PREVENTION report

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Improving the Nation's Health With Performance Measurement

American business and government use performance measurement to improve efficiency and effectiveness, enhance the quality of products and services, and show accountability. Increasingly, public and private health organizations use performance measurement to link resources with outcomes, health risks, and various service and protection mechanisms. Their goal: To improve health in the United States.

In this issue, *Prevention Report* looks at how the U.S. Department of Health and Human Services (HHS) and State and local communities (see *Spotlight*) are applying performance measurement. This *Focus* article describes and shows how States can develop performance measures based on Healthy People objectives. A special *Resources* section provides many names and addresses, including World Wide Web sites, for more information.

Improving health care services through processes and measurement is nothing new. For years, accreditation of facilities and licensure and board certification of health professionals have been hallmarks of quality. The U.S. Preventive Services Task Force, the Office of Disease Prevention and Health Promotion (ODPHP), and panels of professionals convened by the National Institutes of Health, the Agency for Health Care Policy and Research, and other organizations have set clinical guidelines for health services for Americans of all ages.

In the 1990's, employers began monitoring the performance of health plans through the Health Plan Employer Data Information Set (HEDIS®). The Federal Government supported the expansion of HEDIS to measure performance of managed care organizations in serving Medicaid beneficiaries. The public health community has used the goals and objectives of Healthy People 2000 as a framework to drive the performance of Federal, State, and local public health, substance abuse, mental health, and environmental agencies.

As the examples below show, the emphasis is now on devising accountability and improvement strategies and outcome-focused data collection tools.

Performance measurement responds to the need to ensure efficient and effective use of resources, particularly financial resources. At HHS, it links the use of resources with health improvements and the accountability of individual stakeholders.

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OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

The mission of the Office of Disease Prevention and Health Promotion (ODPHP) is to provide leadership for disease prevention and health promotion among Americans by stimulating and coordinating Federal activities. *Prevention Report* is a service of ODPHP.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Performance measures should relate to important national, State, or local health priorities.

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The most recent definition of performance measurement in the health literature comes from the Institute of Medicine:

". . . a continuing (and evolving) process—based in a context of shared responsibility and accountability for health improvement—for (1) selecting and using a limited number of indicators that can track critical processes and outcomes over time and among accountable stakeholders; (2) collecting and analyzing data on those indicators; and (3) making the results available to inform assessments of effectiveness of the intervention and the contributions of accountable entities."

This definition should be familiar to public health officials who have used Assessment Protocol for Excellence in Public Health (APEX-*PH*), an eight-step process for community health assessment and improvement, or know about the processes of total quality management (TQM) and continuous quality improvement (CQI).

Role of GPRA

The Government Performance and Results Act of 1993 (GPRA), a powerful initiative to reinvent government, aims to improve the efficiency and effectiveness of federally funded programs by holding Federal agencies accountable for spending public dollars. Under GPRA, Federal agencies must submit an annual performance plan, beginning with the President's fiscal year 1999 budget. The plan must include defined targets for performance goals, outcome indicators to measure progress toward the goals, a description of resources needed to meet the goals, a basis for comparing actual program results with the goals, a discussion of the process for validating the data that are collected, and an acknowledgment of the role of other parties in meeting goals.

GPRA's influence extends to the States, local jurisdictions, and other organizations that receive Federal funding. Such entities will be held accountable for describing the results that have been achieved with Federal dollars. For agencies using objectives such as Healthy People 2000 to track progress, the move to performance measurement should be a manageable next step.

Measurement Versus Objectives

Performance measurement still is being developed, and currently no single, agreed-upon approach exists. Since *Prevention Report* readers are familiar with tracking Healthy People objectives in Federal, State, and local agencies, the six steps in creating performance measures described below may be useful (see illustration on facing page). Understanding the similarities and differences between criteria for performance measures and health objectives will be helpful, too. Both performance measures and Healthy People objectives need to:

- Be meaningful to a wide audience, including community residents, medical and public health professionals, elected officials, and others.
- Meet statistical requirements of validity and reliability.
- Quantify targets to be measured (that is, the process, outcome, or structure) and related to desired health outcomes.

But performance measures also must:

- Measure results that can be achieved in a short timeframe (example, 5 years or less, as defined by the organization using the performance measure).
- Describe the strategy for reaching the result, where possible.
- Identify the entity that is accountable for the result.

Six Steps in Creating Measures

Step One: *Relate the performance measure to an important national, State, or local health priority area. Healthy People 2000* is a consensus document that contains 319 health objectives for the Nation and can be used as a starting point for developing performance measures. In some public health programs, Healthy People objectives already have been adopted as program objectives.

For example, Congress first used Healthy People in the Omnibus Budget Reconciliation Act of 1989 to define reporting requirements under the Maternal and Child Health Block Grant. Beginning with the fiscal year 1991 report on Maternal and Child Health Activities and Health Status, State-specific information on infant mortality, prenatal care, and immunization rates is reported to Congress. The 1993 reauthorization of the Preventive Health and Health Services Block Grant required reporting based on Healthy People health status measures. Based on consultations with the States, a uniform data set was created based on Healthy People objectives in various priority areas, including tobacco, violence, and heart

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Performance Measurement: Step by Step

This example is based on the State of Maryland's Healthy Maryland 2000 *document.* Prevention Report *acknowledges Maryland's contribution to this special issue on performance measurement.*

STEP 1 **Relate the performance measure to an important national, State, or local health priority area.**

Maryland has undertaken work related to the national health objective to reduce coronary heart disease deaths to no more than 100 per 100,000 people.

STEP 2 **Measure a result that can be achieved in 5 years or less.**

Maryland has identified an achievable result that is linked scientifically to the Healthy People 2000 Heart Disease and Stroke priority area: Increase the proportion of people who engage in light to moderate physical activity to at least 30 percent of the population.

STEP 3 **Ensure that the result is meaningful to a wide audience of stakeholders.**

Target stakeholders are essentially all Marylanders, with an emphasis on school-age children and people at high risk for diseases and medical conditions associated with physical inactivity (for example, persons with hypertension and high cholesterol). Stakeholders include principals, teachers, students, parent-teacher associations, the State education department, State and local health and recreational agencies, public health and medical professionals, and others.

