Assessment of the Uses and Users of HealthierUS and Healthy People 2010

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Executive Summary

Background

The Office of Disease Prevention and Health Promotion (ODPHP) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services (HHS) were interested in surveying state, local, and tribal organizations about their uses of two federal initiatives aimed at improving the health of the U.S. population: HealthierUS and Healthy People 2010 (HP2010). ODPHP and ASPE contracted with NORC to conduct this assessment. The study provides HHS with information regarding the utility of the two programs and strategies for improving the usefulness of the initiatives to state, local, and tribal organizations.

Prior to this study, information about the uses and users of HealthierUS and HP2010 was limited. Though information about both initiatives had been disseminated through various mechanisms including websites, published materials, and other efforts, there was little information available about how organizations use the initiatives concurrently with existing programs to improve health. This assessment investigates the reasons why organizations use or do not use these initiatives. This assessment also provides the information necessary for HHS to make planning decisions, as well as highlights effective strategies that can assist the greater public health community in working towards the nation's most important disease prevention and health promotion goals. The main research questions this study addressed are outlined below.

- What are the organizational characteristics of users and non-users?
- Are organizations aware of HealthierUS, and if so, how are the organizations using the initiative?
- What are the reasons that organizations are not using HealthierUS?
- Are organizations aware of HP2010, and if so, how are the organizations using the initiative?
- What are the reasons that organizations are not using HP2010?

Methods

This assessment included one mailed self-administered questionnaire (SAQ), which was sent to 301 members of state, local, and tribal health organizations. The survey's response rate was 78 percent, resulting in a final sample of 235. Survey results were then summarized within and across organization type. The survey was designed to ascertain how state, local, and tribal health organizations use HealthierUS and/or HP2010. In order to obtain more information regarding HealthierUS and HP2010 from users, NORC conducted follow-up telephone interviews with a sample of 26 survey respondents. Key questions centered on the means of obtaining information from HHS, use of DATA2010[1], Regional Health Administrator (RHA) involvement[2], and integration of HealthierUS and HP2010.

Results: HealthierUS

Overall, awareness of the HealthierUS initiative was high, especially given that the program is in the early stages of implementation. Fifty-three percent of the 235 respondents reported that they were aware of the HealthierUS program. Of those 124 organizations aware of the HealthierUS initiative, slightly less than half,

[1] DATA2010 is an interactive online database that includes the most recent national and selected state data for tracking the HP2010 objectives.

[2] The U.S. Department of Health and Human Services operates ten regional offices across the nation. Each office is directed by a Regional Health Administrator.

or 47 percent, reported using the initiative. This included 27 responding states, or 71 percent of states aware of the initiative, compared to only 38 percent (n=28) of responding local health organizations and 31 percent (n=5) of responding tribal organizations aware of the initiative.

Respondents reported using HealthierUS for outreach and collaboration more often than for internal planning at the organization. Overall, HealthierUS users considered the initiative relevant to the work performed at their organization. Users were also asked to identify the most useful aspect of the HealthierUS initiative to the organization. Media campaigns, promotion of physical activity, and promotion of preventive health were cited most frequently by state and local users. Eighty percent of the responding tribal users selected the promotion of physical activity as the most useful aspect.

Forty-four percent of HealthierUS users (n=25) reported using the initiative to develop new programs such as a partnership with community-based organizations for nutrition education, and 26 users reported expanding existing programs as a result of using HealthierUS at their organization. Furthermore, several HealthierUS users also reported planning programs intentionally around one or more of the four HealthierUS pillars (physical activity, nutrition and diet, preventive health, and healthy choices).

The questionnaire asked HealthierUS users to think about issues that might prevent the organization from using the initiative more. Responses fell into two categories; those related to the program itself, and those related to the organizations. Users overwhelmingly cited barriers at the organization, such as shortages of staff and financial resources. Only a small minority of respondents, less than four percent, cited problems with the initiative's priorities, and nearly 50 percent cited problems with the amount of program material. A significant proportion of users said that the initiative lacks implementation guidance.

Most users (> 80%) reported a lack of financial and staff resources as a barrier to greater implementation of HealthierUS at their organization. Tribes were the only group to have a majority of users report a lack of buy-in from primary decision makers as a major barrier (80%). Competing priorities were also frequently reported.

Sixty respondents from states, localities, and tribes identified their organization as a non-user of HealthierUS. Much like the barriers noted by users of HealthierUS, the 60 non-users cited the lack of staff resources (97%), financial resources (93%), and competing priorities (92%) as the top reasons why their organization does not use HealthierUS.

Results: HP2010

Overall, 83 percent of the respondent organizations were aware of the initiative. All of the responding states, 84 percent of the local health organizations, and 60 percent of the tribal health organizations reported awareness of the initiative. Tribes were statistically less likely to be aware of the initiative compared to both local and state health organizations

Overall, 71 percent of the 189 organizations aware of HP2010 reported using it in their organization. One-hundred percent of the responding states reported using the initiative compared to 65 percent of local organizations, and 48 percent of tribes. HP2010 users reported the different ways in which they use the initiative at their organization in terms of use for research, collaboration and outreach, and for internal planning. Specifically, HP2010 was used regularly to guide organizational priorities and as a framework for planning, goal-setting and agenda-building with over 80 percent of respondents reporting to use the initiative for those purposes.

The HP2010 initiative was viewed by users as highly relevant. The initiative scored slightly lower on a similar scale for effectiveness. HP2010 users were asked to select the most useful aspect of the program to the organization. Both states and localities cited the specific health objectives as the most useful aspect, with the overarching program goals ranking second. Tribes differed significantly, citing the participatory goal setting process more frequently than any other aspect.

The Healthy People initiative was used for program development and expansion at all different types of responding organizations. The types of program activities were diverse, but varied little depending on an organization's type, size, or location. Sixty-five percent of state users (n=26) reported planning programs specifically around one or more of HP2010's focus areas or objectives. This was significantly higher than the 42 percent of local users (n=33) and 27 percent of tribal users (n=3). The states reported using HP2010 objectives as elements in the organization's strategic planning and goal-setting for various departments and program areas. Local and tribal users cited examples of program planning around focus areas more frequently than key objectives.

HP2010 users provided feedback about the barriers to greater implementation of the initiative at their organization. The lack of implementation materials was the only barrier cited that relates to the initiative itself. More users reported organizational issues as barriers. Over 70 percent of users at the state, local, and tribal level cited a lack of financial resources, staff resources, and competing priorities as barriers. State users differed from local and tribal users, both of whom cited a lack of buy-in from primary decision makers as a barrier ($p \leq .05$).

Non-users of HP2010 in the sample were comprised entirely of local and tribal respondents, and they were more often from smaller organizations. The most frequently cited barriers by non-users relate to organizational issues such as resources, competing priorities, and lack of buy-in from decision-makers. However, a lack of implementation guidance and the amount of initiative materials (too few or too many) also received over a 60 percent response.

