Health Association, Model Standards Project. "Media Relations." Available from American Public Health Association, 800 Eye Street, N.W., Washington, D.C. 20001-3710. (202) 777-2742. 1993.

"This manual provides local governments with strategies to obtain media coverage for their efforts to develop local health programs that integrate the 'Healthy Communities 2000: Model Standards' principles. It considers the interrelated needs of the local health departments for coverage and the local media for news of local interest. The manual indicates methods for gaining media attention while operating on a limited budget and it highlights the parts of the Model Standards that are related to current media issues."

❑ International Health Communication Hotline.
http://www.vscc.cc.tn.us/academic/humanities/com100/inhome.html

"It is dedicated to serving the community of health communication researchers, educators, practitioners and administrators by offering a variety of links to health and communication-related

Appendix A: Resources

sites." Provides general communication links, health communication/general health and medicine links, health communication commercial sites, and other useful and interesting sites.

❑ *The International Journal of Nonprofit and Voluntary Sector Marketing*.
http://www.henrystewart.co.uk/journals/nvsm
Provides information on the latest innovations in: fundraising, social and healthcare marketing, education marketing, customer retention and loyalty, advertising and promotion, campaigning and lobbying, database marketing, and marketing software.

❑ *Journal of Health Communication: International Perspectives*.
http://www.tandf.co.uk/journals/tf/10810730.html
This journal provides information on "the latest developments in the field of health communication, including research in social marketing, shared decision making, communication (from interpersonal to mass media), psychology, government, and health education in the United States and the world."

✪ Making Health Communication Programs Work: A Planners Guide.
http://oc.nci.nih.gov/services/HCPW/HOME.HTM

Includes information on planning and strategy selection, determining your target audiences, writing program plans and developing a timetable, selecting channels and materials, characteristics of mass media channels, developing materials and pre-testing, implementing your program, establishing process evaluation measures, steps for involving intermediaries in your program, assessing effectiveness, outcome evaluation, impact studies, and revising the program.

❑ Morgan D.L., Krueger R.A. The Focus Group Kit. Sage Publications, California, 1998.
A set of six short books that take you through the focus group process. The books include: The Focus Group Guidebook, Planning Focus Groups, Developing Questions for Focus Groups, Moderating Focus Groups, Involving Community Members in Focus Groups, and Analyzing and Reporting Focus Group Results.

❑ National Association of County and City Health Officers. *Providing Culturally Appropriate Services: Local Health Departments and Community-Based Organizations Working Together.*
Washington D.C.: National Association of County and City Health Officials. 1994.

This report describes three case studies which implemented activities to address language and cultural needs in their communities. It includes recommendations for health departments along with information about other resources, references, and contacts on multi-cultural health.

✪ Siegel M., Doner L. Marketing Public Health: Strategies To Promote Social Change. Aspen Publications, Maryland, 1998.

This book focuses on marketing principles for public health practice, including challenges and opportunities for marketing social change and public health. It also focuses on using marketing

principles to design, implement, and evaluate public health interventions. In addition, it includes case studies.

❑ Social Marketing Quarterly.
A publication of Best Start, Inc. and The Department of Community and Family Health, College of Public Health, University of South Florida. All articles in the journal "focus on social marketing, or emphasize a component of social marketing and demonstrate how the components(s) fit into and/or apply to a complete social marketing program."

❑ "Social Marketing Can Enhance Prevention Programming." *Prevention Alert*.
http://www.health.org/govpubs/prevalert/html-p43/v1page01.htm
A brief overview of why the Social Marketing Theory can work in public health. It is adapted from the following article: Ling J. C., Franklin B. A. K., Lindsteadt J. F., Gearon, S. A. N. "Social marketing: its place in public health." *Annual Review of Public Health*, 13: 341-362, 1992.

❑ The United States Conference of Local Health Officers and the United States Conference of Mayors. Language and culture in health care: Coping with Linguistic and Cultural Differences: Challenges to Local Health Departments. The United States Conference of Local Health Officers and The United States Conference of Mayors. (Copies can be obtained from 1620 Eye Street, N.W., Washington, D.C. 20026, Tel: (202) 293-7730. 1993.
This reports addresses the barriers encountered in the provision of services to non-English speaking groups at the local level. It also provides recommendations for actions and descriptions of several case profiles.

