NORC FINAL REPORT:

HEALTHY PEOPLE USER STUDY

NORC at the UNIVERSITY OF CHICAGO

Presented to:
U.S. Department of Health and Human Services (HHS)

Presented by:
National Opinion Research Center (NORC)
at the University of Chicago
4350 East West Highway, Suite 800
Bethesda, MD 20814
301-634-9300
301-634-9301 (fax)

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EXECUTIVE SUMMARY

In 2007, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services (HHS) contracted with the National Opinion Research Center (NORC) to conduct the 2008 *Healthy People* User Study. The study serves two purposes. First, it builds on findings from a similar study of *Healthy People* users conducted in 2005, which allows HHS to examine changes over time. Second, it informs HHS about patterns of awareness and usage of the initiative among state, local and tribal health organizations. Specifically, the results document the extent of awareness; describe the nature of use and assess whether use is changing over time; identify barriers to use among these critical audiences; and offer insight to assist in the development of the next iteration of *Healthy People*, *Healthy People 2020. Healthy People 2020* is using current evidence and data, as well as lessons learned from *Healthy People 2010*, to establish new national health objectives reflective of evolving public health priorities. The process of developing *Healthy People 2020* relies on input from the initiative's key stakeholders to ensure a product that is responsive to the needs of its users. The development of *Healthy People 2020* is well underway with release of the initiative's overarching framework scheduled in 2009 and the release of health objectives planned for 2010.

The results of the 2008 *Healthy People* User Study provide HHS with important information on the utilization of *Healthy People 2010*, and for the development of *Healthy People 2020*. First, results of the study indicate that awareness and use of the *Healthy People* initiative is very high among key stakeholders, with overall use of the initiative increasing since the 2005 study. The results also show that both non-users and users of *Healthy People 2010* were more likely to cite issues related to their organization/agency as a barrier to greater use of the initiative, as opposed to issues related to the *Healthy People* initiative itself. However, it is important to recognize that some barriers associated with the initiative itself are impacting key stakeholders' use of the initiative, such as the lack of implementation guides. Finally, study respondents expressed distinct, and conflicting, preferences regarding the format and content of *Healthy People 2020*, which suggests that *Healthy People* is utilized by different organizations in different ways.

BACKGROUND

Each decade since 1979, the U.S. Department of Health and Human Services (HHS) has published a comprehensive set of national public health objectives. Known as *Healthy People*, this initiative is based on the premise that setting objectives and monitoring

progress can motivate action. The most recent iteration, *Healthy People 2010,* consists of 467 objectives, organized into 28 focus areas. It has two overarching goals: (1) to increase the quality and years of healthy life, and (2) to eliminate health disparities.

In 2005, the Office of Disease Prevention and Health Promotion (ODPHP) and ASPE determined a need to investigate the awareness and use of *Healthy People* among the initiative's target audiences. ODPHP and ASPE contracted with the National Opinion Research Center (NORC) to conduct an assessment of how the *Healthy People 2010* initiative was being used by state, local and tribal health organizations/agencies. NORC's *Assessment of the Uses and Users of HealthierUS and Healthy People 2010* (hereafter referred to as the "2005 User Assessment") identified important differences among states, localities, tribes, and organizations/agencies of various sizes in terms of their exposure to and use of the initiatives, as well as the extent to which they found them relevant and effective.

Since the 2005 User Assessment, HHS has undertaken a number of efforts to increase awareness of the *Healthy People* initiative among certain stakeholder groups. For example, ODPHP worked with Regional Health Directors and State *Healthy People* Coordinators to conduct targeted outreach to tribes and local health organizations/agencies to increase their knowledge and use of the initiative. Other HHS and non-federal partners have also disseminated program and implementation tools such as *Healthy Youth* (Centers for Disease Control and Prevention, 2004), *Rural Healthy People 2010* (Gamm & Hutchinson, 2004), and models for state-based *Healthy People* initiatives (State *Healthy People* Plans, 2008). To assess the cumulative impact of these efforts and the current level of awareness and uses of *Healthy People 2010*, a follow-up study—the 2008 User Study—was conducted.

METHODS

The 2008 User Study collected data using a mailed, self-administered questionnaire (SAQ), which was sent to members of state, local, and tribal health organizations/agencies. The survey was developed by reviewing the questionnaire and findings of the 2005 User Assessment, gathering information on HHS-sponsored activities that have taken place over the past two years, and reviewing planning activities that are currently underway to prepare the next decade's set of national objectives for health promotion and disease prevention.

The sample for the 2008 User Study was constructed from multiple sources, with separate sampling frames for state, local, and tribal health organizations/agencies. Included were

two groups within each State's Department of Health; the *Healthy People* State Coordinator (HP Coordinator) and the Chronic Disease Director, as well as a sample of local health organizations. The study also sought responses from two different types of tribal health organizations: individual tribal health organizations and Multi-Tribal Area Health Boards (MTAHB). The project surveyed all HP Coordinators, Chronic Disease Directors, and MTAHB, and, it sampled local and tribal health organizations. The study's sample sizes and response rates are shown in the table below. Survey results were then summarized within and across organization/agency type.

Sample Type	Sample Size	No. Received	Percent Received
***Healthy People* State Coordinators**	53	45	84.9
State Chronic Disease Directors	50	44	88.0
Local Health Organizations	300	212	70.7
Tribal Health Organizations	102	51	50.0
Multi-Tribal Area Health Boards	12	9	75.0
Total	517	361	69.8

To supplement the information gathered through the survey responses, 10 informal discussions with users and non-users of *Healthy People 2010* were conducted. These discussions provided an opportunity for key stakeholders to describe in greater detail their utilization of *Healthy People*, and how the initiative could be improved.

KEY FINDINGS

Overall, 91 percent of the responding organizations/agencies were aware of the initiative. This percentage shows an increase from the 83 percent who were aware of the initiative during the 2005 User Assessment. Of the 327 organizations/agencies that were aware of *Healthy People 2010,* 78 percent reported using it in their organization/agency. This is an increase from the 71 percent of organizations/agencies that reported use of the initiative in the previous study; though not a statistically significant increase.

Users of *Healthy People 2010* indicated the various ways in which their organization/agencies use the initiative. Some of the highlights of these uses are listed below:

- Over 81 percent of users in each sample type reported using *Healthy People 2010* as a data source, to support applications for grants or funding, and as a framework for planning, goal-setting and agenda building.
- The data revealed variation between respondent types pertaining to the aspect of the initiative that is most useful. State level respondents cited the specific health objectives, MTAHB respondents reported leading health indicators, tribal health organization respondents cited the overarching goals, and local health organization respondents indicated the leading health indicators to be the most useful aspect of *Healthy People 2010*.
- Eighty percent of tribal health organizations reported intentionally planning programs around one or more of the *Healthy People 2010* objectives. This was substantially higher for the other *Healthy People 2010* respondent types.

Study respondents also provided information on barriers to using *Healthy People 2010*:

- In terms of barriers related to the *Healthy People* initiative, the most commonly reported barrier by users of *Healthy People 2010* was lack of data to track objectives (32 percent).
- In terms of barriers related to the respondent's organization/agency, insufficient resources was the most commonly cited barrier (76 percent).
- Almost 60 percent of non-users indicated that a lack of implementation guidance was a barrier to greater use of *Healthy People 2010*.
- Notably, the proportion of respondents reporting each type of barrier greatly decreased from 2005.

Finally, to inform the development of *Healthy People 2020,* study respondents were asked various questions about ways to improve the *Healthy People* initiative, and their anticipated uses of *Healthy People 2020:*

- Overall, 47 percent of *Healthy People 2010* users felt that fewer focus areas should be included in *Healthy People 2020*.
- Overall, 69 percent of *Healthy People 2010* users indicated that a reorganization of *Healthy People* would be useful for the next iteration. When asked which format for organizing objectives would be most useful, 37 percent of *Healthy People 2010* users felt it would be most useful to reorganize by risks/determinants (such as tobacco use, genetics, physical environment), 30 percent felt it would be most

useful to reorganize by disease area, and 12 percent felt it would be most useful to reorganize by life stages.

- Overall, *Healthy People 2010* users reported that they are most likely to use *Healthy People 2020* as a framework for planning, goal-setting or decision making (79 percent).
- *Healthy People 2010* users report that they are least likely to use *Healthy People 2020* as a guide to set spending priorities within their organization (42 percent).

CONCLUSION

The 2008 User Study provides an updated snapshot of awareness and use of *Healthy People 2010* three-quarters of the way through the decade, allowing for an assessment of whether use is changing over time; identifying barriers to use of *Healthy People 2010* among state, local and tribal health organizations; and offering insight to assist HHS in preparing the next iteration of national health objectives, *Healthy People 2020.* In synthesizing the key findings of this study, eight conclusions were identified:

1) Awareness and use of *Healthy People* has grown over time, but there continues to be a need for targeted efforts directed toward local and tribal health organizations.
2) The vast majority of *Healthy People 2010* users do not utilize the initiative as a guide for setting spending priorities at their organizations. Rather, spending priorities are determined by available funding mechanisms, which may not be aligned with *Healthy People* goals. Efforts to align *Healthy People* goals and funding resources for state, local, and tribal health organizations may help overcome this barrier
3) User groups utilize *Healthy People* differently and for different purposes. These variations indicate that there may be opportunity for expanded use of the initiative as users learn of other users' *Healthy People* activities. The variations also indicate there is a continued need for targeted outreach efforts to support continued expansion of *Healthy People* utilization.
4) Barriers to use or increased use of *Healthy People* are primarily attributed to organizations/agencies, rather than the *Healthy People* initiative itself. This distinction may be useful when developing outreach efforts to encourage greater use of the initiative.
5) The lack of implementation guidelines is the leading barrier to use among non-users of *Health People*. The extent of this barrier shows an important need that is not being fulfilled by the initiative.

6) In addition to outreach to tribal health organizations, MTAHB's appear to be an effective avenue for communication with tribal health organizations.

7) Chronic Disease Directors have similar levels of awareness and use of *Healthy People* as HP Coordinators, indicating that Federal outreach to states is effective and extends beyond HP Coordinators.

8) To further improve *Healthy People* and its usability, *Healthy People 2020* should include implementation guides and evidence-based practices, and HHS should increase communication with stakeholders to ensure users are aware of the complete spectrum of uses of *Healthy People* (rather than users continuing to use *Healthy People* only in the ways previously established by their organization/agency).

INTRODUCTION

Each decade since 1979, the U.S. Department of Health and Human Services (HHS) has published a comprehensive set of national public health objectives. Known as *Healthy People*, this initiative is based on the premise that setting objectives and monitoring progress can motivate action. *Healthy People* is not only valuable as a Federal goal setting report, but also as a forum for health leaders and individuals across the United States to get involved in directing the nation's public health strategy for the future. Produced through a process of broad stakeholder engagement, it represents the input of key stakeholders in public health at the national, state, and local levels, as well as the general public. A central theme of *Healthy People* is that communities and community partnerships play a pivotal role in promoting healthy living in the U.S., and addressing factors in the physical and social environment that shape the health of Americans.

The most recent iteration of these objectives, *Healthy People 2010*, is the third in a series of HHS publications that specify ten-year health promotion and disease prevention objectives for the nation. *Healthy People 2010* consists of 467 objectives, organized into 28 focus areas. It has two overarching goals: (1) to increase the quality and years of healthy life, and (2) to eliminate health disparities. Studies modeling the potential impact of *Healthy People 2010* suggest that achieving certain objectives would lead to significant increases in the longevity and health of the U.S. population; these effects would be augmented by achieving the goal to eliminate health disparities (Pamuk, Wagner, & Molla, 2004). Because stakeholder involvement has been essential both to developing and achieving public health priorities for the nation, *Healthy People 2010* has been called a "national" effort, rather than simply a "federal" one. Coordinated efforts among federal, state, local, and tribal public health entities are necessary to achieve this end.

The Office of Disease Prevention and Health Promotion (ODPHP) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) decided to conduct the 2008 *Healthy People* User Study (2008 User Study) to better understand how public health agencies and organizations are using *Healthy People,* and to identify barriers to the use of the objectives. This information will assist HHS in evaluating the usefulness of *Healthy People 2010* and developing strategies for improving the utility of *Healthy People* for state, local, and tribal health organizations/agencies. Additionally, the information will provide valuable feedback as HHS prepares to launch development of the next decade's health promotion and disease prevention objectives for the nation, *Healthy People 2020*.