Conclusions

Overall, awareness of the initiatives was high among the target user groups, but the survey's findings identified subgroups, such as tribes and small health organizations, where awareness could be increased. Users saw value in both HealthierUS and HP2010, but would prefer greater integration of the two initiatives by HHS. Both users & non-users considered the lack of implementation tools for HealthierUS and HP2010[3], including financial and staff resources, as the most significant barrier to more widespread utilization.

[3] The HP2010 program currently maintains an implementation toolkit. It is not clear from the survey data if respondents were unaware of this resource, or if they felt it did not meet their needs.

Introduction

The Office of Disease Prevention and Health Promotion (ODPHP) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services (HHS) were interested in surveying state, local, and tribal organizations about their uses of two federal initiatives aimed at improving the health of the U.S. population: HealthierUS and Healthy People 2010 (HP2010). ODPHP and ASPE contracted NORC to conduct this assessment. The study provides HHS with information regarding the utility of the two programs and strategies for improving the usefulness of the initiatives to state, local, and tribal organizations.

HealthierUS Background

HealthierUS was established in 2002 by an Executive Order of the President of the United States. The HealthierUS initiative is 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. The President's HealthierUS initiative uses the resources of the Federal Government to alert Americans to the vital health benefits of simple and modest improvements in physical activity, nutrition, and behavior[4].

Steps to a HealthierUS (Steps) is an initiative from the U.S. Department of Health and Human Services (HHS) that advances the HealthierUS goal of helping Americans live longer, better, and healthier lives. At the heart of this program lie both personal responsibility for the choices Americans make and social responsibility to ensure that policy makers support programs that foster healthy behaviors and prevent disease. A centerpiece of this initiative is the 5-year cooperative agreement program. Through this program, states, cities, and tribal entities receive grant funds to implement chronic disease prevention efforts focused on reducing the burden of diabetes, overweight and obesity, and asthma, and addressing three related risk behaviors—physical inactivity, poor nutrition, and tobacco use[5].

Healthy People 2010 Background

HP2010 represents the third of a series of publications by the U.S. Department of Health and Human Services that specifies ten-year health objectives for the nation. The initiative, containing 567 objectives in 28 focus areas, is based on a systematic approach to improving health that highlights the central role of the physical and social environment in determining health. The central theme of the HP2010 initiative focuses on the role of communities and community partnerships in promoting healthy living in the U.S.

The overarching goals of HP2010 are to 1) Increase quality and years of healthy life, and 2) Eliminate health disparities. Furthermore, each of the 28 focus areas also contains a concise goal statement. This statement frames the overall purpose of the focus area. HP2010 is the basis for coordinated public health action on the national, state, and local levels and has been used as a teaching tool for the next generation of public health leaders. States have built on the national objectives and adapted them to address their specific needs. Individuals, groups, and organizations across America are encouraged to integrate HP2010 into current programs, special events, publications, and meetings. By selecting from among the national objectives, individuals and organizations can build an agenda for community health improvement and can monitor results over time[6].

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[4] For additional information on HealthierUS see < http://www.whitehouse.gov/infocus/fitness/>.

[5] Excerpted from < http://healthierus.gov/steps/steps_brochure.html>.

[6] Excerpted from < http://www.healthypeople.gov/Publications/Cornerstone.pdf>.

HP2010 supports the DATA2010 website. DATA2010 is an interactive online database that includes the most recent national and selected state data for tracking the HP2010 objectives. Available information includes sociodemographic data for population-based objectives (i.e., race and ethnicity, gender, and socioeconomic status) and operational definitions for objectives that have baseline data[7].

Study Background

Healthy People 2010 (HP2010) and HealthierUS are both concerned with improving the health of Americans through disease control and prevention. Though inspired by different time periods and by different leaders, HP2010 and HealthierUS are complementary in their efforts to involve state, regional, and local organizations to improve the health of the nation. Together, these initiatives are a powerful force in the effort to promote health and prevent disease in the U.S.

Evaluation of both initiatives is important for the success of specific strategies for improving health. A thorough understanding of how each of the initiatives, HP2010 and HealthierUS, are being used is invaluable for three specific reasons: (1) it can identify examples of effective strategies and approaches to the use of HP2010 and HealthierUS, and, where possible, the short-term results of those efforts; (2) it can identify barriers to their use at a point in time when HHS could still take effective action to facilitate or support use, particularly in strategically critical audiences; and (3) it can provide information on how the two initiatives can be used together to achieve their goals.

NORC was contracted by the Office of Disease Prevention and Health Promotion (ODPHP) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to complete an assessment of how HP2010 and HealthierUS are being used among key target audiences. The goal of this assessment was to create a comprehensive picture of how the initiatives contribute to state, local or tribal disease prevention and health promotion planning. The results of this study will allow HHS to document the utilization of HealthierUS and HP2010, and to understand the ways that key user groups believe the programs could be improved to encourage greater involvement. The three user groups targeted for the study's survey were officials at 1) state health organizations; 2) local health organizations; and 3) tribal health organizations.

Study Objectives

Prior to this study, information about the uses and users of HealthierUS and HP2010 was limited. Though information about both initiatives had been disseminated through various mechanisms including websites, published materials, and other efforts, there was little information available about how organizations use the initiatives concurrently with existing programs to improve health. This assessment investigated the reasons why organizations use or do not use these initiatives to generate information about improving the utility of each of the programs. This assessment provides the information necessary for HHS to make planning decisions, as well as highlights effective strategies that can assist the greater public health community in working towards the nation's most important disease prevention and health promotion goals. The main research questions this study addressed are outlined below.

- What are the organizational characteristics of users and non-users?
- Are organizations aware of HealthierUS, and if so, how are the organizations using the initiative?
- What are the reasons that organizations are not using HealthierUS?
- Are organizations aware of HP2010, and if so, how are the organizations using the initiative?
- What are the reasons that organizations are not using HP2010?

[7] The DATA2010 website is available at < http://wonder.cdc.gov/data2010/>.

Methodology

Study Design

This assessment included one mailed self-administered questionnaire (SAQ), which was sent to members of state, local, and tribal health organizations. Each individual was asked to complete the one-time survey, lasting approximately 15 minutes. Survey results were then summarized within and across organization type.

The survey was designed to ascertain how state, local, and tribal health organizations use HealthierUS and/or HP2010. The surveys also sought to understand how state, local, and tribal health organizations perceive the utility of HealthierUS and HP2010. The questionnaire consisted of five sections, which are outlined below.

