Progress to Date on *2008-2012 Prevention Agenda Toward the Healthiest State*

The *2008-2012 Prevention Agenda Toward the Healthiest State* was New York's public health improvement initiative for the five-year period beginning in 2008. It was a call to action to local health departments (LHDs), health care providers, health plans, schools, employers and businesses to collaborate at the community level to identify local priorities for improving the health of New Yorkers and to work together to address them. The premises on which the *Prevention Agenda* was based included these three compelling reasons:

- Medical care, even primary care, cannot ensure all the conditions that enable people to live healthy lives.
- Community-based policies and systems designed to make the healthy choice the easy choice are essential to improve health.
- Health care reform will not be successful without greater attention and investment in community-based public health.

The *Prevention Agenda* established 10 public health priorities and corresponding goals. For each priority area, indicators were defined to measure progress toward achieving these goals, including the elimination of racial, ethnic and socioeconomic disparities. LHDs were asked to work with hospitals and community partners to describe community health needs and identify priorities in Community Health Assessments and the 2010-2013 Municipal Public Health Services Plans. Non-profit hospitals were asked to work with LHDs to assess community health issues and identify local priorities in Community Service Plans for 2010-2012. Additional components that supported the development of the *Prevention Agenda* included:

- Technical assistance trainings and webinars
- On-the-road promotion and media
- Outreach to statewide partner organizations and their encouragement of local affiliate participation in prevention activities
- *Prevention Agenda* website that included current data on the health status of New Yorkers, tools for health planning and evaluation, evidence-based interventions, and partners in each county.

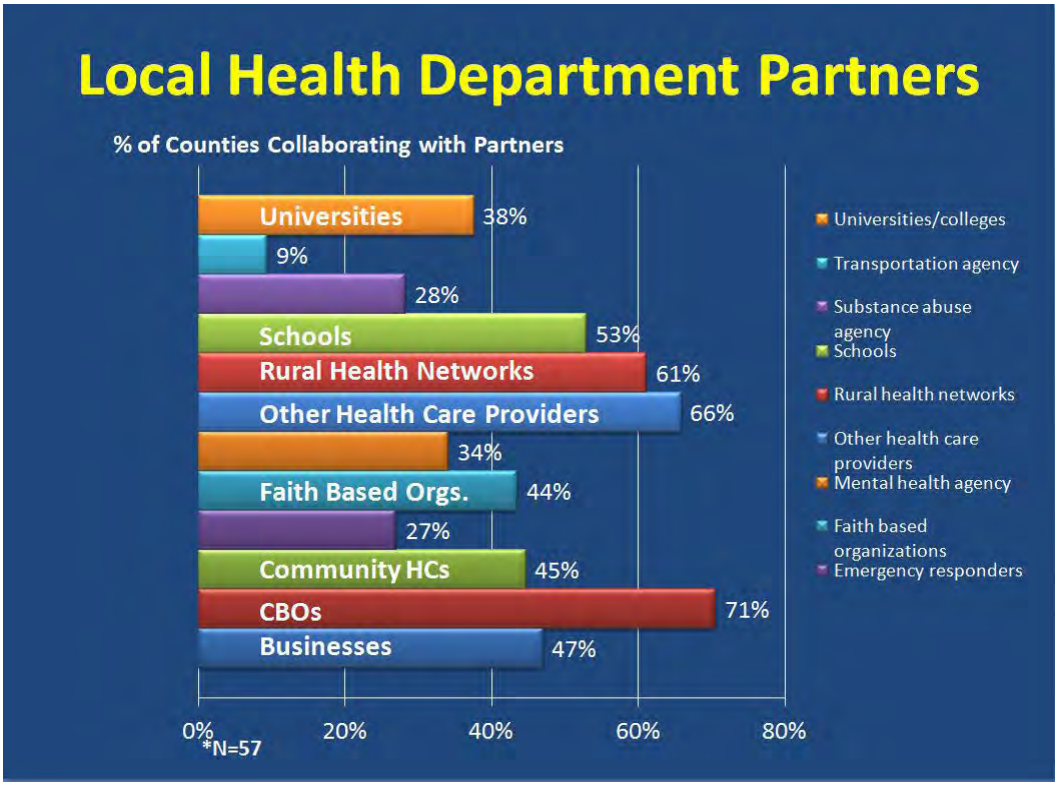
A key facilitator for the community health planning was $7.1 million in HEAL 9 funds that were made available for 18 community health planning projects across the state. The goal of this funding was to encourage a process of structured decision-making to allocate health care resources and enable communities to identify and address preventable health problems that affect the health of New Yorkers in conjunction with the *Prevention Agenda*.

A review of the progress to date in the Prevention Agenda – both the process of collaborating to identify and address local priorities and improvements in health outcomes were assessed to inform the development of the Prevention Agenda 2013-2017. That review is described below.

Progress in Collaborative Planning

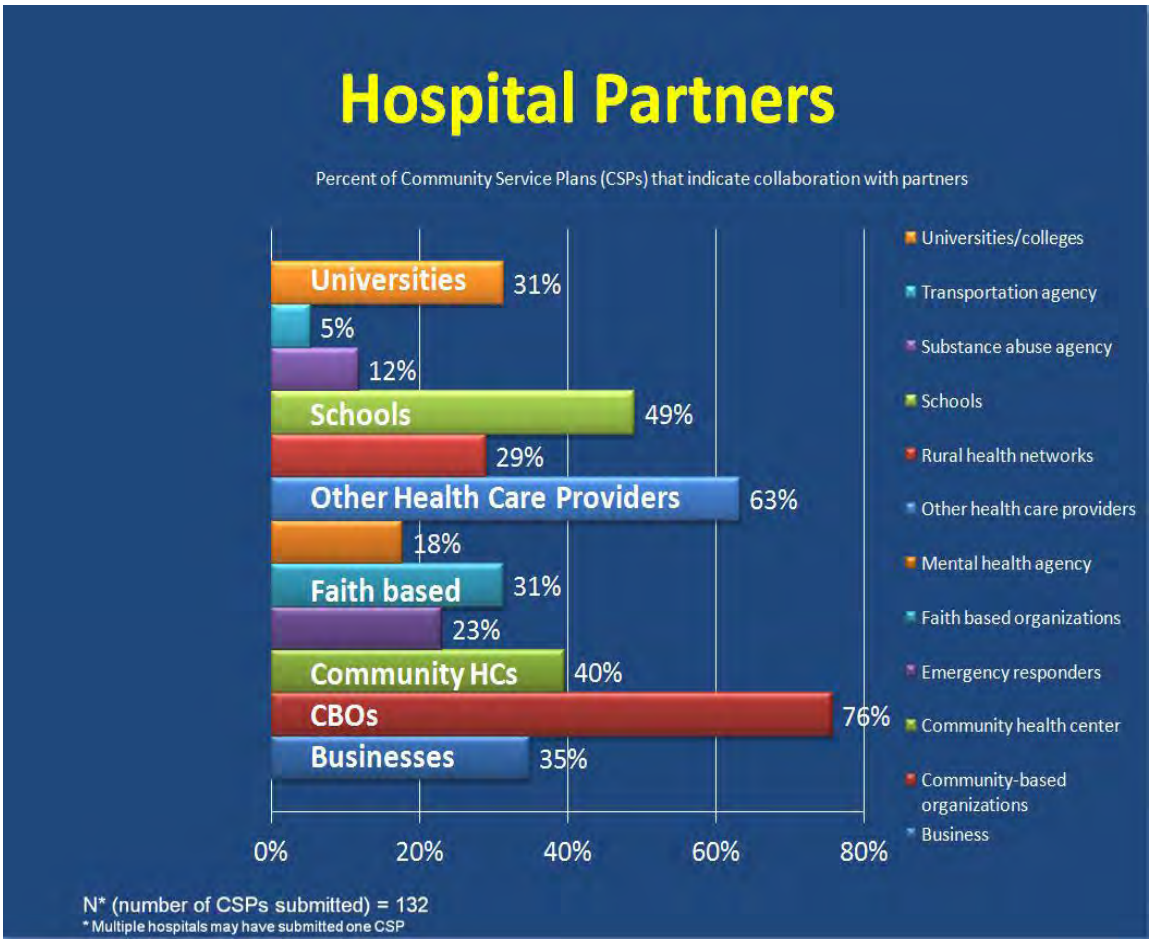
A 2009 review of Community Health Assessments and Community Service Plans (CSPs) submitted by 57 LHDs and 165 hospitals, respectively, found evidence of collaboration to identify public health priorities in every county of the state (Figures 1 and 2). For LHDs and hospitals, the two groups most frequently listed as partners were community-based organizations and health care providers. Many other groups were named as well.

Figure 1



The diversity in partnerships is critical in supporting policies and programs for community health. Each partner can bring assets and offers channels to reach the public. For example, hospitals and health providers can benefit from health-promotion programs offered in the community to make their patients healthier. Businesses have a stake in the health of their employees and their bottom line, and made up one-third of the partners named by hospitals. The priorities picked by the communities determined the type of partnerships needed to take action.

Figure 2



Selection of Prevention Priorities

As shown in Figures 3 and 4, at least two priorities were selected by the LHDs and hospitals in each county. Most often, communities selected *Access to Quality Health Care*, *Chronic Diseases* and *Physical Activity and Nutrition*. *Tobacco Use* was also selected by many hospitals, but by fewer LHDs. Almost all LHDs and hospitals reported that they worked with their partners to identify priorities. Fewer than half of LHDs and hospitals forged strong partnerships that specified roles for each organization on planning and implementation. Very few hospitals or LHDs reported on their progress according to specific process or outcome measures.

Figure 3

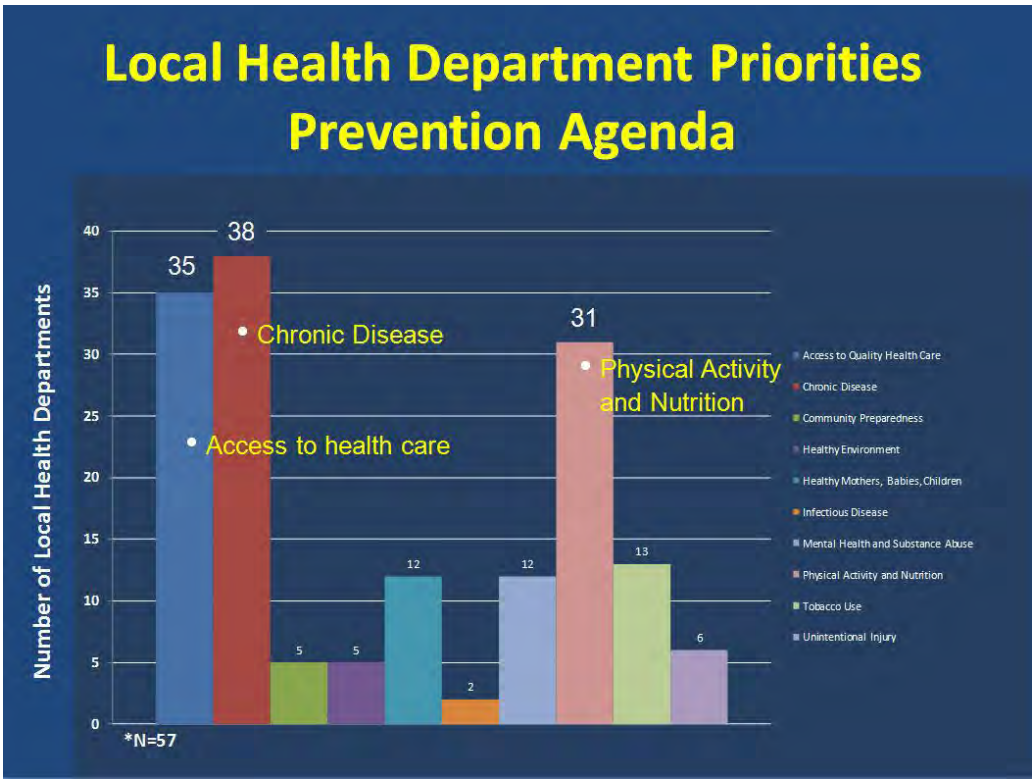


Figure 4

Progress in Collaborative Planning in Local Health Departments

In the fall of 2010, the DOH Office of Public Health Practice asked each LHD to report 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 to address their community's selected *Prevention Agenda* priorities, their progress toward implementing local plans, their challenges, and the technical assistance they need. Each LHD was asked to provide information on the status of their chosen *Prevention Agenda* priorities, especially the two priorities with the most progress and the steps they have taken to implement strategies for those two priorities. Fifty-six of the 58 LHDs responded to the survey. 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 often 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

