Using Healthy People 2020 in Performance Improvement at Local Health Departments

Accreditation Preparation

• Health department must provide documentation of a **collaborative** process

• Examples of tools and processes that may be adapted for the community assessment include MAPP and Healthy People 2020

PHAB Standards and Measures Version 1.5

**STANDARD 1.1:** Participate in or lead a collaborative process resulting in a comprehensive community health assessment.

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>PURPOSE</th>
<th>SIGNIFICANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Measure 1.1 T/A.</strong> Tribal/local partnership that develops a comprehensive community health assessment of the population served by the health department.</td>
<td>This purpose of this measure is to assess the health department’s collaborative process for sharing and analyzing data and information concerning population health, health challenges, and community resources to develop a community health assessment of the population of the jurisdiction served by the health department.</td>
<td>The development of a Tribal/local level community health assessment requires partnerships with other members of the Tribe/community to access data, provide various perspectives in the analysis of data and determination of factors that impact health outcomes, present data and findings, and share a commitment for using the assessment. Assets and resources in the Tribal/local community must be addressed in the assessment, as well as health challenges. Data are not limited to traditional public health data but include, for example, quality of life, attitudes about health behavior, socioeconomic factors, environmental factors (including the built environment), and social determinants of health. Data are provided from a variety of sources and through various methods of data collection.</td>
</tr>
</tbody>
</table>

**REQUIRED DOCUMENTATION**

3. The process used to identify health issues and assets

**GUIDANCE**

3. The health department must document the collaborative process used to identify and collect data and information on health issues, and identify existing Tribal or local assets and resources to address health issues. The process used may be an accepted national model; state-based model; a model from the public, private, or business sector; or other participatory process model. When a specific model is not used, the key steps undertaken that outline the process used should be described.

National models include, for example, Mobilizing for Action through Planning and Partnerships (MAPP), Association for Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US) (http://www.chusa.org/dl/DefaultSource/GeneralFiles/cb_assessingaddressing-pdf.pdf?sfvrsn=1), and the University of Kansas Community Toolbox (http://cb.ku.edu/en/node/9).

Examples of tools or resources that can be adapted or used throughout, or as part of, the community health assessment process include NACCHO’s Resource Center for Community Health Assessments and Community Health Improvement Plans, Community Indicators process project, Asset-Based Community Development model, Tribal Accreditation Readiness Guidebook and Roadmap, Inter Tribal Council of Arizona’s Tribal CHA Toolkit, National Public Health Performance Standards Program (NPHPSP), Assessment Protocol for Excellence in Public Health (APEX/PH), Guide to Community Preventive Services, and Healthy People 2020, RWJF County Health Rankings and Roadmaps: Assess (http://www.countyhealthrankings.org/roadmaps/action-center/assess-need-resources).
PHAB Standards and Measures Version 1.5

Standard 5.2: Conduct a comprehensive planning process resulting in a Tribal/state/community health improvement plan.

**MEASURE**
Measure 5.2.1 L
A process to develop a community health improvement plan

**PURPOSE**
The purpose of this measure is to assess the local health department’s collaborative community health improvement process and the participation of stakeholders.

**SIGNIFICANCE**
While the local health department is responsible for protecting and promoting the health of the population, it cannot be effective acting unilaterally. The health department must partner with other sectors and organizations to plan and share responsibility for community health improvement. Other sectors of the community and stakeholders have access to additional data and bring different perspectives that will enhance planning. A collaborative planning process fosters shared ownership and responsibility for the plan’s implementation. The community health improvement process is a vehicle for developing partnerships and for understanding roles and responsibilities.

**REQUIRED DOCUMENTATION**
1. Community health improvement planning process that included:

**GUIDANCE**
1. The local health department must document the collaborative community health improvement planning process. The process used may be an accepted national model; state-based model; a model from the public, private, or business sector; or other participatory process model. When a specific model is not used, the key steps undertaken that outline the process used should be described.