- Background. Captures data about organizational characteristics such as type, size, and health priorities of organization, as well as the job title of the respondent.
- HealthierUS. Captures data about whether the organization uses HealthierUS, how it uses the initiative, and factors that enable or hinder its use within the organization.
- HealthierUS: Non-users. Captures data – from respondents who report their organization does not use HealthierUS – on why it does not use the initiative, barriers to use, and ascertains general perceptions about the initiative.
- HP2010. Captures data about whether the organization uses HP2010, how it uses the initiative, and factors that enable or hinder its use within the organization.
- HP2010: Non-users. Captures data – from respondents who report their organization does not use HP2010 – on why it does not use the initiative, barriers to use, and ascertains general perceptions about the initiative.

The final questionnaire is included as Appendix 1. The study questionnaire and a follow-up cognitive questionnaire were mailed to three tribal and three local health officials for pre-testing during the OMB comment period. Findings from the pretest were incorporated into the final study questionnaire.

In order to obtain additional information regarding HealthierUS and HP2010 from users, NORC conducted follow-up telephone interviews with a sample of survey respondents. Key questions centered on the means of obtaining information from HHS, use of DATA2010, Regional Health Administrator (RHA) involvement, and integration of HealthierUS and HP2010. We selected a non-random sample for follow-up from respondents to the initial assessment who reported using HealthierUS and/or HP2010. All tribal users were included in the sample (n=12) with the remaining 33 cases split between state and local health departments, for a total sample of 45. These 45 organizations were selected to maximize program diversity and population size, region, and HealthierUS and HP2010 usage.

Study Population

Respondent Universe

The sample included 301 respondents from the 50 states, the District of Columbia, local health organizations, and Native American tribes. 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 state health departments, and sampled local and tribal health organizations. This sample of public health officials was sufficient to provide the type of data necessary to analyze the use of the HealthierUS and HP2010 programs.

The sample frame was constructed from multiple sources and resulted in three separate lists for state, local, and tribal organizations. A list of the 51 Directors of state health departments and the District of Columbia served as the primary contacts for the states. The 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

officials, and the tribal officials were selected from a list of approximately 400 tribal health officials provided by the Indian Health Service (IHS).

Selection Methods

In addition to the census of state health directors, the sampling design utilized systematic samples with equal probability of selection (within organization type) and implicit stratification for the local and tribal respondents. Implicit stratification involves sorting the frame on certain variables so that the sample drawn is representative on that variable. We chose to sort on multiple variables, allowing the study's samples to be representative on 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 2,807 records. However, we removed 49 "inappropriate" records and 37 "tribal" records so that our final sampling frame contained 2,623 organizations. Inappropriate records included duplicate records, records without title or agency name, as well as other inappropriate records such as public health consultants, foundations, special interest groups (for handgun violence, for example), students, and professors.

The sample file was first sorted by urban/rural status. The NACCHO file did not include an urban/rural status variable. This variable was created for sampling using the zip code from the file, which mapped each organization to the state and county in which it resides. We then determined whether this county was inside a Census defined Metropolitan Statistical Area (MSA). The Census Bureau defines MSAs as the counties that involve economic activity related to a central city. If the county was in an MSA, we counted this organization as "urban." Otherwise, we classified the organization as "rural." Finally, the list was also sorted according to Census region, state, and zip code to ensure a regionally representative sample.

Tribal Organizations

The tribal list frame provided by IHS consisted of 385 records. This file also contained a code for the approximate size of Indian population, excluding urban Indian health agencies and a few other organizations. This classification system divided tribes into small (< 2,500 Indian population), medium (2,500 – 10,000), and large (> 10,000). The 50 tribal health agencies with unknown population size were placed into a fourth category for stratification. To achieve a representative mix of tribes, we sorted the file on this size code, as well as by Census region and state.

Final Response Rates

Exhibit 1 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.

Exhibit 1: Final Response Rates

Sample Type	Sample Size	No. Received	Percent Received
State	51	44	86.3%
Local	200	155	77.5%
Tribal	50	36	72%
Total	301	235	78.6%

Data Collection Techniques

Survey Methods

Fielding the survey entailed mailing the questionnaire along with a cover letter to the key staff member at each organization[8]. A self-addressed stamped envelope was included with each survey to facilitate the return the questionnaire directly to the researchers. A follow-up postcard mailing was sent to respondents two weeks after the initial mailing, and a phone call was made to those who had not responded after one month. The phone call also provided an opportunity for the researchers to re-mail or fax questionnaires that had been lost or misplaced. Respondents who asked to complete the questionnaire over the phone were allowed to do so at the time; 32 percent of respondents completed the questionnaire through a telephone administration. All data from the completed questionnaires was entered to create the analytic data file.

Follow-up Interviews

A letter was sent to the 45 selected respondents to alert them to the upcoming scheduling phone call and contact was attempted with all cases. To reach participants, NORC cross-referenced the record of calls from the initial survey to determine the best phone number to reach the selected users. Research assistants called respondents according to a standard call schedule that included placing calls at different times of the day and leaving messages or voice mails at specific intervals during the process. Once a respondent was contacted, the Research Assistant offered to conduct the interview at that time, or scheduled an appointment to conduct the interview at a later date.

Each interviewer conducted the interview using the approved protocol (Appendix 2), which included an introduction to the project specifying the purpose and the confidentiality of the information provided on the call. Research Assistants took notes while interviews were conducted and the notes were revised and annotated directly after the interview to ensure that the data would be understandable by the analysts.

Interview guides included several modules tailored to respondent use of HealthierUS and HP2010 as well as an additional module for tribal users. Interviews typically lasted 15-20 minutes and included time for open feedback from respondents. A listing of characteristics for the 25 respondents is included in Appendix 2.

Study Respondents

Of the 235 respondent organizations, 19 percent were state health agencies, 66 percent were local, and 15 percent represented tribal health organizations. Five of the respondent states are recipients of a Steps to a HealthierUS grant. The individuals completing the questionnaire at each organization varied. The majority of questionnaires (51%) were completed by Directors or Deputy Directors, 11 percent were managers or supervisors, 8 percent were program or research directors and managers, and 7 percent were clinical administrators or directors. Other individuals representing the organizations included; community nurses, health promotion activities coordinators, commissioners, and health agents.

The set of respondent organizations appeared diverse along a number of different facets, including health care priorities, geographic and urban/rural location, and size. Exhibits 2-5 display the data for each of the major organizational characteristics.

[8] In the cover letter, state health directors were asked to identify the most knowledgeable respondent at their organization. Initial phone calls were made to determine the name and contact information of this respondent, and to ensure his or her receipt of the questionnaire.