Figure 5

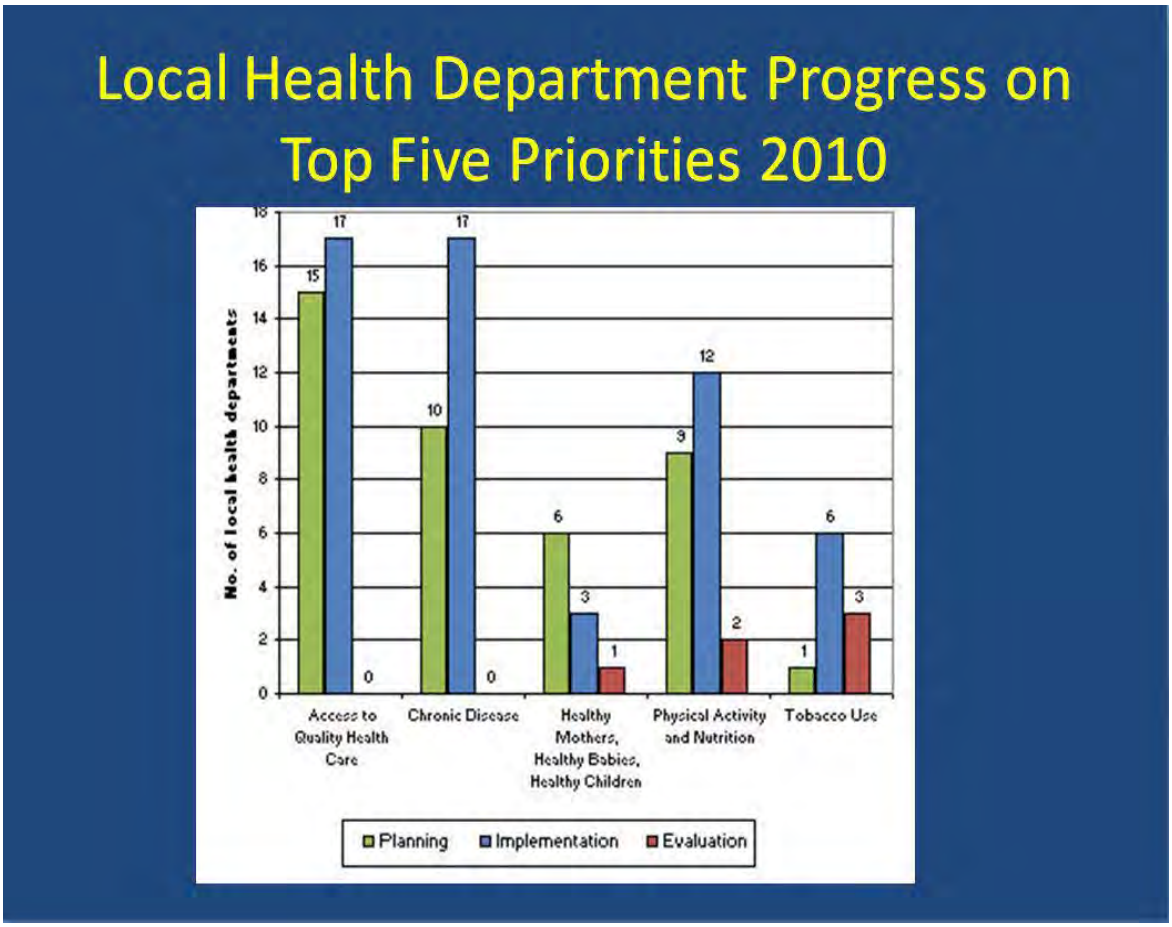


Figure 5 summarizes the number of LHDs that reported their progress in addressing the state's top five priorities through planning, implementing and evaluating intervention strategies. For the two priorities chosen by most counties, *Access to Quality Health Care* and *Chronic Diseases,* most LHDs reported that they had completed the planning process and implemented strategies to address these priorities, but none had evaluated their strategies by 2010. For the other three priorities (*Healthy Mothers, Healthy Babies, Healthy Children*; *Physical Activity and Nutrition*; and *Tobacco Use*), one to three LHDs, respectively, reported that they were in the evaluation phase.

Each LHD provided information on two of their priorities, for a total of 112 reports. 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 percentage of the total priorities that LHDs reported on as their first and second choices. Their responses are 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 percent of the respondents) had not established measures for either priority.

About 40 percent of the LHDs had started collecting baseline data, solicited community input and selected interventions for both priorities. Many 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. Only six LHDs had tested or evaluated interventions for both chosen priorities, while nine had tested an intervention for one of them and eight had evaluated the intervention. The finding that most LHDs had not taken steps to test or implement strategies for either priority indicated that additional support was needed to move forward.

Table 2. Number of LHDs Reporting on Steps Taken to Implement Strategies for *Prevention Agenda* Priorities

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

Technical Assistance Needs

LHDs were asked to identify their top two technical assistance needs that would strengthen their capacity to address *Prevention Agenda* priorities. The two needs rated as equally important by 82 percent of the LHDs were identifying and adapting evidence-based interventions to local settings, and establishing measures to track success. The third- and fourth-ranked needs were accessing and analyzing public health indicator data (47 percent) and spreading successful practices to other areas (36 percent). Needs in these areas are consistent with the information in Table 2, which shows that fewer LHDs had 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 survey question. Another useful perspective is to report results by the chosen priorities. Because the 56 LHDs reported on their two top priorities separately for several questions, results for these questions were analyzed using 112 responses. LHDs reported that:

- Hospitals participated in the collaboration for 81 percent of the priorities. For only 8 percent of the priorities, LHDs reported “no active participation” from hospitals. Non-participation varied

by priority, LHD and region. For 11 percent of the priorities, LHDs did not answer the question on hospital participation.
- Collaboration with most hospital partners was easier than expected, or about what they expected (52 percent of the priorities).
- Communication among all of the partners was good (71 percent of the priorities).
- Staff were qualified and had the skills to do the required work (for 50 percent of the priorities).

LHDs also noted some challenges. For example:
- Funding was not sufficient (51 percent of priorities).
- Competing public health challenges made it difficult to focus on a specific priority (24 percent of priorities).
- Adapting evidence-based intervention strategies to local communities is difficult (21 percent of priorities).

Progress in Collaborative Planning in Non-Profit Hospitals

A review of hospitals' Community Service Plans submitted in 2010 indicated that more than half of them selected *Chronic Disease*, *Access to Quality Health Care*, and *Physical Activity and Nutrition* as their priorities for collaborative action (see Figure 4), which were similar to the priorities that LHDs chose. A majority of the state's hospitals had established partnerships with LHDs and community groups, identified at least two priorities and developed plans to address them.

Most hospitals addressing the *Access to Quality Health Care* priority were focusing on screening and linking eligible patients to insurance programs through the facilitated enrollment process or assigning staff to help patients navigate the health system. In *Chronic Diseases*, the focus most often was diabetes management, prevention of stroke or cancer screening. In *Physical Activity and Nutrition*, the hospitals focused on providing physical activity and nutrition messages with their own staff, seniors or school children.

Some hospitals were working on policies proven to make the community environment healthier for residents and tracking changes from the implementation of these policies. Many hospitals focused on increasing knowledge and awareness via educational workshops, health fairs and information distribution. To monitor their activities, most hospitals had identified process measures, including the number of events they hosted or materials they distributed.

Comparing the Hospital Community Service Plans and the Local Health Department's Community Health Assessments

For both hospitals and LHDs, the top three priorities were *Chronic Diseases*, *Access to Quality Health Care*, and *Physical Activity and Nutrition*. A significant number of hospitals also identified *Tobacco Use*; *Healthy Mothers, Healthy Babies, Healthy Children*; *Mental Health and Substance Abuse;* and *Preventing Unintentional Injuries* as priorities.

The 2010 CSPs and the LHD surveys confirmed that LHDs and hospitals were working together to address *Prevention Agenda* priorities. While a significant number of LHDs and hospitals were in the implementation phase for at least one of their priorities, there are several challenges ahead for them. These include funding, competing public health issues and adapting evidence-based strategies to their communities. DOH's Office of Public Health Practice and the Office of Health Systems Management's

Division of Certification provided technical assistance to both groups in Identifying and implementing evidence-based strategies, and selecting and using performance measures to assess their progress.

Progress to Date in Changing *Prevention Agenda* Indicators

Changes observed for the *Prevention Agenda* indicators were measured in two ways. First, the current level for each of the 35 indicators was compared with the *Prevention Agenda* objective and expressed as a percentage difference. The resulting values were used to assess whether the objectives were achieved, or how far away each county was from reaching the objectives.

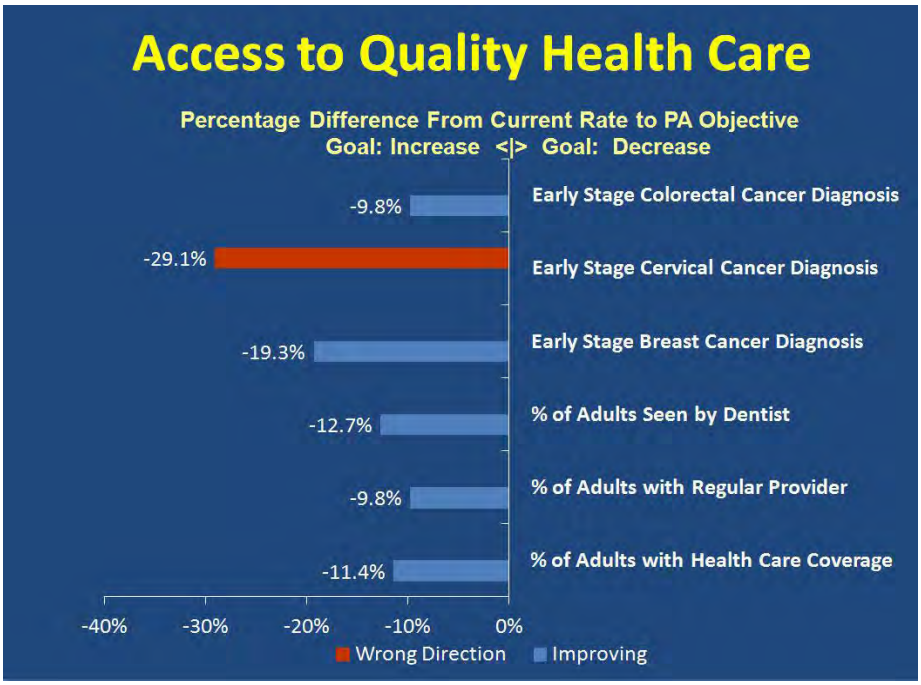
Then, the difference between the baseline levels for each indicator at the start of the *Prevention Agenda* and most currently-available value for the indicator was determined. The difference was then divided by the baseline level and expressed as a percentage.

The results of these comparisons are shown in Figures 6 to 25. Three indicators achieved the target values. Fourteen indicators moved in the wrong direction, one indicator remained unchanged, and there were no new data for one other indicator. Health-related disparities did not improve.

Access to Quality Health Care

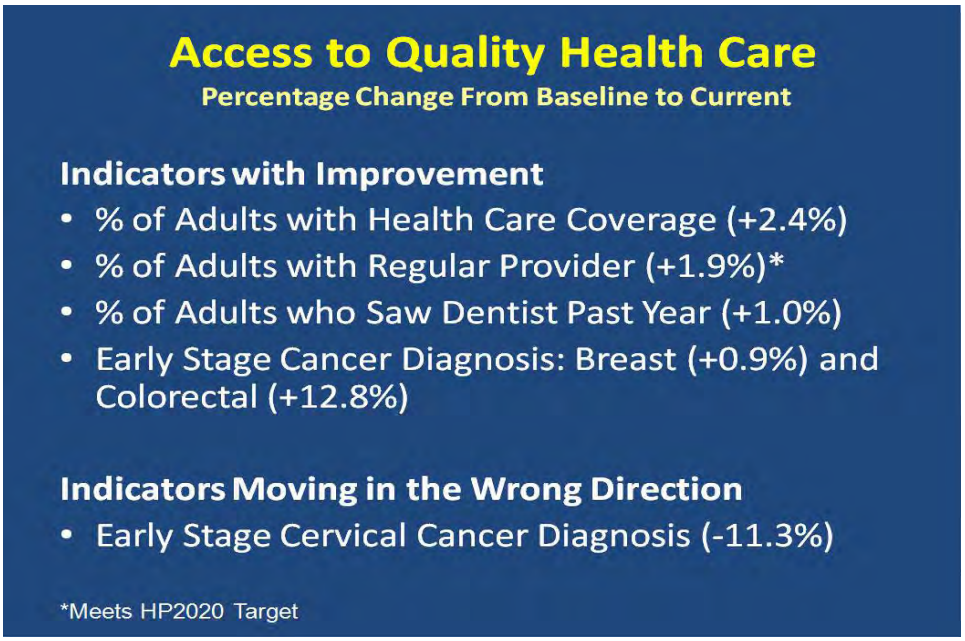
The percentage differences between the current levels of each tracking indicator for this priority and the *Prevention Agenda* objective are shown in Figure 6. All but one tracking indicator for this priority improved. Decreases in the gaps were noted for the proportion of residents with an early stage colorectal cancer diagnosis (9.8 percent), early stage breast cancer diagnosis (19.3 percent), the proportion of adults seen by a dentist (12.7 percent), having a regular health care provider (9.8 percent), and having health care coverage (11.4 percent). The percentage of residents with a diagnosis of cervical cancer at an early stage declined, resulting in a larger gap from the *Prevention Agenda* objective.