   - National models include, for example, Mobilizing for Action through Planning and Partnerships (MAPP), Association for Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US) [http://www.chusa.org/docs/default-source/general-files/ch_assessingaddressing-pdf.pdf?sfvrsn=1], and the University of Kansas Community Toolbox [http://cobk.utk.edu/en/node/5].

   - Examples of tools or resources that can be adapted or used include NACCHO’s Resource Center for Community Health Assessments and Community Health Improvement Plans, Community Indicators process project, Asset Based Community Development model, National Public Health Performance Standards Program (NPHPSP), Assessment Protocol for Excellence in Public Health (APEX/PH), Guide to Community Preventive Services, and Healthy People 2020.

**NUMBER OF EXAMPLES**
1 process

**DATED WITHIN**
5 years

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Performance Improvement Initiatives

- Accreditation
- Strategic Planning
- Community Health Assessment and Improvement Planning
- Quality Improvement
- Performance Management

**The Seven Steps of Performance Improvement Initiatives**

<table>
<thead>
<tr>
<th>PREPARE</th>
<th>SET GOAL</th>
<th>ASSESS</th>
<th>PLAN</th>
<th>ACT</th>
<th>TRACK</th>
<th>IMPROVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepare information, people, and resources</td>
<td>Set goals for your process</td>
<td>Assess your current state</td>
<td>Plan how you are going to achieve your goal given your current state</td>
<td>Implement the plan</td>
<td>Track how well you're achieving your goal</td>
<td>Improve work to better meet goals</td>
</tr>
</tbody>
</table>

All performance improvement initiatives involve these seven steps. The focus of each type of performance improvement, however, differs.
Healthy People 2020 and Performance Improvement

• Healthy People 2020 is an easy-to-use tool for a variety of Performance Improvement Activities, from accreditation to quality improvement to strategic planning to community health assessment and improvement planning.

• Healthy People can provide material for each of the seven steps of performance improvement.

Step One: Prepare

Use the Healthy People website to begin conversations on community health

- Engage stakeholders and build commitment with Healthy People 2020 measures and objectives
- Where does your community stand?
- What health topics are important to your community?


Learn How Other Communities Are Using Healthy People

- Examples and success stories can help recruit organizations and individuals
- NACCHO’s Implementing Healthy People website page http://www.naccho.org/topics/infrastructure/healthy-people/index.cfm
- Healthy People (healthypeople.gov/2020) website provides “field notes” with examples of how Healthy People is being used across the country

Mobilize Partners with the Leading Health Indicators

• Leading Health Indicators (LHIs) are a smaller set of Healthy People objectives selected to communicate high priority health issues
• LHIs can help communicate the importance of Public Health to your community


Story from the field:
Clay County Health Department (FL)

“The Healthy People data is helpful when you’re trying to engage or capture the attention of non-traditional local partners, while you’re working to educate them on their role in the greater local public health system.”

Step Two: Set Goal

Healthy People 2020 Vision

“A society in which all people live long, healthy lives”
That’s what Healthy People is all about!

Overarching goals of Healthy People 2020:
- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death
- Achieve health equity, eliminate disparities, and improve the health of all groups
- Create social and physical environments that promote good health for all
- Promote quality of life, healthy development, and healthy behaviors across all life stages

Creating a Picture of the Future You Wish to Create

Access to Health Services
Clinical Preventive Services
Environmental Quality
Injury and Violence
Maternal, Infant, and Child Health
Mental Health
Nutrition, Physical Activity, and Obesity
Oral Health
Reproductive and Sexual Health
Social Determinants
Substance Abuse
Tobacco

Visioning with the Leading Health Indicators: What topic areas resonate with your community?

