“Are You Ready to “Sail” your SHIP?!

February 11, 2016
Acknowledgement and Disclaimer

- This webinar was supported by funds made available from the Centers for Disease Control and Prevention, Office for State, Tribal, Local and Territorial Support.
- The content of this webinar are those of the authors and do not necessarily represent the official position of or endorsement by the Centers for Disease Control and Prevention.
- ASTHO does not guarantee that states who follow the guidance in this document will meet PHAB requirements, only the PHAB site visitors can make that determination.
Webinar Objectives

- Identify data inputs from the SHA and other areas to inform the SHIP process
- Identify resources for comparative data
- Understand asset mapping as it relates to the SHIP develop process
- Understand ways to identify health disparate populations
USE OF THE CHAT FUNCTION

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YOUR SCREEN
AUDIO QUESTIONS

- If you would like to speak to our presenters directly, we have ample time at the end of the presentations for you to do so.
- Please hit *1 on your telephone and the operator will put you in the queue to ask your question.

Our presenters are excited to speak with their peers directly so we encourage you to use this function!
Our Presenters

NEW YORK

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Developing a State Health Improvement Plan: Guidance and Resources

A Companion Document to ASTHO’s
State Health Assessment Guidance and Resources
Where Do I Find This Resources?

Switch to live website

Where Do I Find This Resources?

Tools to Increase Vaccination
Accreditation and Performance

ASTHO is dedicated to increasing state health agency capacity to improve the performance and quality of the public health system. ASTHO does this by providing technical assistance and resources to states in the areas of accreditation preparation, national performance standards assessment, and quality improvement.

Program Areas

Public Health Accreditation Board Voluntary Accreditation: Resources and guidance to help states prepare and apply for accreditation

The National Public Health Performance Standards: Newly released Version 3.0 Instrument and supporting materials to complete a state level system assessment

Performance Management and Quality Improvement: Current QI initiatives, resources, and links to national quality programs

Featured

ASTHO Publishes Quality Improvement Plan Toolkit
ASTHO Releases White Paper: Collaborative Partnerships for Accreditation Preparation
ASTHO Unveils Customer Satisfaction Toolkit
ASTHO Publishes State Health Assessment Guidance and Resources

Resources

Tools Clearinghouse: Case Studies, Toolkits, Peer Networks, Newsletters
ASTHO Accreditation Library: Repository of Example Accreditation Documentation
Developing a State Health Improvement Plan: Guidance and Resources

June 2015

Developing a State Health Improvement Plan: Guidance and Resources is a companion document to ASTHO’s State Health Assessment Guidance and Resources published by ASTHO in 2014. ASTHO produced this guide to be applicable to state health departments seeking public health accreditation through PHAB as well as to those developing a SHIP but are not seeking accreditation.

The information provided in this guide is intended to be consistent with PHAB requirements and documentation guidance and includes references to PHAB requirements and documentation guidance. The document includes seven modules and describes the process for developing a state health improvement plan (SHIP) and conforming to the Public Health Accreditation Board Standards. Each module includes tips for structuring the planning process and considerations for the implementation phase, key terms and acronyms, specific examples and lessons learned from states, and sample tools and links to additional resources.

Download "Developing a State Health Improvement Plan: Guidance and Resources" (Note: Name and email address are required to access this document.)
Download "Developing a State Health Improvement Plan: Guidance and Resources" Document

Please submit the following information to access this document:

Your name (required)


Agency name (optional)


Email address (required)


Submit Form
Seven Modules

This guidance document includes seven modules and describes the process for developing a state health improvement plan (SHIP):

I. Identifying and Engaging Stakeholders in Planning and Implementation.
II. Engaging in Visioning and Systems Thinking.
III. Leveraging Data Inputs.
IV. Establishing Priorities and Identifying Issues through Priority Setting.
V. Communicating about SHIP Priorities.
VI. Developing Objectives, Strategies, and Measures.
VII. Implementing and Monitoring the SHIP.
Each Module Contains:

- Preview of the content
- The relevant PHAB Standards and Measures
- Ideas for structuring the planning process
- Important considerations
- Key terms and acronyms
- State examples and lessons learned
- Sample tools and links to resources

Throughout: Cross reference to the ASTHO State Health Assessment Guidance and Resources
Links to resources

**FIGURE 1.10 RESOURCES AND LINKS – PARTNERSHIP**

PHAB Standards and Measures

PHAB Standard 5.2 – Conduct a comprehensive planning process resulting in a tribal/state/community health improvement plan.