Figure 6



In Figure 7, four indicators for *Access to Quality Health Care* showed some improvement from the baseline (single or multiple years during the period 2007-2009 for most indicators) to the most recent measurement period, including: the percentage of adults who saw a dentist during the past year, had a regular health care provider, and had health care coverage. The indicator for the percentage of adults with a regular provider met the *Healthy People 2020* target level. The indicator related to percentage of cervical cancer cases detected at an early stage moved in the wrong direction.

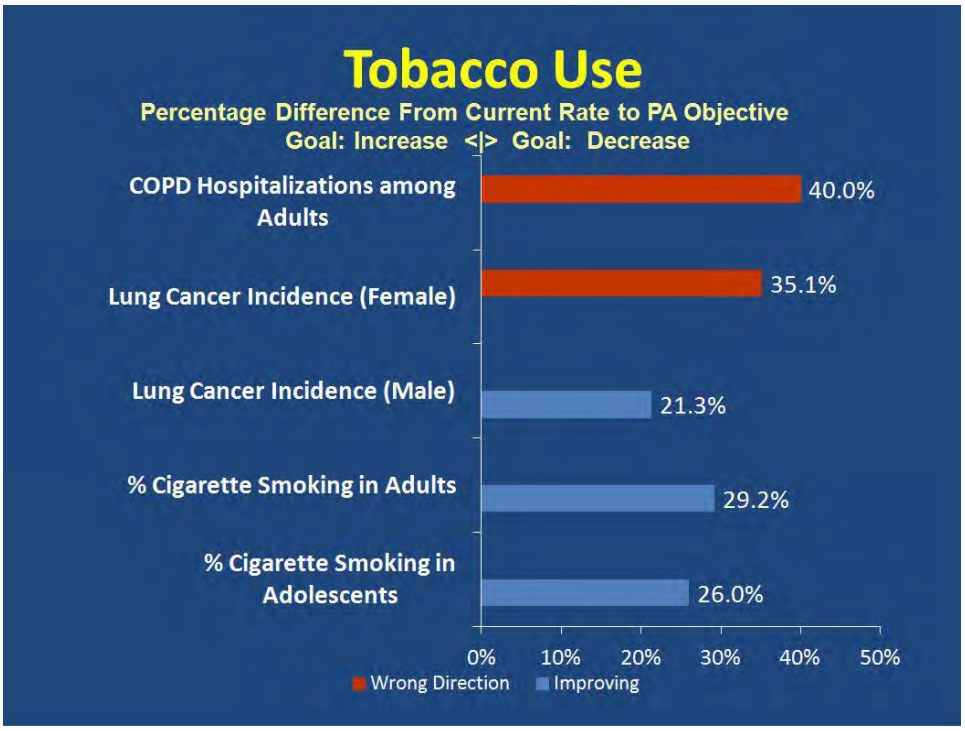
Figure 7


Access to Quality Health Care
Percentage Change From Baseline to Current
Indicators with Improvement
• % of Adults with Health Care Coverage (+2.4%)
• % of Adults with Regular Provider (+1.9%)*
• % of Adults who Saw Dentist Past Year (+1.0%)
• Early Stage Cancer Diagnosis: Breast (+0.9%) and Colorectal (+12.8%)
Indicators Moving in the Wrong Direction
• Early Stage Cervical Cancer Diagnosis (-11.3%)
*Meets HP2020 Target

Tobacco Use

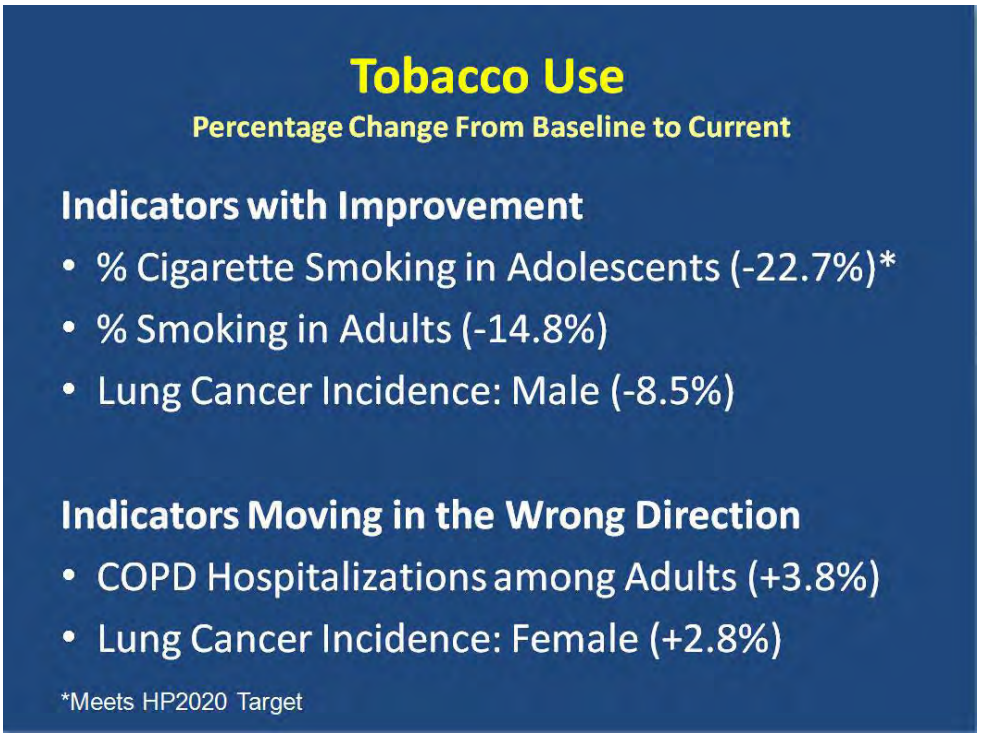
Improvements were noted in three of the five indicators related to tobacco use and its health consequences (Figure 8). Significant reductions in adult smoking and the percentage of adolescents who smoke were observed, but were still well below *Prevention Agenda* objectives. The percentage of adults who were hospitalized for chronic obstructive pulmonary disease (COPD) – a disabling condition tied to smoking – is now 40 percent higher than the *Prevention Agenda* objective. The incidence of lung cancer in women is 35 percent higher. Both these differences are getting larger instead of decreasing.

Figure 8



As shown in Figure 9, the percentage of adolescents who reported daily smoking has dropped by almost 23 percent from the start of the *Prevention Agenda.* Among adults, the decline has been smaller at 14.8 percent. Lung cancer incidence in males is now 8.5 percent lower than at baseline. Two indicators have moved in the wrong direction: the hospitalization rate for COPD among adults rose 3.8 percent and lung cancer incidence increased by 2.8 percent.

Figure 9

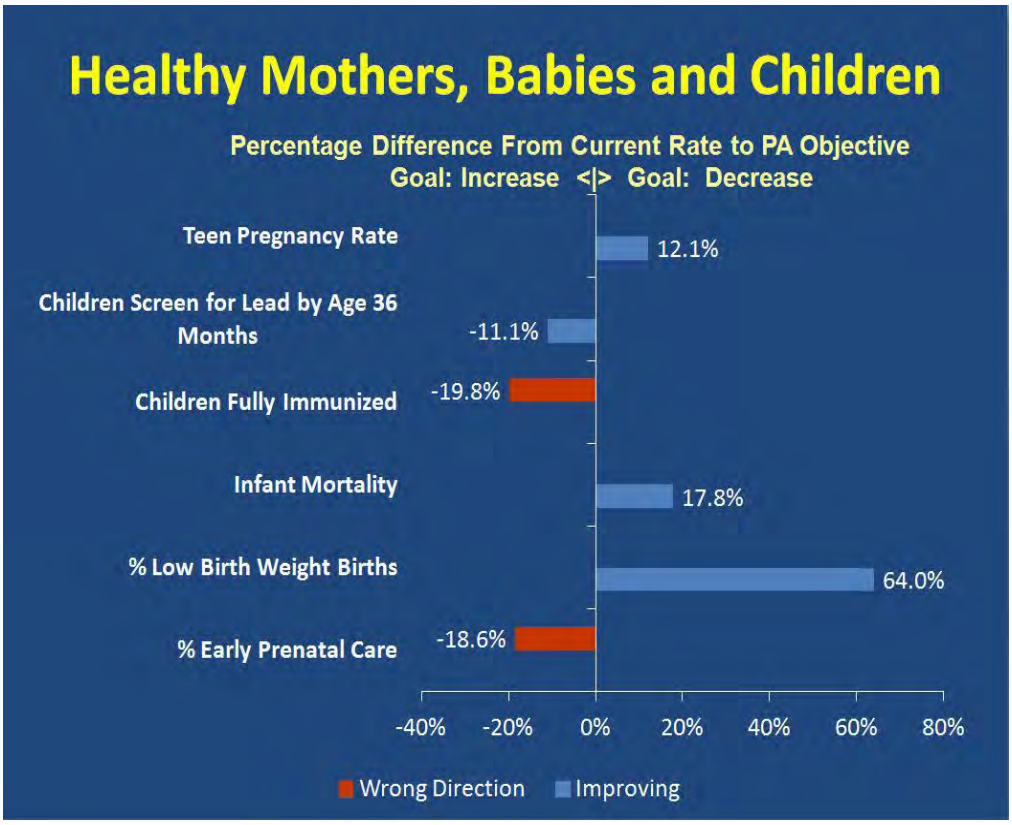


Healthy Mothers, Healthy Babies, Healthy Children

Four of the six indicators for this priority have improved since the baseline but have not reached the corresponding *Prevention Agenda* objectives (Figure 10). The difference between the current teen pregnancy rate and the state objective was 12.1 percent. The gaps for infant mortality (17.8 percent) and the percentage of children screened for lead by age 3 (11.1 percent) are getting smaller, but are still greater than 10 percent. The difference in the percentage of low weight infant births declined as well, but is still 64 percent higher than the *Prevention Agenda* objective.

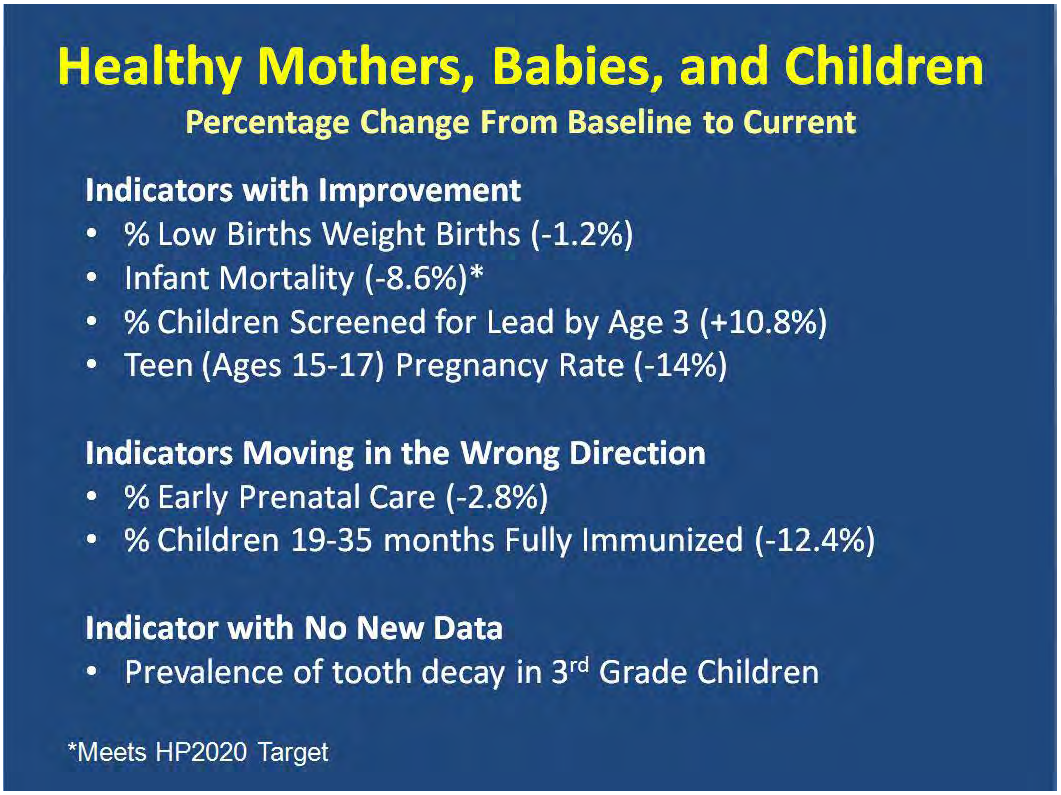
There were widening differences between the *Prevention Agenda* objectives and the current percentage of children who are fully immunized (rate was 19.8 percent lower) and the percentage of children born to mothers receiving early prenatal care (18.6 percent lower).

