# *Setting Health Priorities and Establishing Objectives*

*"Put first things first."*

*—Stephen Covey*

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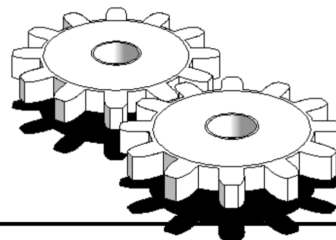
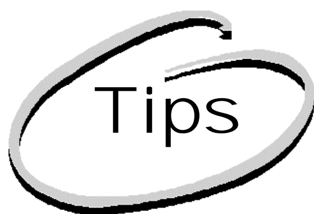
Determining health priorities helps direct resources to the areas that matter most to community partners and that will have the greatest impact on community health status. With so many competing needs, selecting priorities and establishing objectives may seem like an arduous task. However, there are 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




**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

# Process in Action: Examples from the Field

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*

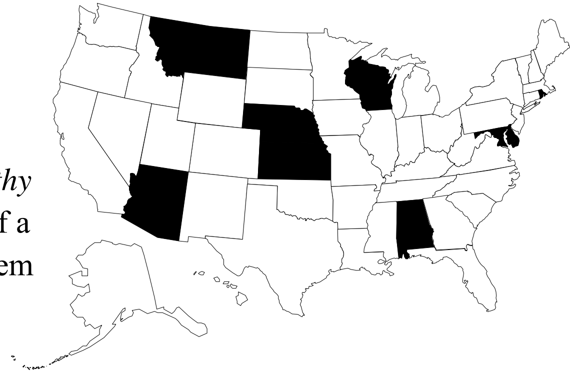
In 1997 the consultation on the Healthy People 2010 framework took place on the Internet. Individuals from 46 of the 50 states "let their voices be heard." New focus areas on public health infrastructure, health communication, and disability and secondary conditions were added to the existing framework.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