Measure 5.2.1 S – A process to develop a state health improvement plan.

Measure 5.2.2 S – State health improvement plan adopted as a result of the health improvement planning process.

Measure 5.2.3 A – Elements and strategies of the health improvement plan implemented in partnership with others.

Measure 5.2.4 A – Monitor and revise, as needed, the strategies in the community health improvement plan in collaboration with broad participation from stakeholders and partners.

(PHAB Standards and Measures Version 1.5, pages 129-143)
IMPORTANT CONSIDERATION: Visioning and Systems Thinking throughout the SHIP Process

Systems Thinking in Public Health


Collective Impact


http://www.ssireview.org/supplement/collective_insights_on_collective_impact
http://www.ssireview.org/articles/entry/the_dawn_of_system_leadership
Placeholder for Polling Questions

Where are you in the SHIP process?

We have not started
We have begun data collection
We have engaged partners and stakeholders
We have an official advisory committee for our SHIP
Our SHIP is complete
MODULE 3

Leveraging Data Inputs

Module Overview

During the SHA process, the state health department and partnership developed key findings from the assessments and data collection and analysis. The SHA data and key findings should be the core used to develop the SHIP. However, depending on the time lapse between the development of SHA and the SHIP, or because other important data sources are of interest, states may wish to update or add to the data used to support the SHIP decisionmaking. In this module, guidance is provided for using SHA data, and other sources of data, to support the selection of SHIP priorities and detailed goals, objectives, strategies, and measures. Approaches and examples for using data to support alignment between the SHIP and local, national, and other state efforts are also provided in this module.

Key Content and Components

- State health assessment report(s).
- Other uses of data in the SHIP process.
- Community-level and regional-level assessments and plans.
- Existing monitoring, surveillance, and evaluation data.
- Statewide summaries for specific issues.
- National rankings and dashboards.
- Inventory of assets and resources.
- Identifying disparities.
PHAB Standards and Measures

PHAB Measure 5.2.1 S – A process to develop a state health improvement plan
Required documentation 1.b – 1.d:

1. State health improvement planning process that included:

b. Information from community health assessments
   Guidance: Data and information from the community health assessment
   provided to participants in the state health improvement planning process to
   use in their deliberations. This may include a list of data sets or evidence that
   participants used for the community health assessment.

c. Issues and themes identified by stakeholders in the community
   Guidance: Evidence that community and stakeholder discussions were held
   and that they identified issues and themes. Community members' definition of
   health and of a healthy community must be included. The list of issues identified
   by the community and stakeholders must be provided as documentation.

d. Identification of assets and resources
   Guidance: Community assets and resources identified and considered in the
   community health improvement process. Community assets and resources
   could be anything in the community that could be utilized to improve the health
   of the community. Community assets and resources could include, for example,
   skills of residents, the power of local associations (e.g., service associations,
   professional associations) and local institutions (e.g., faith based organizations,
   local foundations, institutions of higher learning), as well as other community
   factors for example, parks, social capital, community resilience, a strong
   business community, etc. Community assets and resources can be documented
   in a list, chart, narrative description, etc.

NOTE: Bullet a for 5.2.1 S is on page 34 and bullet e for 5.2.1 is on page 39.