Figure 10



As shown in Figure 11, two indicators moved in the wrong direction since baseline: the percentage of mothers receiving early prenatal care was 2.8 percent lower and the percentage of children 19-35 months who were fully immunized dropped 12.4 percent. No current data are available for the prevalence of tooth decay in third-grade children. The infant mortality rate declined and was actually below the *Healthy People* 2020 objective. The changes between the baseline and current rates were: a 1.2 percent decline in the percentage of low birth weight births; a 10.8 percent increase in the percentage of children screened for lead by age 3, and a 14.0 percent drop in the teen pregnancy rate.

Figure 11



Physical Activity and Nutrition

Of the five indicators for the priority *Physical Activity and Nutrition*, two improved to narrow the differences between the current rate and the *Prevention Agenda* objective, and two got worse (Figure 12). Despite a large gap between the objective and the current percentage of adults eating five or more fruits and vegetables daily (18.8 percent) and the percentage of children enrolled in WIC (24.1 percent), the indicators have improved over time.

The current percentage of adults who are obese has increased and is now 63.3 percent higher than the *Prevention Agenda* objective. The percentage of mothers enrolled in WIC who are still breastfeeding their infants at 6 months of age is dropping and is now 22.4 percent lower than the *Prevention Agenda* objective.

Figure 12

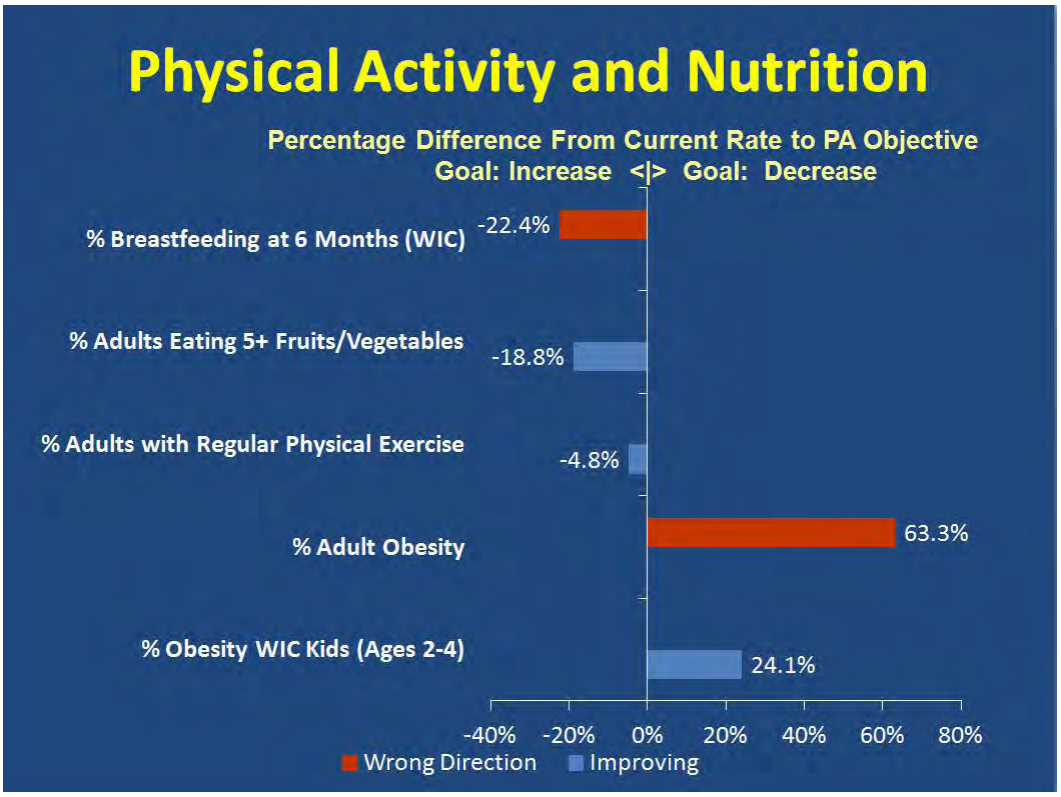
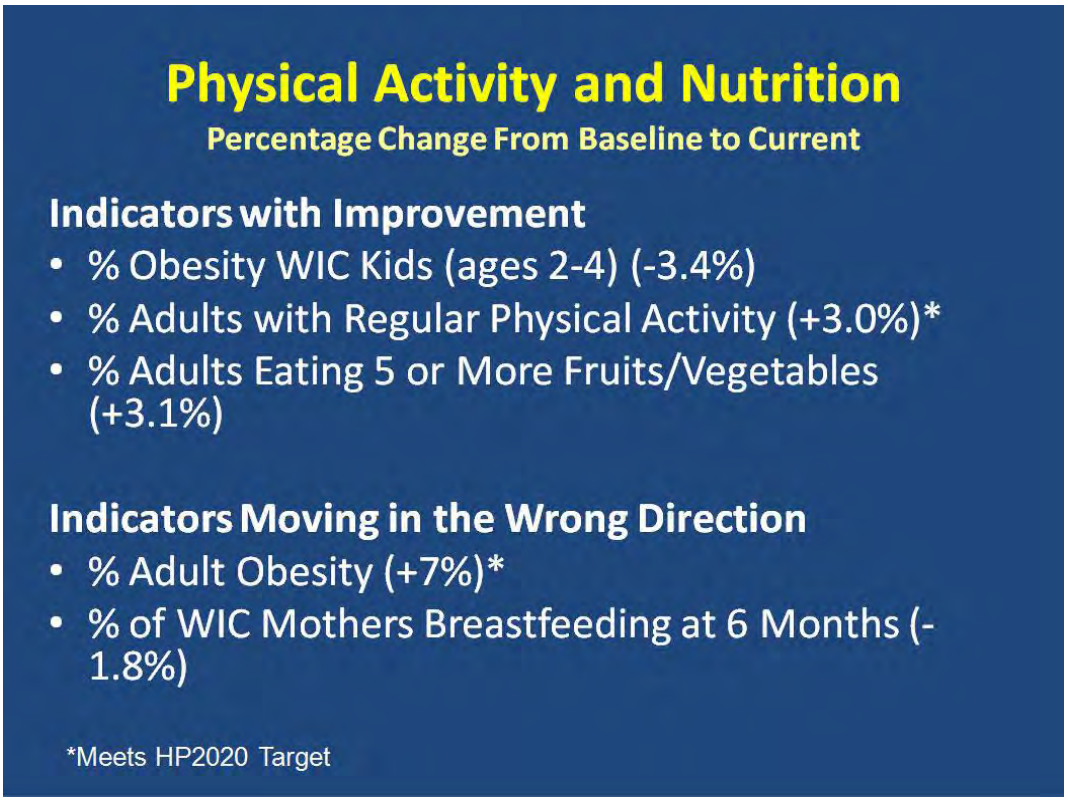


Figure 13 shows the percentage change in indicators from baseline to the current levels. Improvements were noted for three indicators: the percentage of children in WIC (ages 2-4 years) declined by 3.4 percent; the percentage of adults reporting regular physical activity rose by 3.0 percent, meeting the *Healthy People 2020* objective; and the percentage of adults eating five or more fruits and vegetables daily increased by 3.1 percent.

The prevalence of obesity was lower than the *Healthy People 2020* objective but still rose 7.0 percent over the baseline. The percentage of WIC mothers who breastfed their infants at 6 months of age dropped 1.8 percent.

Figure 13

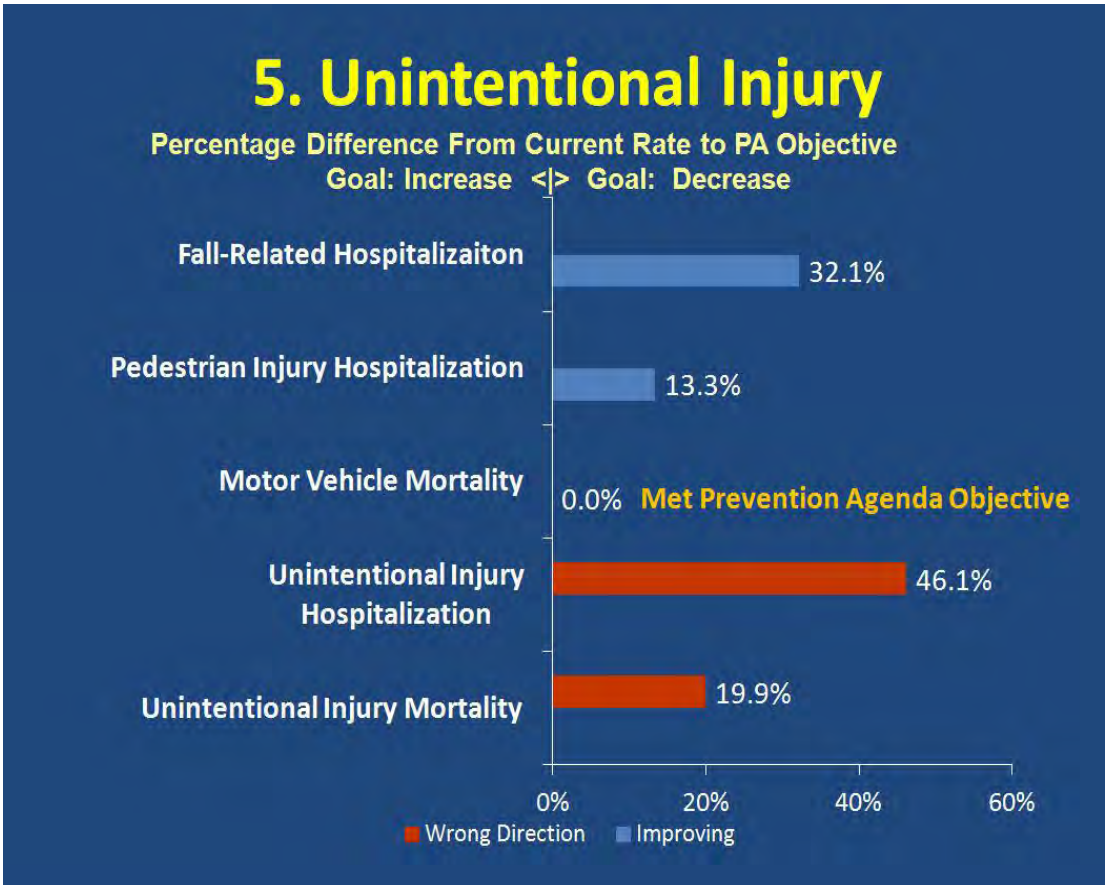


Unintentional Injury

The motor vehicle mortality rate did not change from baseline but met *the Prevention Agenda* objective (Figure 14). Current rates for the two hospitalization-related indicators for this priority improved, but still exceed the *Prevention Agenda's* target values: the hospitalization rate for falls is still 32.1 percent higher and the pedestrian-injury hospitalization rate is 13.3 percent higher than the objective.

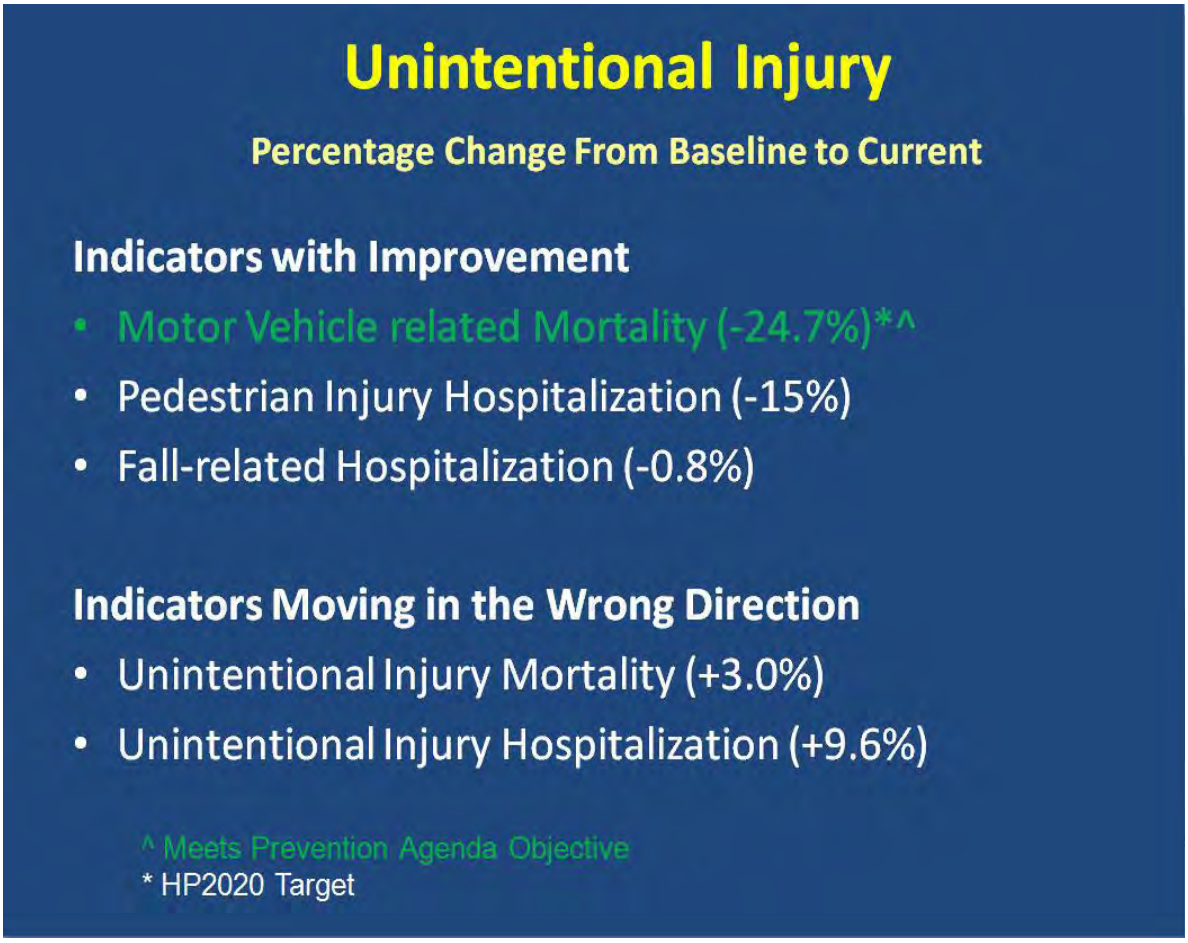
The hospitalization and mortality rates for unintentional injuries were higher than the *Prevention Agenda* objectives and have been increasing. Mortality was 19.9 percent higher than the corresponding objective and 46.1 percent higher for unintentional injury hospitalizations.