Exhibit 2: Priority Areas

What are your organization's priority areas?		
75% or more indicate... Child Health (75%) Disease Prevention (84%) Environmental Health (75%) Immunization (85%) Public Health Preparedness (80%)	**Between 50 and 74% indicate...** Access to care (62%) Childhood Disease (52%) Chronic Disease (65%) Nutrition (65%) Women's Health (59%)	**Less than 50% indicate...** Dental Care (43%) Disabilities (26%) Health Disparities (48%) Health Statistics (44%) Healthcare Workforce (26%) Long-Term Care (19%) Mental Health (25%) Primary Care (31%) Sex/Reproductive Health (47%) Substance Abuse (41%) Unintentional Injury (37%)
Other areas include: WIC, Sanitation Services, Senior Services, and Home Health Care		

Exhibit 3: Organization Size by Number of Full-Time Employees

	Mean	Std Dev	Min	25th Percentile (Q1)	50th Percentile (Median)	75th Percentile (Q3)	Max
State	2,424	2,855	170	500	1,535	3,200	14,000
Local	62	135	1	5	15	50	1,200
Tribal	46	78	1	10	25	39	400

Exhibit 4: Organization Size by Size of Population Served[9]

	Mean	Std Dev	Min	25th Percentile (Q1)	50th Percentile (Median)	75th Percentile (Q3)	Max
State	4.72M	4.70M	.5M	1.28M	3.48M	6.0M	22.0M
Local	146,437	461,934	37	12,580	36,000	100,000	5,000,000
Tribal	11,039	14,977	120	1,000	4,787	13,660	55,000

[9] The Pearson Statistical Test of Correlation shows that these two measures of organization size (number of FTEs and population served) are highly, positively correlated, with r=.83. This is statistically significant at the p<.0001 level.

Exhibit 5: Geographic Spread by Census Regions

	State		Local		Tribal	
	N	%	N	%	N	%
Northeast Region	**9**	**21**	**40**	**26**	**1**	**3**
Division 1: New England	6	14	28	18	0	0
Division 2: Middle Atlantic	3	7	12	8	1	3
Midwest Region	**10**	**21**	**57**	**38**	**7**	**19**
Division 3: East North Central	4	9	30	20	3	8
Division 4: West North Central	6	12	27	18	4	11
Southern Region	**16**	**37**	**32**	**21**	**9**	**25**
Division 5: South Atlantic	8	19	17	11	1	3
Division 6: East South Central	4	9	5	3	0	0
Division 7: West South Central	4	9	10	6	8	22
Western Region	**9**	**21**	**23**	**15**	**19**	**53**
Division 8: Mountain	7	16	11	7	8	22
Division 9: Pacific	2	5	12	8	11	31

Of the local health organizations, 82, or 55 percent, were located in metropolitan statistical areas. According to definitions supplied by the Indian Health Services division at HHS, 19 of the tribes represented are considered small, 9 are medium, 2 are large, and 6 are of an unknown size.

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 extent of awareness, the extent of use, the nature of use, and the kinds of barriers experienced.

Both descriptive and inferential statistics, such as the standard t-test, chi-square test, and multiple comparison procedures were performed in the analysis using SAS version 9.0 software. Non-parametric statistical techniques were also used to analyze the data, including the chi-square test for cross tabulations. Content analysis was utilized for the open-ended items on the questionnaire and interview data. Responses were categorized and tabulated for presentation in the report.

Study Limitations

The study questionnaire was designed to be both short and simple to encourage the participation of busy government and tribal officials. Therefore, many questions were limited to multiple choice questions, which forced answers that may not have fully captured the variety of uses of the initiatives at the organization or the varying stages of integration of the initiatives 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 responsible for completing the questionnaire on behalf of the respondent organization. While the process of obtaining a designated respondent for each organization (either through the State health director

or the sample frame lists) helped to ensure that the most appropriate person answered the questionnaire, the degree to which respondents were familiar with their organization's use of the initiatives cannot be verified. Finally, no follow-up was made to respondents to verify reported or missing information.

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, one for each of the initiatives. These sections parallel one another, and are organized according to the study's major and minor research questions.

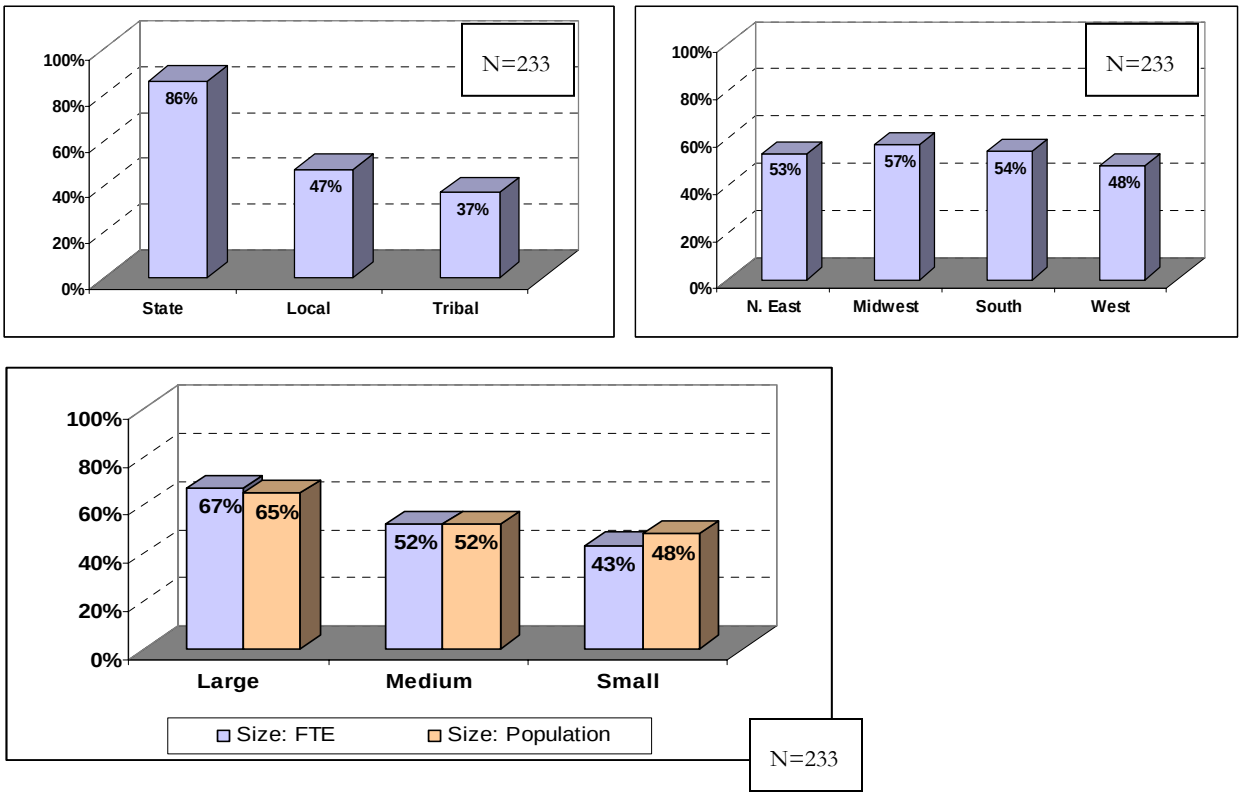
HealthierUS

Awareness

Overall, awareness of the HealthierUS initiative was high among the study's respondents, especially given that the program is in the early stages of implementation. Fifty-three percent of the 235 respondents reported that they were aware of the HealthierUS program. However, this figure does not convey significant differences between the awareness of several different types of organizations. Exhibit 6 shows the variation between types of organizations along these different dimensions. Many of the type, size, and regional differences were statistically significant at the $p \leq .05$ level. States were significantly more likely than local or tribal health entities to be aware of the initiative. There was no statistical difference in awareness between the geographic locations of the organization. Finally, when measured in terms of the number of full-time employees (FTEs), larger organizations[10] were more likely to be aware of HealthierUS than smaller organizations. Organizations serving a larger population were also more likely to be aware of the initiative; however results were only significant at the $p \leq .10$ level.

