

# Prevention Agenda Toward the Healthiest State 2010 Update: Local Health Departments

## Prevention Agenda Toward the Healthiest State

Access to Quality Health Care  
 Chronic Disease  
 Community Preparedness  
 Healthy Environment  
 Healthy Mothers/Healthy Babies/Healthy Children  
 Infectious Disease  
 Mental Health/Substance Abuse  
 Physical Activity/Nutrition  
 Tobacco Use

### Summary

The *Prevention Agenda Toward the Healthiest State* was initiated in 2008 to focus on ten health priorities that could have the greatest impact on the health of New Yorkers. Local health departments (LHDs) and hospitals from every county worked together to identify their local priorities and develop action plans to achieve measurable progress in meeting health-related objectives. Access to Quality Health Care, Chronic Disease, and Physical Activity and Nutrition were the priorities most often selected for collaborative action. These three remained their top priorities, according to the 2010 Prevention Agenda update survey. All but one of the LHDs have established partnerships and developed plans to address their chosen priorities. Many need assistance to implement evidence-based strategies and assess progress toward their goals.

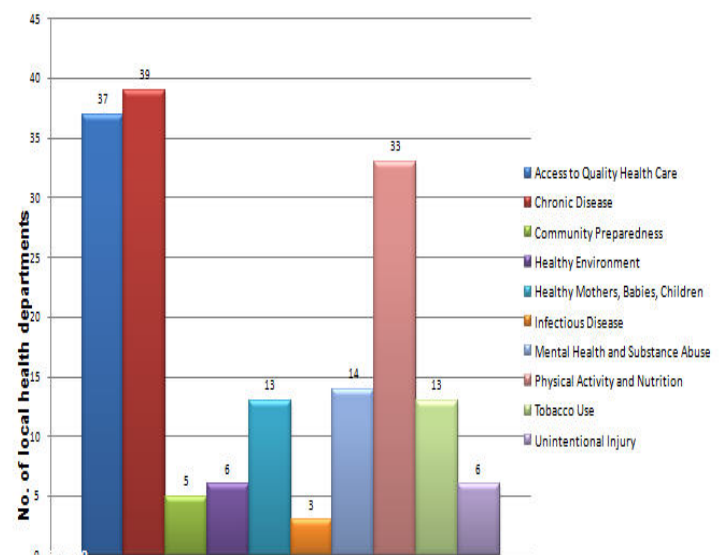
### Background on the Prevention Agenda

The *Prevention Agenda Toward the Healthiest State* was initiated in 2008 as a call to action to LHDs, health care providers, health plans, schools, employers, businesses and other partners to work together to improve the health status of New Yorkers through community-based prevention strategies. The *Prevention Agenda* identified ten priorities for improving the health of New Yorkers, and established measurable objectives and indicators to document progress toward achieving these goals,

including the elimination of racial, ethnic and socioeconomic health disparities.

In 2008, the Department asked the 58 LHDs and more than 166 non-profit hospitals to identify at least two of the priorities, and then work together with insurers, community-based organizations and others to address them. In 2009, these priorities were described in the comprehensive Community Health Assessments submitted by LHDs that summarized data about their communities and described strategies to implement locally. At the same time, hospitals prepared Community Service Plans that described their operational commitment to improve the health of people in their hospital service areas. These documents noted how the LHDs, hospitals and community partners would collaborate on strategies to reach their target populations. The number of counties picking each of the ten priorities is shown below in Figure 1.

**Figure 1**  
*Prevention Agenda Priorities Selected by LHDs, 2009*



Source: 2010-2013 Community Health Assessments

## **Technical Assistance Provided**

When working on the *Prevention Agenda* priorities, communities were encouraged to use an evidence-based decision making approach to identify health issues of concern to local communities, implement proven interventions to address the issues, and monitor their impact on the community's health. To support this approach, the NYSDOH Office of Public Health Practice worked with the Department's public health programs and partner organizations to develop a comprehensive summary of relevant data, provide tools for health planning and evaluation, recommend proven interventions, and identify partners in each county.

### **Web Resources**

Resources for community assessment, planning and evidence-based decision making can be accessed at: [http://www.nyhealth.gov/prevention/prevention\\_agenda/](http://www.nyhealth.gov/prevention/prevention_agenda/). This web-based resource includes statistics that provide a snapshot of the health of New York State residents in each county according to *Prevention Agenda* priorities. Statewide data are stratified by race and ethnicity. County-specific tables enable LHDs and hospitals to assess how well their counties are performing compared to the state as a whole and to the United States.