STEP 4 **Define the strategy that will be used to reach a result.**

The State of Maryland has selected four strategies:

1. Implement a combination of strategies that include consumer education and skills development, health assessment, professional training, and environmental changes.
2. Reinforce risk reduction messages and promote programs and policies in schools, worksites, faith communities, and other settings.
3. Focus on youth and families so that healthy habits are started early and nurtured in the family.
4. Use a health promotion approach tailored to reach diverse ethnic and socioeconomic groups.

STEP 5 **Define the accountable entities.**

The accountable entities depend upon the strategies selected and the way in which a particular community is organized. For Maryland's Strategy 2, these entities include schools, worksites, and community centers. For example, the Cecil County Public Schools have agreed to be accountable for specific tasks related to Strategy 2 and are working in partnership with the Cecil County Health Department to offer healthy lifestyle programs to elementary school children. The programs, such as the **Heart Challenge Course**, bring teachers and food service workers together to promote healthy eating habits and physical fitness through educational games, classroom projects, and other activities that appeal to children.

STEP 6 **Draft measures that meet statistical requirements of validity and reliability and have an existing source of data.**

In consultation with biostatisticians and epidemiologists, organizations can draft measures that are statistically sound. One of Maryland's performance measures might be "Increase to 30 percent the proportion of students in each Cecil County elementary school who engage in light to moderate physical activity for 30 minutes or longer every school day by participating in school physical fitness activities."

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disease. The American Indian Health Care Improvement Act of 1992 also identified 61 Healthy People objectives to be included in reports to Congress.

Step Two: *Measure a result that can be achieved in 5 years or less.*
Performance measures need to reflect results that can be achieved in a relatively short timeframe (5 years or less) so that the impact of programs on the health of a population can be examined in **real time**. For health outcomes that cannot be achieved in a short timeframe, a measure scientifically linked to the outcome of interest can and should be used as the target result.

This is true in the area of chronic diseases, in which there are many long-term health status objectives of national importance that are unlikely to show changes in the first few years of health promotion activity. In fact, these objectives may not show changes for a decade or longer. Monitoring these changes is essential, but such measures cannot be used as a basis for evaluating performance.

For example, research shows that exercise, better nutrition, and smoking cessation can reduce the risk of coronary heart disease. Thus, improvements in exercise, nutrition, or smoking cessation can be used as performance measures.

Step Three: *Ensure that the result is meaningful to a wide audience of stakeholders.*
For example, the result in the Maryland illustration on the preceding page is meaningful to local schools, the State and local education departments, health agencies, parents, students, teachers, administrators, physicians and other health care providers, and many others.

Step Four: *Define the strategy that will be used to reach a result.*
Healthy People 2000 identifies some strategies for meeting long-term objectives for reducing risks and improving services. Many other documents and journals provide additional information about effective strategies. For coronary heart disease, the strategies are geared toward changing exercise, nutrition, and smoking behaviors. The Maryland illustration contains prototype performance measures from one of these areas: exercise.

When a strategy is community-based, gaining local input is essential. Local health departments often have a wealth of knowledge about how to communicate with community members and how to engage the community in developing strategies.

Step Five: *Define the accountable entities.*
Many organizations and individuals share responsibility for health improvements. Performance measures must go beyond describing areas of shared responsibility and identify results to be attained by each accountable entity.

In the further evolution of performance measurement, accountability needs exploration. Two key discussion points are how to define accountability better and how to ensure that successes and failures are treated as learning opportunities.

Step Six: *Draft the performance measures and ensure that they meet statistical requirements of validity and reliability and have an existing source of data.*
Working with epidemiologists and others at health agencies is essential in meeting these requirements.

Healthy People
With its focus on the health of the population, Healthy People 2000 provides a framework for performance measurement. In terms of continuous quality improvement, this initiative has the longest history in HHS. The Public Health Service and its partners have used Healthy People for the past 18 years to set objectives and monitor targets that focus on reducing premature mortality and morbidity rates, as well as disabling conditions. (See *Committee Actions* on page 10 for a report on the Healthy People 2000 Consortium meeting.)

The Healthy People initiative reflects an unprecedented cooperative effort among government (Federal, State, and local agencies with public health, mental health, substance abuse, and environmental responsibility), voluntary and professional organizations, businesses, and individuals. Healthy People goals and objectives represent a national consensus about what it is possible to achieve through prevention. More than 10,000 people and groups commented on the draft documents of *Healthy People 2000*.

By engaging a broad range of partners to draft the objectives from 1987 to 1990, initiative planners hoped these groups ultimately would play a vital role in Healthy People 2000's success. And they have: 44 States have published year 2000 objectives,

Lessons learned from the Healthy People experience can be applied to performance measurement.

and 70 percent of local health departments reported to the National Association of County and City Health Officials that they are using elements of the Healthy People 2000 initiative.

As described above, Healthy People objectives have been incorporated into several Federal statutes, including the Omnibus Budget Reconciliation Act of 1989, the 1993 reauthorization of the Preventive Health and Health Services Block Grant, and the American Indian Health Care Improvement Act of 1992. Through such legislation, Congress has emphasized the importance of Healthy People as an initiative that tracks those health measures of greatest significance to the Nation. Healthy People objectives can serve as a framework for development of performance measures.

Actions and Actors

Healthy People contains many measures relevant to people doing performance measurement and provides direction for determining accountability. For example, about half of the objectives require action by people as individuals or as family members in the form of decisions about diet, exercise, alcohol consumption, tobacco use, and sexual practices. The other half of the objectives identify specific actors—for example, health care providers, schools, businesses, legislators, and government agencies. These objectives lend themselves to being adopted at a State or community level to track the contributions of various stakeholders in the community, such as whether physicians counsel about tobacco cessation or schools offer daily physical education or a comprehensive health curriculum.

Healthy People 2000 also has served as a catalyst for developing better data collection systems to measure the health status of Americans. The initiative has enhanced understanding of health status, risks to health, and use of clinical preventive services. These data now can provide the foundation to build even more refined performance measures.