[10] Organizations falling within the first quartile of the FTE distribution for the sample were categorized as "small." Organizations falling between the first and third quartile were categorized as "medium," and those falling above the third quartile of the distribution were categorized as "large." The same method was used to categorize size in terms of the population served.

Exhibit 6: Awareness of HealthierUS



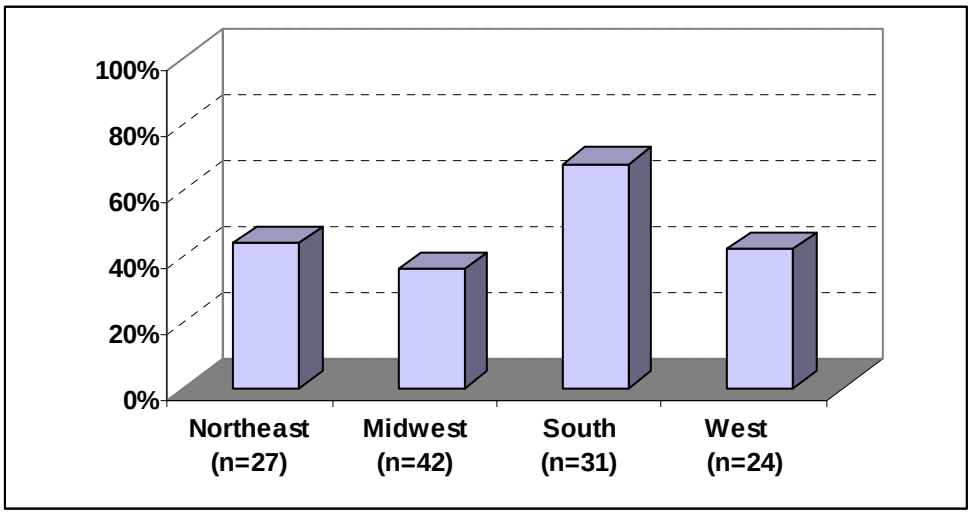
Use of the Initiative

Of the 124 organizations aware of the HealthierUS initiative, slightly less than half, or 47 percent, reported using the initiative. Again, distinct differences existed in the likelihood of using the initiative in terms of the type, size, and location of the organization. Twenty-seven states, or 71 percent of states aware of the initiative, reported using HealthierUS at their organization. However, only 38 percent (n=28) of local health organizations and 31 percent (n=5) of tribal organizations aware of the initiative reported using it. States were significantly more likely to use the initiative compared to their local and tribal colleagues ($p \leq .05$).

Furthermore, the size of the organization led to a statistically significant difference in the likelihood that the organization would use HealthierUS. Two-thirds of the large organizations (as measured by number of FTEs) and slightly less than half of the medium organizations (47%) reported using the initiative, compared with only a quarter of the small organizations. This same pattern holds true when examining differences by size of the respondent organization in terms of the population it serves, with 53 percent of all large and medium organizations using the initiative compared to only a quarter of the small organizations.

There were also a few significant geographical differences among all of the respondents using HealthierUS. Users in the South were significantly more likely to use the initiative compared with those users in the Midwest and West ($p \leq .05$).

Exhibit 7: Geographical Differences in HealthierUS Use



The questionnaire contained a question for all HealthierUS users to describe how the initiative is used at their organization[11]. The question included eight response options classified as either use for internal planning or for collaboration and outreach, as well as a free-text field for other uses. Respondents reported using HealthierUS for outreach and collaboration more often than for internal planning at the organization. Exhibit 8 displays the prevalence of each use according to the type of organization. The table indicates that HealthierUS was used for a variety of purposes among the respondents. However, use of the initiative for guiding spending priorities or for educating the medical community was low. Very few respondents, only seven, offered alternative uses in the free-text field. These included, program integration (n=3), collaboration with other agencies (n=2), and community planning (n=2).

There were very few statistically significant differences according to the organization's size or regional location. Medium-sized organizations used HealthierUS for internal planning more often than small or large organizations. Respondents in the West used HealthierUS more frequently for outreach and collaboration, but less frequently for internal planning than respondents in other areas of the country. Appendix 3 includes the detailed frequencies of use according to organizational size and location.

Three out of the five Steps grantees reported using HealthierUS for internal planning, and 4 used it for outreach and collaboration. None of the grantees used the program to guide spending decisions at their health department. Three used the initiative for internal planning, including collaboration with other statewide health initiatives and program offices. Four of the five grantees (80%) used HealthierUS to promote prevention and raise public awareness. Sixty percent used it for building community partnerships, and 40 percent used it for guiding priorities, training new staff, and outreach to the medical community.

[11] For additional descriptions of HealthierUS and HP2010 programs at the state, local and tribal level, please see Appendix 4.

Exhibit 8: Uses of HealthierUS

	State		Local		Tribal	
	N	**%**	**N**	**%**	**N**	**%**
Internal Planning	**20**	**74**	**23**	**82**	**4**	**80**
Use as a guide to set spending priorities	2	8	13	52	3	60
Use as a framework for planning, goal-setting, or decision making	19	70	20	80	3	75
Collaboration/Outreach	**25**	**93**	**26**	**96**	**4**	**80**
Guide priorities for the organization	15	56	19	83	4	80
Mechanism for building community partnerships for promoting health	22	81	23	92	3	60
Learning tool for new staff	16	59	12	50	2	67
Raise public awareness	22	81	22	88	4	80
Improve the quality of medical care by educating medical community	8	30	11	48	4	80
Tool to promote utilization of preventive services	18	67	21	78	4	80

HHS provides a number of mechanisms for users to access HealthierUS program information. Exhibit 9 shows the proportion of state, local, and tribal respondents that reported utilizing each method. As the graph shows, states relied most frequently on the website, while local health organizations looked toward their state health department, and tribes to their contacts at HHS. During the follow-up telephone interviews, users indicated they were unsure about who to contact at HHS for questions or other implementation concerns. Thus, several users suggested that the website offer names and contact information for staff members at HHS. Users also suggested including links for funding opportunities open to state, local, and tribal health organizations associated with disease prevention and health promotion activities.