(PHAB Standards and Measures Version 1.5, pages 130-131)
Data Sources in the SHIP Process

1. Community-Level and Regional-Level Assessments and Plans
2. Existing Monitoring, Surveillance, and Evaluation Data
3. Statewide Data Summaries for Specific Issues
4. National Rankings and Dashboards
5. Inventory of Assets and Resources
Community-Level and Regional-Level Assessments and Plans
## FIGURE 3.1 WASHINGTON STATE – MATRIX AND LINKS TO COMMUNITY HEALTH ASSESSMENTS PLANS


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Update 04-28-14
Statewide Data Summaries for Specific Issues

Maine Shared Community Health Needs Assessment Data Summaries

Below are data summaries for various geographical portions of the State. These summaries include "top issues" as reported by stakeholders in our 2015 survey, and quantitative demographics and health data from 25 sources. The "full list" includes all 196 indicators selected by the SHNAPP Metrics Committee for inclusion in this project. The "short list" includes 73 selected indicators from the full list. The MS Excel tables include both the short and long versions, along with information on the data source and years of data for each indicator.

Data Sources:
The data sources for the data summaries on this page, as well as the data used in the county and state reports can be found in this document: PDF | Excel

Public Health District Summaries:
- Aroostook - Full list (PDF) | Short list (PDF) | Excel
- Acadia - Full list (PDF) | Short list (PDF) | Excel
- Cumberland - Full list (PDF) | Short list (PDF) | Excel
- Downeast - Full list (PDF) | Short list (PDF) | Excel
- Midcoast - Full list (PDF) | Short list (PDF) | Excel
- Penobscot - Full list (PDF) | Short list (PDF) | Excel
- Western - Full list (PDF) | Short list (PDF) | Excel
- York - Full list (PDF) | Short list (PDF) | Excel

County Summaries:
- Androscoggin - Full list (PDF) | Short list (PDF) | Excel
- Aroostook - Full list (PDF) | Short list (PDF) | Excel
- Cumberland - Full list (PDF) | Short list (PDF) | Excel
- Franklin - Full list (PDF) | Short list (PDF) | Excel
- Hancock - Full list (PDF) | Short list (PDF) | Excel
- Knox - Full list (PDF) | Short list (PDF) | Excel
- Lincoln - Full list (PDF) | Short list (PDF) | Excel
- Oxford - Full list (PDF) | Short list (PDF) | Excel
National Rankings and Dashboards
Inventory of Assets and Resources
FIGURE 3.3 CORE COMPONENTS OF ASSET MAPPING

1. **Define the scope of the asset map.** It is unlikely that a state health department would need an asset map covering all assets in the state. The amount of data would be overwhelming. Decide what topic(s) the asset map is needed for and create an asset map specific to that need.

2. **Define the community.** Similar to the health assessment, the boundaries of an asset map must be clear. It could be a neighborhood, county, region, the whole state, or another form of community.

3. **Identify assets I: Initial scan.** Information on assets can be found in a variety of ways. A good place to start is to collect information from Internet searches or other public databases. Another important source of information can be media reports. (Note: another common method for asset mapping at a local level is surveying a community. While this method may be better suited for asset mapping at the local level, it could be useful in some situations on the state level.)

4. **Identify assets II: Snowball.** Following initial information gathering, it is useful to take a snowball approach by contacting assets that have already been identified and asking for referrals to other assets.

5. **Assess the strengths and weaknesses of assets.** In assessing assets, it is important to remember the purpose of the asset map and use that to guide the examinations. One fundamental question to ask at this stage is, “do the assets meet the needs of the community?” It is likely that additional questions will arise related to the specific purpose of a given asset map.

6. **Identify the gaps.** What unmet needs are left? What assets would meet this need?

**Comprehensive asset assessment:** For a more advanced understanding of community assets, map the relationships between assets and leadership capacities and cultures. A comprehensive assessment examines the interrelatedness of the assets present in a community.
FIGURE 3.5 QUESTIONS TO CONSIDER – PRIORITY POPULATIONS

Adapted from Missouri Department of Health and Senior Services, http://health.mo.gov/data/InterventionMICA/AssessmentPrioritization.html

1. Looking at key health and strategic issues that have come out of SHA and SHIP, what disparities related to demographic factors were found? (e.g., age, gender, income, educational attainment, race, ethnicity, etc.)