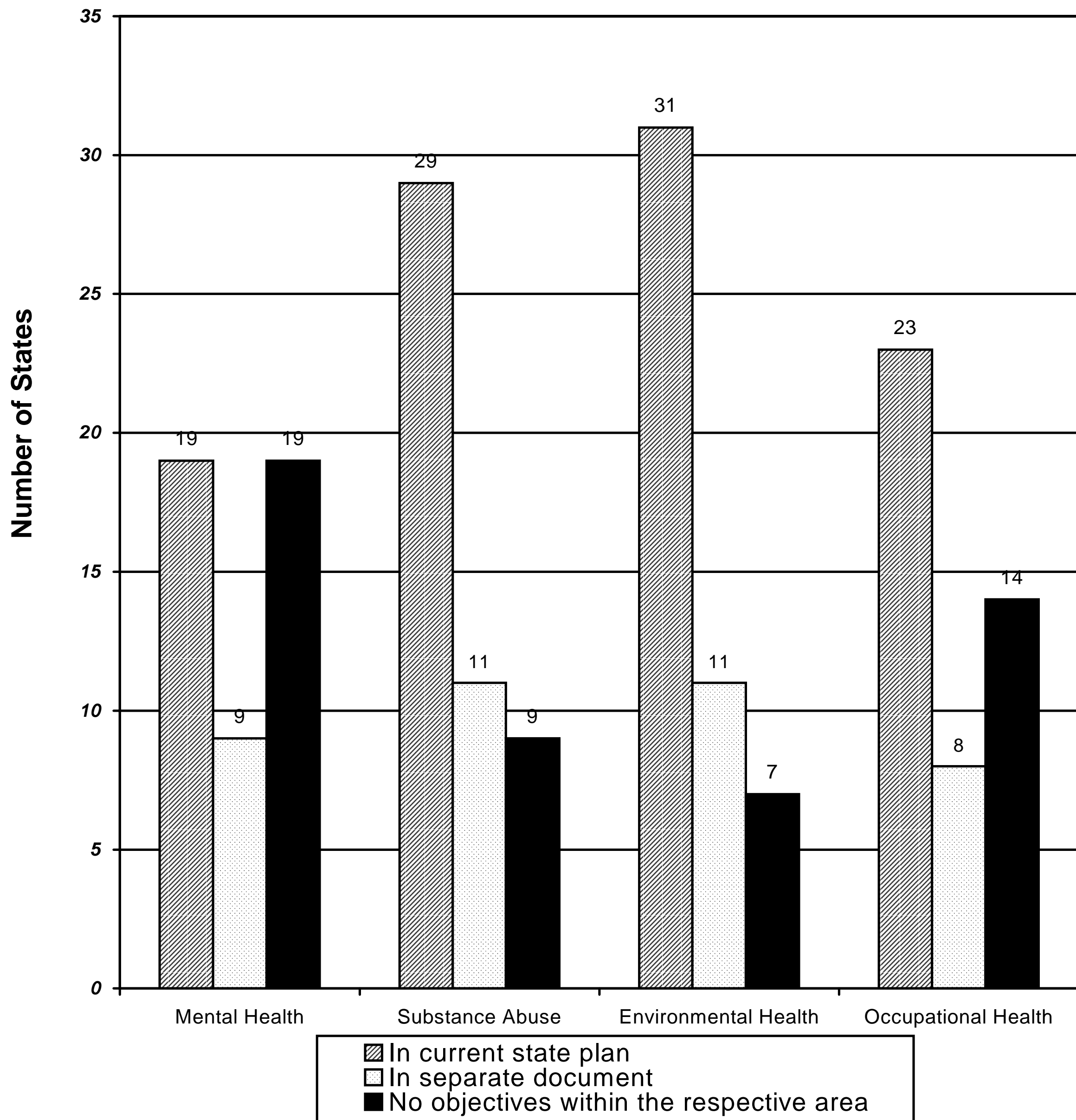
***Number of Objectives by State***

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

| ## Objectives | ***How will we know if we reached the goal?*** |
|---|---|
| Examples<br><br>*By 2010, increase the use of safety belts and child restraints to at least 93% of motor vehicle occupants. (Baseline: 69% in 1997)*<br><br>*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.)*<br><br>*By 2005, increase to 100% the proportion of health plans that offer treatment of nicotine addiction. (Potential data source: state managed care survey)* | *(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)*<br><br>Tips<br><br>• 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.<br>• 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)?<br>• 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.<br>• Set short-term as well as long-term objectives as a motivational strategy.<br>• Be clear with numbers and percentages (e.g., know your denominator). There is a big difference in increasing enrollment by 20 percent, to 20 percent, or by 20 people.<br>• 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.<br>• 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**<br>Examples<br>*Increase tax on cigarettes by at least 75 cents.*<br>*Provide skills training to physicians on effective physical activity counseling*<br>*Enforce laws prohibiting tobacco sales to minors*<br>*Expand sites promoting CHIP and application assistance to employers, neighborhood agencies, parish nursing, YWCA, and others*<br>. | ***How will the objective be reached?***<br>*(specifies the type of activities that must be planned, by whom, and for whom)*<br>Tips<br>• 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.<br>• Consider the specific assets of the state to choose strategies that are achievable.<br>• Ask whether the strategy addresses known risk factors and how it will reduce risk and/or increase health factors.<br>• Provide known effective (efficacious and possible) interventions and strategies.<br>• Seek individuals affected directly or indirectly by the health threat. Enlist their support in responding to getting policy maker or partner support for strategies.<br>• Seek guidance from those who may carry out strategies on the most effective, efficient, and "doable" activities.<br>• 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).<br>• 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:<br>◆ targeted economic development<br>◆ health education<br>◆ social marketing<br>◆ assessment and referral<br>◆ policy (legislation, regulation, program policy)<br>◆ enforcement<br>◆ capacity building (new or improved systems)<br>◆ coordination of services<br>◆ changing the social or physical environment<br>◆ employer programs<br>• Determine if the strategy is likely to reach the target population.<br>• 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** | ➢<br>➢<br>➢ |