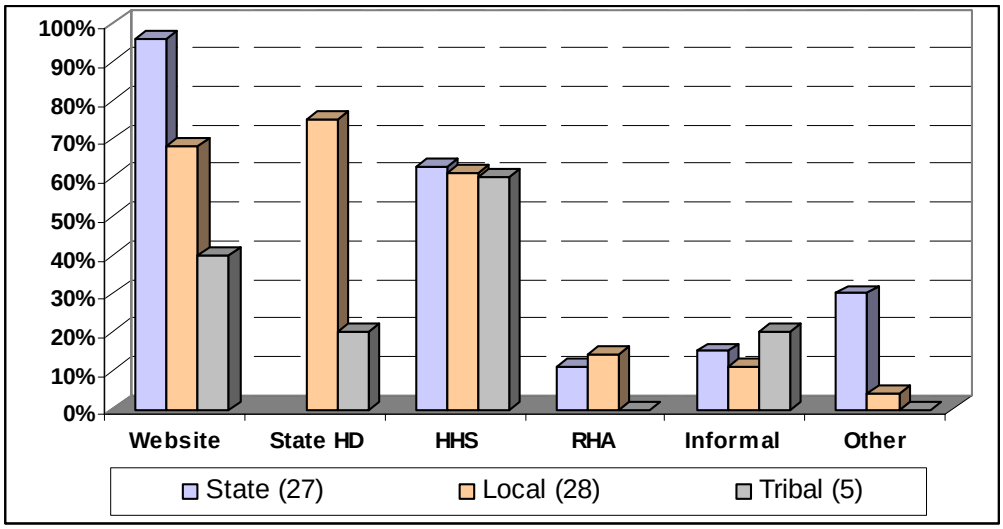
Regional health administrators appear to be an underutilized source of information. Only seven HealthierUS users reported their RHA as an information source. Data collected during the follow-up telephone interviews confirm this finding. Respondents typically did not have a clear understanding of who specifically their RHA was, as well as who they could contact from HHS regarding HealthierUS and HP2010. This did not appear to differ between state and local users, and even Steps grantees stated no contact with the RHA regarding HealthierUS and HP2010, though some reported interaction with their RHA on other projects. After stating that their organization had received no assistance from their RHA regarding HealthierUS and HP2010, one respondent was asked about how useful that type of contact might be. The respondent replied saying, "On

other initiatives, we have worked with the RHA and it's been very productive. We were one of the pilot sites for [another HHS] initiative and the folks from Region 2 were very helpful to us." "They came out and were very supportive of us. They were a great morale boost…"

Another respondent stated that the only contact they had received from their RHA was to confirm contact information for the HP2010 person in the state. The respondent went on to say, "I think personal contact with state coordinators has gone down the tubes. When Secretary Thompson created HealthierUS, I became very confused as to whether that meant HP2010 was gone. When that happened, my personal contact with HHS precipitously dropped. There were less communications coming. I think if they could restore it to the way it was, that would be good. I do think personal contact has gone by the wayside." When asked about contact with the RHA regarding HP2010, that respondent said "…They don't ever respond. I told them that what they ought to do is to convene states in the region and talk about how states were doing with HP2010 and how it was being implemented, and what we could learn from one another but there has been no invitational meeting set up….there's no personal contact."

Another state respondent did not even know what an RHA was and stated, "I don't even have a contact person and when we do have questions, it's hard. Once in a great while, we'll get a phone call, but besides that I don't know how to find someone. I didn't know who to send my report to." Only one local user, participating in a state Steps grant, had any contact with their RHA and most local users did not know what an RHA was. All the tribal users relied on Indian Health Services for this type of support, so therefore did not utilize their RHA. Many respondents discussed their desire for more regional meetings with other health departments to learn more about best practices and regional health concerns.

Exhibit 9: Accessing HealthierUS Information



Overall, HealthierUS users considered the initiative relevant to the work performed at their organization. Exhibit 10 displays the mean scores and confidence intervals for the question that asked users to note the relevancy of HealthierUS to their work, with one being "Not Relevant," and a five being "Extremely Relevant." Mean scores fell between 3.60 and 4.19 depending on the type, size, or location of the organization, however, there are no statistically significant differences as seen in the overlapping confidence intervals. Steps grantees did not differ either, with a mean score of 3.6 and a range of 3.0 – 5.0.

Exhibit 10: HealthierUS Relevancy

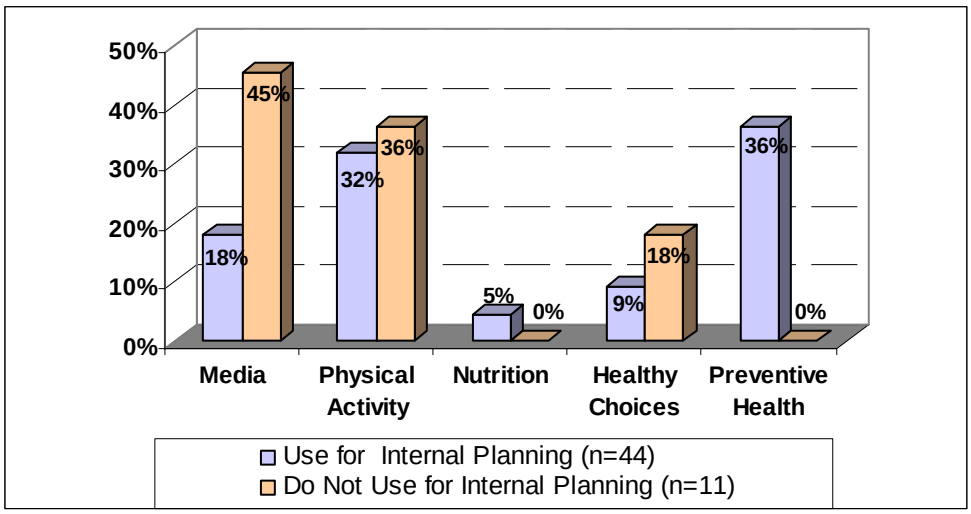
1=Not Relevant *5=Extremely Relevant*	***Type***			***Size: FTE***			***Region***			
	State (n=27)	**Local (n=28)**	**Tribal (n=5)**	**Large (n=24)**	**Medium (n=28)**	**Small (n=7)**	**I (n=12)**	**II (n=16)**	**III (n=21)**	**IV (n=10)**
Mean	3.85	3.75	3.80	3.75	3.82	4.14	3.75	4.19	3.62	3.6
95% Confidence Interval	(3.5–4.2)	(3.4–4.1)	(2.8–4.8)	(3.3-4.2)	(3.5-4.2)	(3.6-4.7)	(3.2-4.3)	(3.9-4.5)	(3.2-4.1)	(2.9-4.3)

Users were also asked to identify the most useful aspect of the HealthierUS initiative to the organization. Media campaigns, promotion of physical activity, and promotion of preventive health were cited most frequently by state and local users. Eighty percent of the five responding tribal users selected the promotion of physical activity as the most useful aspect, with only one tribal user selecting the promotion of preventive health (see Exhibit 11 below). Steps grantees responded similarly to other state users with two of the five (40%) choosing the promotion of physical activity, and the remaining three selecting media campaigns, promotion of preventive health, and a free-text selection of program integration across the department. No statistically significant differences existed between users based on organization size or regional location. However, respondent organizations that cited use of HealthierUS for internal planning purposes differed significantly from organizations that did not use the initiative for that purpose. As seen in Exhibit 12, respondents that used HealthierUS for internal planning cited the promotion of preventive health as the most useful aspect more frequently, while those respondents who only used the initiative for outreach and collaboration cited the media campaigns more frequently ($p \leq .05$).