STUDY BACKGROUND AND SIGNIFICANCE

In 2005, ODPHP and ASPE determined it was necessary to investigate the extent to which coordinated efforts to achieve Federal health promotion and disease prevention goals had occurred. They contracted with the National Opinion Research Center (NORC) to conduct an assessment of how the *Healthy People 2010* and *HealthierUS* initiatives were being used by state, local and tribal health organizations/agencies. NORC's *Assessment of the Uses and Users of HealthierUS*[1] *and Healthy People 2010* (2005 User Assessment) sample included 301 respondents from the 50 states, the District of Columbia, local health organizations, and tribal health organizations. The unit of analysis for the sample was the organization, meaning that no more than one survey was sent to each organization. The sample frame was constructed from multiple sources and resulted in three separate lists for state, local, and tribal health organizations. A list of the 51 Directors of state health departments and the District of Columbia served as the primary contacts for the states. A list of approximately 2,700 members of the National Association of County and City Health Officials (NACCHO) served as the sample frame for the local health organizations, and tribal health organizations were selected from a list of approximately 400 tribal health organizations provided by the Indian Health Service (IHS).

The 2005 User Assessment identified important differences among states, local, and tribal health organizations, as well as among organizations/agencies of various sizes in terms of their exposure to and use of the initiatives and the extent to which they found them to be relevant and effective. The results revealed that over 80 percent of responding state, local, and tribal health organizations were aware of *Healthy People 2010*, and more than 70 percent reported using it. States and localities said they use *Healthy People 2010* to guide their research, outreach, and internal planning processes, and they typically found specific health objectives to be the most useful aspect of the initiative. In contrast, tribal health organizations were more likely to mention the participatory goal-setting process of *Healthy People 2010* as its most useful aspect. Tribal health organizations and small state, local, and tribal health organizations were also less aware of *Healthy People 2010* than larger organizations. The variation in these results was consistent with studies that have shown marked differences in localities' readiness to meet specific *Healthy People 2010* objectives (Kanarek & Biala, 2003).

[1] The *Healthier US* initiative is an initiative established by Executive Order of the President (2003) and designed to: 1) increase physical activity, 2) promote responsible dietary habits, 3) increase utilization of preventive health screenings, and 4) encourage healthy choices concerning alcohol, tobacco, drugs, and safety among the general public.

Since the 2005 User Assessment, HHS has undertaken a number of efforts to increase awareness of the *Healthy People* initiative among certain stakeholder groups. For example, ODPHP worked with Regional Health Administrators and State *Healthy People* Coordinators to conduct targeted outreach to local and tribal health organizations to increase their knowledge and use of the initiative. Other HHS and non-federal partners have also disseminated program and implementation tools such as *Healthy Youth* (Kanarek & Biala, 2003), *Rural Healthy People 2010* (Gamm & Hutchinson, 2004), and models for state-based *Healthy People* initiatives (State *Healthy People* Plans, 2008). These efforts demonstrated the need for a follow-up study to the 2005 User Assessment to assess awareness and uses of *Healthy People 2010* among state, local, and tribal organizations/agencies.

As such, ASPE and ODPHP again contracted with NORC to conduct the 2008 User Study. The 2008 User Study advances knowledge of who among state, local, and tribal health organizations/agencies is using Healthy People 2010, where and how they are using it, and to what extent respondents view it as contributing to their own disease prevention and health promotion efforts . This information is important because it can:

- Document the nature of use near the end of the decade, and assess whether use is changing over time;
- Identify barriers to use of *Healthy People 2010* by these key audiences; and
- Offer insight to assist HHS in preparing the next generation of national health objectives, *Healthy People 2020.*

The 2008 User Study also provides data in support of ODPHP's annual Program Assessment measure: the percentage of states that use the national objectives in their health planning processes. In 2005 and 2006, 96 percent of states reported using *Healthy People 2010* objectives in their planning processes, representing an increase from the 2002 and 2004 usage rates of 45 and 65 percent, respectively. ODPHP's 2007 target of having 96 percent of states use national objectives in their planning has already been achieved, but its 2008 target is set at 98 percent. The data collected in this study will help ODPHP to measure progress toward this goal.

METHODOLOGY

STUDY DESIGN

The 2008 User Study collected data using a mailed, self-administered questionnaire (SAQ), which was sent to members of state, local, and tribal health organizations/agencies. Each individual was asked to complete the one-time survey, lasting approximately 15 minutes, on behalf of his or her organization. Survey results were then summarized within and across organization/agency type. As mentioned, the survey was designed to ascertain how state, local, and tribal health organizations/agencies use *Healthy People 2010*, whether the use of *Healthy People 2010* has changed during the decade, and how these organizations/agencies anticipate using *Healthy People 2020*. The questionnaire consisted of four sections, which are outlined below:

1) Background Information. Captured data about organizational/agency characteristics such as type, size, and health priorities of organization/agency, as well as the job title of the respondent.

2) Uses of *Healthy People 2010*. Captured data about whether the organization/agency uses *Healthy People 2010*, how it uses the initiative, and factors that enable or hinder its use within the organization/agency.

3) Uses of *Healthy People* 2020. Captured data—from respondents who report their organization/agency does use *Healthy People 2010*—about organization/agencies' anticipated uses of *Healthy People* 2020, and desired format of *Healthy People* 2020.

4) Non-Users of *Healthy People* 2010. Captured data from respondents who report their organization/agency does not use *Healthy People 2010* on why it does not use the initiative, barriers to use, and ascertains general perceptions about the initiative.

The format described above allowed for the collection of essential demographic information on all respondents, regardless of their use of *Healthy People*. By asking respondents about their current uses of *Healthy People 2010* before asking about their anticipated uses of *Healthy People 2020*, the questionnaire enabled respondents to fully consider the activities and uses they were most familiar with, and then identify how *Healthy People* can be improved. This survey design was developed by reviewing and revising the questionnaire from the 2005 User Assessment. In addition to reviewing the key findings of the 2005 User Assessment, input was also gathered to include questions measuring the impact of HHS-sponsored activities that have taken place over the past three years, as well as planning activities that are currently underway to prepare the next decade's set of

national objectives for health promotion and disease prevention. Since the 2008 User Study did not address *HealthierUS*, there was an opportunity to develop a questionnaire that included more detailed questions on some other issues pertaining to *Healthy People 2010*, while still minimizing respondent burden. Key research questions that framed the data collection strategy for the 2008 User Study can be found in Exhibit 1.

After completing the survey data collection, 10 informal discussions were conducted with users and non-users of Healthy People 2010, from each of the respondent groups. These discussions lasted between fifteen and thirty minutes and provide qualitative information on utilization of Healthy People 2010, and ways the next iteration could be improved.

A pretest of the survey instrument was conducted to ensure the questions and available responses were clear to respondents and that the questions captured the intended information. The study questionnaire was mailed to three former employees of tribal health organizations and four former state Chronic Disease Directors. Pre-testing participants were identified by the National Indian Health Board (NIHB) and The National Association of Chronic Disease Directors, ensuring the questionnaire was tested by people similar to those in the survey sample. These participants completed the questionnaire on their own, and then participated in a modified cognitive interview with NORC staff; reviewing the structure and context of the questionnaire and providing feedback on their understanding and perceptions of the survey. Findings from the pretest were incorporated into the final study questionnaire. The study received clearance from the Office of Management and Budget (OMB Clearance Number 0990-0329). The final questionnaire is included as Appendix 1.

STUDY POPULATION

The participant list for the 2008 User Study was constructed from multiple sources, with separate sampling frames for state, local, and tribal health organizations/agencies. The state level sample sought responses from two groups within each state's Department of Health: the *Healthy People* State Coordinator (HP Coordinator) and the Chronic Disease Director. HP Coordinators were included because they are directly involved in *Healthy People* and are a primary audience and proprietor of the initiative.

Exhibit 1: Key Research Questions

1. What are the organization/agency characteristics of users and non-users of *HP2010,* and has this changed since the 2005 User Assessment?
What is the type, size, and location of the organization/agency? What population(s) does the organization/agency serve? What health priorities does the organization/agency support? Who is the target audience for the organization's health promotion and disease prevention efforts? Which employees and/or departments within the organization/agency are involved in implementing disease prevention and health promotion programs? What are the characteristics of the organization/agency?
2. Are organizations aware *Healthy People 2010*, and if so, how are the organizations/agencies using the initiative? Has the use of *Healthy People 2010* changed since the 2005 User Assessment?
Is the organization/agency aware of *Healthy People 2010*? If so, how did they receive information about the initiative? Has the organization/agency incorporated the *Healthy People 2010* initiative into its planning of health activities? If so, how did it do this? If using *Healthy People 2010*, is the organization/agency measuring changes in health behaviors or health outcomes in targeted populations? What resources have been most helpful in supporting the organization's *Healthy People 2010* activities?
3. What are the reasons that organizations/agencies are not using *Healthy People 2010*?
What barriers to using *Healthy People 2010* exist at the organization/agency? What aspects of the initiative pose obstacles or challenges to using *Healthy People 2010* at the organization/agency? What changes to this initiative would increase its usefulness? What assistance could HHS provide to overcome barriers to organization/agency use?
4. What components of *Healthy People 2010* are most useful to users?
Do organizations/agencies use the overarching goals, objectives and indicators? If so, how frequently? Which of these elements are most useful to the organization/agency? What process does the organization/agency use to select priority objectives /indicators from *Healthy People 2010*? Does the organization/agency use *Healthy People 2010* as a source of data for benchmarking or evaluation?
5. What elements would be useful in the final assessment of *Healthy People 2010*?
Is the organization/agency intending to assess progress towards *Healthy People 2010* goals? If so, how? To what extent should accomplishment of the objectives themselves be the standard by which the initiative's success is measured? Should other factors be taken into account in judging the impact of *HP2010*, such as: enhanced capacity in states and localities; new partnerships among governmental and private sector organizations; or newly developed strategies for achieving the initiative's overarching goals?
6. What key components should be considered in framing the next iteration of health promotion and disease prevention objectives for the nation?
How can HHS improve the next iteration of national health objectives to be more useful to state/local/tribal organizations/agencies? To what extent are overarching goals a critical element of *Healthy People?* To what extent are focus areas a critical element of *Healthy People?* Should the next iteration of *Healthy People* contain more, fewer, or a similar number of objectives? Would a reorganization (e.g., by health risks/ determinants, by disease areas, by leading indicators) of objectives be helpful to state/local/tribal entities? How involved should states, localities, and tribes be in framing the next iteration of *Healthy People*?

Chronic Disease Directors were included because they work within the state public health agency and may or may not be directly involved with *Healthy People,* but they are likely to be impacted by *Healthy People* goals.

As another key stakeholder in the efforts to improve the health of the nation, the views of local health organizations were included as a separate sample. A list of 3,707 members of the National Association of County and City Health Officials (NACCHO) served as the sample frame for the local health organizations.

The study also sought responses from two different types of tribal health organizations: individual tribal health organizations and Multi-Tribal Area Health Boards (MTAHB). Tribal health organizations provide health support to their individual tribe, while MTAHB advise in the development of positions on health policy, planning, and program design for a number of tribes in an area. While not every tribe is affiliated with a MTAHB, these organizations can be an important resource for implementation and outreach to the tribal health community. By including these two types of tribal health organizations, the 2008 User Study was able to more accurately capture the perspective of tribal health organizations and the unique ways in which they use *Healthy People 2010*.

The final sample included 517[2] respondents from the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, local health organizations, and tribal health organizations. The unit of analysis for the sample was the organization, meaning that no more than one survey was sent to each organization. The project took a census of HP Coordinators, Chronic Disease Directors, and MTAHB, and sampled local and tribal health organizations. A list of the 53 HP Coordinators and Chronic Disease Directors (including the District of Columbia, Puerto Rico, and the U.S. Virgin Islands) served as the primary contacts for the states. As noted above, NACCHO's list of health officials served as the sample frame for the local health organizations, and the tribal health organizations were selected from a frame of 280 tribal health organization contacts provided by Indian Health Services (IHS). Finally, all12 MTAHB were selected from the list provided by IHS.