# 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.

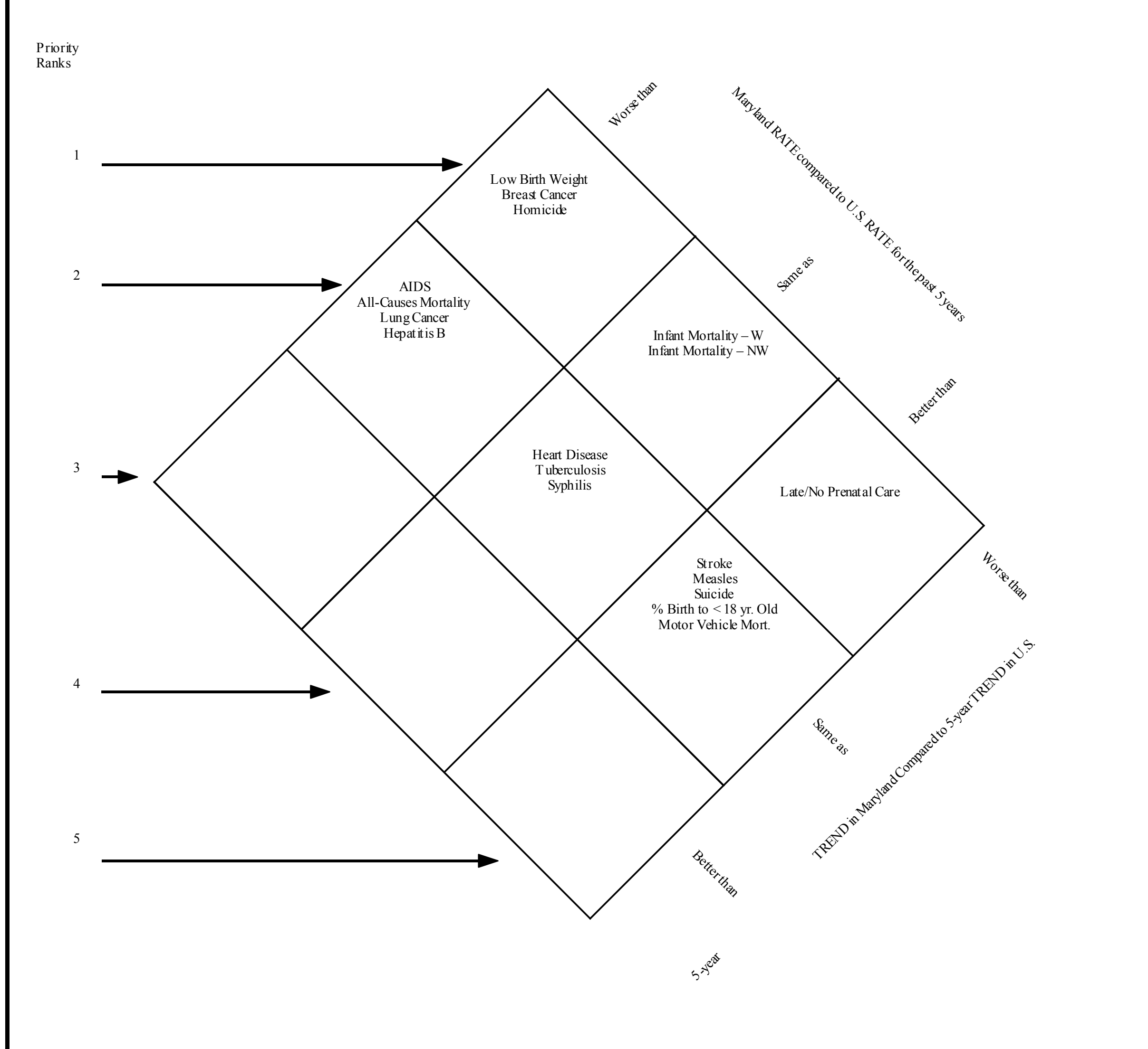
Maryland is in the process of determining community-based priorities in partnership with its 24 local jurisdictions. The state and local collaboration and network of resources has allowed monitoring of the population health needs by using centrally organized data collection and analysis. In addition, 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