Figure 14



The motor vehicle-related mortality rate dropped 24.7 percent since the baseline (Figure 15). In addition to meeting the *Prevention Agenda* objective, the rate also met the *Healthy People 2020* target. Hospitalizations for pedestrian injuries fell 15 percent and fall-related hospitalizations declined a modest 0.8 percent, but both were still higher than the state objective.

Figure 15

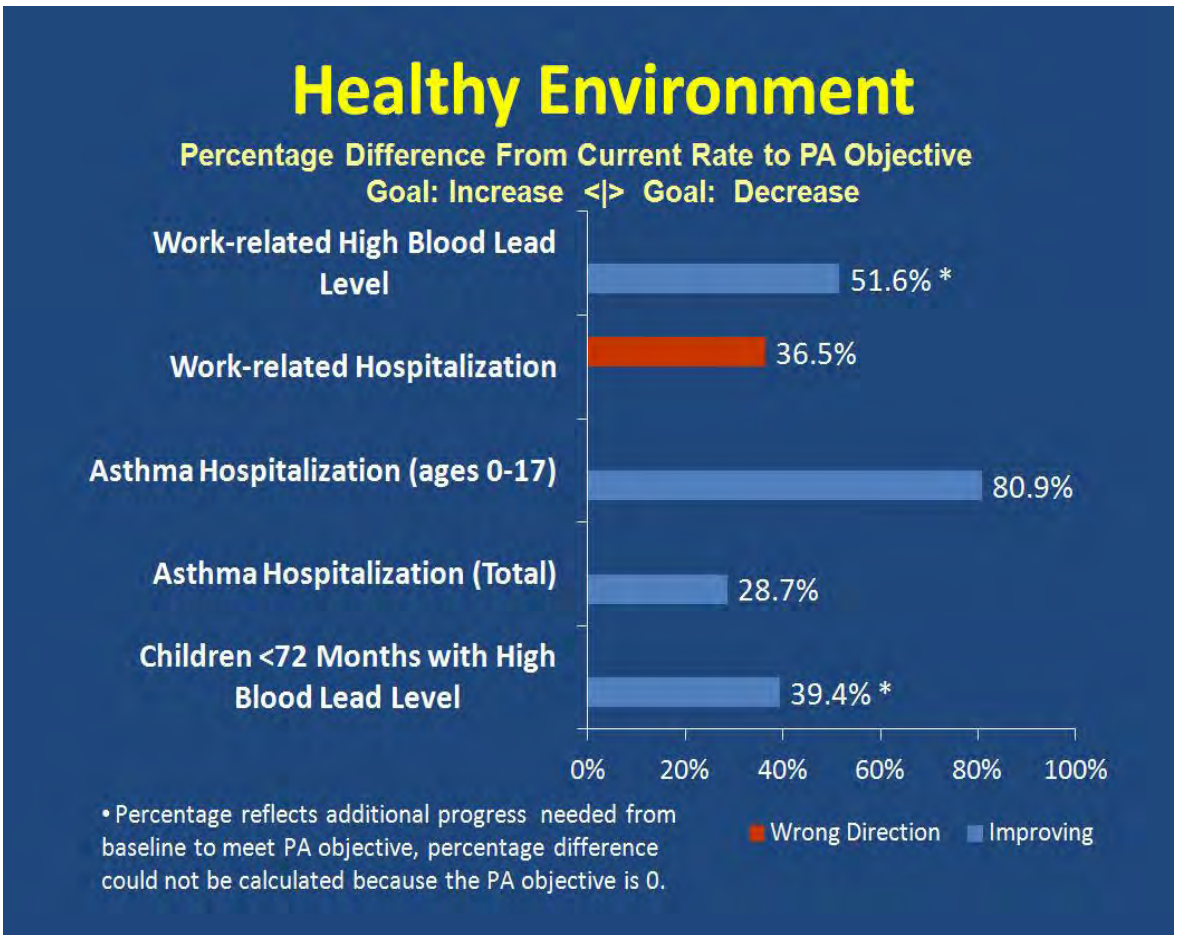


Healthy Environment

Four of the five indicators for this priority have improved, but are still higher than the *Prevention Agenda* objective (Figure 16). The rate of asthma hospitalizations is 28.7 percent higher than the state objective, and the asthma hospitalization rate among children age 0-17 years is 80.9 percent higher.

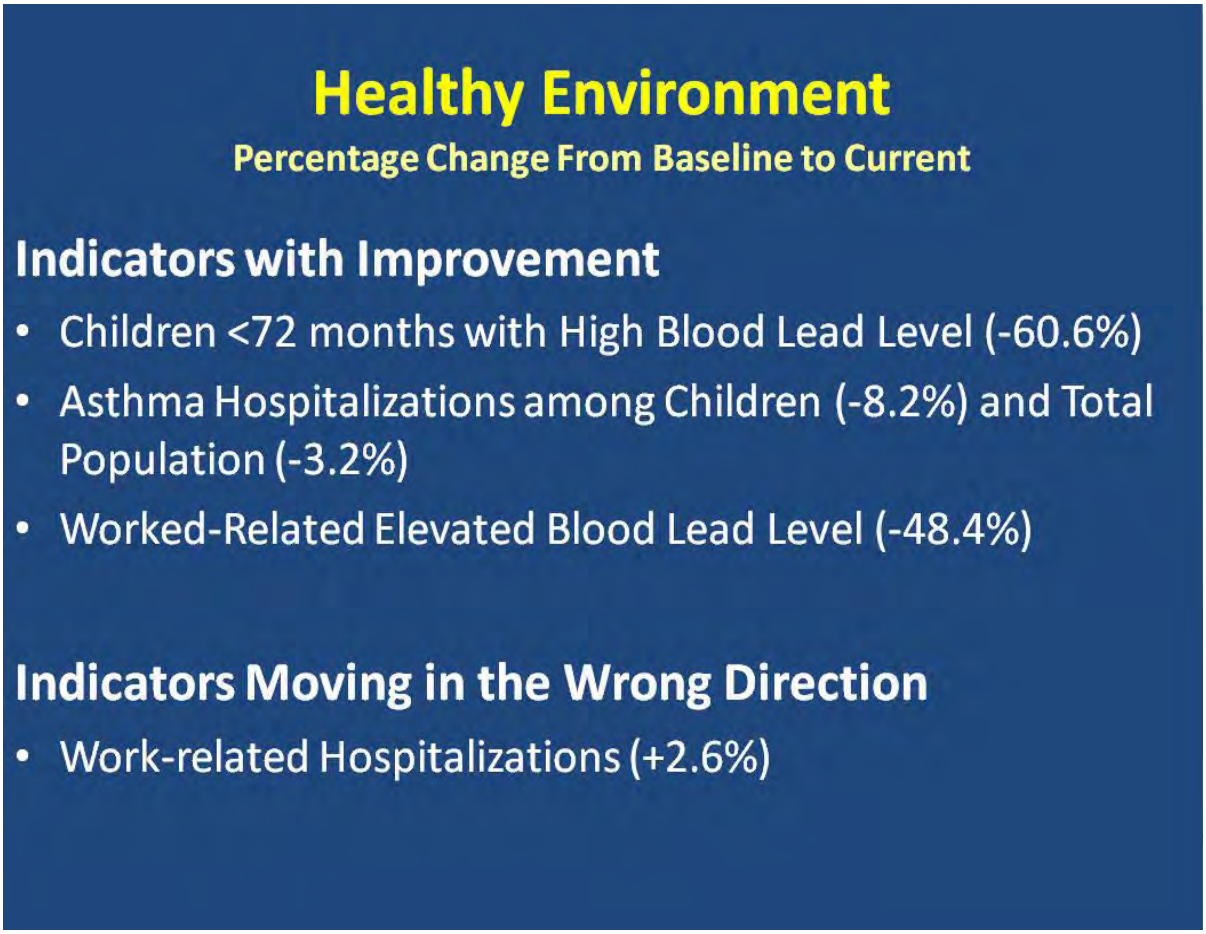
The work-related hospitalization rate has increased since baseline and is currently higher that the state objective. The percentage of children less than 6 years old with high blood lead levels is also higher than the *Prevention Agenda* objective, but the percentage difference could not be calculated because the *Prevention Agenda* objective is zero.

Figure 16



As shown in Figure 17, three of the *Healthy Environment* indicators have improved since baseline, including the percentage of children under age 6 with a high blood level (60.6 percent reduction); the rate of hospitalization among children (8.2 percent reduction) and asthma hospitalizations among people of all ages (3.2 percent decline). The rate of work-related hospitalizations rose 2.6 percent since the baseline period.

Figure 17



Chronic Diseases

All four mortality indicators related to *Chronic Diseases* improved, but only female breast cancer mortality met the *Prevention Agenda* objective (Figure 18). The coronary heart disease hospitalization rage declined 2.5 percent since the baseline period and met the *Prevention Agenda* objective. The rate of hospitalization for congestive heart failure also declined since baseline, but is still 30.3 percent higher than what is was at the start.

All three diabetes-related indicators moved in the wrong direction and remain substantially higher than the *Prevention Agenda* targets. The percentage difference from baseline was 43.6 percent for diabetes short-term complications among adults, 43.5 percent for children and adolescents between ages 6-17 years, and 56.1 percent for the prevalence of diabetes among all New Yorkers.