### **Leadership**

An ad hoc committee of the NYS Public Health Council, led by Jo Ivey Boufford, MD, President of the NY Academy of Medicine, has helped the NYSDOH to advance the *Prevention Agenda*. The committee established a leaders group consisting of 25 organizations representing public health, health care and community stakeholders. They have supported *Prevention Agenda* efforts at the state and local levels. For example, the NYSDOH used webinars and in-person meetings hosted by the Healthcare Association of New York State and the Greater New York Hospital Association to provide technical assistance to LHDs and hospitals about community health planning. The New York State Association of County Health Officials hosted a technical assistance workshop on evidence-based approaches to reduce risk and promote health in addressing local priorities.

## **2010 Prevention Agenda Update**

In the fall of 2010, the Office of Public Health Practice asked each LHD for an update on their county's progress toward planning and implementing strategies described in the 2010-2013 Community

Health Assessments. The purpose of the survey was to assess what LHDs have done toward addressing the community's selected *Prevention Agenda* priorities; their progress toward implementing local plans; the challenges they are facing; and the technical assistance they need. Each LHD was asked to provide information on the two *Prevention Agenda* priorities for which they had made the most progress.

### **Survey Results**

Fifty-six of the 58 LHDs responded to the survey. Each LHD provided information on their two selected priorities, supplying information on a total of 112 priorities. LHDs were most likely to provide updates on Access to Quality Health Care (n=32), followed by Chronic Disease (n=27), Physical Activity and Nutrition (n=23), Healthy Mothers, Healthy Babies, Healthy Children (n=10), and Tobacco Use (n=10). The findings are described in two ways: 1) the number of the LHDs that responded to each question; and 2) the percent of the total priorities that LHDs reported on as their 1<sup>st</sup> and 2<sup>nd</sup> choices. These findings are summarized below in five categories: priorities, intervention strategies, measures, technical assistance needs, and priority-specific results.

### **Priorities**

The majority (n=36) of LHDs reported that they had not changed their priorities. Sixteen LHDs added a new priority and four dropped a priority (Table 1). Nutrition and Physical Activity was the priority most likely to be added by LHDs.

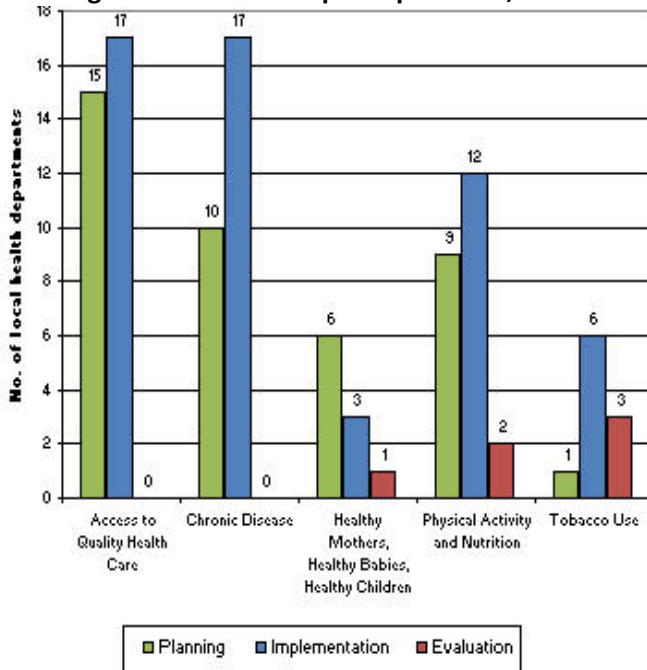
**Table 1**  
**Number of LHDs adding or dropping a priority, 2010**

Priority	No. of LHDs adding priority	No. of LHDs dropping priority
Nutrition and Physical Activity	3	0
Access to Quality Health Care	2	0
Chronic Disease	2	0
Tobacco Use	2	0
Healthy Mother, Healthy Babies, Healthy Children	2	1
Infectious Disease	1	0
Healthy Environment	0	1
Mental Health and Substance Abuse	1	0
Unintentional Injury	1	1
Community Preparedness	0	1
Number of LHDs	16	4

## Intervention Strategies

The survey included questions about the strategies being used for each of the two priorities the LHDs selected. The LHDs were in varying phases of addressing the two priorities. Of the 56 LHDs, 12 were in the planning phase for both priorities; 17 were in the implementation phase for both; and one was in the evaluation phase for both priorities. The other 26 were in varying phases for the two priorities, with most (21) in the planning or implementation phases. These results are illustrated in Figure 2 for the top five selected priority areas.