Step Three: Assessment

Using Healthy People Topic Areas for Assessment

- Find potential indicators and/or data sources for specific health topic areas
- Some may only have national statistics, but many have state and local data as well

<table>
<thead>
<tr>
<th>HDS-2</th>
<th>Reduce coronary heart disease deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline:</td>
<td>126.0 coronary heart disease deaths per 100,000 population in 2007 (age adjusted to the year 2000 standard population)</td>
</tr>
<tr>
<td>Target:</td>
<td>108.8 deaths per 100,000 population</td>
</tr>
<tr>
<td>Target-Setting Method:</td>
<td>Projection (20 percent improvement)</td>
</tr>
<tr>
<td>Data Source:</td>
<td>National Vital Statistics System--Mortality (NVSS--M), CDC, NCHS</td>
</tr>
</tbody>
</table>
Target-setting

- Each Healthy People topic area includes an overall goal and specific, measurable objectives
  - The number of objectives ranges from 2 (Healthcare-Associated Infections) to 43 (Injury and Violence Prevention)

<table>
<thead>
<tr>
<th>AH-1</th>
<th>Increase the proportion of adolescents who have had a wellness checkup in the past 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline:</td>
<td>68.7 percent of adolescents aged 10 to 17 years had a wellness checkup in the past 12 months, as reported in 2008</td>
</tr>
<tr>
<td>Target:</td>
<td>76.6 percent</td>
</tr>
<tr>
<td>Target-Setting Method:</td>
<td>10 percent improvement</td>
</tr>
<tr>
<td>Data Source:</td>
<td>National Health Interview Survey (NHIS), CDC, NCHS</td>
</tr>
</tbody>
</table>

Adapting Healthy People for local use

**National Objective: D1:** Reduce the annual number of new cases of diagnosed diabetes in the population.

- Target: 7.2 new cases per 1,000 population aged 18 to 84 years.
- Baseline: 8 new cases of diabetes per 1,000 population aged 18 to 84 years occurred in the past 12 months, as reported 2006-2008
- Target setting method: 10 percent improvement

**Your Objective:** Reduce the number of new cases of diagnosed diabetes in the county population

- Target: 9 new cases per 1000 population aged 18 to 65 years.
- Baseline: 10 new cases per 1,000 population aged 18 to 65 years in the past 12 months.
- Target setting method: 10 percent improvement
Leading Health Indicators and Assessment

- Use the LHIs as a starting point for collecting data and choosing indicators
- What are the challenges for your community?
- What are the successes?

**The Access to Health Services Leading Health Indicators are:**
- Persons with medical insurance (AH5.1)
- Persons with a usual primary care provider (AH5.3)

**The Oral Health Leading Health Indicator is:**
- Persons aged 2 years and older who used the oral health care system in the past 12 months (CH.7)

**The Maternal, Infant, and Child Health Leading Health Indicators are:**
- Infant deaths (MCH.1.1)
- Preterm births (MCH.9.1)

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**Story from the Field: Partnership for a Healthier Alexandria (VA)**

“We are using Healthy People to assist in the identification of community indicators for our community health assessment”

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Step Four: Plan


Making sense of all the data

- Do any assessment findings stand out? Are there indicators that are significantly far off from Healthy People targets?
- Explore how the Healthy People topic areas relate to one another to help brainstorm potential strategic issues

Where does your community rank nationally?

Identify strategic issues based on which topic areas your community falls behind on


Address the social determinants

Healthy People guidance on starting a dialogue about the underlying causes of poor health or quality of life in your community

Explore the social determinants of health topic area

Story from the Field: RiverStone Health (MT)

“We’re comparing our community health assessment data to where Healthy People 2020 is at [to figure out goals for our community]”


Step Five: Act

Identifying strategic issues

- Each Healthy People topic area includes an overview of why it’s an important issue in public health
- “Related topic areas” helps link together strategic issues from Healthy People to assessment data


Identifying strategic issues with the Leading Health Indicators

- The LHI topic areas aim to consolidate related priority issues
- Example: Clinical Preventive Services
  - Access issues?
  - Quality of care issues?
  - Low rates of recommended immunizations?
  - Other social determinants related to this LHI:
    - Educational attainment
    - Stable employment
    - Safety of neighborhoods

Story from the Field:
Sedgwick County Health Department (KS)

“We use Healthy People 2020 at our agency as a resource for selecting strategic directions and determining priorities.”

