Findings, Goals, Objectives, and Strategies

1. PUBLIC/COMMUNITY HEALTH DATA AND INFORMATION

Findings:

- ✓ Monitoring health status to identify problems and potential interventions was identified as a priority essential service by the Turning Point Partnership. Conducting community health assessments (CHAs) is a major activity within this service.

- ✓ A wide range of public and private agencies and organizations conduct CHAs, which serve a number of purposes, including: describing community health status and priority issues and populations; identifying factors that contribute to the health of the community; assessing the use of local resources; demonstrating the need for new or expanded programs or policies; proving the need for funding and other resources; and complying with government requirements.

- ✓ Local community health assessments required by government and private agencies often result in duplication of effort, since they request the same or similar assessment information from numerous local government and private agencies. Where possible, local assessments should be prepared collaboratively by local health departments, hospitals, managed care organizations, and non-profit organizations serving the local population. Sharing of data and information among these agencies will greatly improve the quality of the CHAs. Based on previous efforts to promote collaboration, however, policy and/or legislative changes are needed to assure CHA collaboration and coordination between, at a minimum, hospitals and local health departments.

- ✓ A survey of local health departments on CHA capacity and training needs, a survey and facilitated workshop of many other public and private community partnerships and organizations, as well as meetings with the local Turning Point staff identified processes, needs, barriers and resources related to conducting CHAs. (Survey/Report and Recommendations of Governmental and other public and private community-based partners identifying processes, needs, and resources related to conducting CHAs, June, 1998, Roz Lasker and NYSDOH; and Survey and Report of Local Health Departments on Assessment Capacity and Training Needs, Summer/Fall, 1998)

- ✓ All types of organizations face difficulty in locating, obtaining and applying relevant data. Common data and information problems that affect the quality and timeliness of CHAs, reported by more than half of the CHA agency participants, include:

    - Where to find CHA data and information
    - Availability of small area data
    - Timeliness of data
    - Staff time to work with data
    - Availability of information on HIN
    - Access to, and ability to use PCs, the Internet and browsers

- ✓ Surveys suggest that LHDs and other local CHA agencies could benefit from training/technical assistance to improve their CHA data and information skills, including:
    - Assessment models (e.g. APEX, Patch)
    - Developing local data systems
    - Developing report cards/performance measures
    - Analyzing/mapping small area data
    - Program evaluation
    - Data Analysis

- ✓ A review of the 59 CHAs completed by LHDs in the first cycle of using new, comprehensive assessment guidelines that recommend collaboration confirms the findings listed above. This review demonstrates the great need to improve access to timely, high-quality CHA data and information, particularly at the county and sub-county levels.

- ✓ Data collection, analysis, communication and application skills also need to be strengthened. There are many innovative and effective ways to promote the use of data and information for local community health improvement activities, including setting priorities and goals, planning interventions, consensus-building, advocacy, mobilizing local partnerships, and monitoring health status and program outcomes.

- ✓ The work group members and project participants overwhelmingly endorsed the development of a web-based, centralized clearinghouse of CHA data and information that is easily accessible for all CHA staff as a first step.

<u>Goal:</u> Strengthen ability of communities to monitor health status to identify broad range of determinates that affect health of their residents.

Objectives:

1. Provide training and technical assistance to improve the use of data and information for Community Health Assessment and improvement according to the following timetable:

Strategies:

- By 2000, provide training to help LHDs access and apply information to update and improve their CHAs, based on findings from LHD surveys and CHA reviews.

- By 2000, develop formal public health informatics training and technical assistance programs.

- Annually implement, evaluate and refine training and technical assistance, and other types of support.

Lead Organization: NYSDOH (Local Health Services and the Center for Community Health's Public Health Information Unit)

Collaborators: NYSACHO; HANYS; University at Albany School of Public Health

2. By 2000, align community health assessment processes of hospitals and local health departments.

Strategies:

- Develop guidance for collaboration between LHDs and hospitals in the development of community service plans and community health assessments.

- Make community health assessment data available to other partner agencies, including hospitals.

- Provide training on how hospitals and local health departments can collaborate on assessments.