2. What geographic disparities were identified?

3. What are the priority population(s) you would like to impact through your strategies?

4. Who are subgroups of the priority population(s), if any?

5. What is approximate number of people comprising the priority populations and any of its subgroups?

6. What are the shared social and cultural characteristics of the priority populations?

7. What stakeholders can be engaged to increase engagement and impact for the priority populations?

8. Other considerations for working with the priority populations?
Leveraging Data inputs

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Office of Public Health Practice
New York State Department of Health
How does this work fit with the accreditation required documents? PHAB – Domain 1

**Domain 1**: Conduct and Disseminate Assessments Focused on Population Health Status And Public Health Issues Facing the Community

- **Standard 1.1**: Participate in or Lead a Collaborative Process Resulting in a Comprehensive Community Health Assessment

  - **Measure 1.1.1 S**: A state partnership that develops a comprehensive state community health assessment of the population of the state:
    - Participation of representatives from a variety of state sectors
    - Regular meetings or communications with partners
    - The process used to identify health issues and assets
PHAB – Domain 1 (cont’d)

Measure 1.1.2 S: A state level community health assessment

- **Required documentation 1:** A state level community health assessment that includes:
  - a. Data and information from various sources contributed to the community health assessment and how the data were obtained
  - b. Demographics of the population
  - c. Description of health issues and descriptions of specific population groups with particular health issues and health disparities or inequities
  - d. Description of factors that contribute to the state populations’ health challenges
  - e. Description of existing state assets or resources to address health issues

- **Required documentation 2:** Opportunity for the state population at large to review drafts and contribute to the community health assessment

- **Required documentation 3:** The ongoing monitoring, refreshing, and adding of data and data analysis
Background – New York State

• Previous State Health Improvement Plan (SHIP): Prevention Agenda 2008-2012
• Current SHIP: Prevention Agenda 2013-2018
• New York State SHA and SHIP development in 2012:
  ▫ Assessed progress of 2008-2012 cycle;
  ▫ Developed State community health needs assessment (SHA); and
  ▫ Developed State Health Improvement Plan (SHIP)

Materials available:

• NYS PHAB application with pre-requisites submitted December 2012
Prevention Agenda 2013-2018: Steered by Ad Hoc Leadership Group

Collaborative effort led by committee appointed by Public Health and Health Planning Council, including leaders from more than 140 organizations (e.g., Healthcare, Business, Academia, CBOs, Local Health Departments, OMH and OASAS).

Final Priorities based on active participation from members of committee and stakeholder feedback.
State Health Assessment

Conducted late 2011 to early 2012 and presented to statewide stakeholders in February 2012 to help select five priorities for 2013-2018:

- Progress to Date on Prevention Agenda 2008-2012
- Description of Population and General Health Status
Progress to Date on Prevention Agenda 2008-2012
(State previous SHIP)

Goal was to improve the health status of NYS population for the 10 health priority areas via state and local collaboration and interventions with focus on prevention rather than clinical activities. We assessed and summarized progress to date of PA 2008-2012

- Collaboration between LHDs and hospitals on the implementation of local health improvement plans regarding priorities selected, partners, progress of implementation and gaps and lessons learned
- Status of leading indicators in the 10 areas, including disparities (summary on slide 20)

Key Component: Collaborative Community Health Planning Processes

Local health departments (n = 58) asked to work with hospitals and community partners to describe community health needs and identify priorities in Community Health Assessments and Municipal Health Services Plans 2010-2013

Non-profit hospitals (n = 165) asked to work with LHDs to assess community health issues and identify local priorities in Community Service Plans 2010-2012
Prevention Agenda Priorities Selected by Counties

- Access to health care
- Chronic Disease
- Physical Activity and Nutrition

*N=57
Prevention Agenda Hospital Priorities

- Access to Quality Health Care
- Chronic Disease
- Community Preparedness
- Healthy Environment
- Healthy Mothers, Healthy Babies, Healthy Children
- Infectious Disease
- Mental Health and Substance Abuse
- Physical Activity and Nutrition
- Tobacco Use
- Unintentional Injury