## 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

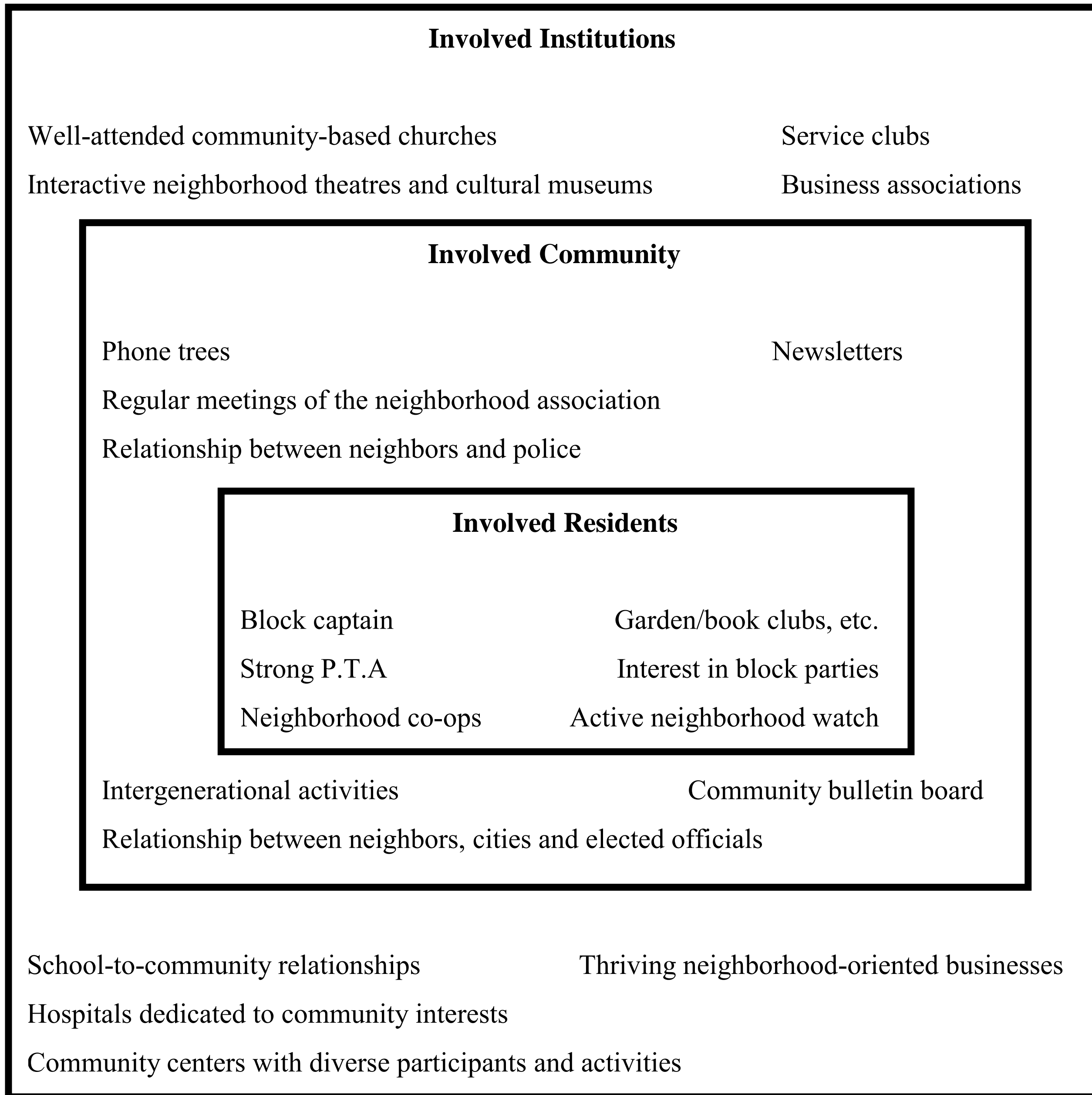
**Physical Resources**
Vacant land
Commercial and industrial structures
Housing
Energy and waste resources

**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




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

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