Lead Organization: NYSDOH (Local Health Services and Bureau of Hospital and Primary Care)

Collaborators: NYSACHO; HANYS

3. By 2001, address priority CHA data and information gaps.

Strategies:

- Develop data and training on community assets identification and mapping community health data.
- Develop/improve data to monitor and improve child health.
- Improve community-level data and profiles with:
  - ◊ More sub-county community-level data;
  - ◊ Standardized small area indicators;
  - ◊ Small area inter-census population estimates;
  - ◊ Risk factor (Behavioral Risk Factor Surveillance System, Youth Risk Behavior Survey) information at local level;
  - ◊ Web-based access to community level data;
  - ◊ Managed Care Data;
  - ◊ Other valuable and available sources of data not widely used for CHA.

Lead Organization: NYSDOH (Center for Community Health's Public Health Information Unit)

Collaborators: Academia; NYSDOH Office of Managed Care

4. By 2002, Standardize and centralize CHA data and information so that all community partners can have electronic access to the most current public health data, information and resources.

Strategies:

- By 2000, improve CHA data and information available to LHDs via the Health Information Network.
- Help to develop NYSDOH data and information access policies through Departmental information management policy advisory groups.

- By 2001, disseminate Healthy People 2010 indicators for New York State via NYSDOH web sites.

- By early 2001, agree on where NYSDOH web-based clearinghouse will reside so that it is accessible to all public and private organizations conducting CHAs.

- By Fall, 2001, add annotated directory of data resources and comprehensive data from multiple agencies to the clearinghouse.

- Annually develop and update standard indicators for use by multiple agency health assessments.

- By 2002, develop registry of community health improvement projects and best practices.

Lead Organization: NYSDOH (Information Systems and Health Statistics Group and the Center for Community Health's Public Health Information Unit)

Collaborators: NYS Community Health Partnership; NYSACHO; Academia; Consultants; New York State Academy of Medicine

2. COMMUNICATION AND MOBILIZATION:

Findings:

- ✓ A focused discussion with the Turning Point local partnerships indicated that they want assistance in developing mechanisms to convey value of community health improvement activities to local community leaders, policy makers and consumers. Local partnerships also requested technical assistance on marketing public health and community health.

- ✓ Outreach, community organizing, marketing and communications are capacities identified as being very important to improve the success of local community health partnerships in New York (New York State Healthy Communities Survey, 1999. New York State Community Health Partnership).

- ✓ Organizational and cultural diversity are ongoing challenges for state and most local partnerships.

- ✓ Experience working with local partnerships and with local health departments during recent public health crises indicates that local organizations have a range of technological skills and capabilities needed for communication. These skills depend on local governmental support, availability of dedicated staff, and availability of training. The inequities in skill levels make local and regional communication difficult.

- ✓ Local partner organizations need assistance in improving technological expertise and need links to state and local partners who can assist them.

- ✓ Recent public health emergencies demonstrate that tools for rapid communication are important and necessary for local government staff and providers within communities.

Goal: Promote broader and more effective participation by and more effective communication among diverse groups in community health improvement activities.

Objectives:

1. By 2000, start a campaign to raise consciousness and broaden knowledge about and participation in community health improvement efforts at state and local levels.

Strategies:

- Test brand identity and themeline selected by New York State Community Health Partnership in internal and external written communications of New York State Community Health Partnership members.

- Develop usage guidelines for brand identity.

- Using brand identity and themeline, implement marketing/public relations campaign to inform policy makers about community health improvement.

- Develop community health communications kit including guidelines and materials to help New York State Community Health Partnership organizations and local partnerships to send the community health message to members, potential partners and the public-at-large.

- Provide New York State Community Health Partnership newsletter electronically so that local partnerships can use content in local newsletters.

- Work with statewide and local organizations representing diverse constituencies and populations currently missing from the state partnership to solicit involvement and to recruit coalition members.

Lead Organization: SCAA (as a member of the NYS Community Health Partnership).

Collaborators: Other Partnership organizations

1. By 2001, train communities to conduct social marketing and media advocacy campaigns on local health priorities.

Strategies:

- Develop and implement a course for community health partnerships on social marketing. The focus would be on the use of marketing techniques to advocate for improved community health. Skills would include: appropriate application of social marketing techniques; coalition-building and maintenance; and media advocacy.