% of CSPs with Selected Priority

- Chronic Disease: 62%
- Access to health care: 50%
- Physical Activity and Nutrition: 45%
- Tobacco: 32%
- 6% for Infectious Disease
- 3% for Mental Health and Substance Abuse
- 6% for Healthy Environment
- 18% for Healthy Mothers, Healthy Babies, Healthy Children
- 19% for Community Preparedness
- 10% for Unintentional Injury

N* (number of CSPs submitted) = 132
* Multiple hospitals may have submitted one CSP
County Health Department Partners

- Businesses: 47%
- CBOs: 71%
- Community HCs: 45%
- Faith Based Orgs: 27%
- Rural Health Networks: 34%
- Other Health Care Providers: 66%
- Schools: 53%
- Universities: 9%

Percentages of partners by type:
- Universities/colleges
- Transportation agency
- Substance abuse agency
- Schools
- Rural health networks
- Other health care providers
- Mental health agency
- Faith based organizations
- Emergency responders
- Community health center

* N=57
Hospital Partners

- Universities/colleges 31%
- Transportation agency 5%
- Substance abuse agency 12%
- Schools 49%
- Rural health networks 29%
- Other health care providers 63%
- Mental health agency 18%
- Faith based organizations 31%
- Emergency responders 23%
- Community health center 40%
- Community-based organizations 35%
- Businesses 76%

Note: The graph shows the percentage of partnership involvement with various organizations by hospitals.
LHD Progress on top five priorities 2010
### Steps taken to implement strategies, 2010

<table>
<thead>
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<th>Steps taken to implement strategies</th>
<th>For Both Priorities</th>
<th>For Only One Priority</th>
<th>For Neither Priority</th>
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<tr>
<td>Established measures to track progress</td>
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<td>21</td>
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<tr>
<td>Started collecting baseline data for priority</td>
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<td>Solicited community input</td>
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<td>Evaluated interventions</td>
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Challenges

• Funding to carry out planning and implementation, especially for those counties/partnerships without Heal 9 grants,

• Competing public health challenges (H1N1),

• Adapting evidence-based intervention strategies to local communities,

• Identifying and using short-term improvement measures to assess progress toward Prevention Agenda goals.
Progress to Date:
2010 Status Of 51 Prevention Agenda Indicators

- 35 Indicators improving
- 3 Indicators achieved target:
  - Coronary Heart Disease Hospitalizations
  - Newly Diagnosed HIV Case Rate
  - Motor Vehicle Related Mortality
- 14 Indicators moving in the wrong direction
- 1 Indicator unchanged
- 1 Indicator no new data
- Disparities not improving
Description of Population and General Health Status

PHAB: Measure 1.1.2 S (b and c)

- b. Demographic: A description of the demographics of the population served by the state health department

- c. Description of health issues and descriptions of specific population groups with particular health issues and health disparities or inequities; must include the existence and extent of health inequities between and among specific populations or areas of the state

Description of Population Demographics and General Health Status
New York State, 2012

Description of population demographics and health-related environment.................................................. 9

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Description of General Health Status

Status for:

- Maternal and infant health
- Infectious diseases
- Chronic diseases
- Mental health and substance abuse
- Health risk behaviors

Presented: trend data for state and compared to the U.S. and HP2020 objectives, where available; disparities by race/ethnicity, gender, age group, and geographic (county), where available.
Population Distribution by Age and Gender, New York State, 2000, 2010

Data Source: US Census Bureau

Note: the percent change of USA total population (from 2000 to 2010) is 9.7%.
Population by Race/Ethnicity, New York State, 2010

White non-Hispanic, 11,304,247, 59%

Hispanic, 3,416,922, 18%

Asian non-Hispanic, 1,406,194, 7%

American Indian/Alaska Native non-Hispanic, 53,908, <1%

Black non-Hispanic, 2,783,857, 14%

Two or more races, non-Hispanic, 326,034, 2%

Data source: Census 2010 Redistricting Data
Percent Change in Population by Race/Ethnicity, New York State, 2000 and 2010

- White non-Hispanic: -3.9%
- Black non-Hispanic: -1.0%
- American Indian and Alaska Native non-Hispanic: 2.7%
- Asian non-Hispanic: 35.7%
- Native Hawaiian and Other Pacific Islander non-Hispanic: 1.7%
- Hispanic: 19.2%
- Total: 2.1%

Data source: Census 2000 Redistricting Data and Census 2010 Redistricting Data
Income and Poverty
New York State and U.S.