Exhibit 11: Most Useful Aspect of HealthierUS

	State (n=27)	**Local (n=27)**	**Tribal (n=5)**
Media Campaigns	26%	22%	0%
Promotion Physical Activity	26%	30%	80%
Promotion Nutrition	4%	4%	0%
Promotion Healthy Choices	7%	15%	20%
Promotion Preventive Health	26%	30%	0%

Exhibit 12: Most Useful Aspect of HealthierUS by Type of Use



Forty-four percent of HealthierUS users (n=25), including two Steps grantees, reported using the initiative to develop new programs such as a partnership with community-based organizations for nutrition education, and 26 users reported expanding existing programs as a result of using HealthierUS at their organization. Several HealthierUS users also reported planning programs intentionally around one or more of the HealthierUS pillars (physical activity, nutrition and diet, preventive health, and healthy choices).

Those respondents that reported using HealthierUS for collaboration and outreach at their organization were more likely to use the initiative for program development or expansion ($p \leq .01$). Seventy percent of users engaged in outreach and collaboration activities used the initiative for program development or expansion, compared to none of those users not engaged in outreach and collaboration.

There were no statistical differences between users' likelihood to develop or expand programs based on HealthierUS depending on their type, size, or location. Furthermore, the types of program activity showed little variability across these dimensions. Exhibit 13 describes the types of program development occurring at state, local and tribal respondent health organizations as a result of HealthierUS.

Exhibit 13: HealthierUS Program Development

State	Local	Tribal
8 New Programs: • 3 – Physical Activity/Obesity prevention • 2 – Steps to a HealthierUS grants • 2 – Building community partnerships • 1 – Addressing health disparities across chronic disease programs	14 New Programs: • 6 – Prevention (CVD, Diabetes, Asthma, etc) • 3 – Building community partnerships • 3 – Physical Activity/Obesity Prevention • 2 – Tobacco/Risky Behaviors	3 New Programs: • 1 – Physical Activity/Obesity prevention • 1 – Women's Health • 1 – Prevention (CVD, Diabetes, Asthma, etc)
11 Expanded Programs: • 5 – Increase collaboration across program areas and localities • 3 – Physical Activity/Obesity Prevention • 1 – Employee Wellness • 1 – Tobacco/Risky Behaviors • 1 – Women's Health	12 Expanded Programs: • 4 – Physical Activity/Obesity Prevention • 3 – Tobacco/Risky Behaviors • 3 – Prevention (CVD, Diabetes, Asthma, etc) • 2 – Increase collaboration across program areas	3 Expanded Programs • 3 - Prevention (CVD, Diabetes, Asthma, etc)

Users in all types and sizes of organizations reported evaluating the use of HealthierUS at their organization by measuring changes in health behaviors or outcomes related to HealthierUS activities. Overall 37 users, 63 percent, reported measuring change using existing data or new data collections. There were no statistically significant differences between different types or sizes of organizations. Exhibit 14 displays the methods different types of organizations were employing to measure change.

Exhibit 14: Methods to Measure Changes from HealthierUS

	State	Local	Tribal
New outcomes data collection	71%	59%	75%
Qualitative data	35%	41%	25%
Trends in existing data	100%	71%	50%