Figure 18

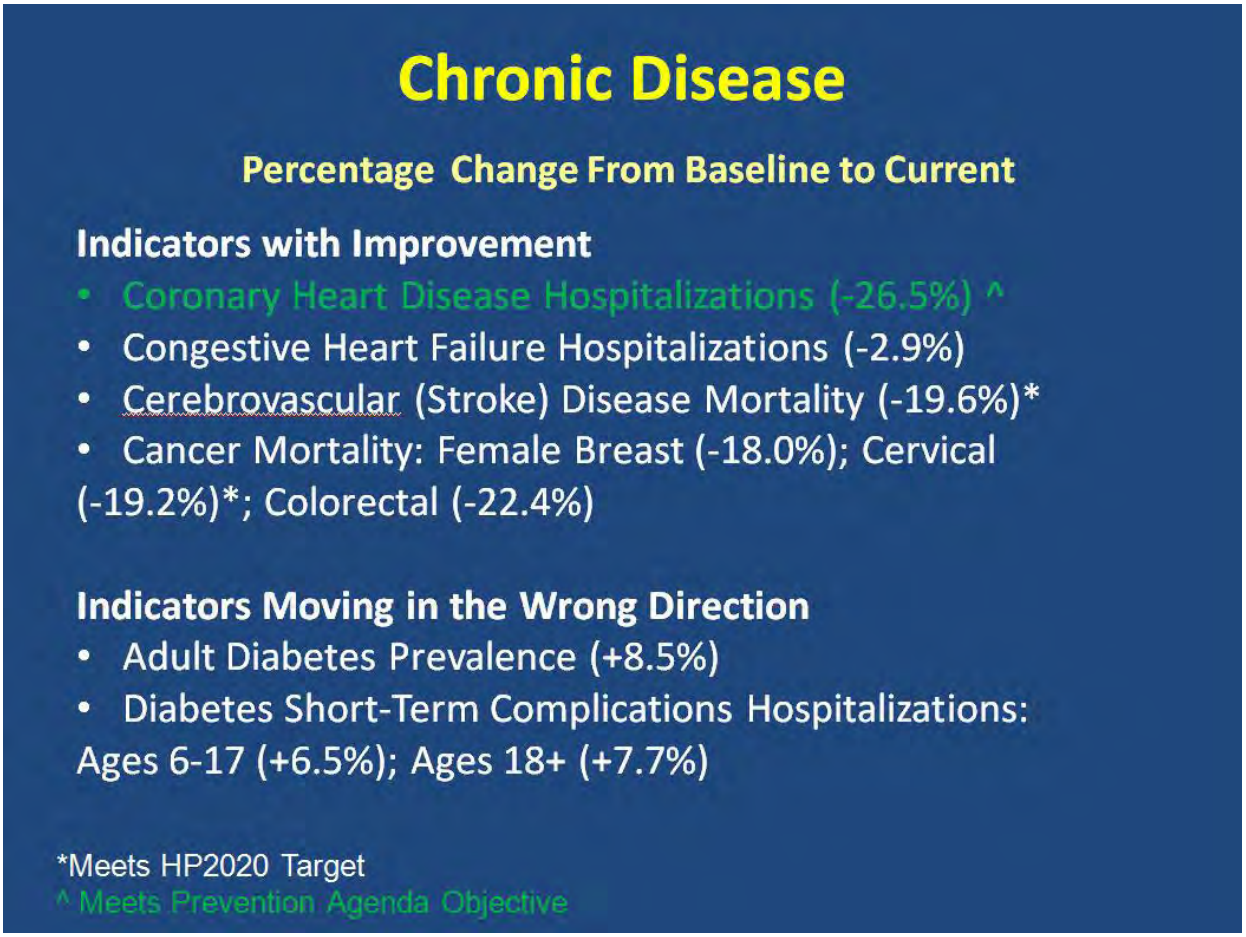
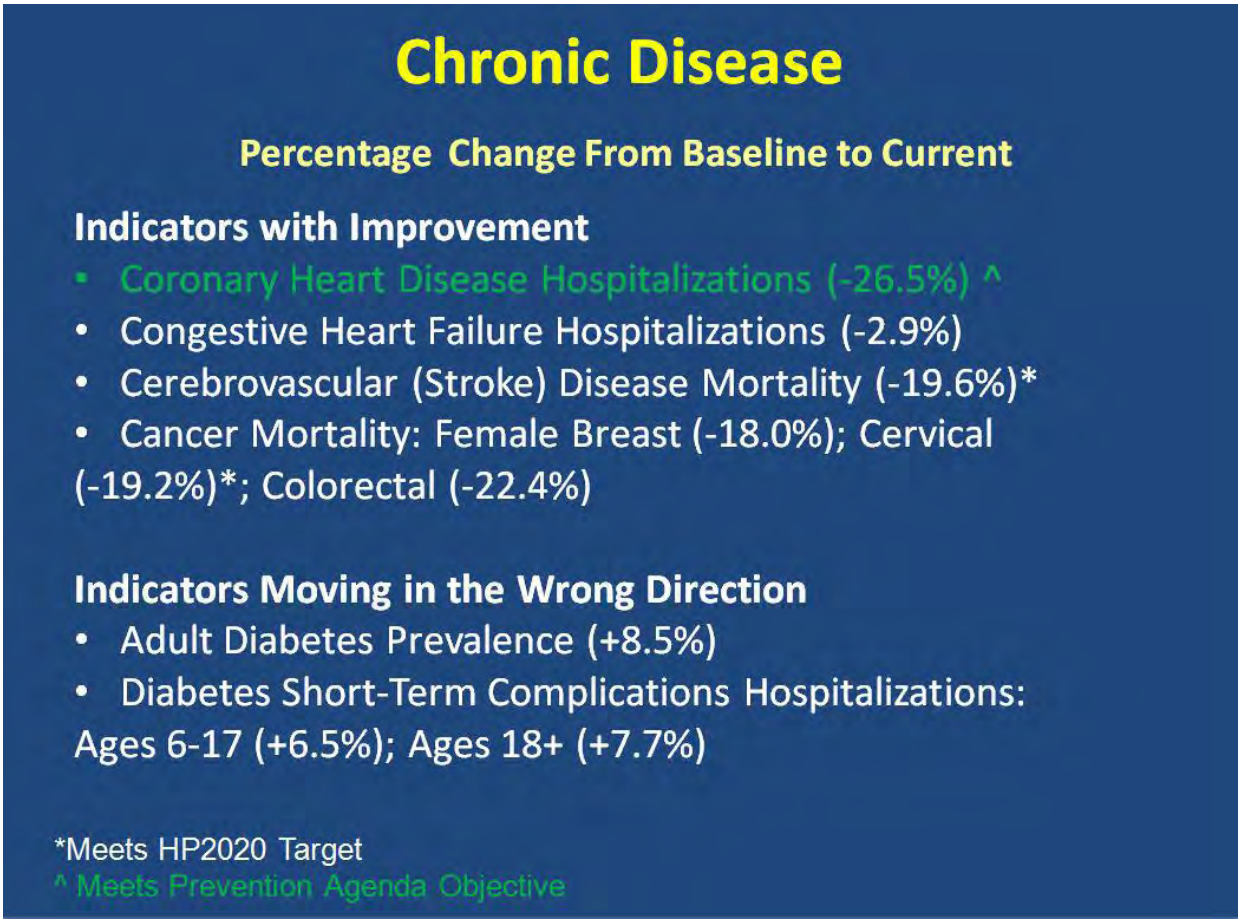


Figure 19 shows the percentage change from baseline to the most current value for each chronic disease indicator. Six indicators moved in the right direction, with a 26.5 percent reduction in coronary heart disease hospitalizations (which met the *Prevention Agenda* objective) and a 2.9 percent reduction in congestive heart failure hospitalizations. Mortality rates also declined for several causes, including 19.6 percent for stroke (which also met its *Prevention Agenda* objective), 19.2 percent for cervical cancer, and 18.0 percent for female breast cancer.

Three diabetes-related indicators moved in the wrong direction: the prevalence of diabetes rose 8.5 percent, and hospitalizations for short-term complications from diabetes increased 6.5 percent among those ages 6-17 years and 7.7 percent for adults.

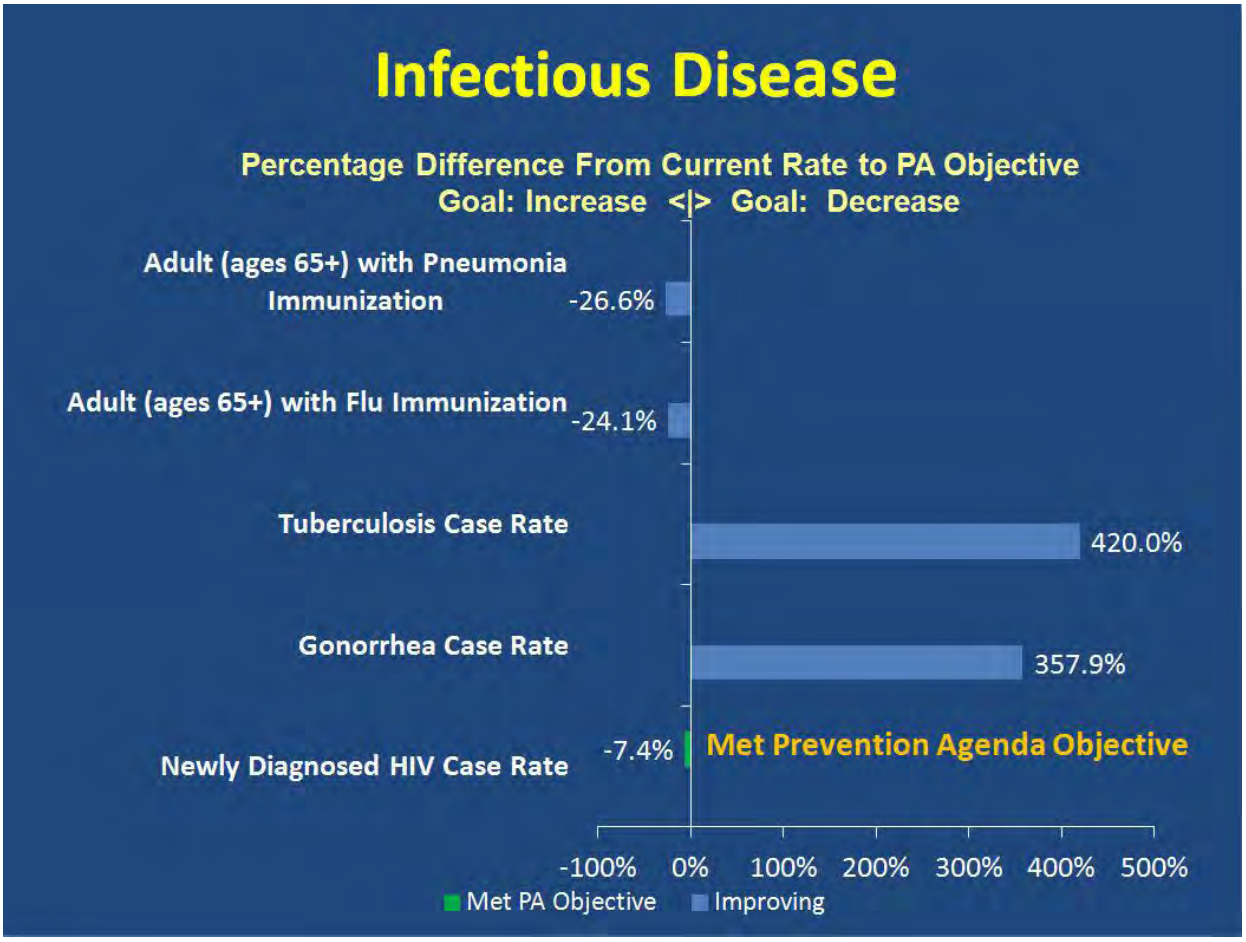
Figure 19



Infectious diseases

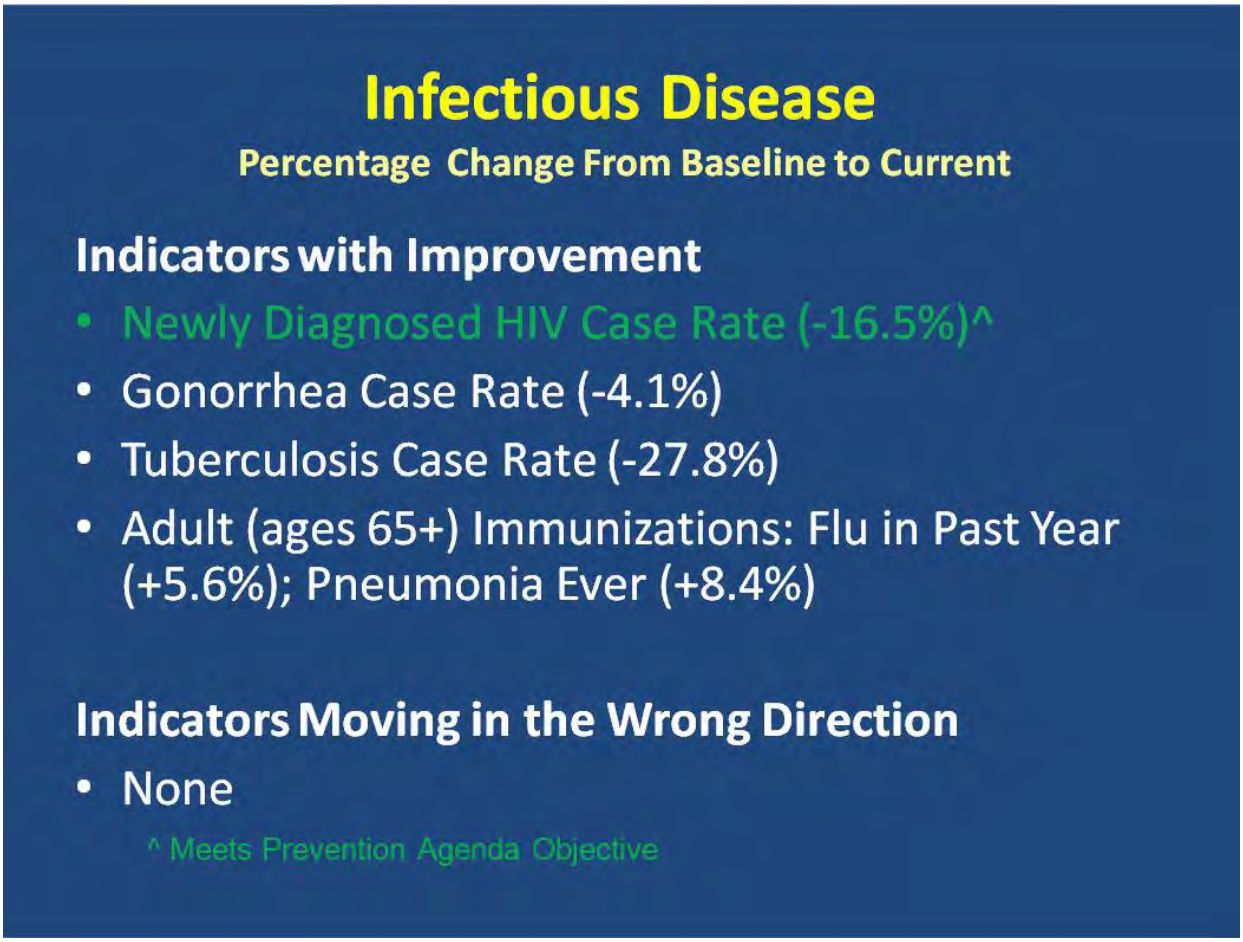
All five indicators for this priority area have improved since baseline (Figure 20). One of them, the newly diagnosed HIV case rate, declined 7.4 percent and met the *Prevention Agenda* objective. The percentage of adults 65 years and older who have received the recommended immunizations was 26.6 percent lower than the state objective for pneumonia immunizations and 24.1 percent lower for flu.