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<tr>
<td>% of Families with Children (Ages &lt;18) Below Poverty</td>
<td>16.9%</td>
<td>17.9%</td>
<td>17.9%</td>
</tr>
<tr>
<td>% of Families Below Poverty</td>
<td>11.5%</td>
<td>11.5%</td>
<td>11.3%</td>
</tr>
<tr>
<td>% of Persons Aged 16+ Unemployed</td>
<td>4.3%</td>
<td>6.2%</td>
<td>6.9%</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau
Note: Median Income in 2010 Inflation-adjusted dollars
Percentage of Families Living in Poverty, 2006-2010

Source: U.S. Census Bureau, 2006-2010 American Community Survey

Percent Counties Are Shaded Based On Quartile Distribution
- 0 - <0.85 : Q1 & Q2
- 0.85 - <1.04 : Q3
- 1.04 - : Q4

New York State: 10.8

Map of New York State with counties shaded to show percentage of families living in poverty.
Education
New York State and U.S.

<table>
<thead>
<tr>
<th>High School (4 Year) Graduation Rate*</th>
<th>NYS 2000</th>
<th>NYS 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60.5%</td>
<td>70.8%</td>
</tr>
<tr>
<td>% Persons Aged 25+ who are HS Graduates**</td>
<td>80.0%</td>
<td>84.9%</td>
</tr>
<tr>
<td>% Persons Aged 25+ with Bachelor's...</td>
<td>27.4%</td>
<td>32.5%</td>
</tr>
<tr>
<td></td>
<td>28.2%</td>
<td></td>
</tr>
</tbody>
</table>


** U.S. Census Bureau
Leading Causes of Death, New York State, 2000 - 2009

Heart Disease, 207/100,000
Cancer, 160/100,000
CLRD, 31/100,000
Stroke, 26/100,000
Pneumonia/flu, 20/100,000
Unintentional Injury, 20/100,000
Age-Adjusted* Heart Disease Death Rate per 100,000 by Race/Ethnicity, New York State, 2000-2009

* Age-adjusted to U.S. Census 2000 population
Infant Mortality Rate, New York State and U.S., 2002-2011

Source: America’s Health Rankings, 2011
Note: Data are presented by report year and include data years: (1998-1999) - (2007-2008).
Infant Mortality Rate per 1,000 Live Births by Race/Ethnicity, New York State, 2000-2009

HP 2020: 5.6/1000
Infant Mortality
Rate Per 1,000 Live Births
2007-2009

New York State: 5.4

Infant Death Rate
Counts Are Shaded Based On Quartile Distribution

0 - <5.5: Q1 & Q2
5.5 - <6.7: Q3
6.7+: Q4

*** Indicates Rate Is Based On Fewer Than 10 Cases

Source: Vital Statistics

Department of Health
Prevalence of Obesity among Children and Adults, New York State and U.S., 2001-2010

Source: Behavioral Risk Factor Surveillance System, Adults ages 18+
Pediatric Nutrition Surveillance System, Children ages 2-4 years
PHYSICAL ACTIVITY & NUTRITION
Age-Adjusted Percentage of Adults* Who are Obese
New York State by County, 2009

*Adults 19 Years of Age and Older
Counties are shaded based on quartile distribution

- 15.0-27.6 (Q1 & Q2): 31
- 27.6-29.8 (Q3): 15
- 29.8+: Q4: 15

Source: NYSDOH, Focused WEEI
Prepared by: The Office of Health Informatics, Public Health Information Group, GIS
Questions Contact: infohealth@health.ny.gov
Index of Disparity for Public Health Priority Areas, New York State, 2007 - 2009

Indicators are based on the most current data available and range between the years 2007 and 2009.