- Develop and implement several locally based social marketing campaigns that address key community health priorities of New York State communities.

Lead Organization: NYS Community Health Partnership

1. By 2002, assure that organizations participating in community health improvement activities are technologically capable of communicating (via e-mail, videoconferencing, teleconferencing, etc.) with their local partners, regionally and throughout the state.

Strategies:

- Pilot test computer desk-top systems as a communication tool for local health departments.

- Pilot test methods for local health departments and hospitals to strengthen capacity to communicate rapidly during health emergencies.

- Based on results of pilot tests, implement communication systems improvements.

- Offer ongoing training on use of Health Information Network to a range of LHD staff and to non-LHD partners who have access to it.

- Develop directory of telecommunication capabilities (i.e., video teleconferencing, satellite hook-up information) and technology training for each county.

Lead Organization: NYSDOH

Collaborators: NYSACHO; HANYS

3. RESTRUCTURING INVESTMENTS:

Findings:

- ✓ State aid represents 19 percent of total spending by local health departments on public health services in 1999. Grants represent 29 percent of the total spending.

- ✓ State government provides the largest share of resources for community health partnership functioning (New York State Healthy Communities Survey, 1999. New York State Community Health Partnership).

- ✓ The consolidation of child and family health funding from multiple state contracts into a single contract in Monroe County achieved administrative efficiencies for the county; increased the county's flexibility and authority to manage and maximize resources; and improved accountability through increased utilization of health outcome measures. However, the process is labor intensive and requires the commitment of state and local staff to achieve meaningful results. The process can be supported best through use of outside consultants who can help guide the counties through the process and keep the process on track. (Removing Categorical Barriers to Child and Family Health Services: The Monroe County, New York Experience, 1998 Meridian Consulting Services Inc.)

- ✓ A local partner's experience in trying to identify the source, amount, and regulations pertaining to government and private funding that supports community health and health services within a locality, indicates that local funding information is not easily available, and requires skills and resources to collect and analyze it.

- ✓ Long-term funding from government and non-governmental sources is essential to sustain community health improvement processes.

- ✓ Statewide support for community health collaboration needs to be fiscally supported and encouraged.

Goal: Restructure investments to better support communities to identify and address the broad range of determinates that affect the health of their residents.

Objectives:

1. By 2002, make government support for community health improvement more accessible to local partners.

Strategies:

- Review the current Article 6 reimbursement methodology to see whether it can be improved to make it compatible with the ten essential public health services.

    - Create a pool of consultants to assist interested LHDs to consolidate NYSDOH-funded programs/contracts as per Monroe consolidation.

    - Simplify and streamline grant application process from NYSDOH to partnerships, CBOs, and LHDs by developing a predictable schedule, a common format and a web-based calendar of grant opportunities.

    - Improve capability of local partnerships to identify sources and amounts of funds within their communities that support community health improvement.

    Lead Organization: NYSDOH

    Collaborators: NYSACHO; HANYS

    2. Investigate and create long-term institutionalized funding mechanisms to support community health efforts in New York State so that community health can be sustained.

    Strategies:

    - Explore establishing public health trust fund, foundation or endowment to support community health improvement in New York State.

    - Develop educational sessions for policy makers and directors of statewide organizations about need to invest in prevention.

- Identify and obtain funding to support the Community Health Partnership as statewide organization that can support community health improvement.

Lead Organization: HANYS

Collaborators: SCAA

4. ACCESS

Findings

- ✓ Access to health services is a local health priority for 56 percent of the counties whose LHDs completed community health assessments and identified local priorities in 1998-99. (Assessment of LHD Health Priorities, 1999, Department of Health Local Health Services Unit.)

- ✓ Access for the uninsured is one of the most important goals of local community health partnerships surveyed in Fall, 1999 (New York State Healthy Communities Survey, 1999. New York State Community Health Partnership)

- ✓ Access is a priority for the three local Turning Point partnerships funded in New York State.

- ✓ Many community health coalitions are working to increase enrollment in Medicaid and Child Health Plus and to increase use of services by enrollees. Activities of these coalitions include: developing and implementing marketing campaigns; conducting facilitated enrollment; and identifying needed policy changes by government and health care providers to achieve access improvements. Implementing local campaigns requires additional capacity in advocacy and social marketing.