❑ Walsh D.C., Rudd R.E., Moeykens B.A., Moloney T.W. "Social Marketing for Public Health." *Health Affair,* 12(2):104-19, 1993.
"Marketing techniques and tools, imported from the private sector, are increasingly being advocated for their potential value in crafting and disseminating effective social change strategies. This paper describes the field of social marketing as it is used to improve the health of the public. A disciplined process of strategic planning can yield promising new insights into consumer behavior and product design. However, the "technology" cannot simply be transferred without some translation to reconcile differences between commercial marketing and public health."

Other Useful Resources

❑ American Association for Health Education. http://www.aahperd.org/aahe/template.cfm
"Serves health educators and other professionals who promote the health of all people. AAHE encourages, supports, and assists health professionals concerned with health promotion through education and other systematic strategies."

❑ Association of State and Territorial Directors of Health Promotion and Public Health Education. http://www.astdhpphe.org/index.html
"The mission is to promote the quality practice of health education and health promotion as core disciplines of public health practice and to advocate for quality health education/health promotion programs and strategies to address the nation's leading health problems."

❑ Centers for Disease Control and Prevention. (CDC) http://www.cdc.gov
The mission of the CDC is, "to promote health and quality of life by preventing and controlling disease, injury, and disability." The web site contains information ranging from research to funding issues and from various guidelines to health information. This site is searchable by key word.

❑ National Institutes of Health. (NIH) http://www.nih.gov
Contains various information on health, news, funding opportunities, and scientific resources. It also has its own search engine.

❑ National Library of Medicine http://www.nlm.nih.gov
The National Library of Medicine (NLM), the world's largest medical library, collects materials in all areas of biomedicine and health care. NLM produces a number of free online databases that can be searched to identify publications (books or journal references) on specific health related topics including topics of interest to public health. NLM is a national resource for all U.S. health science libraries through a National Network of Libraries of Medicine. The public can call toll-free for referral to a network library member in their area: 888-346-3656.

MEDLINE – http://www.nlm.nih.gov/databases/freemedl.html

MEDLINE is the National Library of Medicine's online database that contains almost 10 million references to journal articles in the health sciences. Approximately 4,000 medical journals are indexed in MEDLINE. The time period covered is 1960 to the present. Seventy-six percent of the articles have abstracts. NLM has developed two interfaces for searching MEDLINE: (1) PubMed and (2) Internet Grateful Med. Both services have online instructions available (under Help in PubMed and the Internet Grateful Med User's Guide from the IGM homepage) to assist users in searching MEDLINE effectively.

LOCATORplus – http://locatorplus.gov/

LOCATORplus is the National Library of Medicine's new Web-based catalog. LOCATORplus allows anyone with Internet access to find out what books, journals, audiovisuals, manuscripts, and other items are contained in the NLM collections.

HSR Search – http://www.nlm.nih.gov/nichsr/nichsr.html

HSR Search is the National Library of Medicine's search interface designed to give users a single access point to several NLM databases with health services research-specific information. This new feature is accessible from the National Information Center on Health Services Research and Health

Care Technology (NICHSR) homepage. HSR Search allows users to enter one or more terms that are then ANDed together for them. HSR Search runs a query against the following NLM databases: HealthSTAR, HSRProj, DIRLINE, HSTAT, and a prototype HSR Tools database. Users may select all or some of these when sending a query. It is expected that in the future that the HSR Search will be replaced by an NLM gateway that is currently being developed by Library staff. This gateway, which will be a much more sophisticated state-of-the-art access mechanism, will provide access to NLM's databases beyond the HSR suite.

National Information Center on Health Services Research and Health Care Technology – http://www.nlm.nih.gov/nichsr/nichsr.html

NICHSR is the National Library of Medicine's focal point for health services research information. The goals of NICHSR are to make the results of health services research, including practice guidelines and technology assessments readily available to health practitioners, health care administrators, health policy makers, payers, and the information professionals who serve these groups; to improve access to data and information needed by the creators of health services research; and to contribute to the information infrastructure needed to foster patient record systems that can produce useful health services research data as a by-product of providing health care. See the NICHSR Related Web Sites (links) for important resources.