SELECTION METHODS

In addition to the census of state level respondents and MTAHB, the sampling design utilized systematic samples with equal probability of selection (within organization/agency

[2]The original sample was 520, however three respondents were serving as both the State Healthy People Coordinator and the Director of Chronic Disease within their state. Their role as Healthy People Coordinator was given precedence and these respondents were directed to answer the survey using their views as a Healthy People Coordinator.

type) and implicit stratification for the local and tribal health organization respondents. Implicit stratification involves sorting the frame by certain variables so that the sample drawn is representative of that variable. The selected sample was sorted by multiple variables, allowing the study's samples to be representative of more than one dimension. This procedure is described for both local and tribal health organizations below.

Local Health Organizations

The NACCHO list frame consisted of 3,707 records. The sample file was first sorted by central urban/other urban/rural status. The NACCHO file did not include an urban/rural status variable. Therefore, this variable was constructed for sampling using the zip code to map each organization to the county in which it resides and to determine whether the location was inside a Census defined Metropolitan Statistical Area (MSA)[3]. Additionally, the list was sorted according to Census region, Census division, state, and zip code to ensure a regionally representative sample.

Tribal Health Organizations

The tribal list frame consisted of 292 tribal health organizations, and was developed by IHS through a compilation of multiple listings and a careful review of each tribe's service type and contact information. Of the 292 entities, 12 were MTAHB and were selected with certainty for the final sample. The remaining 280 tribal entities formed the frame for the tribal health organization sample. The list was sorted by service type (Direct Service, Title I, Title V)[4], user population size (small, medium, large), region, and state. The final sample consisted of 102 tribal health organizations, and was equally distributed by region, size, and service type.

FINAL RESPONSE RATES

Exhibit 2 displays the overall response rates on the questionnaire, as well as the response rates for each key user group. Additional summary statistics for the respondent population are presented in the Study Respondents section.

[3] MSAs are geographic entities defined by OMB for use by Federal statistical agencies in collecting, tabulating, and publishing Federal statistics. A MSA contains a core urban area of 50,000 or more population.

[4] Direct Service tribes are tribes that receive services directly from IHS; Self-determining self-contracting tribes under Title I contract some services directly and receive some services from the federal government; self-governance tribes under Title V contract for most or all healthcare (and other services).

Exhibit 2: Final Response Rates

Sample Type	Sample Size	No. Received	Percent Received
***Healthy People* State Coordinators**	53	45	84.9
State Chronic Disease Directors	50	44	88.0
Local Health Organizations	300	212	70.7
Tribal Health Organizations	102	51	50.0
Multi-Tribal Area Health Boards	12	9	75.0
Total	517	361	69.8

DATA COLLECTION TECHNIQUES

The questionnaire was fielded from October 2008 until March 2009. Fielding the survey entailed mailing the questionnaire along with a cover letter to an identified staff member at each organization/agency. A self-addressed stamped envelope was included with each survey to facilitate the return of the questionnaire directly to NORC, the survey contractor. A follow-up letter was sent to non-respondents two weeks after the initial mailing, including information about completing the survey online; 26 percent of respondents completed the questionnaire online. Telephone prompting of those who had not responded began one month after the initial mailing. The telephone prompt also provided an opportunity to collect contact information for re-mailing or faxing questionnaires that had been lost or misplaced. Respondents were also given the option of completing the questionnaire over the telephone at that time; 5 percent of respondents completed the questionnaire over the telephone. Exhibit 3 indicates that for all sample types, mail was the most common mode of completion, followed by the web and then telephone.

Exhibit 3: Mode of Completion by Sample Type

Sample Type	Mail Option	Web Option	Telephone Option
***Healthy People* State Coordinators**	71%	27%	2%
State Chronic Disease Directors	61%	36%	2%
Local Health Organizations	73%	24%	3%
Tribal Health Organizations	57%	29%	12%
Multi-Tribal Area Health Boards	44%	33%	22%
Total	68%	26%	5%

Based on the 2005 User Assessment, the data collection period was anticipated to end within four months of the initial mailing being sent. However it was determined that additional time was necessary due to slower than anticipated survey response. The original follow-up protocol established a limit of eight calls for non-respondents, after which the individual case was closed and removed from further follow-up. The maximum limit on call attempts was relaxed due to the unexpected difficulty in reaching respondents during the telephone prompting. Also, a review of call logs revealed that the cases that were being closed after eight follow-up attempts included a high proportion of respondents that appeared inclined to participate in the survey[5]. Thus, during the third month of data collection this limit was relaxed and non-response cases were closed on an individual basis (after 15-25 call attempts). This resulted in a longer (yet more successful) data collection period, ending five months after the initial mailing was sent. Appendix 2 includes summary information on methodological lessons learned, which may be useful should this study be repeated.

FOLLOW UP DISCUSSIONS

Following the data collection and analysis period, NORC lead 10 informal discussions with users and non-users of *Healthy People 2010,* from each of the sample types. These discussions provided an opportunity to gather more in-depth information on issues and themes that emerged during data analysis. The discussions resulted in the collection of qualitative data that provides specific examples supporting many of the study's conclusions.

To choose respondents for follow-up discussions, NORC carefully reviewed survey responses and selected a set of respondents whose uses, perceptions, and anticipated uses of *Healthy People* varied. Selected respondents were then sent an email providing information describing the purpose of the follow-up discussions. These emails were followed by calls to answer any additional questions and to schedule the discussion.

The follow-up discussions were designed to be open-ended, each flowing differently depending on each respondent's experiences and insights. An informal discussion guide was used to ensure the appropriate broad information was gathered in response to the

[5] When reached by NORC interviewers, these respondents expressed a willingness to participate at a later time. However, follow-up attempts only reached answering machines and voice mails. Relaxing the limit on call attempts allowed interviewers to reach these willing participants.

issues and themes identified during data analysis. The informal discussion guide includes specific sections for *Healthy People 2010* users and *Healthy People 2010* non-users. A supplemental section was also developed specifically for MTAHB, to gather information on this new respondent type and how they interact with tribal health organizations. Finally, the informal discussion guide included a section on *Healthy People 2020* to capture information on participation with the development of *Healthy People 2020*, as well as perceptions on how the initiative could be improved. The information discussion guide is included in Appendix 3.

STUDY RESPONDENTS

Of the 361 respondent organizations/agencies, 12 percent were HP Coordinators, 12 percent were Chronic Disease Directors, 2 percent were MTAHB, 14 percent were tribal health organizations, and 59 percent were local health organizations. The job titles of individuals completing the questionnaire at each organization varied. The highest percent of questionnaires (59 percent) was completed by Directors or Deputy Directors, while 13 percent were managers or supervisors, and 5 percent were clinic administrators/directors. Other individuals representing the organizations included: state health planners, epidemiologists, biostatisticians, policy analysts, bureau chiefs, health educators, district health officers and public health nurses.

The set of respondent organizations/agencies appears diverse in many ways, including health care priorities, geographic locations, and size. Respondents were asked to indicate all of the health priority areas that their organization addresses. Exhibit 4 shows the health priority areas selected by over 75 percent of respondents, between 50 and 74 percent of respondents, and fewer than 50 percent of respondents. For example, over 75 percent of respondents indicated that disease prevention is a priority area for their health organization/agency. Disease prevention and public health preparedness are both areas that 85 percent of respondents selected as priorities. Exhibit 5 displays the distribution of respondent organizations according to Census region.

Exhibit 4: Priority Areas of Responding Organizations

75% or more indicate...	Between 50 and 74% indicate...	Less than 49% indicate...
Disease Prevention (85%)	Child Health (72%)	Sex/Reproductive Health (49%)
Public Health Preparedness (85%)	Environmental Health (72%)	Health Statistics (47%)
Immunization (81%)	Chronic Disease (68%)	Substance Abuse (43%)
Health Promotion (80%)	Nutrition (68%)	Unintentional Injury (37%)
	Women's Health (63%)	Primary Care (32%)
	Access to Care (63%)	Healthcare Workforce (27%)
	Health Disparities (54%)	Mental Health (24%)
	Dental Care (51%)	Disabilities (18%)
	Childhood Diseases (50%)	Long Term Care (14%)

Exhibit 5: Geographic Spread by Census Regions

	State Samples[6] N	State Samples %	Local Sample N	Local Sample %	Tribal Samples[7] N	Tribal Samples %
Northeast Region	**16**	**18**	**43**	**20**	**3**	**5**
Division 1: New England	10	11	27	13	2	3
Division 2: Middle Atlantic	6	7	16	7	1	2
Midwest Region	**21**	**24**	**62**	**29**	**15**	**25**
Division 3: East North Central	8	9	31	14	7	12
Division 4: West North Central	13	15	31	14	8	13
Southern Region	**30**	**34**	**80**	**38**	**10**	**17**
Division 5: South Atlantic	15	17	35	17	0	0
Division 6: East South Central	7	8	24	11	1	2
Division 7: West South Central	8	9	21	10	9	15
Western Region	**22**	**25**	**27**	**13**	**32**	**53**
Division 8: Mountain	15	17	15	7	14	23
Division 9: Pacific	7	8	12	6	18	30

[6] Includes both Healthy People State Coordinators and State Chronic Disease Directors.

[7] Includes both Multi-Tribal Area Health Boards and Tribal Health Organizations.

Respondents from state health organizations, local health organizations, and tribal health organizations were organized into size categories based on the size of the population served by the organization/agency[8]. Each of the size categories was derived analytically using the distribution of the population served variable for each respondent type. Three categories (small, medium, and large) were set for each respondent group, with each of the categories making up roughly 33 percent of each respondent group. Exhibit 6 below identifies parameters for each groups' size categories.

Exhibit 6: Size Parameters by Sample

Size Category	States (n=89)	Tribal Health Organizations (n=51)	Local Health Organizations (n=208)
Small	≤2 million	≤2,000	≤30,000
Medium	2-6 million	2,000-6,000	30,000-100,000
Large	≥6 million	>6,000	>100,000

DATA ANALYSIS

Data analysis focused on identifying results of the key research questions. In addition to answering this core set of questions, the analysis compared the key respondent groups and determined the extent to which certain characteristics of the organization seem to be related to the level of awareness, the level of use, the nature of use, and the kinds of barriers experienced. All analyses were conducted using SAS version 9.1 software.

STUDY LIMITATIONS

The study questionnaire was designed to be both short and simple in order to encourage the participation of busy government officials. Many questions were limited to multiple choice items. This limited the number of possible answers and may not have fully captured the variety of uses of the initiative or the varying stages of integration of the initiative into existing programs. An exhaustive questionnaire would likely have resulted in a much lower response rate. A second limitation relates to the selection of the individual to be responsible for completing the questionnaire on behalf of the respondent organization/agency. The degree to which respondents were familiar with their organization/agency's use of the initiative cannot be verified. Another limitation is the

[8] Multi-Tribal Area Health Boards were not partitioned into size categories due to their limited number.

inability to generalize some of the tribal health organization results because of the limited number of respondents. For example, while 75 percent of MTAHB responded to the survey, the actual number of respondents was only 7. Finally, no follow-up was made with respondents to verify reported information or retrieve missing data.

