

PHIP	COMMUNITY HEALTH STATUS ASSESSMENT (CHSA)	HEALTH SYSTEM CAPACITY ASSESSMENT (HSCA)	PRIORITIZATION	STRATEGIC PLANNING	ACTION	EVALUATION
QUESTION	What are the top 30 population health outcomes in Boulder County? Population health outcomes are diagnoses or direct causes of mortality, morbidity, shortened life expectancy, and/or poor quality of life.	What is the capacity of the health system in Boulder County to address population health outcomes? Where are system's strengths and challenges?	Of the 30 population health outcomes, what are the 6 strategic priorities that the health system in Boulder County should use as a common focus on over the next five years?	Given health system capacity, what is our strategic plan to address each of the 6 strategic priorities? How will the individual and social determinants of population health outcomes be addressed? How will each of the health system partners in Boulder County address these priorities?	Given the strategies selected, how does each agency, program, and individual in the health system of Boulder County contribute to carrying out the strategy?	Is the health system in Boulder County effectively addressing the strategic priorities via the selected strategies? If not, why not?
METHOD	Merge lists of population health outcomes at 3 levels: National: Center for Disease Control & Prevention (CDC) Winnable Battles, Healthy People (HP) 2020 State: State health (CDPHE) 2010 objectives Local: Staff & partner input Merging the above lists and eliminating duplicates yields a manageable 30 outcomes.	With community partners, complete Local Public Health Performance Assessment Instrument for the health system. This instrument uses National Public Health Performance Standards (NPHPS) to assess local provision of the 10 Essential Public Health Services (ESPH).	Prioritize population health outcomes via community discussion based on criteria (severity, prevalence, and actionability as perceived by participants based on their personal experience and expertise) and process developed from initiatives by state health (CDPHE), other PHIP pilot counties, and contractors.	With community partners, review resources and social determinants (economic opportunity, physical environment, social factors) and individual factors (health behaviors, access, utilization, quality of care) to define how to address each strategic priorities. Identify sociodemographics of target population. Specify partner commitment to address each strategic priority.	Operationalize each strategy the strategic plan at the agency, program, and individual level so that each person understands their role and responsibility in carrying it out. Conduct each service/activity to the extent possible within the existing framework of mandated and core public health services.	Track performance via implementing a data management and display system (DMDS) of indicators for each strategic priority as well as for the population health outcomes. Display rate, change over time, status compared to baselines and targets. Review state (CDPHE) Boulder County profile indicator set.
PARTICIPANTS	BCPH staff, key community partners	BCPH staff, community partners, contractor	BCPH staff, community partners, contractor	BCPH staff, community partners	BCPH staff, community partners	BCPH staff, DMDS contractor
BCPH STAFF ROLE	Staff identify health issues in All-Staff Meeting. Program coordinators identify health issues in leadership team meetings.	Program coordinators draw on staff experience to provide examples of Essential Public Health Services at program level, division rep. gets examples to contractor	Program coordinators draw on staff expertise to review outcomes and identify their priority areas, to be considered by division representative in prioritization meetings	Drawing on staff expertise, program coordinators suggest objectives, target populations, indicators, baselines, targets, strategies to be considered by division rep. in planning meetings	Program coordinators build priorities and strategies into their strategic planning and op plans, and conduct related services/activities	Program coordinators provide indicator data. Health Planning displays data. Directors and leadership teams interpret data to evaluate and plan.
RESPONSIBLE	BCPH Health Planning presents final list compiled from participant input	Contractor presents final list compiled from participant input and analysis	Contractor presents final list compiled from participant input	BCPH PHIP Core produces final plan	BCPH and partner agency directors ensure action on strategic priorities	BCPH Health Planning and Contractor display and manage data
DELIVERABLE	30 population health outcomes	Capacity score for health system provision of the 10 Essential Public Health Services	6 strategic priorities	Plan consisting of strategies , inc. objective, population, indicator, baseline, target, Essential Service area, strategy, partner commitment for each priority	Report of actions taken, i.e. strategies conducted to address each strategic priority	Display of indicators for each strategic priority and for each population health outcome
DUE DATE	End of January 2011	End of May 2011	Middle of June 2011	End of July 2011	Start by August 2011	Start by December 2011

CONTINUOUS QUALITY IMPROVEMENT PROCESS, REPEATING EVERY 5 YEARS

Public Health Improvement Process

We identify the socio-demographics (including age) of the target population/s.