Partners in Information Access for Public Health Professionals –

http://nnlm.gov/partners/

This is a new collaborative project to provide public health professionals with timely and convenient access to information resources to help them improve the health of the American Public. Project partners include the: Association of State and Territorial Health Officials (ASTHO); Centers for Disease Control and Prevention (CDC); Health Resources and Services Administration (HRSA); National Association of County and City Health Officials (NACCHO); National Library of Medicine (NLM); National Information Center on Health Services Research and Health Care Technology (NICHSR), NLM; National Network of Libraries of Medicine (NN/LM); and the Public Health Foundation (PHF). This resource includes special sections on: (1) Tools to aid in identifying Grants and Grant Writing, (2) Tools for Education and Training , and (3) information about libraries within your own local geographic areas to assist you in obtaining documents and related library services or for developing local partnerships.

Current Bibliographies in Medicine –   http://www.nlm.nih.gov/pubs/resources.html

Current Bibliographies in Medicine is the National Library of Medicine's publication series which contains selected references on a distinct subject area of medicine of current popular interest, e.g., domestic violence assessment by health care practitioners. See especially the CBM on Public Health Informatics (http://www.nlm.nih.gov/pubs/cbm/phinform.html) and health literacy related bibliographies (forthcoming).

HSRProj – http://www.nlm.nih.gov/nichsr/db.html#hsrp

HSRProj is one of the information products developed by the National Information Center on Health Services Research and Health Care Technology (NICHSR), a component of the National Library of Medicine. HRSProj contains descriptions of research in progress funded by federal and private grants and contracts for use by policy makers, managers, clinicians and other decision makers. It provides access to information about health services research in progress before results are available in a published form. Records cover both grants and contracts awarded by several major public and private funding agencies and foundations.

Users can retrieve names of performing and sponsoring agencies, names and addresses of the principal investigator, beginning and ending years of the project, level of funding, information about study design and methodology (including demographic characteristics of the study group), number of subjects in the study population, population base of the study sample, and source of the project data. Project descriptions are also included whenever possible.

HSTAT - http://hstat.nlm.nih.gov/

HSTAT is a free, electronic resource developed under the auspices of the National Library of Medicine (NICHSR office) that provides access to the full-text of documents useful in health care decision making. STAT includes: clinical practice guidelines, quick-reference guides for clinicians, consumer brochures, and evidence reports sponsored by the Agency for Health Care Policy and Research (AHCPR); AHCPR technology assessment reports; National Institutes of Health (NIH) consensus development conference and technology assessment reports; NIH Warren G. Magnuson Clinical Center research protocols; HIV/AIDS Treatment Information Service (ATIS) resource documents; Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment (SAMHSA/CSAT) treatment improvement protocols; and the Public Health Service (PHS) Preventive Services Task Force Guide to Clinical Preventive Services. It also provides a link to the Centers for Disease Control and Prevention (CDC) Prevention Guidelines Database.

MEDLINEplus – http://www.nlm.nih.gov/medlineplus/

MEDLINEplus is the National Library of Medicine's new consumer health information service. See links for health consumers to libraries participating in this project (http://medlineplus.nlm.nih.gov/medlineplus/libraries.html).

❑ Public Health Foundation Healthy People 2010 Audioconference Series.
http://www.phf.org/hp2010/2010ac.htm
The materials in the audioconference series "serve as reference materials for states as they build their own health objectives plan." The topics in the series include: Building State and Local Health Objectives; Using Data to Set and Measure Health Objectives; Making the Link; Translating Healthy People Objectives into Local Targets; Lessons Learned for 2010: The Good , the Bad, and the Ugly.

- Society for Public Health Education. http://www.sophe.org

  "The mission is to provide leadership to the profession of health education and health promotion to contribute to the health of all people through advances in health education theory and research, excellence in health education practice, and the promotion of public policies conducive to health."

- U.S. Department of Health and Human Services. http://www.hhs.gov

  "The Department of Health and Human Services is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. The department contains more than 300 programs, covering a wide spectrum of activities." The web site contains a plethora of information and you are able to search the sight by key word.