RESULTS

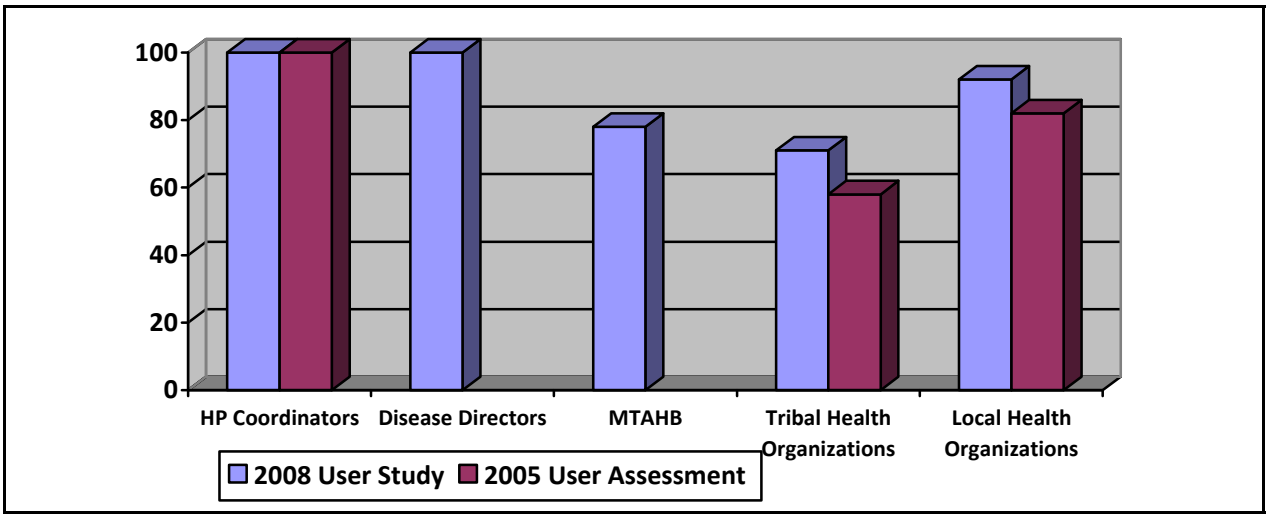
The following sections describe the results of the survey and provide answers to the study's main research questions. The results section is organized into two subsections, the first of which focuses on *Healthy People 2010*, the second on *Healthy People 2020*. Broad comparisons to the 2005 User Assessment are included in both sections. These sections are further organized according to the study's major and minor research questions.

HEALTHY PEOPLE 2010

AWARENESS

Healthy People 2010 had a high level of visibility with the responding health organizations/agencies. Overall, 91 percent of the responding organizations/agencies were aware of the initiative. This percentage shows a statistically significant increase from the 83 percent that were aware of the initiative in the 2005 User Assessment. All of the responding HP Coordinators and Chronic Disease Directors, 92 percent of the local health organizations, 78 percent of the MTAHB, and 71 percent of the tribal health organizations reported awareness of the initiative. These levels of awareness show a statistically significant increase since 2005 for local health organizations. Furthermore, while awareness is growing among local and tribal health organizations, these organizations continue to be significantly less likely to be aware of the initiative compared to state health organizations (see Exhibit 7).

Exhibit 7: *Healthy People 2010* Awareness



USE OF THE INITIATIVE

Overall, 78 percent of the 327 organizations/agencies that were aware of *Healthy People 2010* reported using the initiative. This is an increase over the 71 percent of organizations/agencies that reported use of the initiative in the previous study. One-hundred percent of the Chronic Disease Directors and MTAHB who were aware of *Healthy People 2010* reported using the initiative compared to 96 percent of HP Coordinators[9], 74 percent of local health organizations, and 43 percent of tribal health organizations. These results show a statistically significant increase in the percentage of local health organizations that reported using the initiative from the 2005 User Assessment, while also showing that states are significantly more likely than local and tribal health organizations to use the initiative, and local health organizations are significantly more likely than tribal health organizations to use the initiative. Between HP Coordinators and Chronic Disease Directors, the results indicate that all 49 responding states use *Healthy People 2010*[10]. Exhibits 8-11 display the variation of use across sample type, region, and organization/agency size. These results indicate a general tendency of higher use of *Healthy People 2010* among larger organizations.

Exhibit 8: Use of *Healthy People 2010* among Those Aware of the Initiative

Sample Type	2005 User Assessment (%)	2008 User Study (%)
***Healthy People* State Coordinators**	100	96
State Chronic Disease Directors	*Not Surveyed*	100
Local Health Organizations	65	74*†
Tribal Health Organizations	48	43‡
Multi-Tribal Area Health Boards	*Not Surveyed*	100
Total	71	77

*Local Health Organizations' reported use of HP2010 has grown significantly since at p<0.05

†Local Health Organizations are significantly less likely to use than States at p<0.05

‡Tribal Health Organizations are significantly less likely to use than Local Health Organizations and States at p<0.05

[9] Two state coordinators did not provide an answer to this question; however the respondents went on to answer the HP2010 user's questionnaire, so those states are counted as "users" in the analyses.

[10] One state did not respond to the survey, so the study cannot assert 100% usage among states.

Exhibit 9: Use of *Healthy People 2010* among Those Aware of the Initiative[11]

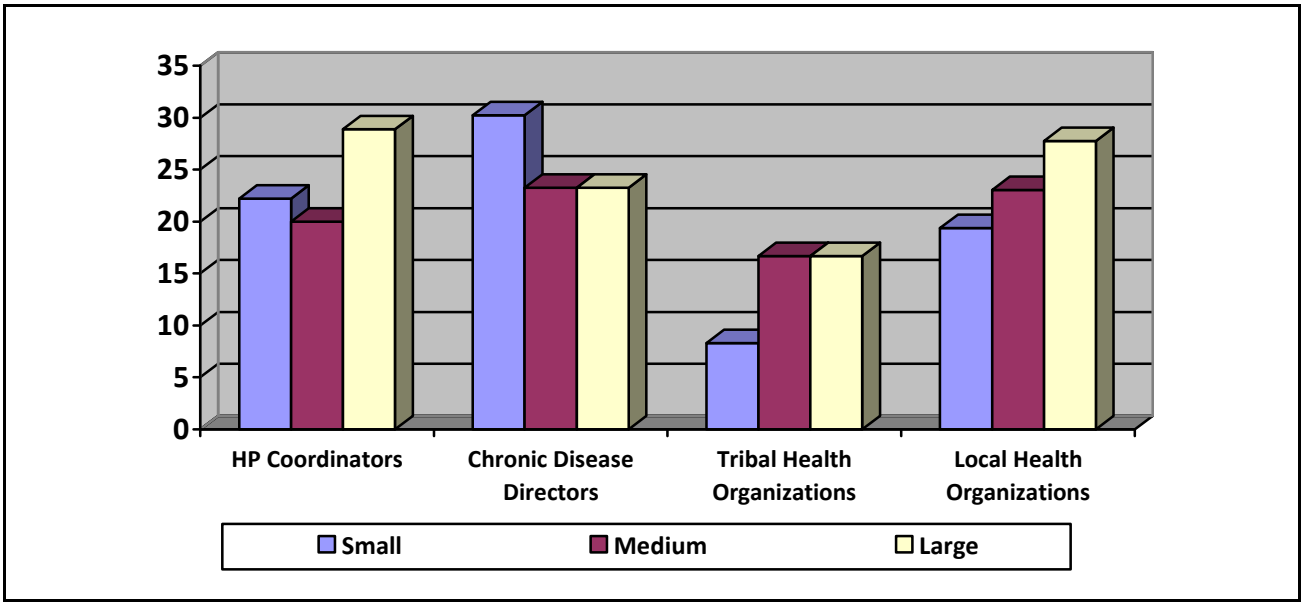
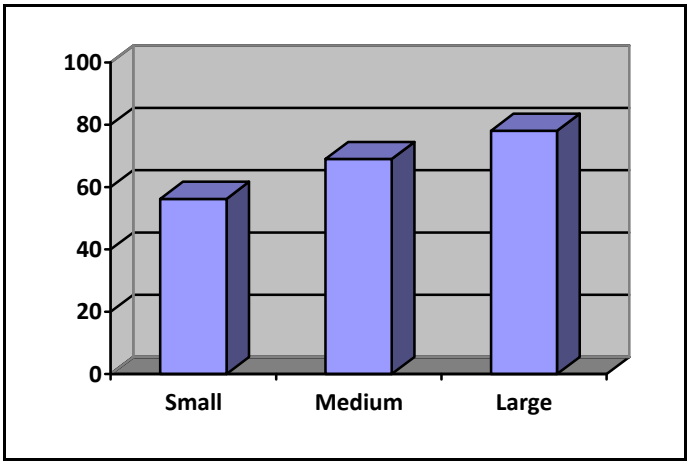
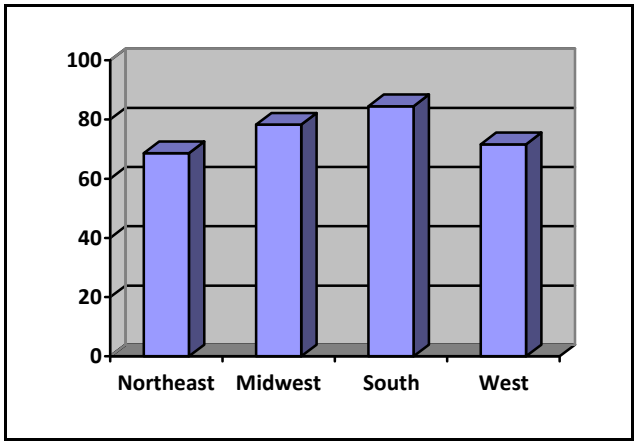


Exhibit 10: Percent of Respondents Who Use *Healthy People 2010* by Size of Population Served



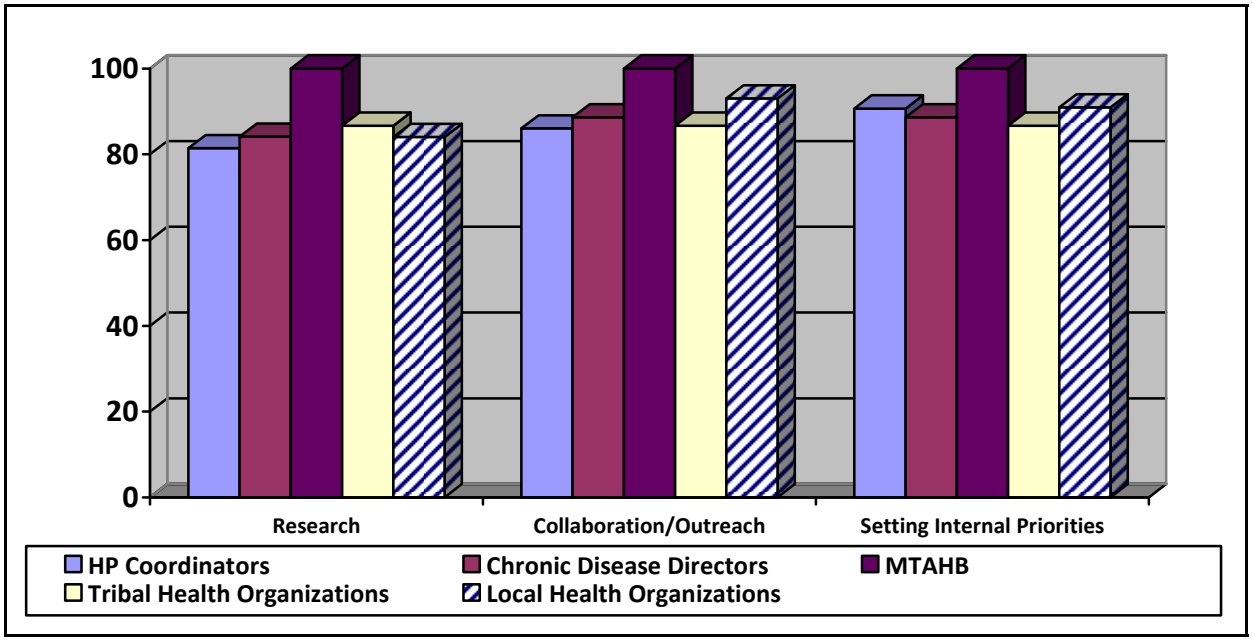
[11] MTAHB were excluded due to small sample size.

Exhibit 11: Percent of Respondents Who Use *Healthy People 2010* by Census Region



Healthy People 2010 users reported the different ways in which they use the initiative at their organization/agency in terms of use for research, collaboration and outreach, and for internal planning. Exhibit 12 presents the type of use by respondent type. MTAHB and tribal health organizations were more likely than the other organization/agency types to report using *Healthy People 2010* for research purposes. Tribal health organizations have greatly increased their use of *Healthy People 2010* for research purposes, with only 55 percent of tribal health organizations reporting use for research in 2005 compared to over 80 percent in 2008.

Exhibit 12: *Healthy People 2010* Types of Use by Organization Type



Over 81 percent of respondents in each sample type reported using *Healthy People 2010* as a data source, as well as a framework for planning, goal-setting and decision making. Organizational/agency uses also include using the initiative to help legislators and as a surveillance tool. While 85 percent of overall users reported using *Healthy People 2010* to support applications for grants or other funding and 84 percent reported using the initiative to guide priorities for the organization/agency, only 37 percent used it as a guide to set spending priorities within the organization/agency.