We develop strategies to impact each outcome that we chose as a strategic priority. To do so, staff and community partners review and address a range of risk and preventive factors including:

- resources (health system capacity to provide the Essential Public Health Services)
- individual factors (health behaviors, access, utilization, quality of care)
- social determinants (social factors, physical environment, economic opportunity).

Our work in the public health system is to impact these factors and determinants to progress on our strategic priorities, as well as continue providing all core and mandated public health services.

We choose a few (6?) specific outcomes as strategic priorities.

LIFE COURSE

SOCIAL DETERMINANTS

INDIVIDUAL FACTORS

POPULATION HEALTH OUTCOMES

PREGNANCY

EARLY CHILDHOOD

CHILDHOOD

ADOLESCENCE

ADULTHOOD

LATER LIFE

PHYSICAL ENVIRONMENT	SOCIAL FACTORS	ECONOMIC OPPORTUNITY
Examples: Built environment Safety Environmental quality	Examples: Social support/networks Leadership Political influence Violence Racism National influences Government policies Cultural norms	Examples: Income Employment Education Housing

HEALTH BEHAVIORS & CONDITIONS	MENTAL HEALTH	ACCESS, UTILIZATION, & QUALITY OF CARE
Examples: Nutrition Physical activity Tobacco use Injury Sexual behavior Overweight	Examples: Depression Suicide attempts Substance abuse Functional status and quality of life	Examples: Health insurance coverage Received needed care Provider availability Preventive care (e.g. screening)

MORBIDITY

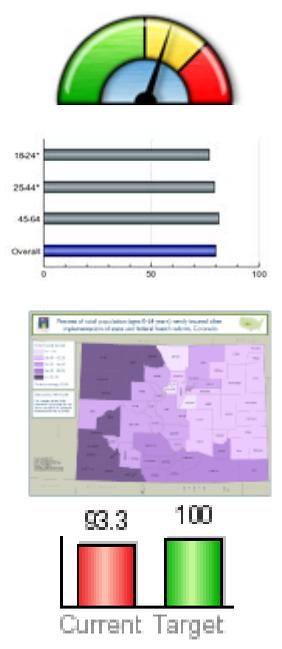
MORTALITY

QUALITY OF LIFE

LIFE EXPECTANCY

Each PHIP cycle starts and ends with population health outcomes. PHIP cycles start with identifying outcomes as strategic priorities. PHIP cycles end with evaluating the improvement in outcomes. The middle of each PHIP cycle consists of efforts of the health system to impact factors and determinants that improve outcomes.