Lack of Data Points

There are, however, 75 objectives that lack a second data point by which to measure progress 7 years into the decade. Some data systems provide only one measurement a decade, for example, prevalence of depression, overweight, and dental decay. The frequency of data collection should be examined when developing performance measures.

As emphasis on performance measures grows, so will demand for better data and the timely release of those data. Monitoring performance will require as much current data as possible. Small area analysis with information by age, race, and gender will be a challenge. Greater emphasis on interventions will require new data collection among providers of services not traditionally surveyed. At a time of increasingly limited resources, engaging in performance measurement is a critical response to the public's demand for efficient use of public funds.

Lessons learned from the Healthy People experience can be applied to performance measurement. First, having agreement about what information needs to be measured has resulted in a commitment of resources to monitor and track the measures. Second, having a set of 10-year targets has served to direct the activities of stakeholders in the public and private sectors, even those over which the Federal Government has no direct authority.

Challenges Ahead

Performance measurement offers a promise of improved management and improved outcomes. It builds on a long history and extensive experience in techniques to strengthen and improve government health programs. As the health community moves toward a future that includes performance measurement, program successes will follow.

The Healthy People initiative has served to focus the activities of many stakeholders in the public and private sectors. These objectives can drive performance measurement by creating targets toward which activities can be directed. In addition to health objectives, performance measures need to include a short-term result, an improvement strategy, and accountable entities. In addition, success with performance measurement will rely upon the ability to create responsive data systems that generate timely data.

SPOTLIGHT

Local, State, and Federal Measurement Programs

At different levels of government, performance measurement programs are underway. For example, Santa Clara County in California, the State of North Carolina, and several HHS agencies have launched performance measurement programs to evaluate health systems. These programs and processes of development and implementation are spotlighted as examples of approaches to performance measurement.

Santa Clara County's Gameboard Approach

California's fifth largest county has developed comprehensive performance management (CPM), a countywide system of managing public services based on measurable performance. CPM is both a product and a process. Santa Clara County has a training manual that uses an eight-step gameboard to teach department managers and staff how to develop CPM products and follow a management-employee involvement process. The products are missions, goals, and performance measures for the programs. The process requires managers and staff to participate fully as a team in discussions of what the program's picture of CPM should be.

The labor-management partnership has been important in implementing CPM. Through management-employee involvement committees (MEICs), every service unit or program forms a partnership between management and labor to assess the services provided in terms of the mission and goals, customers, and performance measures. In the health field, 12 MEICs operate in mental health, 3 in alcohol and drug services, 2 in public health (tuberculosis and teen pregnancy), 6 in the medical facility, and 3 in school-linked service (managed by public health but incorporating services from all health departments, as well as social services).

An example of a fully developed MEIC is the one in mental health on Clozaril/Risperidone. In this case, a committee and staff already existed for the purpose of reviewing severely mentally ill clients who were candidates for these antipsychotic drugs. The MEIC, which includes the committee and staff, has been able to create measures and modify the existing data system to collect the measures. This MEIC is well on the way to completion of its measurement process, though the process is expected to be fine-tuned over time.

As CPM enters its third year of development, approximately 40 percent of the county is using the process. Training is available for both staff and facilitators to assist MEICs in their work.

Santa Clara's next steps are gathering information to determine the degree of implementation and the need for support by its agencies, as well as revising its countywide mission and service priorities. With plans to tie performance measures to the budget by 1999, the county considers CPM an ongoing system of management in which services can be based on measurable results. (For additional information, write Mary Lou Fitzpatrick, CPM Coordinator, Office of the County Executive Administration, County of Santa Clara, County Government Center, East Wing, 11th Floor, 70 West Hedding Street, San Jose, CA 95110.)

Accountability in North Carolina

Focusing on public health accountability, North Carolina is developing a three-level system, with Level I encompassing health status indicators; Level II, process and outcome measures; and Level III, the monitoring of activities.

Level I consists of a community wellness index (CWI), which provides a snapshot of health status in each county. The CWI has 30 outcome indicators divided into 8 categories, with the indicators generally consistent with or identical to Healthy People 2000 indicators. State officials have used the outcome indicators to generate composite rankings for each county and plan to disseminate broadly this local health status information to public health officials, the media, and the public.

Level II is the core of the accountability system, with 32 process and outcome measures that address how well the community is responding to local health needs. These measures are tied to the responsibilities of local health departments, as well as to those of the community, and include infant mortality rates and the receipt of well child care by Medicaid-eligible children. The State has considered demographics and geography, stratifying counties into four groups and generating rankings in each group. The Governor or the State Health Director will award superior performance in

two categories: outstanding achievement and most improved. Low performers will meet with a team from the State Health Director's office to develop an action plan to be carried out and evaluated over 3 years.

Level III refers to the current monitoring activities, most of which are program specific or mandated by the Federal Government. By having a separate level of indicators, the State can ensure that required monitoring activities are carried out in a coordinated manner and that they complement but do not duplicate Level II assessments.

The State has been compiling data for accountability indicators through its health services information system and other sources (vital statistics, immunization registries) to provide counties with performance assessments. To create a more efficient data collection process, the State intends to evaluate its data system needs and to add essential elements and eliminate those that are not used. (For additional information, write Kevin Ryan, M.D., M.P.H., Chief, Women's Health Section, North Carolina Division of Maternal and Child Health, P.O. Box 27687, Raleigh, NC 27626-0587.)

Performance Measurement in HHS: Three Examples

Agencies in HHS are contributing to the evolution and consensus development for performance measurement. Since September 1996, HHS has been reviewing progress and shaping the future approach to performance measurement in selected public health programs. The HHS Performance Partnership initiative described herein has three core elements: performance measurement, administrative flexibility, and consolidation.

Performance Partnerships are an important theme for budget and legislative programs for this Administration. During 1997, the Department will continue to work in partnership with State and local governments to identify meaningful program outcomes and determine pertinent performance measures to assess program effectiveness. As described below, the success of these efforts depends on accommodating data and surveillance capacity issues and providing technical assistance and training.

In a related effort, the Department commissioned the National Academy of Sciences (NAS) to study existing performance objectives for specified grant areas, as well as the necessary data systems for implementing performance measurement.