- ✓ As defined by local health partnerships, access must be defined broadly to include access to community-based preventive services in addition to medical treatment services. Addressing access in a comprehensive fashion requires additional skills.

Goal: Improve the ability of local community health coalitions to identify, address and track access to health services including prevention.

Objective:

1. Develop a technical assistance program to assist community health partnerships to address access.

Strategies:

- Develop and publicize definition of access that includes prevention as well as traditional medical services.
- Examine policy changes needed to strengthen access to health care, including prevention.
- Develop and implement training for community partnerships on how to use population-based strategies to address access issues. This includes how to conduct systems analysis of preventive health resources and medical service availability within a locality.
- Develop and test measures to be used to assess progress toward improving access.
- Establish a feedback loop from local partnerships to state policy makers to report and address concerns regarding local access issues.

Lead Organization: NYS Community Health Partnership

Collaborator: NYSDOH

5. CAPACITY BUILDING:

Findings:

- ✓ Capacity building is defined as developing the systemic and individual capabilities of the public health workforce to address community health improvement. The public health work force consists of the individuals employed by or working with any of the public and private organizations – LHDs, hospitals, community groups – promoting community health improvements.

- ✓ Capacity building must be linked directly to priority community health improvement functions and activities and should be driven by the needs of communities and the public health workforce more than by the expertise that happens to be readily available.

- ✓ Capacity building must recognize the shared responsibility of community health improvement among and within agencies, groups and partners; and link their capacity building activities. Disease prevention and health promotion leading to healthy human development across the life course requires multidisciplinary, cross-agency efforts in which families and community groups have meaningful participation. Capacity building gains leverage when carried out with groups, partners and teams which must work together to achieve the long range goals of community health improvement.

- ✓ Capacity building activities should be tailored to the full spectrum of the public health professionals engaged in community health improvement, ranging from entry-level to very experienced. These include administrators, program managers, educators, community organizers, environmental health professionals, nurses, front-line health care and other human service professionals, physicians, as well as researchers, analysts and planners.

- ✓ Capacity building should be coordinated with, and sponsored and endorsed by a broad base of relevant groups, associations and agencies, including state and local government agencies, hospitals and other health care providers, other community-based organizations and consultants and academia. The New York State Community Health Partnership is an ideal inter-agency, statewide collaborative within which to sponsor capacity building for community health improvement

- ✓ Capacity building requires significant resources and a financial plan to sustain support. Financial and other resources must be defined, focused and reallocated to support sustained, innovative and multi-year capacity building.

- ✓ The NYS Public Health Assessment Project survey (1997) on local health training needs and national studies on how to prepare public health professionals conclude that, because public health work is demanding and often crisis-driven, professionals need incentives to take advantage of training and other capacity-building resources. Incentives include: agency support; convenience in attending; geographic accessibility; paid tuition; credentialed programs, increased use of distance learning techniques; and more practical and applied skill-building methods. More practice paradigms can be added to academic public health programs.

- ✓ There are a variety of effective and innovative public health training resources, methods and models available across multiple disciplines, and all of these have a place in a coordinated approach to building capacity. These include: on-site or regional in-person training; distance learning; training videos; satellite broadcasts; computer and web-based courses; symposia; and train-the-trainer or scenario-based approaches. Many could yield continuing education credits. An experimental approach to capacity building should be followed, allowing testing and modification based on formative evaluation in an incremental manner.

- ✓ Capacity building should build on and improve efforts already under way in New York State, such as the Northeast Public Health Leadership Institute sponsored by University at Albany School of Public Health; and the monthly satellite broadcasts. In addition, new approaches should be tried that build on best practices and innovative models in other states (e.g., Missouri)**.**

- ✓ Information gathered on the Missouri Institute for Community Health Leadership indicated that such institutes play an important role by enlisting community partners and leaders who can become empowered through ongoing and incremental leadership and skill-development activities. These leaders bring new skills and mentoring relationships to their future community health improvement efforts.

Goal: Strengthen skills of the public health work force and the capacity of communities to address the broad range of determinates that affect the health of their residents.

Objectives:

1. Develop and implement training and education opportunities and curricula around priority areas identified during strategic planning process.