Social Determinants of Health / Health Equity Framework

DELIVERABLE	About 30 population health outcomes impacting mortality, morbidity, shortened life expectancy and/or poor quality of life*	Capacity score for health system on provision of the 10 Essential Public Health Services	About 6 strategic priorities on which to focus (alongside ongoing core and mandated public health services)	Plan of strategies , inc. objective, indicator, benchmark/ standard, Essential Public Service target area, partner commitment for each strategic priority	Report of actions re each strategic priority by impacting individual and social determinants in specific sub-populations	Display of indicators for each strategic priority and for each population health outcome
EXAMPLES	<p>The list of population health outcomes might look like this:</p> <ul style="list-style-type: none"> Diabetes Heart disease Stroke Prostate cancer Female breast cancer Lung and bronchial cancer Colorectal cancer Sexually-transmitted disease Food- and waterborne disease Vaccine-preventable disease Vector-borne disease Unintentional injury- musculoskeletal Teen pregnancy Unplanned/unintended pregnancy Healthcare associated infections Osteoarthritis Blood disorders Kidney disease Asthma Depression Substance abuse disorders Mental health disorders-other Suicide Victim of violence Infant mortality Pre-term births Hypertension COPD Alzheimer's Chronic liver disease Hyperlipidemia Back and neck pain 	<p>Capacity scores for each EPHS are listed. Depression scores would assess health system capacity to:</p> <ol style="list-style-type: none"> 1. Monitor health status to identify depression 2. Diagnose & investigate depression cases 3. Inform, educate, empower re depression 4. Mobilize community partnerships to address depression 5. Develop policies and plans that support individual and community efforts to address depression 6. Enforce laws and regulations to protect health and ensure safety of those with depression 7. Link to and provide care for those w/depression 8. Assure competent workforce to address depression 9. Evaluate effectiveness, accessibility, quality of depression services 10. Research new solutions to depression 	<p>Example strategic priorities identified from the list of population health outcomes by the community process might be:</p> <ul style="list-style-type: none"> Depression Influenza/Pneumonia Healthcare associated infections Asthma Unintentional injury Infant mortality 	<p>If, for instance, the capacity score for EPHS 2 – diagnose and investigate cases of depression – is lower than other EPHS scores, a strategy like the following may be identified to address it.</p> <p>Objective: Increase proportion of primary care physician office visits that screen adults aged 19 years and older for depression.</p> <p>Population: Adults aged 19+</p> <p>Indicator: Percent of primary care physician office visits that screened adults aged 19 years and older for depression</p> <p>Baseline: 2.2% of primary care physician office visits screened adults aged 19 years and older for depression in 2007.</p> <p>Target: 2.4% (a 10% improvement)</p> <p>Essential Public Health Service: 2/diagnose & investigate</p> <p>Strategy: Circulate a proven screening instrument to facilitate physician screening for depression.</p> <p>Partner commitment: Primary care physicians will.... Hospitals will.... BCPH will....</p>	<p>Low-income Energy Assistance Program helps with heating bills for low-income clients w/ depression diagnoses to improve living space [physical environment]</p> <p>Mental Health Center agrees to receive low-income clients referred by physicians who screen [economic opportunity]</p> <p>OASOS addresses stigma of seeking mental health screening [social factors]</p> <p>Addiction Recovery Detox staff screen for and follow up on depression referrals [behavior]</p> <p>Boulder Medical Center physicians commit to screen for depression [access to care]</p> <p>Postpartum Depression Project recommends best tools to detect post-partum depression [quality of care]</p> <p>Women’s Health Center advocates for policy requiring depression screening [policy]</p>	<p>Visuals showing rate, change over time, status compared to baselines and targets for indicators like screening and depression rates, such as:</p>  <p>The visualizations include:</p> <ul style="list-style-type: none"> A gauge chart with a needle pointing to a value on a scale from 0 to 100. A horizontal bar chart with four bars labeled 1824, 2544, 4564, and Overall, with a scale from 0 to 100. A map showing geographic data points. A bar chart comparing 'Current' (93.3) and 'Target' (100) values.

* The outcomes list consists of those most often cited in sources consulted and is not all-inclusive. It is an unordered, working list. Top outcomes change over time (consider polio, HIV/AIDS). Risk and preventive factors are addressed in system capacity assessment, strategic plan, action, and indicators. Outcomes are often risk factors for other outcomes (e.g. hyperlipidemia for hypertension, pain for depression). *Infectious disease* was re-organized as sexually transmitted, food and waterborne, vaccine-preventable, and vector-borne. *Cancer* was subdivided into the cancers with the four highest prevalence rates: prostate, female breast, lung and bronchial, and colorectal. Based on the DSM-IV/WMH-CIDI disorders categorization by the National Institute of Mental Health, *Mental health disorders – other* includes anxiety, mood, impulse-control, and substance disorders. Life expectancy and quality of life are measures of morbidity and mortality; as such, they will be reported but not prioritized as outcomes. Core and mandated public health services continue alongside focused work on outcomes identified as strategic priorities.