NAS supports HHS' conversion from process objectives to more outcome-oriented measures but emphasizes the importance of data development. The draft NAS report points out the difficulty of articulating measures that accurately reflect success or failure in the program areas. The final report is expected in spring 1997.

The efforts of three HHS agencies—Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), and Health Resources and Services Administration (HRSA)—to move to performance measurement are described below.

Emphasis on Outcomes at CDC

CDC is developing health status indicators, uniform data sets, and public health surveillance; streamlining

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To create a more efficient data collection process, North Carolina intends to evaluate its data system needs and to add essential elements and eliminate those that are not used.

RESOURCES

This issue of *Prevention Report* provides an overview and examples of performance measurement. More information is available in the literature and via the Internet, as the list of selected resources below illustrates.

The **Foundation for Accountability** (FACCT) produces reports and guidebooks to address consumer needs for accountability information. No web site currently is available, but information may be obtained by calling (503)223–2228 or through e-mail to **info@facct.org**.

The **General Accounting Office** has produced a number of reports and testimonies relating to performance measurement. Relevant reports, listed by publication date, include:

Managing for Results: Achieving GPRA's Objectives Requires Strong Congressional Role (GAO/T-GGD-96-79, Mar. 6, 1996).

GPRA Performance Reports (GAO-GGD-96-66R, Feb. 14, 1996).

Managing for Results: Status of the Government Performance and Results Act (GAO-T-GGD-95-193, June 27, 1995).

Managing for Results: Critical Actions for Measuring Performance (GAO/T-GGD-95-193, June 20, 1995).

Managing for Results: Experiences Abroad Suggest Insights for Federal Management Reforms (GAO/GGD-95-120, May 2, 1995).

Government Reform: Goal-Setting and Performance (GAO/AIMD/GGD-95-130R, Mar. 27, 1995).

Managing for Results: State Experiences Provide Insights for Federal Management Reforms (GAO/GGD-95-22, Dec. 21, 1994).

Improving Government: Measuring Performance and Acting on Proposals for Change (GAO/T-GGD-93-14, Mar. 23, 1993).

Performance Budgeting: State Experiences and Implications for the Federal Government (GAO/AFMD-93-41, Feb. 17, 1993).

Performance Measurement: An Important Tool in Managing for Results (GAO/T-GGD-92-35, May 5, 1992).

Program Performance Measures: Federal Agency Collection and Use of Performance Data (GAO/GGD-92-65, May 4, 1992).

Documents can be ordered and further information can be obtained through the U.S. General Accounting Office, P.O. Box 6015, Gaithersburg, MD 20884–6015; (202)512–6000. Some documents are available online at **http://www.gao.gov**. Others may be ordered through the site.

The **National Academy of Public Administration** (NAPA) serves public and private organizations as a resource of advice and expertise on public management and administration. The web site at **http://relm.lmi.org/napa/index.html** describes each program area, offers recent reports and products, and has a search engine to locate other performance measurement sources. For information, call (202)347–3190.

The **Alliance for Redesigning Government**, a NAPA program (see above), offers extensive information on performance measurement and government. The web site at **http://www.clearlake.ibm.com/Alliance/** features alliance projects and links to other references, the Reinventing Government database, and *The Public Innovator* online news bulletin.

As mentioned in *Spotlight*, the **National Academy of Sciences** is studying performance measurement in mental health; substance abuse; HIV infection, sexually transmitted diseases, and tuberculosis; chronic diseases; immunization; and three areas of prevention (disabilities, rape, and emergency medical services). The draft *Assessment of Performance Measures in Public Health: Phase I Report* is available on the web at **http://www.dhhs.gov/progorg/io**. The final report is due in spring 1997. Additional related reports are:

Improving Health in the Community: Role for Performance Monitoring. J.S. Durch, L.A. Bailey, and M.A. Stoto, eds. Washington, DC: National Academy Press, 1997.

Managing Managed Care: Quality Improvement in Behavioral Health. M. Edmunds, R. Frank, M. Hogan, D. McCarty, R. Robinson-Beale, and C. Weisner, eds. Washington, DC: National Academy Press, 1996.

Copies are available from the National Academy Press, Office of News and Public Information, 2101 Constitution Avenue NW., Washington, DC 20418; (201)334–3313 or (800)624–6242.

The **National Performance Review** is the initiative led by Vice President Gore to reinvent government so that it works better and costs less. The web site offers background on the initiative, reports of its studies, a library, and links. Valuable resources include:

Reaching Public Goals: Managing Government for Results—A Resource Guide. T. Brandt, B. Godwin, H. Hadd, and B. Rollins, eds. Washington, DC: National Performance Review, 1996.

For further information, visit the web site at **http://www.npr.gov** or call (202)632–0150.

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State/Local/International

The web sites listed below feature a sponsor's performance efforts or offer general performance measurement updates, articles, and references.

Grande Prairie, Alberta
http://www.city.grande-prairie.ab.ca:80/perform.htm

Minnesota
http://www.mnplan.state.mn.us/

Oregon
http://www.econ.state.or.us/opb/index.htm

United Kingdom
http://www.quality.co.uk

Data Sources/Programs and Agencies

The **Agency for Health Care Policy Research** has designed CONQUEST 1.0, a computer tool that uses clinical performance measures for health plans, providers, and purchasers to assess service quality. For information on CONQUEST 1.0, visit the web site at **http://www.ahcpr.gov/research/conquest. htm**. For details on the agency, see **http://www.ahcpr.gov**.

With a focus on performance, the **National Committee for Quality Assurance** (NCQA) evaluates and reports on the quality of managed health care plans. NCQA created HEDIS® 3.0, a measurement tool for consumers, corporations, and public purchasers to assess quality of health plans. NCQA recently released its *Quality Compass* reports that present comparative information of accreditation and HEDIS measures for managed care plans. The web site at **http://www.ncqa.org** offers information on the committee's findings, as well as links to HEDIS and its reports.

Other Related Articles/Resources

How To Lower Health Care Costs by Improving Health Care Quality: Results-Based Continuous Quality Improvement. M.D. Sloan. Milwaukee, WI: ASQC Quality Press, 1994.