Variations in how the use of *Healthy People 2010* changed over time did exist among respondents in the different sample types. Approximately 40 percent of states and 47 percent of tribal health organizations reported their use of the initiative changing over time, while only 26 percent of local health organizations and 29 percent of MTAHB reported any change. Of those that did report changes in usage, the types of changes included increased use for performance measurement and priority/goal setting as well as greater use for program planning and evaluation. Many also reported increased use for forging community partnerships and coalitions and conducting community health assessments. Also noted was greater use of the *Healthy People 2010* initiative in directing and writing grant applications.

Healthy People 2010 users were asked to select the most useful aspect of the program to the organization/agency (see Exhibit 13). Both of the state respondent groups cited the specific health objectives as the most useful aspect, with the overarching program goals and leading health indicators ranking second and third, respectively. MTAHB reported leading health indicators to be the most useful aspect, while tribal health organizations cited the overarching goals as the most useful. Local health organizations also varied from the other respondent types, citing data resources and leading health indicators as the most useful; however the overarching goals and specific health objectives also received high rankings from this group.

Exhibit 13: *Healthy People 2010* Most Useful Aspect

	HP Coordinator (n=43)	Chronic Disease Director (n=44)	Multi-Tribe Area Health Board (n=7)	Tribal Health Organizations (n=15)	Local Health Organizations (n=144)
Overarching Goals	16%	16%	29%	**47%**	19%
Specific Health Objectives	**28%**	**34%**	0%	7%	17%
Data Resources	14%	9%	14%	7%	21%
Leading Health Indicators	14%	21%	**57%**	7%	**22%**
Focus Areas	12%	9%	0%	7%	6%
Participatory Goal Setting	2%	0%	0%	0%	2%
Other	14%	9%	0%	27%	11%

Healthy People 2010 users also reported on ways the initiative impacted development of new programs and expanded existing programs within their organization/agency. While all respondent types indicated they used *Healthy People 2010* to develop new programs, and expand existing programs, tribal health organizations were the only group for which *Healthy People 2010* served this role for the majority of users. Seventy-three percent of tribal health organizations have developed new programs resulting from *Healthy People 2010*, while only 37 percent of HP Coordinators, 23 percent of Chronic Disease Directors, 43 percent of MTAHB and 43 percent of local health organizations reported using *Healthy People 2010* in this manner. Similarly, 80 percent of tribal health organizations expanded existing programs. This is in contrast to the 37 percent of HP Coordinators, 41 percent of Chronic Disease Directors, 57 percent of MTAHB and 51 percent of local health organizations that indicated their organizations/agencies have expanded programs as a result of *Healthy People 2010*. Organizations/agencies were most likely to cite new or expanded programs in the areas of nutrition, physical activity and obesity, cancer, and diabetes prevention and education. In addition, several organizations/agencies mentioned new or increased programming in the area of health disparities. Exhibit 14 displays the *Healthy People 2010* focus areas that have garnered program planning by organizations/agencies. For example, 72 percent of users reported they planned programs around the nutrition and overweight focus area.

Exhibit 14: Program Planning around *Healthy People 2010* Focus Areas

51% or more planned around...	Between 25% and 50% planned around...	Less than 24% planned around...
Nutrition and Overweight (72%) Tobacco Use (72%) Immunization and Infectious Diseases (70%) Maternal, Infant, and Child Health (66%) Diabetes (66%) Physical Activity and Fitness (64%) Cancer (59%) Heart Disease and Stroke (57%) Oral Health (56%) Education and Community-Based Programs (54%) Sexually Transmitted Diseases (54%) Environmental Health (51%)	Access to Quality Health Services (49%) Family Planning (47%) HIV (47%) Injury and Violence Prevention (47%) Public Health Infrastructure (44%) Health Communication (42%) Food Safety (40%) Substance Abuse (29%)	Arthritis, Osteoporosis, and Chronic Back Conditions (22%) Respiratory Disease (21%) Vision and Hearing (17%) Mental Health and Mental Disorders (15%) Occupational Safety and Health (13%) Chronic Kidney Disease (11%) Disability and Secondary Conditions (12%) Medical Product Safety (4%)

Ninety-two percent of *Healthy People 2010* users reported they were aware of at least one objective. They were asked to indicate how relevant the objectives were to their organization/agency's work, on a scale of 1 to 5; 1 meaning not relevant and 5 meaning significantly relevant. Overall, the mean rating was 3.9. The highest percentage within each respondent type rated the relevancy of objectives at 4 or 5 (see Exhibit 15). The degree of relevancy reported in 2008 is similar to that reported in 2005. Relevancy has increased for tribal health organizations, from an average of 3.3 in 2005 to 4.3 in 2008. The reasons among those rating the objectives as highly relevant to the work of their organization/agency were that the objectives allowed for a comparison of state progress to national objectives, and the objectives assisted in planning, goal setting, and benchmarking. Among those rating the objectives as not very relevant to the work of their organizations/agencies the reasons included not having appropriate state or county level data sources to measure the objectives, objectives being too specific, and organizations/agencies lacking the resources and funds to support efforts to measure the objectives.

Exhibit 15: Relevancy of *Healthy People 2010* Objectives

1=Not Relevant 5=Extremely Relevant	HP Coordinators N=39	Chronic Disease Directors N=42	Multi-Tribal Area Health Boards N=6	Tribal Health Organizations N=13	Local Health Organizations N=126
Mean	4.2	4.1	4.0	4.3	3.7

To further assess how *Healthy People 2010* impacted organizations/agencies' program development, and the extent to which *Healthy People 2010* objectives were used, respondents were asked about program planning around specific objectives. Eighty percent of tribal health organizations reported planning programs intentionally around one or more *Healthy People 2010* objectives. This was higher than the 57 percent of Chronic Disease Directors, 54 percent of HP Coordinators, 49 percent of local health organizations and 43 percent of MTAHB reporting use for planning purposes.

MONITORING PROGRESS

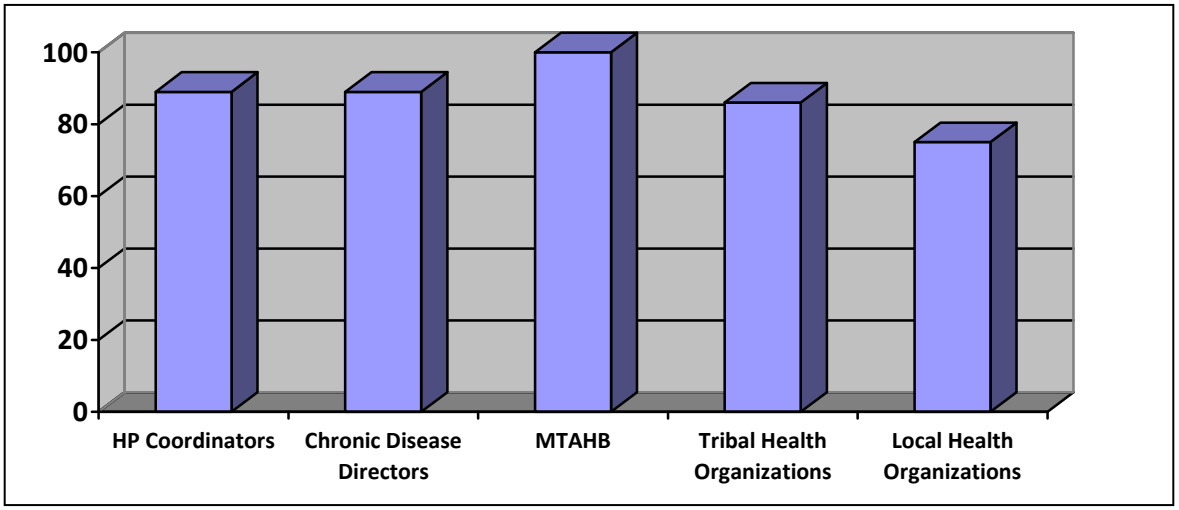
In addition to questions on current use of *Healthy People 2010*, the 2008 User Study sought to identify whether and how organizations/agencies assessed progress towards their own objectives as well as whether user organizations/agencies anticipated conducting final assessments at the end of the decade. There was variation among respondent types' likelihood of measuring changes in health behaviors or outcomes related to the use of *Healthy People 2010*. Chronic Disease Directors reported the highest likelihood of efforts to measure change at 89 percent. This is followed by HP Coordinators at 74 percent, tribal health organizations at 60 percent, MTAHB at 57 percent and local health organizations at 50 percent. Exhibit 16 shows the different methods users employed to measure changes in outcomes and behaviors related to the use of *Healthy People 2010* at the organization/agency. For state and local health organizations the most common method of measuring change was conducting an evaluation of trends, using existing data on health outcomes. MTAHB and tribal health organizations used the collection and evaluation of new data on health outcomes to measure changes in behavior or outcomes. MTAHB also reported using the collection and assessment of qualitative data, such as case studies and focus groups, to measure change.

Exhibit 16: Methods of Measuring Change

	HP Coordinators (n=43)	Chronic Disease Directors (n=44)	Multi-Tribal Area Health Boards (n=7)	Tribal Health Organizations (n=15)	Local Health Organizations (n=144)	Total (n=252)
Collection and evaluation of new data on health outcomes	23%	39%	57%	47%	25%	29%
Collection and assessment of qualitative data	2%	7%	57%	27%	8%	10%
Evaluation of trends in existing data	44%	77%	43%	40%	33%	44%

The survey also asked respondents if their organizations/agencies conducted assessments of the achievement of program goals related to *Healthy People 2010* objectives and targets. Over 70 percent of MTAHB and 60 percent of state organizations conduct such assessments, while only 47 percent of tribal health organizations and 42 percent of local health organizations conducted these assessments. Of the *Healthy People 2010* users who conducted assessments of the achievement of program goals related to *Healthy People 2010* objectives and targets, 100 percent of MTAHB, 89 percent of HP Coordinators and Chronic Disease Directors, 86 percent of tribal health organizations, and 75 percent of local health organizations found that progress toward the program goals was made (Exhibit 17). In terms of specific areas of progress, respondents were most likely to mention improvements in the areas of tobacco use, oral health, nutrition and fitness, and childhood immunization services.

Exhibit 17: Proportion Measuring Progress towards Program Goals, among Those Measuring Change



Respondents were asked whether their organization/agency planned to conduct a final assessment of progress toward objectives at the end of the decade. Forty-one percent of users did not know if their organizations/agencies would be conducting a final assessment of the achievement of program goals, while 27 percent expect to conduct a final assessment and 29 percent do not.

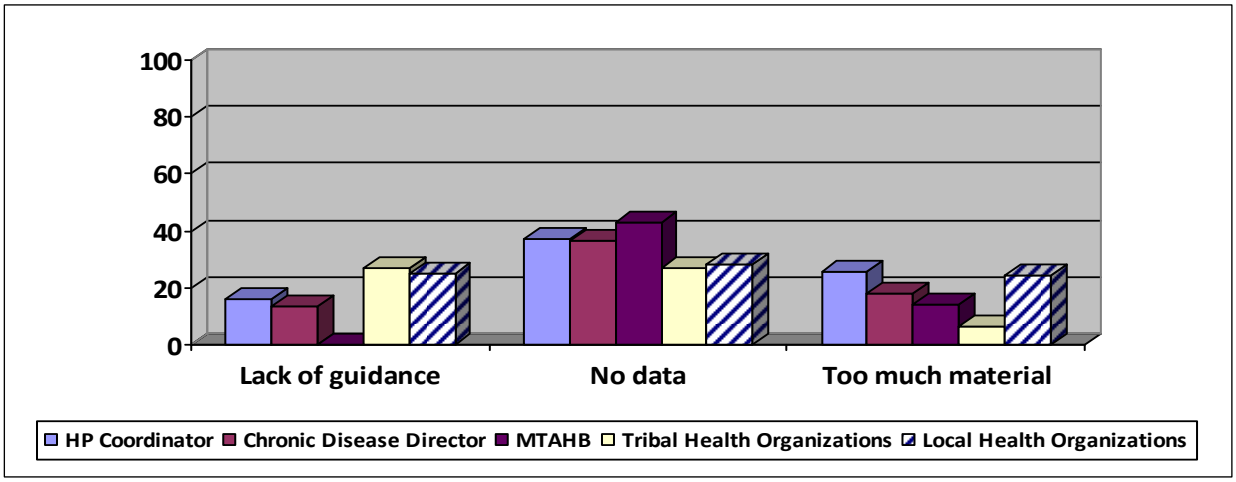
When asked for suggestions of ways HHS could encourage more progress toward the goals and objectives of *Healthy People 2010*, respondents most commonly recommended increasing funding, with an emphasis on provision of increased staff resources. Many also suggested greater guidance at the local level. In addition, several respondents requested that HHS provide more technical assistance and data analysis tools to facilitate reporting. Finally, organizations/agencies indicated they would also benefit from the dissemination of best practice guidelines and examples of programs that have been particularly successful.