Step Six: Track

Establish a system to monitor the indicators over time

Healthy People releases progress reports for most topic areas every 2-4 years


“Healthy People has always been a national tool we’ve looked at for setting baselines and targets.”

– Brandon Skidmore, KS State Health Department

Step Seven: Improve

Healthy People’s Intervention and Resources tab for each topic area includes:
- Clinical recommendations
- Community interventions
- Consumer information

Overview tab includes:
- Description, references and sources for peer-reviewed journal articles related to each topic area of interest

Make the action cycle manageable with topic-specific materials

Make the action cycle count with evidence-based practices

Clinical, community, and consumer information and recommendations from:

**The U.S. Preventive Services Task Force**, an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. Sponsored since 1998 by the Agency for Healthcare Research and Quality (AHRQ), the Task Force is the leading independent panel of private-sector experts in prevention and primary care.

**The Task Force on Community Preventive Services**, established by the U.S. Department of Health and Human Services (DHHS) in 1996 to develop guidance on which community-based health promotion and disease prevention interventions work and which do not work, based on available scientific evidence. The Centers for Disease Control and Prevention (CDC) is the DHHS agency that provides the Task Force with technical and administrative support.

**Healthfinder.gov**, a government agency sponsored by the Office of Disease Prevention and Health Promotion and its health information referral service to provide information and tools to consumers.

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**Topic specific interventions and resources**

<table>
<thead>
<tr>
<th>Community Interventions</th>
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<tbody>
<tr>
<td>The following evidence-based community interventions come from the <a href="http://www.cdc.gov/">Guide to Community Preventive Services</a>, Centers for Disease Control and Prevention (CDC).</td>
</tr>
</tbody>
</table>

**Behavioral and Social Approaches to Increase Physical Activity: Individually-adapted Health Behavior Change Programs**

Individually-adapted health behavior change programs to increase physical activity teach behavioral skills to help participants incorporate physical activity into their daily routines. [Learn more](#).

**Behavioral and Social Approaches to Increase Physical Activity: Social Support Interventions in Community Settings**

Social support interventions focus on changing physical activity behavior through building, strengthening, and maintaining social networks that provide supportive relationships for behavior change (e.g., setting up a buddy system, making contracts with others to complete specified levels of physical activity, or setting up walking groups or other groups to provide friendship and support). [Learn more](#).

**Campaigns and Informational Approaches to Increase Physical Activity: Community-Wide Campaigns**

Community-wide campaigns to increase physical activity involve many community sectors, include highly visible, broad-based, component strategies, and may also address other cardiovascular disease risk factors. [Learn more](#).

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Make the case for funding

• Get the data
• See how you measure up
• Connect to something larger
• Identify new stakeholders and partners
• Plan a strong public health program

Story from the Field: West Virginia Association of Local Health Departments (WV)

“After spending many years in Illinois with a primary care association, I used Healthy People constantly for writing and managing grants”
Healthy People 2020
Resources for Performance Improvement

Map-It Resource – Mobilizing Partners

• A list of potential public, private, and volunteer organizations
• Questions to consider when organizing a coalition
• www.healthypeople.gov/2020/implementing/mobilize.aspx

MAP-IT Resources: Assess & prioritize

- Brainstorm about community strengths and assets
- How do you prioritize issues in your community?

MAP-IT Resources: Formulating strategies

- What is our goal?
- How will we know when we have reached our goal?
Community Toolbox Resources

- Assessing community needs and resources module
- Analyzing community problems and solutions
- Useful for multiple phases of MAPP

Stay connected with Healthy People

- Subscribe to newsletters to hear about what’s going on in the world of public health and what may affect you locally
- “Who’s Leading the Leading Health Indicators?”
Many thanks!

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202-507-4240  
blaymon@naccho.org