**Figure 2**  
**LHD Progress to Date for top five priorities, 2010**



LHDs were asked about the steps they have taken to implement strategies for the two priorities they selected. This information is summarized in Table 2. All but one of the LHDs responded that they had built or strengthened partnerships and one-quarter had established measures to track their progress in both priorities. However, 21 LHDs (38% of the respondents) had not established measures for either of their two priorities.

About 40 percent of the LHDs had started collecting baseline data, solicited community input and selected interventions for both priorities. Many of the other LHDs had taken these steps for at least one priority. However, 16 LHDs had not started collecting baseline data, 14 had not solicited community input, and 10 had not selected interventions for either priority. A small number of

LHDs had tested or evaluated interventions for both of their chosen priorities, while nine had tested an intervention for one of the priorities and eight had evaluated an intervention. The finding that most LHDs have not yet taken steps to test or implement strategies for either one of their priorities may indicate additional support is needed to move forward.

**Table 2**  
**Number of LHDs reporting on steps taken to implement strategies for *Prevention Agenda* priorities, 2010 (n=56)**

Steps taken to implement strategies	For Both Priorities	For Only One Priority	For Neither Priority
	#	#	#
Built or strengthened partnerships	55	0	1
Established measures to track progress	15	20	21
Started collecting baseline data for priority	24	16	16
Solicited community input	25	17	14
Selected interventions	24	22	10
Tested interventions	4	9	43
Evaluated interventions	2	8	46

## Measures

LHDs are using a variety of measures to track their progress. For example, process measures include attendance at events, the number of materials distributed, and referral statistics for facilitated enrollers. Some of the reported outcome measures pertain to organizational and policy changes, such as the number of health care facilities that become tobacco-free. Individual-level changes, such as improved patient satisfaction, are being tracked using clinic-based or population surveys. The *Prevention Agenda* indicators are being used in many counties as outcome measures. Optimally, measures are needed for program monitoring and quality improvement. Most of the measures being tracked by the LHDs are process measures such as number of participants or events, rather than changes in behaviors, organizations and the environment. There is a need to balance the use of process and outcome measures for their intervention strategies.

## Technical Assistance Needs

LHDs were asked to identify their top two needs for technical assistance that would strengthen their capacity to address the *Prevention Agenda* priorities. The two needs rated as equally important by 82% of the LHDs were identifying and adapting evidence-based interventions to local settings and establishing measures to track success. The third and fourth ranked technical assistance needs were accessing and analyzing public health indicator data (47%) and spreading successful practices to other areas (36%). Needs in these areas are consistent with the information in Table 2, which shows that a lower number of LHDs have taken steps to establish measures and collect baseline data for their priorities.

## Priority-Specific Results

The information presented so far is organized by the number of LHDs responding to each question in the survey. Another useful perspective is to report results by the chosen priorities. Since the 56 LHDs reported on their two top priorities separately for several questions, the results for these questions were generated based on 112 responses for their chosen priorities. LHDs reported that:

- Hospitals participated in the collaboration for 81% of the priorities. For only 8% of the priorities, the LHDs reported “no active participation” from hospitals. This non-participation varied by priority, LHD and region. For 11% of the priorities, LHDs did not answer the question on hospital participation.
- Collaborating with most hospital partners was easier than expected, or about what they expected (52% of the priorities).
- Communication among all of the partners was good (71% of the priorities).
- Staff were qualified and had the skills to do the work required of them (for 50% of the priorities).

LHDs also noted some challenges. For example:

- Funding was not sufficient (51% of priorities).
- Competing public health challenges made it difficult to focus on a specific priority (24% of priorities).
- Adapting evidence-based intervention strategies to local communities is difficult (21% of priorities).

## Conclusion and Next Steps

The update confirmed that LHDs and hospitals are working together to address *Prevention Agenda* priorities. The top three priorities that LHDs continue to work on are Access to Quality Health Care, Chronic Disease, and Physical Activity and Nutrition.

While a significant number of LHDs are in the implementation phase for at least one of their priorities, the survey results indicate that there are several challenges ahead. These include funding, competing public health issues and adapting evidence-based strategies to their communities. The Office of Public Health Practice, DOH program staff and partner organizations will explore options to meet these challenges and propose a plan for how technical assistance can be provided in two key areas:

- Identification and implementation of evidence-based strategies.
- Selection and use of performance measures to assess progress.

The Office of Public Health Practice will also develop a plan for how it can assist those LHDs still in the planning stages to take action to implement evidence-based strategies for their *Prevention Agenda* priorities.