BARRIERS AND RECOMMENDATIONS

Healthy People 2010 users provided feedback about the barriers they experienced to implementing the initiative within their organization/agency. Barriers were classified as being related to the *Healthy People* initiative or being related to the respondent's organization/agency. Overall, respondents were less likely to select barriers related to the initiative, as compared to barriers related to their organization/agency. In fact, barriers imposed by the initiative itself were selected by less than 45 percent of any sample type. When looking at barriers related to the *Healthy People* initiative, the most commonly reported barrier was the lack of data to track objectives (32 percent), followed by too much material (22 percent) and a lack of guidance on how to implement (21 percent). However,

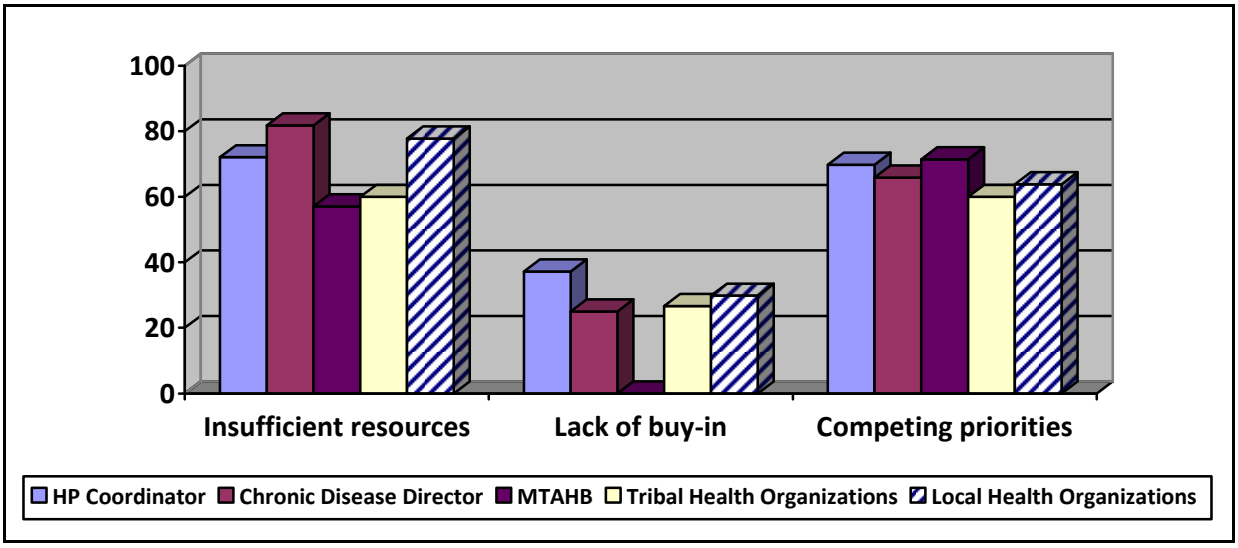
the percent of users indicating too much material, and a lack of guidance on how to implement as barriers to use has statistically significantly decreased since 2005. Exhibit 18 illustrates how each respondent type reported each of these three barriers.

Exhibit 18: Barriers Related to *Healthy People 2010*



When examining barriers related to the respondents' organization/agency overall, insufficient resources was the barrier cited most frequently (76 percent), followed by competing priorities (65 percent) and lack of buy-in from primary decision makers (30 percent). The two leading barriers (insufficient resources and competing priorities) have decreased significantly since the 2005 User Assessment. Exhibit 19 illustrates the percentage for each barrier, by respondent type. The exhibit also shows that these barriers did not vary greatly among respondent types.

Exhibit 19: Barriers Related to Organizations



In general, an organization/agency's size did not correlate with barriers to use. This was true for barriers related to the *Healthy People* initiative and for barriers related to the respondents' organization/agency. However, "lack of guidance on how to implement" was a significantly stronger barrier of use for small organization/agencies than large organizations/agencies. Thirty-two percent of small organization/agencies using *Healthy People* 2010 indicated that lack of implementation guidance was a barrier to using the initiative more, while only 16 percent of large organizations/agencies cited this as a barrier.

Healthy People 2010 users identified different types of technical assistance (TA) that they believed might improve the organization/agency's ability to further implement the initiative (Exhibit 20). When asked to select specific areas where technical assistance is needed, respondents were most likely to request technical assistance in providing examples of programs demonstrating progress towards *Healthy People 2010*'s goals, followed by examples of how other states and/or organizations/agencies use *Healthy People*. MTAHB were also likely to request guidance on collecting data to track progress toward achieving *Healthy People* objectives. Tribal health organizations also stated they would benefit from assistance with translating *Healthy People 2010* into action, and from HHS identifying individuals who can provide assistance.

Exhibit 20: *Healthy People 2010* Technical Assistance

	HP Coordinators (n=43)	Chronic Disease Directors (n=44)	Multi-Tribal Area Health Boards (n=7)	Tribal Health Organizations (n=15)	Local Health Organizations (n=144)	Total (252)
Translating *HP2010* into action	61%	61%	57%	**60%**	52%	56%
Guidance on collecting data to track progress toward *HP2010* objectives	42%	39%	**71%**	53%	49%	47%
Examples of how others are using *HP2010*	65%	57%	43%	**60%**	56%	57%
Identify HHS contacts for assistance	35%	23%	29%	**60%**	31%	32%
Using *HP2010* for partnering/coalition building	40%	25%	43%	53%	40%	38%
Examples of programs demonstrating progress toward *HP2010*'s goals	**67%**	**66%**	**71%**	**60%**	**61%**	**63%**

Respondents were also given the opportunity to comment in a "free-text" field of the survey about other ways HHS could help users progress toward reaching the *Healthy People 2010* goals. Providing increased funding led the list of suggestions in this area. Respondents specifically cited the need for funding of evidence-based interventions. Additionally, respondents reported a need for more "user friendly" materials and more technical assistance. Many also suggested that HHS provide examples of success stories of *Healthy People 2010* use.

NON-USERS OF THE INITIATIVE

Non-users of *Healthy People 2010* (n=73) were almost entirely local and tribal health organization respondents; however two HP Coordinators did indicate their organizations/agencies did not use *Healthy People 2010*. In reviewing demographic information on the organizations/agencies that do not use *Healthy People 2010,* 44 percent of small, 31 percent of medium, and 22 percent of large organizations/agencies were found to be non-users of *Healthy People 2010*. Additionally, 47 percent of respondents in the Northeast, 27 percent of respondents in the Midwest, 19 percent of respondents in the South, and 40 percent of respondents in the West were non-users of *Healthy People 2010*.

Non-users were also given the opportunity to describe through specific answer options as well as through "free-text" fields the barriers that prevent them from using the initiative. Exhibit 21 displays the distribution of responses of potential barriers listed on the questionnaire. As was true in 2005, the most frequently cited barriers relate to organization/agency issues, such as resources and competing priorities. However, nearly 60 percent of non-users cited a lack of implementation guidance as a barrier to use.

Notably, the percentages of organizations/agencies reporting each type of barrier have greatly decreased from 2005, with the top five leading barriers showing a statistically significant decrease. For example, in 2005, 93 percent of non-users reported lack of buy-in from decision makers as a barrier that prevented them from using the initiative, compared to only 40 percent in 2008. Likewise, the percentage of non-users who reported competing priorities as a barrier decreased from 93 percent in 2005 to 67 percent in 2008. Issues related to the *Healthy People* initiative itself have also decreased as barriers to use. In 2005, 63 percent of respondents indicated that "too much material" was a barrier. This percentage has gone down to 40 percent in the 2008 User Study. Similarly, the percent reporting that lack of guidance on how to implement as a barrier to use decreased from 76 percent in 2005 to 56 percent in 2008.

Exhibit 21: *Healthy People 2010* Non-User Barriers

Issues Related to Organization/Agency:	2005 User Assessment	2008 User Study
Insufficient resources available*	96%	86%
Competing priorities *	93%	67%
Lack of buy-in from decision-makers*	93%	40%
Issues Related to *Healthy People* Initiative:	**2005 User Assessment**	**2008 User Study**
Lack of guidance on how to implement*	76%	56%
Too much material*	63%	40%
No data to track objectives	*Not asked*	34%
Too close to end of timeframe	*Not asked*	14%
Don't agree with *HP2010* priorities	3%	3%
Too little material	12%	0%

* Indicates that 2005>2008, p≤.05

Further information regarding barriers to use was gathered through respondents' answers to questions about the number of focus areas and objectives in *Healthy People 2010* (Exhibit 22). Both of the HP Coordinators who were non-users of *Healthy People 2010* indicated that there were too many focus areas and objectives. Forty-five percent of the local and tribal health organizations had no opinion about the number of focus areas, while 31 percent said there are too many, 18 percent said there is an appropriate number, and one respondent reported too few focus areas. Respondents felt similarly about the number of objectives; 51 percent had no opinion, 28 percent reported too many, 14 percent said it was the appropriate number, and 3 percent reported too few. When asked about the organization of objectives in *Healthy People 2010*, 60 percent had no opinion, 18 percent indicated reorganization would be useful, and 16 percent reported it is appropriately organized.

Exhibit 22: Non-Users' Opinions on Number of Focus Areas and Objectives (Local and Tribal Health Organizations)

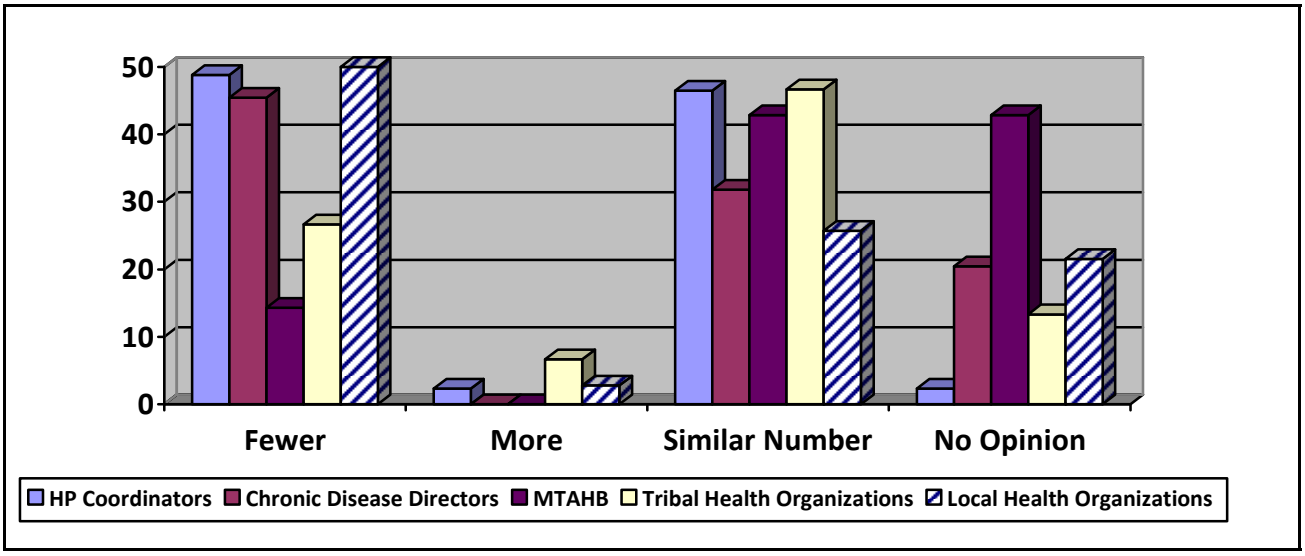
	Focus Areas	Objectives
Too many	31%	28%
Appropriate number	18%	14%
Too Few	1%	3%
No Opinion	45%	51%

To gather a more complete understanding of how *Healthy People* could better meet the needs of its target audiences, non-users were asked to specify which framework(s) their organization/agency does use to set health objectives. Tribal health organizations reported reliance on tribal council strategic planning and IHS priorities. Two tribal health organizations specified the Indian Health Services Manual as a framework used by their organization/agency to set health objectives. Local health organizations cited community assessments and community health improvement plans as well as Board of Health Guidelines, the Public Health Competency Handbook, the United Health Care Foundation Index, the Public Health Core Priorities, and NACCHO's protocol for assessing community excellence in environmental health. Non-users were also asked if they felt *Healthy People 2010* was lacking in some way, and 19 percent indicated they did. Specifically, these non-users cited a lack of funding for implementation and follow-up, and non-applicability to local and small jurisdictions as ways in which *Healthy People 2010* was lacking.