Appendix A: Resources

Appendix B: Healthy People State, Territorial, and Tribal Action Contacts

State Contact Information

Alabama
Mr. Jim McVay
Director of Health Promotion and Chronic Disease
Alabama Department of Public Health
P. O. Box 303017
Montgomery, AL 36130-3017
E-mail: jmcvay@adph.state.al.us
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Alaska
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Health and Social Services Planner
Data and Evaluation Unit
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Alaska Department of Health and Social Services
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E-mail: Debbie_Lowenthal@health.state.ak.us
Voice: (907) 465-5663
Fax: (907) 465-8637

Arizona
Ms. Geri Tebo
Healthy Communities Coordinator
Arizona Department of Health Services
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Phoenix, AZ 85017
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Voice: (602) 542-1918
Fax: (602) 542-1265

Arkansas
Ms. Christine Patterson, MSW
Director of the Office of Minority Health
Arkansas Department of Health
Slot #52
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Little Rock, AR 72205
E-mail: cpatterson@healthyArkansas.com
Voice: (501) 661-2193
Fax: (501) 661-2414

California
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Research Analyst
Center for Health Statistics
California Deparment of Health Services
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Fax: (916) 324-5599

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Colorado Department of Health
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Fax: (303) 782-0095

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Director of Research and Planning
Office of Policy, Planning and Evaluation
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Voice: (860) 509-7120
Fax: (860) 509-7160

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Director of Administration
Division of Public Health
Delaware Dept. of Health & Social Services
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Voice: (302) 739-3034
Fax: (302) 739-3008

District of Columbia
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Public Health Advisor
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Voice: (202) 442-9039
Fax: (202) 442-4833

Florida
Mr. William Alfred
Operations Management and Consultant
Manager
Florida Dept. of Health & Data Analysis
4052 Bald Cypress Way, Bin #A05
Tallahassee, FL 32399-1706
E-mail: B_Alfred@doh.state.fl.us
Voice: (850) 245-4009
Fax: (850) 921-1898

Georgia
Mr. Jack Kirby
Deputy Director
Division of Public Health
Georgia Department of Human Resources
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Atlanta, GA 30303
E-mail: jkirby@dhr.state.ga.us
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Georgia
Ms. Michele Mindin
Director for Grant Development and
Management
Georgia Division of Public Health
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Appendix B: Contacts

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Fax: (605) 226-7670

Alaska Area Indian Health Service
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Serving: AK
Voice: (907) 729-3686

Albuquerque Area Indian Health Service
5338 Montgomery Blvd., NE
Albuquerque, NM 87109-1311
Serving: NM, CO, TX
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Fax: (505) 248-4500

Bemidji Area Indian Health Service
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Fax: (218) 759-3511

Billings Area Indian Health Service
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Billings, MT 59103
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Fax: (406) 247-7230

California Area Indian Health Service
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Serving: CA
Voice: (916) 566-700
Fax: (916) 566-7053

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Oklahoma City Area Indian Health Service
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Oklahoma City, OK 73112
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Fax: (405) 951-3780

Phoenix Area Indian Health Service
Two Renaissance Square
40 North Central Avenue
Phoenix, AZ 85004
Serving: AZ, NV, UT
Voice: (602) 364-5039

Portland Area Indian Health Service
1220 S.W. Third Avenue - Room 476
Portland, OR 97204-2892
Serving: ID, OR, WA
Voice: (503) 326-2020
Fax: (503) 326-7280

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Appendix C:
State and National Healthy People Web Sites

State Web Sites

[An asterisk (*****) denotes that the state's Healthy People 2000 and/or 2010 plan is available on the state web site.]

Alabama*
http://www.adph.org/administration/ha2010.pdf

Alaska*
http://www.hss.state.ak.us/dph/deu/ha2010/default.htm

American Samoa
http://www.samoanet.com/asg/

Arizona*
2000: http://www.hs.state.az.us/plan/2000/az2000.htm
2010: http://www.hs.state.az.us/phs/healthyaz2010/index.htm

Arkansas
http://www.healthyarkansas.com/

California*
http://www.dhs.ca.gov/chs/ohir/yr2000/yr2000.htm

Colorado
http://www.cdphe.state.co.us/

Connecticut*
http://www.state.ct.us/dph/OPPE/sha99/shacontents.htm

Delaware*
http://www.healthydelaware.com

District of Columbia*
http://dchealth.dc.gov/information/healthy_people2010/index.shtm