Lessons Learned From High Performing Organizations in the Federal Government. Washington, DC: Federal Quality Institute (available from the Government Printing Office), 1994.

Measuring Program Outcomes: A Practical Approach. H. Hatry, T. van Houten, M.C. Plantz, and M.T. Greenway. United Way of America Task Force on Impact, 1996.

Quality Assurance in Medicine: Experience in the Public Sector. K.N. Lohr and R.H. Brook. Santa Monica, CA: Rand, 1984.

Quality in Health Care: Theory, Application and Evolution. N.O. Graham. Gaithersburg, MD: Aspen Publishers, 1995.

Total Quality in Health Care: From Theory to Practice. E.J. Gaucher and R.J. Coffey. San Francisco: Jossey-Bass Publishers, 1993.

Announcements

Save the Date!

The 1997 Healthy People 2000 Consortium meeting will be held on November 7 in Indianapolis. The theme, *Reducing Health Disparities: How Far Have We Come?*, will be the focus of the morning session. In the afternoon, the lead agencies for the Healthy People 2010 Priority Areas will conduct roundtable discussions on proposals for the Healthy People 2010 objectives. This exchange will be an especially valuable opportunity to participate in the development of Healthy People 2010.

Healthy People 2010 Development Guide

Do you want to submit objectives for Healthy People 2010 but do not know how to do so? A national call for Healthy People 2010 objectives will be made in the fall of 1997. This event and others will be described in the forthcoming *Healthy People 2010 Development Guide.* The guide will help Consortium members and others to participate in the Healthy People process.

This summer, single copies of the *Healthy People 2010 Development Guide* will be available from the ODPHP Communication Support Center (OCSC). During its initial distribution, this guide will be sent to Consortium members and others currently involved with the Healthy People process. To promote participation and encourage widespread dissemination, photocopying will be encouraged. In addition, concurrent with its printing, the *2010 Guide* will be posted on the Internet at the Healthy People home page. (Note that the current Healthy People 2000 web site is **http://odphp.osophs.dhhs.gov/pubs/hp2000**.) See back page for information on ordering the guide or other material from OCSC.

Building the Prevention Agenda for 2010: Lessons Learned

Healthy People 2000 Consortium Meeting
New York City, November 15, 1996

In her keynote address to the Healthy People 2000 Consortium, Dr. Ilona Kickbusch, Director of the Division of Health Promotion, Education, and Communication of the World Health Organization (WHO), challenged members to address three key questions:

- Where is health created?
- Which investment creates the largest health gain?
- Does this investment reduce the health gap?

She suggested six principles to guide the development of Healthy People 2010, the next generation of health promotion and disease prevention objectives: the social model of health, investment goals, reduction of gaps and social gradients, policy-relevant indices, partnerships and alliances, and international and sustainable development. Dr. Kickbusch referred to the nations of the world participating in WHO's "Renewing the Health for All" strategy. She emphasized that the United States has a unique opportunity to provide leadership by demonstrating that national prevention objectives can guide policy and strategies for population health improvement.

These remarks set the stage for a stimulating day of discussion and interaction among the 185 Healthy People 2000 Consortium members, invited guests from the business community, and representatives of the Federal Government.

In her opening remarks, Dr. Jo Ivey Boufford, Principal Deputy Assistant Secretary for Health, HHS, reviewed major accomplishments in health promotion and disease prevention during the past year. She cited the President's youth tobacco initiative, improved rates of childhood immunization, and the release of the *Dietary Guidelines for Americans* and the *Surgeon General's Report on Physical Activity and Health*.

Healthy People 2000 Progress

Dr. Boufford also provided a summary of progress on the 319 Healthy People 2000 objectives. According to the *Healthy People 2000 Review, 1995-6,* which was released at the Consortium meeting, 8 percent of the objectives had reached or surpassed the year 2000 targets. Progress had been made toward another 40 percent of the objectives. This good news was offset by the 26 percent of objectives that were either moving away from the year 2000 targets or showed mixed results or no change. Baselines had yet to be set for 19 objectives, or 5 percent of objectives, and 20 percent had no new data with which to evaluate progress.

Dr. Boufford described the new partnerships forming between the health care delivery system and public health community to address these challenges. She also noted that Dr. Philip R. Lee, Assistant Secretary for Health, HHS, had extended invitations

to the State substance abuse, mental health, and environmental agencies to be members of the Healthy People 2000 Consortium and welcomed them to this meeting.

A panel led by Dr. Michael McGinnis, Scholar in Residence at the Institute of Medicine (IOM), reviewed the lessons learned over the past 18 years. According to Dr. McGinnis, the most prominent successes of the process included the explicit commitment of the Nation to measurable goals and the recruitment of thousands of people to participate in the development of the Nation's prevention agenda, which made it a truly democratic activity. He stated that the achievement of the 1990 life-stage targets was the most striking success and recalled that targets to reduce mortality by 20 to 25 percent seemed ambitious at the time they were set. Dr. McGinnis said, "To close the gaps in health disparities among racial, economic, geographic, and population groups remains one of the country's most significant challenges."

Panel on Lessons Learned

Michael Stoto, Director of the IOM Division of Health Promotion and Disease Prevention, addressed the difficulties of identifying and funding data systems to track objectives. Dr. Martin Wasserman, Maryland Department of Health and Mental Hygiene Commissioner, described the importance and use of the objectives in forming Healthy Maryland 2000 (for related information, see *Focus*, page 3). In framing the 2010 objectives, he advised, "If it's not broken, don't fix it; build on successes using (Healthy People) 2000 as the foundation; and keep it simple." He also counseled that the new Federal document should promote State and local objectives, particularly in addressing special populations. Jack Elinson, Professor Emeritus, Sociomedical Sciences Department, Columbia School of Public Health, challenged the Consortium to think about building the next decade's prevention objectives based on public opinion polls that would give the American people the opportunity to describe their health priorities.