HEALTHY PEOPLE 2020

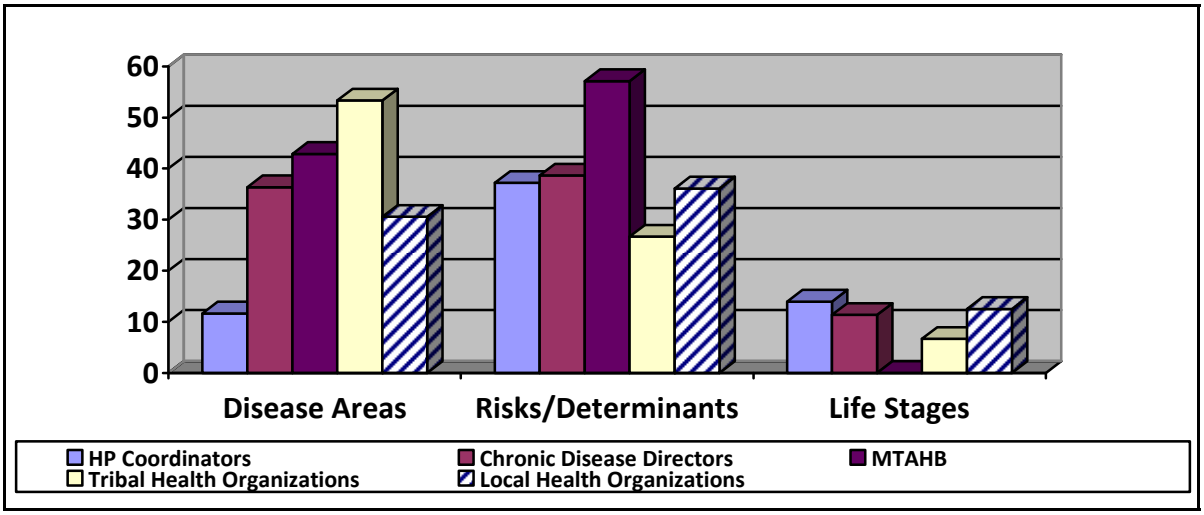
The survey provided respondents with an opportunity to submit information to help in the development of *Healthy People 2020*. *Healthy People 2010* users were asked their opinions on the number of focus areas that they would like to see in *Healthy People 2020*. Overall, 47 percent of *Healthy People 2010* users felt that fewer focus areas should be included, 32 percent felt that there should be no change in the number of focus areas and only 2 percent felt that there should be more focus areas as compared to *Healthy People 2010*. Exhibit 23 illustrates *Healthy People 2010* users' views on the number of focus areas that should be included in *Healthy People 2020*, as compared to *Healthy People 2010*. There was no significant difference across respondent type regarding whether or not the number of focus areas should be changed.

Exhibit 23: Opinion on Number of Focus Areas to include in *Healthy People 2020*



Users were then asked about the organization of *Healthy People 2020.* Sixty-nine percent indicated that a reorganization of *Healthy People* would be useful for the next iteration. When asked which format for organizing objectives would be most useful 37 percent of *Healthy People 2010* users felt it would be most useful to reorganize by risks/determinants, 30 percent felt it would be most useful to reorganize by disease area and 12 percent felt it would be most useful to reorganize by life stages. Tribal health organizations appear to differ in their opinion of which type of reorganization of *Healthy People* would be most useful. The majority of HP Coordinators, Chronic Disease Directors, MTAHB and local health organizations indicated it would be most useful to reorganize by risks/determinants while the majority of tribal health organizations felt that it would be most helpful to reorganize by disease area. As was true overall, each respondent type indicated that life stages would be the least popular way of organizing *Healthy People*. These results are shown in Exhibit 24.

Exhibit 24: Format for Reorganization



Both users and non-users of *Healthy People 2010* were asked about their organization/agency's anticipated use of *Healthy People 2020* (Exhibit 25). Overall, *Healthy People 2010* users reported that they are most likely to use *Healthy People 2020* as a framework for planning, goal-setting or decision making (79 percent) and for guiding organizational priorities (74 percent). *Healthy People 2010* users report that they are least likely to use *Healthy People 2020* as a guide to set spending priorities within their organization/agency (42 percent). Anticipated use of *Healthy People 2020* among non-users of *Healthy People 2010* ranged from 13 percent (guide to set spending priorities) to 35 percent (mechanism for building community partnerships).

Exhibit 25: Anticipated Uses of *Healthy People 2020*

	HP2010 Users	*HP2010* Non-Users
Framework for planning, goal-setting, or decision making	79%*	32%
Guide priorities for organization/agency	74%*	31%
Mechanism for building community partnerships	68%*	34%
Model for participatory goal setting	53%*	22%
Guide to set spending priorities in organization	42%*	14%

*p<0.05

When examining anticipated uses of *Healthy People 2020* by respondent type, some differences did exist among users of *Healthy People 2010:* tribal health organizations and MTAHB were more likely than others to anticipate using *Healthy People 2020* to guide priorities for their organization/agency; MTAHB were also more likely than the other groups

to anticipate using *Healthy People 2020* as a mechanism for building community partnerships; tribal health organizations were more likely than any other to anticipate using *Healthy People 2020* as a guide to set spending priorities in their organizations; and tribal health organizations were significantly less likely than all other groups to anticipate using *Healthy People 2020* as a framework for planning, goal setting or decision making.

Exhibit 26: Anticipated Uses of *Healthy People 2020* by Respondent Type

	HP Coordinators	Chronic Disease Directors	Multi-Tribal Area Health Boards	Tribal Health Organizations	Local Health Organizations	Total
Framework for planning, goal-setting, or decision making	**72%**	**80%**	**100%**	67%	**81%**	**79%**
Guide priorities for organization	63%	68%	86%	**80%**	78%	74%
Mechanism for building community partnerships	63%	57%	86%	67%	72%	68%
Model for participatory goal setting	51%	48%	57%	67%	54%	53%
Guide to set spending priorities in organization	33%	41%	43%	60%	44%	42%

When looking at anticipated use by region and by organization/agency size, few differences existed. *Healthy People 2010* users in the northeast were more likely than users in other regions to anticipate using *Healthy People 2020* to guide organizational priorities or as a guide to set spending priorities, and *Healthy People 2010* users in the west were substantially less likely to anticipate using *Healthy People 2020* as a mechanism for building community partnerships. *Healthy People 2010* users in large organizations/agencies were less likely than those in mid size or small organizations/agencies to anticipate using *Healthy People 2020* as a guide to set spending priorities.

Both users and non-users were asked to share additional comments about ways HHS could improve the next iteration of *Healthy People*. Users of *Healthy People 2010* suggested making more technical assistance resources available, and making the web site more user-friendly. Non-users recommended that HHS focus on local applicability and implementation issues.

DISCUSSION

The 2008 *Healthy People* User Study results enhance our understanding of the awareness and use of *Healthy People 2010*, provide information to aid in the development of strategies for improving the utility of *Healthy People* to state, local and tribal health organizations/agencies, and provide valuable feedback as HHS develops *Healthy People 2020*. In analyzing the key findings of this study, eight important conclusions were identified:

1) Awareness and use of *Healthy People* has grown over time, but there continues to be a need for targeted efforts directed toward local and tribal health organizations.

2) The vast majority of *Healthy People 2010* users do not utilize the initiative as a guide for setting spending priorities at their organizations. Rather, spending priorities are determined by available funding mechanisms, which may not be aligned with *Healthy People* goals. Efforts to align *Healthy People* goals and funding resources for state, local, and tribal health organizations may help overcome this barrier.

3) User groups utilize *Healthy People* differently and for different purposes. These variations indicate that there may be opportunity for expanded use of the initiative as users learn of other users' *Healthy People* activities. The variations also indicate there is a continued need for targeted outreach efforts to support expansion of *Healthy People* utilization.

4) Barriers to use or increased use of *Healthy People* are primarily attributed to organizations/agencies, rather than the *Healthy People* initiative itself. This distinction may be useful when developing outreach efforts to encourage greater use of the initiative.

5) The absence of implementation guidelines is the leading barrier to use among non-users of *Health People*. The extent to which this is a barrier shows an important unmet need by the initiative.

6) In addition to outreach to tribal health organizations, MTAHB's appear to be an effective avenue for communication with tribal health organizations.

7) Chronic Disease Directors have similar levels of awareness and use of *Healthy People* as HP Coordinators, indicating that Federal outreach to states is effective beyond HP Coordinators.

8) To further improve *Healthy People* and its usability, *Healthy People 2020* should include implementation guides and evidence-based practices, and HHS should increase communication with stakeholders to ensure users are aware of the spectrum of uses of *Healthy People* (rather than users continuing to use *Healthy People* only in the ways previously established by their organization/agency).

AWARENESS AND USE OF *HEALTHY PEOPLE 2010*

The results from the 2008 User Study indicate that *Healthy People 2010* is a highly visible initiative—with awareness of the initiative among responding organization/agencies increasing between 2005 and 2008. This increase appears to be due to a rise in awareness among local and tribal health organizations and may be related to the aforementioned focused outreach efforts undertaken by HHS and its partners since the 2005 study. Degree of use among those aware of the initiative also increased from 71 percent in 2005 to 77 percent in 2008. Although tribal and local health organizations continue to be less likely to use the initiative than states, there have been gains in use among the local health organizations. These results suggest that recent efforts on the part of HHS to target outreach to local groups and to disseminate implementation tools have been effective in encouraging local usage of *Healthy People 2010*. The gains in awareness and use seen by local and tribal health organizations may also be related to concurrent work by these organizations/agencies to develop their capacity to implement programs that cross specific disease and behavior areas like *Healthy People 2010* does. In fact, tribal health organizations were substantially more likely than the other sample types to report that *Healthy People 2010* resulted in the development of new programs and the expansion of existing programs. HHS should continue its focused outreach and dissemination efforts to these groups.

Specific uses of *Healthy People 2010* remained largely unchanged between 2005 and 2008. The 2008 results continue to show that the percentage of respondents reporting that they use the initiative as a guide to set spending priorities is low. This finding identifies a potential barrier to the initiative's effectiveness since it may not be reasonable to expect that organizations/agencies will achieve outcomes related to the *Healthy People 2010* objectives if they are not using the initiative to direct funding within their organization/agency. In a follow-up discussion with a HP Coordinator who does not use *Healthy People 2010*, the respondent explained "Since the health department receives 80 percent of funding from grants or reimbursement, we're driven by funding agencies, so basically we do whatever we're told to do based on funding. So everything goes back to funding. When staff applies for funding, they don't go to *Healthy People 2010*, they go to documents from the funding agencies and submit a grant application that is built on the needs of the funding agencies." This HP Coordinator's experience is consistent with the reality that external funding availability may drive priorities for programming, rather than the overall priorities of *Healthy People 2010*. If the priorities of the funding organizations are not consistent with *Healthy People 2010 goals*, there may be an impediment to meeting the goals and objectives of *Healthy People 2010*.

AWARENESS AND USE ACROSS RESPONDENT GROUP

In the 2008 User Study input from tribal health organizations was expanded to include a larger number and a greater mix of tribal health organizations, thus increasing the precision and reliability of the 2008 findings for this sample type. Tribal health organizations indicated a higher rate of awareness of *Healthy People 2010* in 2008 than in 2005. However, this awareness did not translate into increased use of the initiative. This suggests that the aforementioned HHS outreach efforts were successful in increasing knowledge about the initiative but there remains a need for resources and tools to help translate this knowledge into action among this target audience.