Federated States of Micronesia
http://www.fsmgov.org/ngovt.html

Florida
http://www.doh.state.fl.us

Georgia
http://health.state.ga.us/

Guam
http://mail.admin.gov/gu/pubhealth/index.html

Hawaii*
http://www.state.hi.us/health/resource/Healthy_Hawaii/opdh2000.htm

Idaho
http://www2.state.id.us/dhw/

Illinois
http://www.idph.state.il.us/home.htm

Indiana
http://www.state.in.us/isdh/

Iowa*
http://www.idph.state.ia.us/sa/h_ia2010/contents.htm

Kansas
http://www.kdhe.state.ks.us/bhp/

Kentucky*
http://publichealth.state.ky.us/healthy_ky_2010.htm

Louisiana*
http://www.dhh.state.la.us/OPH/pub.htm

Maine*
http://www.state.me.us/dhs/boh/healthyme2k/healthyme2k.htm

Mariana Island
http://www.mtccnmi.com/community/CHCSaipan/index.htm

Maryland*
2000:   http://mdpublichealth.org/ohp/html/hm2000.html
2010:   http://mdpublichealth.org/ohp/html/hip.html

Massachusetts
http://www.state.ma.us/dph/fch1.htm

Michigan
http://www.mdch.state.mi.us/

Minnesota*
http://www.health.state.mn.us/divs/chs/phg/intro.html

Mississippi
http://www.msdh.state.ms.us/

Missouri*
http://www.health.state.mo.us/PreventionAndWellness/welcome.html

Montana
http://www.dphhs.mt.us/index.htm

Nebraska*
http://www.hhs.state.ne.us/profiles/nebraska/profile.htm

Nevada
http://www.state.nv.us/health/

New Hampshire*
http://www.healthynh2010.org/

New Jersey*
2000:   http://www.state.nj.us/health/hcsa/rmtoc.htm
2010:   Vol. 1: http://www.state.nj.us/health/chs/hnj2010vol1.pdf
        Vol. 2: http://www.state.nj.us/health/chs/hnj2010vol2.pdf

New Mexico
http://www.health.state.nm.us/website.nsf/frames?ReadForm

New York*

http://www.health.state.ny.us/nysdoh/phforum/hlthcomm.pdf

North Carolina*

http://www.healthycarolinians.org/healthobj2010.htm

North Dakota*

http://www.health.state.nd.us/ndhd/pubs/hlthrisk/intro.htm

Ohio*

http://www.odh.state.oh.us/Resources/repts1.htm

Oklahoma*

http://www.health.state.ok.us/program/planning/obj2000/summary.html

Oregon*

http://www.ohd.hr.state.or.us/chs/hsi/or_hsi.htm

Pennsylvania*

http://www.health.state.pa.us/hpa/ship/ship.htm

Rhode Island*

http://www.healthri.org/chic/healthypeople/home.htm

South Carolina

http://www.scdhec.net/

South Dakota

http://www.state.sd.us/doh/

Tennessee

http://www.state.tn.us/health/

Texas*

http://www.tdh.state.tx.us/dpa/HP2000A.htm

Utah*

http://hlunix.hl.state.ut.us/action2000/hsind.html

Vermont*

2000: http://www.state.vt.us/health/hv2k.htm
2010: http://www.state.vt.us/health/_admin/pubs/2000/hv2010/hv2010.htm

Virgin Islands

http://www.gov.vi/health/

Virginia*
2000:   http://www.vdh.state.va.us/commish/healthy/index.htm
2010:   http://www.vdh.state.va.us/hv2010/index.html

Washington*
http://www.doh.wa.gov/Publicat/96_HWS/hws-intr.htm

West Virginia*
2000:   http://www.wvdhhr.org/bph/hp2000/updates/hp2000.htm
2010:   http://www.wvdhhr.org/bph/hp2010/objective/contents.html

Wisconsin
http://www.dhfs.state.wi.us/

Wyoming
http://wdhfs.state.wy.us/wdh/

National: Office of Disease Prevention and Health Promotion Web Sites

Office of Disease Prevention and Health Promotion
http://odphp.osophs.dhhs.gov/

Environmental Health Policy Committee
http://www.health.gov/environment

healthfinder™
http://www.healthfinder.gov/

Healthy People 2000
http://odphp.osophs.dhhs.gov/pubs/hp2000/

Healthy People 2010 Home Page
http://www.health.gov/healthypeople/

National Health Information Center
http://nhic-nt.health.org

Partnerships Conference
http://www.health.gov/partnerships/

Public Health Functions Project
http://www.health.gov/phfunctions/

Science Panel on Interactive Communication and Health
http://www.scipich.org

U.S. State and Local Government Gateway, Health
http://www.health.gov/statelocal/

U.S. State and Local Government Gateway, Families and Children
http://www.hhs.gov/families/

HHS Partner Gateway
http://www.hhs.gov/partner/