Figure 20



As shown in Figure 21, the newly diagnosed HIV case rate fell 16.5 percent from baseline and met the *Prevention Agenda* objective. A reduction of 4.1 percent in the gonorrhea case rate was noted, and the tuberculosis case rate dropped 27.8 percent. Both indicators for adult immunizations increased as well: 5.6 percent for flu immunizations and 8.4 percent for ever having a pneumococcal immunization.

Figure 21



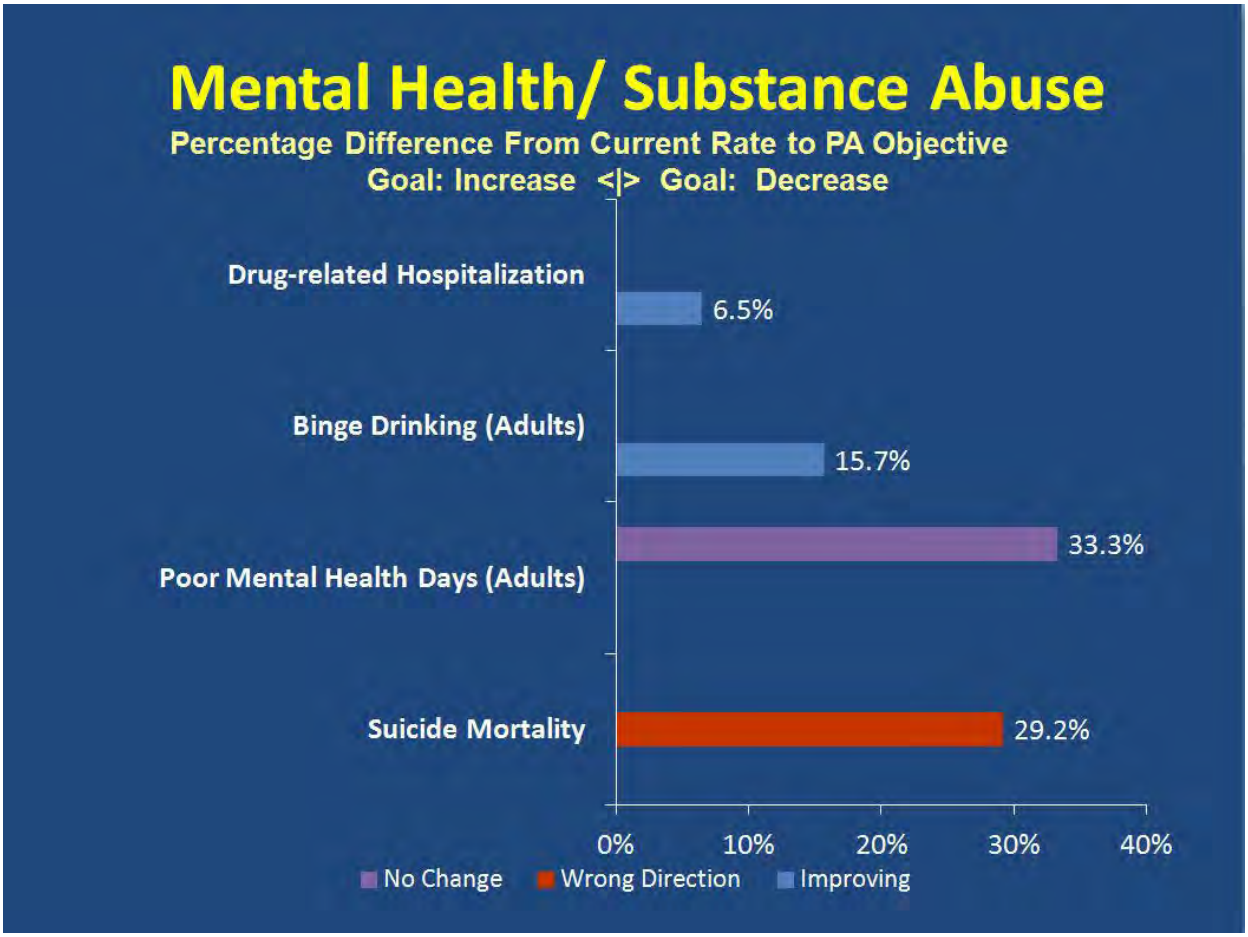
Mental health and substance abuse

Four indicators were established for monitoring mental health and substance use. As shown on Figure 22, two indicators improved since baseline: the rate of drug-related hospitalizations is still 6.5 percent higher than the *Prevention Agenda* objective and the prevalence of binge drinking among adults is 15.5 percent higher than the state objective.

The percentage of adults reporting that their mental health was not good on most or all days was 33.3 percent higher than the state objective.

The suicide mortality rate is currently 29.2 percent higher than the target set for the Prevention Agenda, and has increased since baseline.

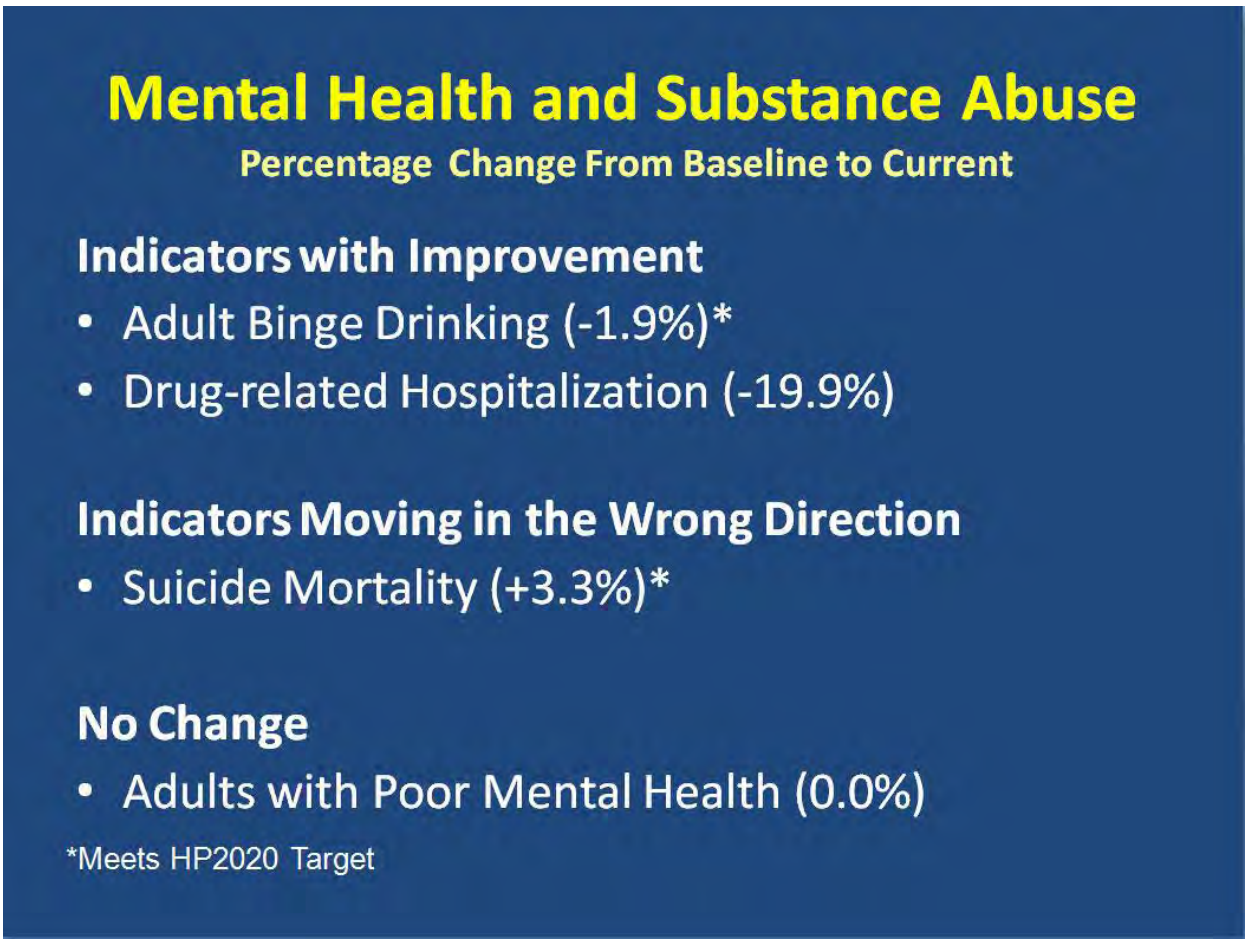
Figure 22



Two indicators have improved since the baseline period, but are still higher that the *Prevention Agenda* objective. The prevalence of binge drinking among adults declined 1.9 percent and now meets the *Healthy People 2020* objective. The rate of drug-related hospitalizations increased 19.9 percent since the baseline period.

The suicide mortality rate increased 3.3 percent and is moving in the wrong direction. There was no change in the percentage of adults with poor mental health.