Strategies:

- By 2000, develop and implement a LHD commissioner/director leadership training.
- By 2001, expand leadership training to more public health professionals.
- In 2000, provide training to improve Community Health Assessment updates due by LHDs in 2000.
- By 2000, develop and implement training on how local communities can collaborate on the development of CHAs required of LHDs and Community Service Plans required of hospitals.
- By 2001, support training/technical assistance activities through a web-based Community Health Clearinghouse and other web-based training, with linkages to national sites.
- Annually, identify new CHA improvement training needs.

Lead Organization: NYSDOH (Local Health Services Unit, Public Health Information Unit, and Information Systems and Health Statistics Group)

Collaborators: NYSACHO; HANYS; University at Albany SPH; other Academia

1. Plan and implement a Community Health Institute for local partnerships and coalitions across the spectrum of professions, agencies and community groups comprising the public health workforce that will achieve sustained success in community health improvement.

Strategies:

Over four years:

- provide technical assistance and training to community health improvement teams.
- develop and evaluate short courses and workshops offered for multi-disciplinary groups of health care professionals.

Methods:

- By 2001, expand satellite broadcast series to additional participants and seek new partners.

    - By 2001, develop a structure and application process for technical assistance and training to community health improvement teams.

    - By 2002, establish a network of agencies that can approve continuing education credits to enable streamlined process for accreditation process.

    - By 2002, initiate at least three technical assistance and training projects linked to community health improvement teams.

    - Conduct process evaluation of capacity building initiatives offered through the Community Health Institute.

    - Annually refine capacity-building curricula and operation based on process evaluation results.

    - In 2003, conduct outcome evaluation for future planning.

    - By 2004, implement at least five short courses and workshops for multi-disciplinary groups of public health practitioners related to community health improvement.

Lead Organizations: Cornell University; NYSACHO; NYSDOH (as members of NYS Community Health Partnership)

Collaborators: University at Albany School of Public Health; other Academia; the Greater New York SOPHE Chapter

6. QUALITY IMPROVEMENT:

Findings:

- ✓ Monitoring process and outcomes is an essential part of the community health improvement process.
- ✓ State and local partnerships involved in community health improvement do not regularly use performance measures to track progress toward goals or objectives.
- ✓ The Public Health Agenda Project found that performance monitoring of local health departments should include process, capacity and outcome measures leading to a comprehensive reporting system for LHDs. (Public Health Agenda Report, 1998. NYSDOH and NYSACHO).
- ✓ The Monroe County consolidated funding project promoted the use of performance measures by LHDs in conjunction with community partners.

Goal: Incorporate continuous quality improvement in public and community health improvement efforts.

Objectives: Develop and implement a quality improvement process in community and public health efforts.

Strategies:

- Conduct annual analyses of mobilizations on current public health threats and emergencies and ability to respond to future events.
- By 2000, convene an outcomes and performance measures work group with members from the Public Health Agenda Project to establish a statewide set of performance measures to be used by all local health departments when reporting to the NYSDOH. These measures can serve as the basis for consolidated performance monitoring of the quality of public health in New York. To assist with quality assurance, disseminate the Healthy People 2010 indicators to community health partnerships and LHDs for use in New York State.

- Provide models for and technical assistance on how LHDs and community health partnerships can monitor health status in their counties using the QUARs data on managed care plans.

Lead Organization: NYSDOH

Collaborators: Partnership members

References:

1. New York State Public Health Council, Communities Working Together for a Healthier New York, September, 1996.

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4. New York State Association of County Health Officials and New York State Department of Health, Public Health Agenda Report, 1999.

5. Meridian Consulting Services Inc., Removing Categorical Barriers to Child and Family Health Services: The Monroe County, New York Experience, June, 1998.

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7. New York State Public Health Agenda Committee, "Planning and Funding Local Public Health in New York State: The New Public Health Agenda", 1998.

8. Survey/Report and Recommendations from Survey and Facilitated Workshop of Governmental and other public and private community-based partners identifying processes, needs, and resources related to conducting CHAs. (May-June, 1998)

9. Survey and report of Local health Departments on Assessment Capacity and Training Needs (Summer/Fall, 1998)

Appendices

1. Summary Recommendations for Action
2. Partnership Organizational Chart