- Tuberculosis Case Rate
- HIV-New Case Rate*
- Asthma Hospitalizations*
- Drug-related Hospitalizations*
- Infant Mortality
- Colorectal Cancer Mortality*
- Fall Hospitalizations, Ages 65+
- Suicide Mortality*
- COPD Hospitalizations, Ages 18+
- Breast Cancer Mortality*
- Unintentional Injury Hospitalizations*
- Pedestrian Injury Hospitalizations*
- Stroke Mortality*
- Binge Drinking, Ages 18+
- Lung Cancer Incidence-Male*
- Breastfeeding at 6 Mo, WIC
- Early Prenatal Care
- Poor Mental Health, 14+ Days, Ages 18+
- Health Care Coverage, Ages 18+
- Regular Health Care Provider, Ages 18+
- Cigarette Smoking, Ages 18+
- Seen Dentist in Past Year, Ages 18+

* Rate age-adjusted to the 2000 US population
**Rate for New York State, excluding New York City
# Rate includes Hispanics and Non-Hispanics
Sharing and Communicating with Stakeholders

Meeting agendas and materials shared:

Suggested Criteria to Consider in Selecting Priority Actions

- Disease burden
- There are evidence-based (or promising or “next practice”) interventions to prevent causes of the health problem
- Feasibility (resources, infrastructure)
- Community/partner support
- Health departments have leverage to make change
- Can move the needle on health disparities
- Can be monitored with specific, quantifiable measures
Stakeholder feedback = Survey + Discussions

1. What did communities view as strengths in their experiences working with the 2008-2012 Prevention Agenda?
2. What were some challenges working with the 2008-2012 Prevention Agenda?
3. How can these strengths and challenges be addressed through the next version in the 2013-2017 Prevention Agenda?
4. What are key issues that need to be addressed in the 2013-2017 Prevention Agenda?

1. What went well or not so well with the 2008-2012 Prevention Agenda from the perspective of your organizations? For any specific priority area that your organization may have participated in, what went well or not so well?
2. How do we achieve greater participation from stakeholder organizations (including yours) in the local community health planning and implementation process?
3. How can we assure that our new plan addresses disparities in each of the priority areas?
4. Does the proposed set of five priority areas for 2013-2017 Prevention Agenda address the priorities or concerns in your community or for your organizations?
   • If so, how might your community organization be most effective in addressing one or more of the priorities?
   • If not, how would you change them or what different priorities would you suggest?
5. Would a member of your organization be willing to serve on a committee to address an identified issue?

## Stakeholder Feedback

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Challenges</th>
</tr>
</thead>
</table>
| • Specificity of priorities  
  • Local health departments and hospitals encouraged to collaborate | • Priorities too broad e.g. access to care  
  • Resources: Funding, data, |

<table>
<thead>
<tr>
<th>Five Priorities</th>
<th>Address Challenges:</th>
</tr>
</thead>
</table>
| • Prevent chronic diseases  
  • Promote a healthy and safe environment.  
  • Promote healthy women, infants and children.  
  • Promote mental health and prevent substance abuse.  
  • Prevent HIV, STDs, vaccine-preventable diseases and health care-associated infections | • Focus on disparities and social determinants of health  
  • Include long-term indicators and intermediate measures |

State Health Assessment (cont’d)

PHAB: Measure 1.1.2 S (d and e)

After five priority areas were selected, data were analyzed within each of the five priority areas to assess and develop
- d. Contributing Causes of Health Challenges
- e. Summary of State Assets

These documents were used to support the selection and development of SHIP intervention strategies and recommendations, as well as tracking indicators to monitor progress of SHIP implementation.
Contributing Causes of Health Challenges

Contents:

- Background, health burden and trend data, disparities (SES and geographic), risk factors, and challenges in addressing the disease/condition

Link:

Summary of State Assets

Content summary: identified programs and partners available that can contribute to policies and existing resources for each health issue to address the five health priorities.