Worksite Health Promotion

The luncheon address by David Hunnicutt, President of the Wellness Councils of America (WELCOA), outlined how worksite health promotion can help reshape the American prevention agenda. He stressed the importance of maintaining a healthy workforce to improve productivity and employer responsibility to maintain safe workplaces, as well as to empower employees to make sound health decisions. Emphasizing that public-private partnerships are the future of health promotion, Dr. Hunnicutt encouraged businesses to do more in their communities.

An afternoon session focused on the inclusion of business groups in the Consortium. Business associations already are in the Consortium, and the number could be expanded. As for engaging individual employers, there was a variety of viewpoints. Issues included achieving an adequate diversity of minority- and women-owned, small, and large businesses with geographic representation.

State Action as Framework

Dr. Lee led the discussion on State action, using the Healthy People 2000 prevention framework. He noted the importance of building data capacity to support objectives and other performance measurement activity. He also reminded the audience that Healthy People has bipartisan support and is good public health.

In the community action session, Deborah Bohr, Vice President of the Hospital Research and Education Trust, reviewed lessons learned at the outset of the healthy communities movement in the United States. William Powanda, Vice President of Griffen Health Services Corporation, described the Healthy Valley Connecticut initiative as one way to develop a healthy community.

Dr. Claude Earl Fox, Deputy Assistant Secretary for Disease Prevention and Health Promotion, closed the session with an outline of plans for Healthy People 2010 development. That schedule includes the first meeting of the Secretary's Council on Health Promotion and Disease Prevention Objectives for 2010 in spring 1997. The input of Consortium members obtained through focus groups will be used in shaping the proposed framework for the priority areas and the proposed criteria for objectives. In 1997, lead agency work groups will draft objectives. In the fall of 1998, the review copy will be published for public comment. During 1999, public comment will be synthesized, and the 2010 objectives will be released in 2000. Dr. Fox encouraged the support and involvement of all Consortium members in the Healthy People 2010 development process.

ACTIVITIES

MEETINGS

1997 American Occupational Health Conference. Orlando, FL. American College of Occupational and Environmental Medicine. (847)228–6850. **May 9-16.**

Partnerships for Health! National Rural Health Association 20th Annual National Conference. Seattle, WA. National Rural Health Association. http://www.NRHArural.org. **May 21-24.**

The Power of Spirit - 1997 Annual Meeting. New Orleans, LA. American College Health Association. (410)859–1500. **May 28-31.**

4th Annual National School Health and HIV Prevention Leadership Conference. Atlanta, GA. Society of State Directors of Health, Physical Education, and Recreation. (703)476–3400. **June 9-12.**

The La Leche International Conference: Celebrating 40 Years of Mother-to-Mother Support. Washington, DC. La Leche League International. (847)519–7730, x223; http://www.lalecheleague.org. **July 3-6.**

Strengthening Our Commitment to Alzheimer Care: The Sixth National Alzheimer's Disease Education Conference. Chicago, IL. Alzheimer's Association. (312)335–5790. **July 20-23.**

Twelfth International Interdisciplinary Conference on Hypertension in Blacks. London, England. International Society of Hypertension in Blacks, Inc. (404)875–6263. **July 20-24.**

Partnerships, Technologies, and Communities: Evolving Roles for Health Data - 1997 Joint Meeting of the Public Health Conference on Records and Statistics and the Data Users Conference. Washington, DC. Centers for Disease Control and Prevention. http://www.cdc.gov/nchswww/nchshome.htm. (301)436–7122. **July 28-31.**

Symposium on Advances in Clinical Nutrition: The American College of Nutrition 38th Annual Meeting. New York, NY. American College of Nutrition. (212)777–1037. **September 26-28.**

On the Air

Tobacco

According to the Arizona Department of Health Services, more than 3.9 million people were reached during the first year of its tobacco-tax-funded campaign to brand tobacco as a "smelly, puking habit." The campaign was launched during last year's Super Bowl with the airing of the Frankenstein's monster ad. The campaign's second year began with the 1997 Super Bowl premiere of a new spot titled "P.P." It stars a dog named Barkley that has an attitude to match his basketball namesake's and demonstrates an extremely effective means of extinguishing secondhand smoke. Six English and three Spanish TV spots and nine English and three Spanish radio commercials ran during the campaign's first year. As an adjunct to the campaign, community-based coalitions sponsored tobacco prevention education in schools and merchant education programs. Campaign funds are running low, and Arizona Governor Fife Symington and legislators are working to lift the spending cap and fund the campaign as voters intended. Contact the Arizona Smokers' Helpline at (800)556–6222.

OnVideo

Violent and Abusive Behavior

The Bureau For At-Risk Youth has a comprehensive, curriculum-based, violence prevention video series for middle and high school age children. Featuring youth counselor Michael Pritchard, *Peace*Talks™ addresses issues critical to teens, such as anger management, conflict resolution, racial divisions; violence triggers—drugs, alcohol, and guns; dating pressures; and sexual harassment. Mr. Pritchard gives practical answers to surviving in today's violent world and offers strategies for teens to adopt to protect themselves and their communities from the threat of violence.

The Bureau's "The Silent Victims Speak" is a three-video series that presents experiences shared by adults who grew up in violent homes and then shows followups from a panel of experts, including therapists, social workers, and police officers. The series presents coping strategies for young people growing up with family violence. The videos are: "Growing Up With Domestic Violence," "Impact of Domestic Violence on Children," and "Coping With Domestic Violence."

To order or for more information, write to The Bureau For At-Risk Youth at P.O. Box 760, Plainview, NY 11803–0760, or call (800)99–YOUTH.

Online

Crosscutting

NetWellness™, the University of Cincinnati's electronic consumer health library at **http://www.netwellness.org** offers a database of current information about virtually every health topic. The site links to other databases, such as the Merck Manual Physicians' Desk Reference and Health Source Plus (which contains the full text of over 200 medical journals and abstracts for over 500 other journals). Other features include news items, links to several current network news services and 35 partner organizations, a search engine, and a health professionals directory that lists over 900 physicians on staff at the University of Cincinnati

Hospital. Visitors can ask health care experts specific questions and browse the questions and answers of other users. NetWellness has received Point Communications' "Top 5% of the Web" award and recently was named a semifinalist in the National Information Infrastructure Awards Program for extraordinary achievement in information highway applications.