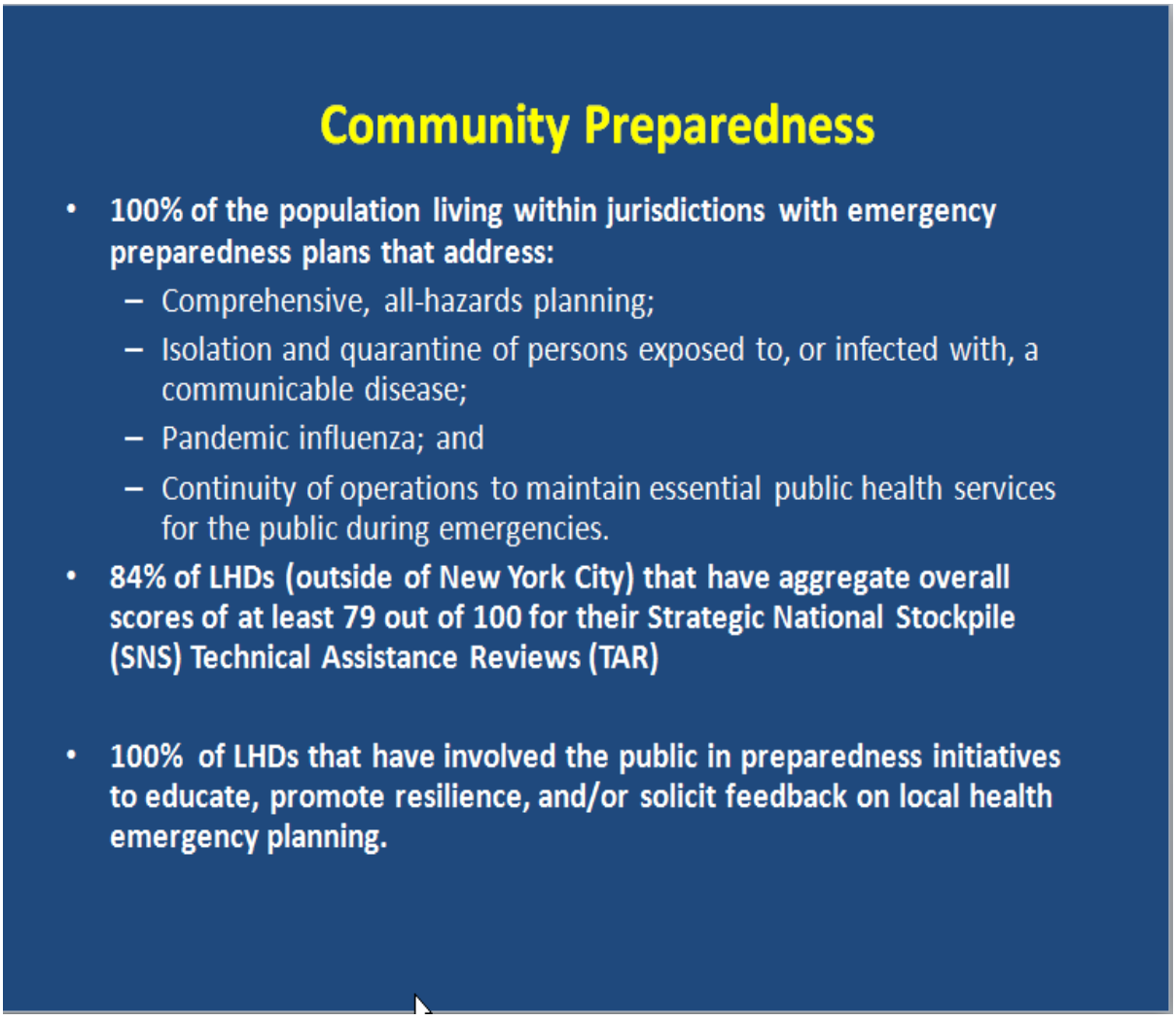
Figure 25



Community preparedness

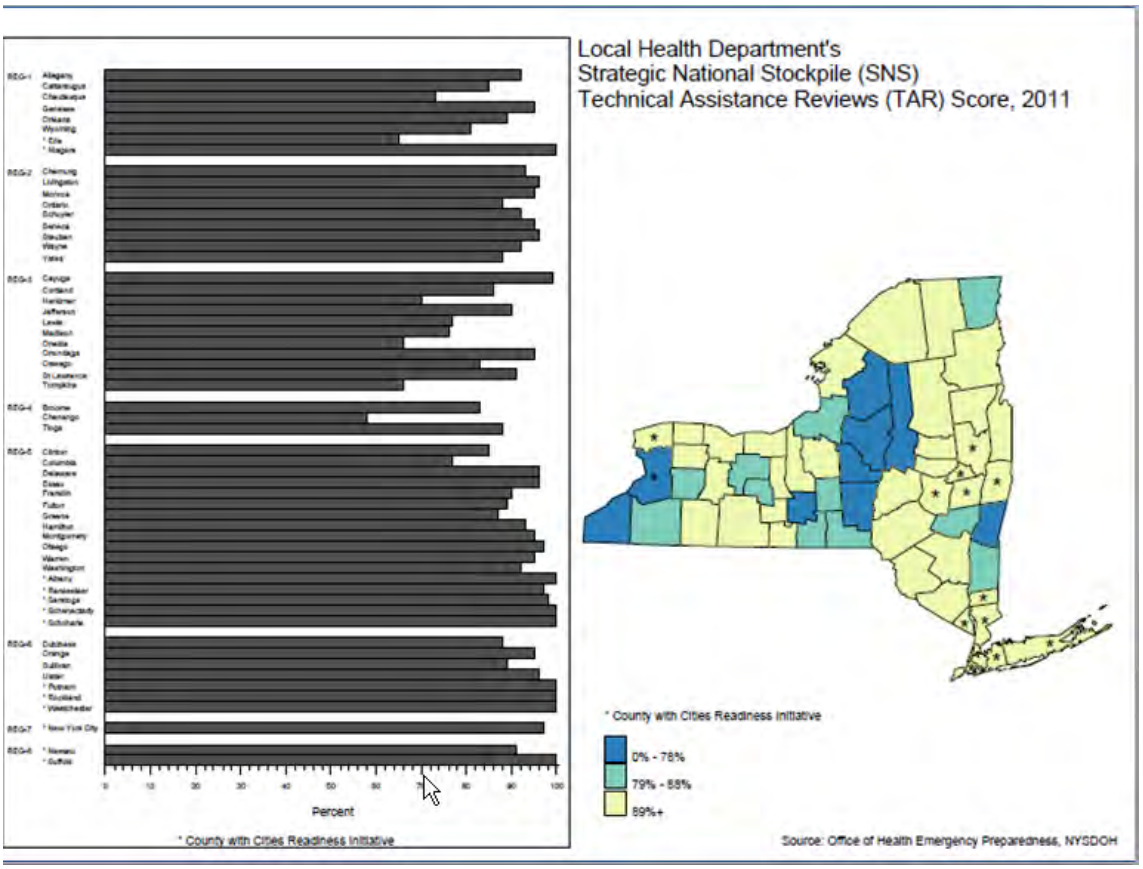
All New York residents live within jurisdictions that have emergency preparedness plans addressing the critical elements of community preparedness (see Figure 26 for specific elements). Most of the LHDs (84 percent) serving a county other than New York City scored high enough on their Strategic National Stockpile Technical Assistance Review to meet national standards and all of them have involved the public in preparedness initiatives about local health emergency planning.

Figure 26



As shown in Figure 27, the scores for Technical Assistance Reviews in 2011 for each county's Strategic National Stockpile varied from x to y. A map showing the percentile distribution of scores accompanies the county-by-county breakdown. All but one of the counties has a score of at least 80 percent.

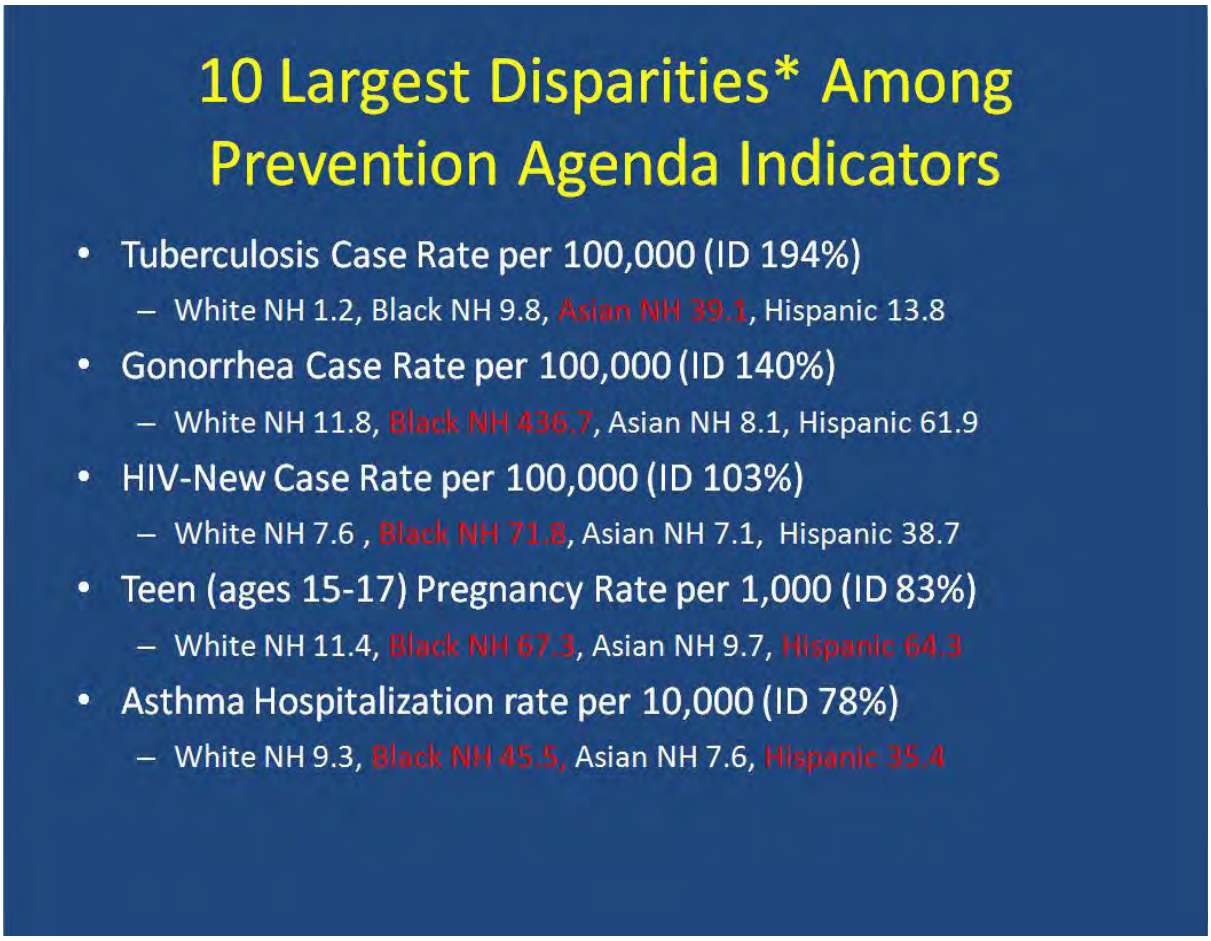
Figure 27



Health disparities

Figures 28 and 29 show the *Prevention Agenda* indicators with the ten largest disparities, as measured by an Index of Disparity. * For each indicator, the rates for selected population subgroups are shown in parentheses, with the subgroup having the greatest disparity and its rate highlighted in red. For nine of the 10 indicators, non-Hispanic Blacks had the highest rates. Other groups exhibiting large disparities were non-Hispanic Asians (tuberculosis case rate) and Hispanics (teen pregnancy and asthma hospitalization rates).

Figure 28



* The largest percentages represent the greatest disparities. For more information on the method of calculating the index of disparity, see Appendix B. Description of Data Sources.

Figure 29

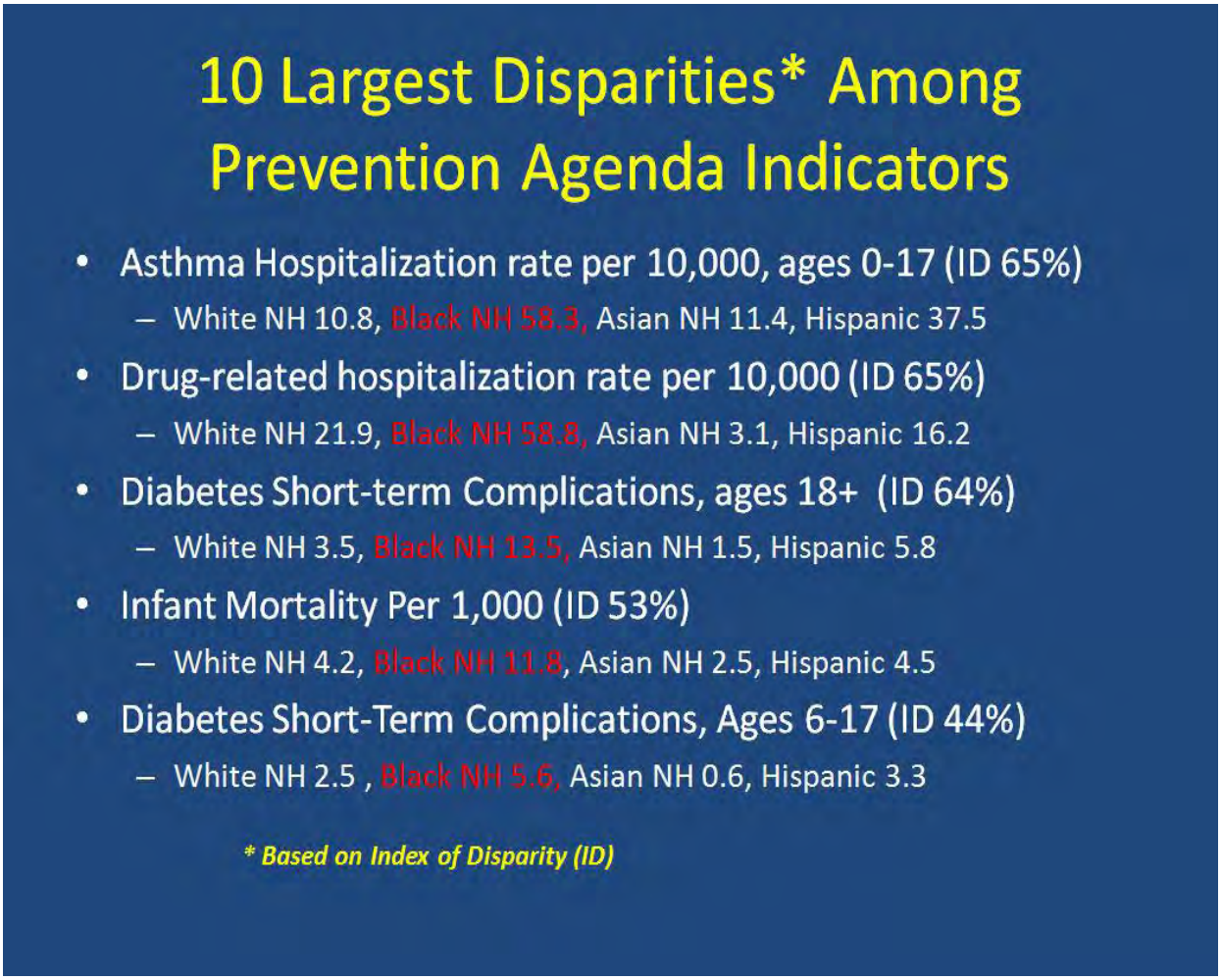

10 Largest Disparities* Among Prevention Agenda Indicators
• Asthma Hospitalization rate per 10,000, ages 0-17 (ID 65%)
– White NH 10.8, Black NH 58.3, Asian NH 11.4, Hispanic 37.5
• Drug-related hospitalization rate per 10,000 (ID 65%)
– White NH 21.9, Black NH 58.8, Asian NH 3.1, Hispanic 16.2
• Diabetes Short-term Complications, ages 18+ (ID 64%)
– White NH 3.5, Black NH 13.5, Asian NH 1.5, Hispanic 5.8
• Infant Mortality Per 1,000 (ID 53%)
– White NH 4.2, Black NH 11.8, Asian NH 2.5, Hispanic 4.5
• Diabetes Short-Term Complications, Ages 6-17 (ID 44%)
– White NH 2.5 , Black NH 5.6, Asian NH 0.6, Hispanic 3.3
* Based on Index of Disparity (ID)

Figure 30 shows the *Prevention Agenda* indicators that are associated with the largest number of New Yorkers potentially impacted by the observed disparities for the indicators, along with the corresponding Index of Disparity.

Figure 30