Link:
Data Used to Support Implementation of SHIP

• Prevention Agenda Tracking Dashboard:
  https://www.health.ny.gov/preventionagendadashboard

• Local CHAs/CHIPs and annual progress on the implementation of local plans from LHDs and hospitals:

• Sharing progress with statewide stakeholders:
### Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections

<table>
<thead>
<tr>
<th>Prevention Agenda (PA) Indicator</th>
<th>Data Views</th>
<th>PA 2018 Objective and Most Recent Data</th>
<th>Indicator Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>36 - Percentage of children with 4:3:1:5:3:1:4 immunization series - Aged 19-35 months</td>
<td><img src="image1" alt="Data Views" /></td>
<td><img src="image2" alt="PA 2018 Objective" /></td>
<td><img src="image3" alt="Significantly Improved" /></td>
</tr>
<tr>
<td>37 - Percentage of adolescent females with 3 or more doses of HPV immunization - Aged 13-17 years</td>
<td><img src="image1" alt="Data Views" /></td>
<td><img src="image2" alt="PA 2018 Objective" /></td>
<td><img src="image4" alt="No Significant Change" /></td>
</tr>
<tr>
<td>38 - Percentage of adults with flu immunization - Aged 65+ years</td>
<td><img src="image1" alt="Data Views" /></td>
<td><img src="image2" alt="PA 2018 Objective" /></td>
<td><img src="image3" alt="Significantly Improved" /></td>
</tr>
<tr>
<td>39 - Newly diagnosed HIV case rate per 100,000</td>
<td><img src="image1" alt="Data Views" /></td>
<td><img src="image2" alt="PA 2018 Objective" /></td>
<td><img src="image3" alt="Significantly Improved" /></td>
</tr>
<tr>
<td>39.1 - Difference in rates (Black and White) of newly diagnosed HIV cases</td>
<td><img src="image1" alt="Data Views" /></td>
<td><img src="image2" alt="PA 2018 Objective" /></td>
<td><img src="image3" alt="Significantly Improved" /></td>
</tr>
<tr>
<td>39.2 - Difference in rates (Hispanic and White) of newly diagnosed HIV cases</td>
<td><img src="image1" alt="Data Views" /></td>
<td><img src="image2" alt="PA 2018 Objective" /></td>
<td><img src="image4" alt="No Significant Change" /></td>
</tr>
<tr>
<td>40 - Percentage of HIV-infected persons with a known diagnosis who are in care</td>
<td><img src="image1" alt="Data Views" /></td>
<td><img src="image2" alt="PA 2018 Objective" /></td>
<td><img src="image5" alt="Worsened" /></td>
</tr>
<tr>
<td>41 - Gonorrhea case rate per 100,000 women - Aged 15-44 years</td>
<td><img src="image1" alt="Data Views" /></td>
<td><img src="image2" alt="PA 2018 Objective" /></td>
<td><img src="image3" alt="Significantly Improved" /></td>
</tr>
<tr>
<td>42 - Gonorrhea case rate per 100,000 men - Aged 15-44 years</td>
<td><img src="image1" alt="Data Views" /></td>
<td><img src="image2" alt="PA 2018 Objective" /></td>
<td><img src="image3" alt="Significantly Improved" /></td>
</tr>
</tbody>
</table>
Click on the County Dashboard to view more data.
To select other indicators below county level
PHAB feedback on NYS accreditation application and site visit

“The New York State Department of Health has an outstanding partnership with stakeholders and community organizations including local health departments.

The level of collaboration was clearly evident in multiple site visit meetings. The strength of collaboration is most evident in the success of NYS DOH's state health improvement plan called "The Prevention Agenda."

NYS DOH has been highly successful engaging partners across the state in the implementation of the Prevention Agenda. NYS DOH has used the local health department contracting process to guarantee commitment to community level implementation.”

…well-organized and informative…. The process of combining the review of an older SHIP with a new assessment leading to an updated SHIP seemed to work well for partners.

…. impressively evidence-based, easy to understand and comprehensive
Questions??

Hit *1 on your telephone key pad and the operator will queue you up to speak directly with the presenters.

Our presenters are excited to speak with their peers directly so we encourage you to use this function!
THANK YOU!

For further information, do not hesitate to contact me:
Denise Pavletic
dpavletic@astho.org