Furthermore, responses from the tribal health organization sample indicated that the 2005 conclusion that tribes use *Healthy People* in a manner uniquely to that of state and local organizations/agencies was affirmed. Tribal health organizations cited the overarching goals as the most useful aspect of the initiative; an aspect the other respondent types considered the *second* most useful. Tribal health organizations were also the only respondent type for which *Healthy People 2010* has resulted in the development of new programs and expansion of existing programs *for a majority* of the respondents, and were more likely than the other respondent types to report that they plan programs intentionally around the *Healthy People 2010* objectives. Additionally, tribal health organizations reported the highest degree of relevance between the *Healthy People 2010* objectives and the organization's work.

These findings are particularly interesting for two reasons. First, they confirm that tribal health organization users experience *Healthy People* in a different way than state and local organizations/agencies. Recognizing this unique use of *Healthy People* may enable HHS to better respond to the needs of tribal health organizations. Tribal health organizations may be a constituent group that is very ready to use *Healthy People* but, they also need more targeted assistance for developing and executing implementation plans, identifying what data sources are available to them, and determining how the existing *Healthy People* objectives can be made applicable to their organization/agency.

Second, the results suggest that state and local health organizations use *Healthy People* in a way that builds on previous, established efforts. This is an important note for the implementation of *Healthy People 2020*, as HHS may need to consider implementation campaigns that will inform users of new ways of incorporating *Healthy People* into their work, rather than having users rely only on their previous experiences with *Healthy People*. For example, in a follow-up discussion, one local user of *Healthy People 2010* stated, "You have to take the book for what it is. It gives baselines, tells you where you need to be and

where you are in comparison." Like many state and local users, this respondent's organization/agency has been utilizing *Healthy People 2010* as a benchmarking tool, with less utilization for program planning or expansion.

The results gathered from the tribal health organizations were instrumental in providing information on the unique tribal health organization uses of *Healthy People*, however additional insights on the tribal health community's relationship with *Healthy People* was gathered from the responses provided by MTAHB. More than three-quarters of these MTAHB were aware of *Healthy People 2010* and, as was true for state organizations, 100 percent of the MTAHB that were aware of *Healthy People 2010* reported use. This high degree of usage suggests that MATHB may be viable networks through which to disseminate information and increase use of *Healthy People 2010* among tribal groups. This finding validates IHS's conclusion that these boards may be a useful mechanism for working and communicating with tribal health organizations.

Follow-up discussions with MTAHB as well as with tribal health organizations provided additional information on how the two sample types interact and how *Healthy People* can better meet the needs of tribal health organizations. In conducting discussions with one MTAHB that does use *Healthy People 2010,* and one that is not aware of the initiative, we found that the MTAHB's role in tribal health varies depending on the board's and tribe's structures. The MTAHB using *Healthy People 2010* was highly involved in the tribes' health program planning and implementation. The respondent explained that the MTAHB "works with tribes to: do community assessments and needs assessments, locate resources, funds, and training opportunities, and implement programs in each local community. [The MTAHB] provides overall coordination and management, as well as technical assistance - taking on the administration load, and letting tribes go to work." In contrast the MTAHB unaware of *Healthy People 2010* explained that each tribe conducts its own health programs, and the board serves as more broad oversight. This variation in roles indicates that outreach to tribal health organizations can be complex, but communication to MTAHBs can be vital for reaching them.

The 2008 User Study was also expanded to include a second state sample, Chronic Disease Directors. Though not directly involved with *Healthy People* this is a position within the state agency that is likely to be impacted by *Healthy People* goals. The results of the study indicate that information regarding the *Healthy People* initiative is in fact getting to these individuals—with 98 percent of them reporting awareness of the initiative and 100 percent of those who were aware reporting use. Perhaps not surprising, the responses for the Chronic Disease Directors did not substantially differ from HP Coordinators on any question. These results suggest that knowledge of the initiative is organization-based, not

role-based at the state level. Given the similarity of their user profile future studies of *Healthy People* use may eliminate the Chronic Disease Director sample for reasons of cost.

Finally, the results of the current study can be helpful to policymakers in clarifying which aspects of the *Healthy People* initiative are most useful to various constituent groups. Specific aspects of *Healthy People 2010* considered *most useful* varied by respondent type. HP Coordinators and Chronic Disease Directors cited that the most useful aspect of the initiative was its identification of specific health objectives. MTAHB reported leading health indicators as most useful, and tribal health organizations cited overarching goals as most useful. Local health organizations further differed from the other respondent types by indicating that the leading health indicators and data resources were the most useful aspects of *Healthy People 2010*. These results suggest a call for a variety of outreach and support efforts, while also emphasizing the diverse needs of users, to be met by *Healthy People 2020*.

BARRIERS TO USE

In both 2005 and 2008, users of *Healthy People 2010* were most likely to cite barriers related to their organization/agency as opposed to barriers related to *Healthy People 2010* when asked about issues preventing their organizations/agencies from using *Healthy People 2010* more. These findings are not surprising, but are very important to note when considering the difficulties encountered by *Healthy People* audiences and the appropriate mechanisms for addressing these difficulties. One mechanism by which HHS could increase familiarity and use of the *Healthy People* initiative is by funding micro grants directed towards *Healthy People 2010* use, as they have in the past. In the event that providing direct funding to these organizations/agencies may not be an option for HHS, another suggestion is for HHS to use its resources and influence to increase exposure of the *Healthy People* initiative to other potential funders and key stakeholders including state legislatures. For barriers related to the initiative itself, the most commonly reported barrier for users overall was lack of data to track objectives. Future research could seek to gather information on particular focus areas and/or objectives where more data is needed. This information could then be used to aid in the identification of the health objectives (sub-objectives and developmental objectives) and data sources to be included in *Healthy People 2020*.

As in 2005, non-users of the initiative were comprised almost entirely of local and tribal health organizations. Specific reasons for non use mirror the barriers faced by users of the

initiative—organization/agency issues such as limited resources in terms of staffing and funding, and competing priorities continue to top the list, though at notably lower levels than in the 2005 User Assessment. However, unlike the findings of the 2005 User Assessment, a lack of implementation guidance and the amount of materials (too much material) also received a large response from non-users in the 2008 User Study. These barriers are directly related to *Healthy People* and should be considered when assessing areas of improvement to target for the next iteration. Non-users and users alike would benefit from increased technical assistance focused on translation and comprehension of the materials. Also, it may be helpful for HHS to develop and disseminate more implementation and data collection tools that could be used to help organizations/agencies utilize the initiative. The anticipated usefulness of these types of tools and guides were highlighted in a number of follow-up discussions. One *Healthy People 2010* local user said "If there is a way to include a section in each topic area on some best practices for implementation that would be wonderful. It would be helpful without costing us anything." Another local user asked for the inclusion of real examples, saying it is "always useful to see what others do, even though we will have to morph it to fit our community. But it would be an opportunity to see other creative thinking, and an opportunity to provide information on things we have done well."

IMPLICATIONS FOR *HEALTHY PEOPLE 2020*

The findings contained within this report are useful in informing the assessment, development, and implementation of *Healthy People 2020.* The variations in use reported above parallel the distinct and competing opinions regarding the organization of *Healthy People* and the number of focus areas and objectives that should be included in *Healthy People 2020*. In sum, there is no clear consensus from *Healthy People* 2010 users about how to organize *Healthy People 2020*, or how many areas to include within any organizational format. These findings mirror discussions that have occurred in the *Healthy People 2020* Federal Interagency Workgroup, the Secretary's Advisory Committee on Disease Prevention and Health Promotion Objective for 2020, and across the regional meetings hosted by ODPHP in 2008.

Together these findings and discussions suggest that *Healthy People* is utilized by different people in different ways, and these differences make aspects of the initiative more or less useful depending on the audience. To serve the various needs of different stakeholder groups, *Healthy People 2020* should be a dynamic initiative that enables users to continue having access to the aspects of the initiative that help them support movement towards meeting the national health goals. This conclusion supports the decision to

develop *Healthy People 2020* using a two-pronged approach which addresses risk factors and determinants of health, as well as specific conditions/disease areas. The results additionally support the development of a web-based format for *Healthy People 2020*, which will enable users to more easily link objectives, and connect to implementation strategies and evidence-based practices.

To further improve the *Healthy People* initiative, users would benefit from the inclusion of implementation guides and evidence-based practices and interventions. The addition of these materials would provide users with information to help their resources stretch further, while expanding the use of programs, policies, and interventions shown to be effective. The need for these materials is conveyed in the previously described requests by local users. The need for evidence-based practices and implementation guides was also made apparent by one user at the state level who explained, “An evaluation component is missing from *Healthy People 2010*. Planning is not evidence based. There are initiatives out right now to evaluate planning. Value would be added if certain components of planning could be evaluated with evidence based science. There has been discussion for a web site with evidence based interventions to go with objectives. There should be a component of *Healthy People* objectives with proven effective interventions. Such a link to the interventions to meet the goals would be a big help.”

Finally, increased and more efficient communication between HHS and *Healthy People* stakeholders could provide users with a more complete understanding of *Healthy People* and the tools it provides. From the follow-up discussions we found very little engagement in the development process for *Healthy People 2020*, even among the users of *Healthy People 2010*. Of the ten discussions that took place, only two spoke of participation in the *Healthy People 2020* process, one of which was minimal (periodic notices through APHA). While this could be a call for increased communication and outreach efforts, HHS should be heartened to know that many of the changes they are pursuing for *Healthy People 2020* are highly sought by the initiative’s key audiences. The MTAHB user explained “we find ourselves drawn more and more to environmental issues. We really like the Social Ecological Models. We talk about determinants of health, so I think everybody would like to see a broader emphasis that way.” A local user stated that “the whole emphasis on social determinants of health is really taking off in our community. People are really starting to see connections, and anything 2020 can do to support that would be great.” Additionally, a local non-user of *Healthy People 2010* requested a disaster preparation and management area of focus, to support his organization/agency’s work in that area. HHS is already working to include, and even emphasize these areas in *Healthy People 2020*, though more outreach may be needed to inform key audiences of these updates.

The study results indicate the importance of building on past *Healthy People* iterations and demonstrate that within all organization/agency types, both users and non-users have an interest and a willingness to work with HHS to bring about even greater implementation of the *Healthy People 2010* and *Healthy People 2020* initiatives.

FUTURE RESEARCH

Given the important timing of this study in terms of the release of *Healthy People 2020*, several follow-up studies and dissemination activities should be considered.

1. *Targeted assessment of prior outreach efforts.* Following the 2005 User Assessment, HHS engaged in outreach activities to encourage broader involvement with the *Healthy People* initiative. Targeted assessment of those outreach efforts using qualitative data collection such as discussions with regional health administrators and participating organizations would help determine how well those efforts were experienced by the key stakeholders. Such information could be useful for planning outreach activities in support of *Healthy People 2020*.

2. *Repeat the User Study early in the next decade*. Planning for *Healthy People 2020* has utilized a more inclusive approach than past iterations. Users may be more aware of the process and engaged in the final product. Further, the development activities emphasize the importance of implementation activities to motivating the nation. Repeating the User Study early in the decade will provide valuable insight into how the new initiative is perceived by key stakeholders and assess whether newly developed implementation tools are reaching end users. By conducting it early in the decade, a new User Study will facilitate refinement of the implementation activities. Lessons learned regarding the methodology and scope of the 2008 User Study can be found in Appendix 2.

3. *Dissemination of the findings from the 2008 User Study*. The results of the 2008 User Study indicate broad support for *Healthy People* among key target audiences, and continued growth in terms of the breadth and depth of how *Healthy People* is used. HHS should celebrate the success of this important initiative. Further, the opinions and suggestions for the format and scope of *Healthy People 2020* parallel many ideas being put into process by HHS. While the 2008 User Study was not developed to assess stakeholders' views on decisions for *Healthy People 2020,* the results indicate that *Healthy People 2020* will be improved in ways important to key stakeholders. This finding should be explored for further

dissemination as another avenue for engaging stakeholders and emphasizing their importance to the *Healthy People* initiative and its development.

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