Physical Activity and Fitness
The Southeast Chapter of the American College of Sports Medicine's web site at **http://www. fau.edu/divdept/exsci/seacsm/sehomepage.htm** presents membership information; a Healthy People 2000 section with the names and telephone numbers of regional and State representatives, major objectives of the initiative, chapter projects, and helpful hints for a healthier life; upcoming meeting announcements; grant information; job and internship bulletin boards; tables of contents and subscriber information for *Medicine & Science in Sports & Exercise*; and links to other sites.

HIV Infection
CDC has a new Business Responds to AIDS (BRTA) and Labor Responds to AIDS (LRTA) web site at **http://www.brta-lrta.org** that provides materials and assistance for setting up effective HIV/AIDS worksite programs, including resources for employers and employees, such as the BRTA Manager's Kit and LRTA Labor Leader's Kit; samples of print ads for employer publications and newsletters; related publications; and links to HIV/AIDS-related web sites. Business, labor, and community leaders give personal accounts of successful programs. CDC's Business and Labor Resource Service, developed in conjunction with workplace education experts and business and labor leaders, links callers from business and labor with resources designed to help them prepare to manage issues related to HIV/AIDS in the workplace. To speak with an AIDS-in-the-workplace specialist, call (800)458–5231 or send e-mail to **blrs@cdcnac.org**.

Immunization and Infectious Diseases
HHS has put up an electronic public service announcement called "Get the Flu Shot, Not the Flu" for Medicare beneficiaries at **http://fightflu.hcfa.gov**. The program is targeting both consumers and health care providers on parallel web sites. For more information, call Laura Koziol at (202)690–7179.

In Print

Crosscutting
In collaboration with the Federal Office of Rural Health Policy, the **National Rural Health Association** (NRHA) is conducting an initiative to develop State rural health associations for better representation and service for rural health care consumers. Contact Rosemary McKenzie, NRHA, One West Armour Blvd., Suite 301, Kansas City, MO 64111; (816)756–3140; or send e-mail to **rm@nhraural.org**.

The Bureau For At-Risk Youth has a free kit to help schools and organizations apply successfully for Government and private grants for violence prevention, substance abuse, and other guidance-related programs. This packet of information includes two pamphlets, "How To Prepare a Successful Grant Proposal" and "Where To Find Funding for Your Program," and a catalog describing more than 1,000 videos, books, pamphlets, curricula, and other resources for youth programs in schools and organizations nationwide. Most of these products qualify for Safe and Drug-Free Schools, Title I, Goals 2000, and other Federal, State, and private funding.

Write to The Bureau For At-Risk Youth, P.O. Box 760, Plainview, NY 11803–0760, or call (800)99–YOUTH.

Cost-Effectiveness in Health and Medicine, Project Summary reviews the roles and limitations of cost-effectiveness analyses (CEAs) as a policy tool and outlines recommendations for enhancing the quality and comparability of CEAs of alternative public health and medical care strategies.

The summary was prepared from the full report of the same name by the Panel on Cost-Effectiveness in Health and Medicine and published by ODPHP, Office of Public Health and Science, HHS. For a single copy (handling fee, $5), contact the ODPHP Communication Support Center (301)468–5960. (For information about ODPHP's new center, see back page.)

Mental Health and Mental Disorders
Multicultural Issues in Counseling: New Approaches to Diversity, 2nd ed., edited by Courtland C. Lee, Ph.D., gives proven strategies for working effectively with culturally diverse clients. The ideas presented

are from personal and professional experiences of each chapter's authors, who are scholars from the specific cultural group covered or who have intimate knowledge of a particular group. The book is designed to help mental health professionals apply their awareness of and knowledge about cultural diversity to appropriate skills development with specific client groups. It offers techniques and strategies for individual and group counseling with such diverse clientele as Native, African, Asian, Latino, and Arab Americans. Case studies illustrate the foundations of culturally responsive counseling.

The book is available from the American Counseling Association Distribution Center at (800)4ACA–648 or (301)470–4ACA. To receive a review copy, contact Geoffrey Darnell at (703)823–9800, x338.

The National Community Mental Healthcare Council® (NCMHC) has published the 40-page *Principles for Behavioral Healthcare Delivery*, a how-to guide on providing quality consumer care. The Council represents more than 900 community-based behavioral health care providers, associations, networks, and public authorities. Send $10 per copy plus $4 shipping and handling to NCMHC, 12300 Twinbrook Parkway, Suite 320, Rockville Pike, Rockville, MD 20852.

The National Institute on Aging's *Progress Report on Alzheimer's Disease 1996* is available on the Internet at **http://www.alzheimers.org/adear** or by calling the Alzheimer's Disease Education and Referral Center at (800)438–4380. The 32-page book reports on advances in diagnosis and treatment and highlights studies on such questions as genetic testing for Alzheimer's disease.

The third edition of the *Alzheimer's Education and Training Resource* catalog lists over 100 publications and videos related to all aspects of the disease and its management. It is organized into categories of caregiving resources, including disease/behaviors, environment, professional caregivers, training, and family and therapeutic interventions. Featured in the catalog is the "Comfort Care" video training series, which has over 19 hours of specific training in caring for people with dementia. Programs in the series include "Understanding Alzheimer's Disease," "Creative Interventions With the Alzheimer's Patient," "Programming for Dementia," "Understanding and Managing Difficult Behaviors," and "Dementia-Specific Policies and Procedures." For further information, contact Geriatric Resources at (800)359–0390.

Unintentional Injuries
The Consumer Product Safety Commission (CPSC) has released the first issue of its *Consumer Product Safety Review*, a quarterly publication providing national consumer product-related injury and death data, consumer product research activities and emerging hazard studies, and the latest product recalls. A mechanism for reporting incidents involving consumer products, the publication is designed to assist in reviewing, developing, and implementing consumer product safety guidelines.

To order, go to "Publications" at the CPSC's web site at **http://www.cpsc.gov** or call (202)512–1800.

Educational Aid

Unintentional Injuries
The Fatal Vision Starter Kit contains a pair of goggles, "walk-the-line" and instructional videotapes, trainer's guide, and participant handouts. For information, contact Curt Kindschuh at (414)924-5751 or Mike Aguilar at (800)272-5023.

Fatal Vision simulator goggles, introduced at Wisconsin Governor Tommy Thompson's Conference on Highway Safety last summer, have become an important tool in the ongoing fight to stop alcohol- and drug-impaired driving among young people. While wearing the goggles, volunteers experience the visual distortions resulting from intoxication or drug impairment and literally "see" how quickly an impaired driver can turn fun into devastating consequences. At the simulated .17 blood alcohol level, everything is thrown off—from participants' depth perception to hand-eye coordination to equilibrium.

Fatal Vision goggles are used by police officers, driver education instructors, Citizens Against Drug Impaired Drivers, hospitals, teachers, Mothers Against Drunk Driving chapters, U.S. Navy, U.S. Air Force, U.S. Army National Guard, Business Against Drunk Drivers, and other traffic safety programs across America.

The Center for Mental Health Services has a data development effort, the Mental Health Statistics Improvement Program, that is funding States to identify and use performance measures, including consumer-oriented indicators.

(Spotlight, *continued from page 7)*

systems; and improving accountability for grants. Its State and local partners have called for better organization of reporting and data requirements.

In responding to its partners' requests, CDC has recognized the importance of focusing on outcomes for specific target populations to examine program effectiveness more directly.

By organizing nationwide meetings on performance measurement and collaborating with relevant committees, CDC has developed national recommendations for measuring program performance. The agency is attempting to integrate the development of performance measures reported by grantees and CDC (as required by the Government Performance and Results Act).

SAMHSA's Partnership Efforts

SAMHSA is working internally and with the States to advance performance partnership efforts. Discussions with the National Association of State Alcohol and Drug Abuse Directors and the National Association of State Mental Health Program Directors have ensured that SAMHSA's reauthorization addresses performance-based systems.

With the States and NAS, SAMHSA also is working to identify and implement specific performance measures for substance abuse and mental health. The Center for Substance Abuse Treatment has awarded contracts to 14 States to develop performance measures for substance abuse treatment. The Center for Substance Abuse Prevention is working with the States to identify prevention outcome indicators based on risk and resiliancy factors. In addition, the Center for Mental Health Services has a data development effort, the Mental Health Statistics Improvement Program, that is funding States to identify and use performance measures, including consumer-oriented indicators.

HRSA's Integrated Performance Measurement Strategy

HRSA initiated the development of a performance management strategy with a full review of its programs and their readiness for measuring performance, using GPRA requirements as the basis for the review. HRSA is well along in its efforts for program-specific performance goals and measures within an integrated performance management strategy. HRSA linked its performance and strategic goals in the five Annual Performance Plans submitted for the 1998 budget and is extending these linkages for the 1999 submissions. In addition, the agency is realigning its strategic plan more closely to GPRA guidelines. HRSA is involving a wide range of partners and obtaining expert technical assistance.

An example of HRSA's efforts is the development of performance measures for its Maternal and Child Health Block Grant program. Started in summer 1996, the task was coupled with an effort to make technical revisions to the block grant application guidance from HRSA's Maternal and Child Health Bureau (MCHB). The committee responsible is led by the MCHB Director of the Office of State and Community Health. Activities to date have included compiling indicators from a variety of sources and categorizing them by population groups and by the MCHB Pyramid of Health Services (direct personal services, enabling services, population-based services, and infrastructure building). In March, MCHB presented its measures to the Association of Maternal and Child Health Programs and is scheduled to send draft guidance to States in April. Over the summer, MCHB will conduct pilot tests and by November have final guidance to States for use in 1998.

Other Sections

The *Focus* and *Resources* sections provide additional examples and opportunities to learn more about performance measurement at local, State, and Federal levels. International resources also are listed. Through performance measurement, the Federal Government and organizations around the world increasingly are managing for results.

ETCETERA

The **National Library of Medicine** (NLM) is offering grants to encourage medical research institutions, health science schools, hospitals, and professional organizations to connect to the Internet. Domestic public and private nonprofit institutions engaged in health sciences administration, education, research, and/or clinical care are eligible.

Single institutions may obtain up to $30,000 and groups or cooperatives of health-related institutions, up to $50,000. Projects should emphasize initiating Internet access or extending existing access; costs for web site development are discouraged.

Inquiries regarding programmatic issues go to Frances E. Johnson, Division of Extramural Programs, NLM, Building 38A, Room 5S-506, Bethesda, MD 20894; (301)496–4621; fax (301)402–0421; e-mail **fjohnson@nlm.nih.gov**. Inquiries regarding fiscal matters go to Ruth Bortz, Grants Management Specialist, Division of Extramural Programs, NLM, Bethesda, MD 20894; (301)496–4253; fax (301)402–0421; e-mail **bortz@nes.nlm.nih.gov**.

Breaking New Ground in Health Communications, a series of one-page summaries from the Center for Substance Abuse Prevention, is a time-saving collection of practical applications and resources. The summaries will help health communicators customize messages and materials for specific populations, involve the target audience in the planning and implementation stages of a program, conduct relevant formative research, and choose effective dissemination strategies. Free copies of individual summaries or the full collection are available from the National Clearinghouse for Alcohol and Drug Information at (800)729–6686, order number BNG000.

NEW SOURCE FOR ODPHP PUBLICATIONS—OCSC!

The **ODPHP Communication Support Center (OCSC)** is the new source for ***single*** copies of Healthy People 2000 and other ODPHP materials. Single copies are available for nominal shipping and handling fees.

To receive a publications list or to order publications: call (301)468–5960 *between 8:30 a.m. and 5:30 p.m. EST;* write to OCSC, P.O. Box 37366, Washington, DC 20013-7366; fax to (301)468–7394. Contact GPO for bulk orders: (202)512–1800.

For publications available electronically, visit the National Health Information Center* at **http://nhic-nt.health.org** or the ODPHP web site at **http://odphp.osophs. dhhs.gov**.

*The National Health Information Center, which formerly disseminated these materials, will continue to operate as an information and referral service.

OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION

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