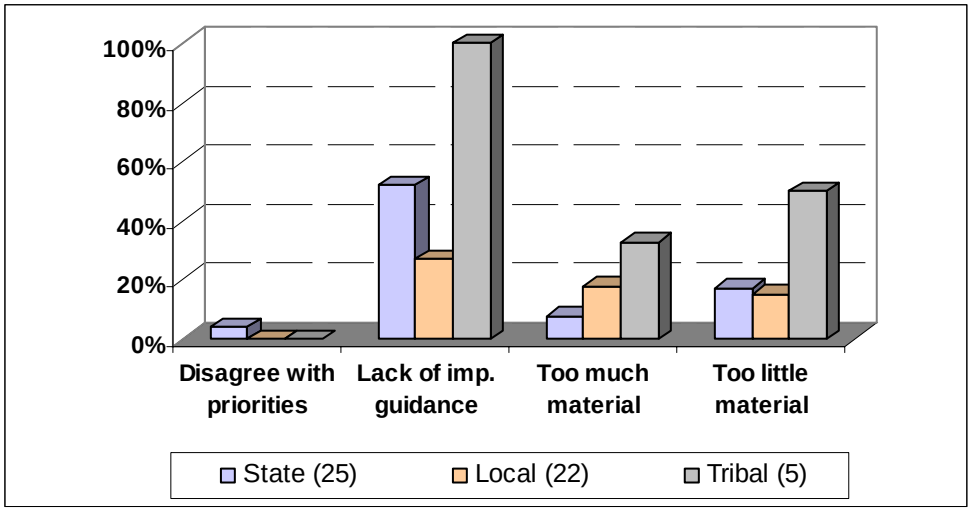
Barriers and Recommendations

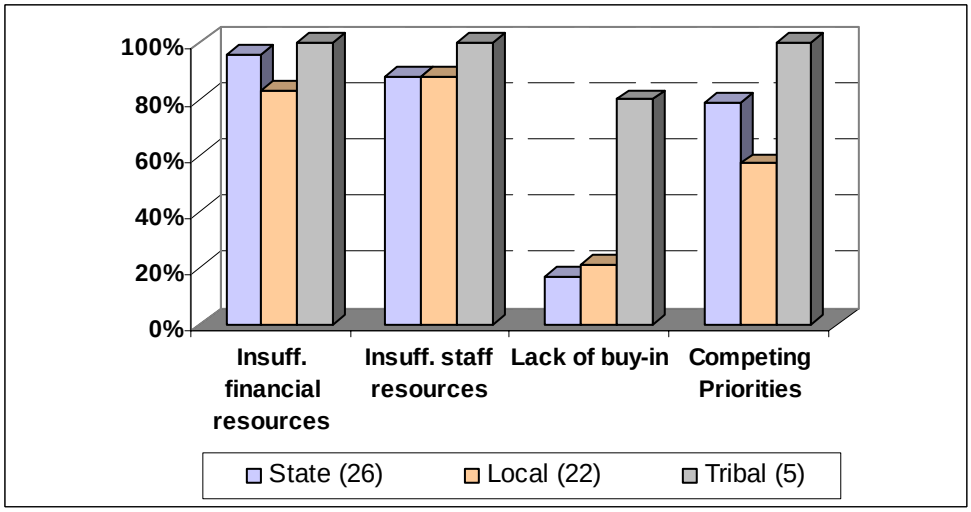
The questionnaire asked HealthierUS users to think about issues that might prevent the organization from using the initiative more. The response options were broken down into two categories; those related to the program itself, and those related to the organizations. As Exhibit 15 shows, users overwhelmingly cited barriers at the organization. Only a small minority of respondents, less than 4 percent, cited problems with the initiative's priorities, and less than 50 percent cited problems with the amount of material. However, a large proportion of users reported that the initiative lacks implementation guidance. Tribes and small

organizations in terms of FTEs were more likely to report the lack of implementation guidance as a barrier ($p \leq .05$).

Most users (> 80%) reported a lack of financial and staff resources as a barrier to greater implementation of HealthierUS at their organization. This included four out of the five users receiving Steps grants. Tribes were the only group to have a majority of users report a lack of buy-in from primary decision makers as a major barrier (80%). Competing priorities were also frequently reported, especially for small organizations ($p \leq .05$).

Exhibit 15: HealthierUS Barriers to Implementation





The questionnaire also afforded users with several opportunities to provide suggestions for ways HHS could improve HealthierUS to encourage greater utilization. Exhibit 16 shows how different forms of technical assistance (TA) might be valued at state, local, and tribal health organizations. Looking across the different types of organizations, best practices and implementation tools were in high demand (> 55%). Examples of how others are using HealthierUS was the only form of TA selected by a majority of Steps grantees.

Exhibit 16: HealthierUS Technical Assistance

	State (n=27)	Local (n=27)	Tribal (n=5)
Translating HealthierUS into action	70%	56%	60%
Prevention guidelines	59%	48%	60%
Examples of how others are using HealthierUS	78%	63%	60%
HHS contacts	41%	26%	20%
Curriculum materials	56%	52%	100%
Data collection tools	52%	63%	80%
Data evaluation tools	56%	70%	100%
Using HealthierUS for partnering/coalition building	37%	30%	40%
Examples of programs demonstrating progress toward HealthierUS areas	56%	44%	20%

Users were also given the opportunity to provide recommendations to HHS on ways it could encourage progress toward the HealthierUS goals. Two-thirds of respondents commented on the need for more financial resources at the state, local, and tribal levels. Four respondents from state and local organizations, including a Steps grantee, commented that if HHS cannot provide direct dollars, the department should coordinate training sessions and/or provide implementation tools and products that can be easily adapted to existing programs. Five respondents commented that implementation could be improved if HHS would clarify the relationships between HealthierUS, HP2010, and other programs. Somewhat similarly, three respondents noted that formal partnering agreements between HHS, IHS, state, local, and tribal health organizations would help ensure that all the key stakeholders are working together and efficiently.

This theme re-emerged during the follow-up telephone interviews when users were asked the general concluding question, "Do you have any other suggestions or comments for HHS on anything we haven't covered?" Respondents who were HealthierUS and HP2010 users remained confused regarding how to link the two programs. Many were confused regarding the overlap and wondered how to link the goals of both programs effectively and efficiently. One HealthierUS and HP2010 user with a Steps grant said, "We really need linkages between HealthierUS and HP2010. I'm not sure if those linkages are as clear right now as they could be. It would be nice if [HHS] identified a contact person [for HealthierUS] in each state, similar to the HP2010 contact person." The same respondent went on to say, "Our HealthierUS [program] is primarily through the Steps to a HealthierUS program. Because those are smaller scale, we can certainly shoot for the goals of HP2010 in those communities. I'm not really aware of any major coordination between the two." One state user said that the HealthierUS and HP2010 programs in their state were not coordinated and wondered, "Why are we all working separately from each other?" When asked how their locality coordinates its HealthierUS and HP2010 programs, a local user stated that "There is overlap, but I don't understand the differences, to me it's one big set of information." However one state user indicated that their state HP2010 program integrated HealthierUS as another aspect of its overall state 2010 initiative and did not find a conflict in that.

Non-Users of the Initiatives

As noted earlier, localities, tribes and health organizations with fewer FTEs or serving a small population were significantly less likely to use HealthierUS. Much like the barriers noted by users of HealthierUS, the 60 non-users cited the lack of staff resources (97%), financial resources (93%), and competing priorities (92%) as the top reasons why their organization does not use HealthierUS. Exhibit 17 shows the full list of barriers to use cited by the survey's HealthierUS non-users.

Exhibit 17: HealthierUS Non-User Barriers

Barriers	% Reporting
Don't agree with priorities	11%
Too little material	14%
Too much material	37%
Lack of buy-in	38%
Lack of implementation guidance	70%
Competing priorities	92%
Insufficient financial resources	93%
Insufficient staff resources	97%

Some other barriers offered by non-users in the free-text fields included a belief that the initiative is too duplicative of programs already in place (n=8), that the organization is too unfamiliar with the initiative to consider implementation (n=7), the initiative is not in-line with the organization's current priorities (n=3), the organization applied for, but did not receive, a Steps to a HealthierUS grant (n=3), and the initiative has not been evaluated or validated (n=2).

Despite these barriers, non-users generally felt that the program's four priority areas are an appropriate focus (43%). Forty-six percent of non-users did not have an opinion about the focus, and 9 percent felt it is too broad while 1 percent felt HealthierUS is too narrowly focused. Of the 26 non-users with an opinion about whether HealthierUS is lacking in some way, 57 percent responded in the affirmative. When asked how the program is lacking and what HHS could do to encourage more progress toward the HealthierUS goals, one third of the respondents said that HHS needs to do more outreach and education about the program, not just to state, local, and tribal health departments, but also to state and local policymakers. A quarter of the respondents suggested that HHS do more to coordinate with state, local, and tribal programs already in place, such as statewide Healthy People programs, to identify opportunities for collaborations between HHS and other health departments. Twenty-two percent of the non-users suggested that HHS think of other funding mechanisms besides the grant program to fund HealthierUS initiatives. Specific suggestions included sending money through the states, funding community-based organizations, and funding healthcare providers or research institutions. Just fewer than 20 percent of respondents commented on the need for HHS to consolidate its portfolio of disease prevention and health promotion activities to provide a clear set of priorities, goals, and methods to achieve them.

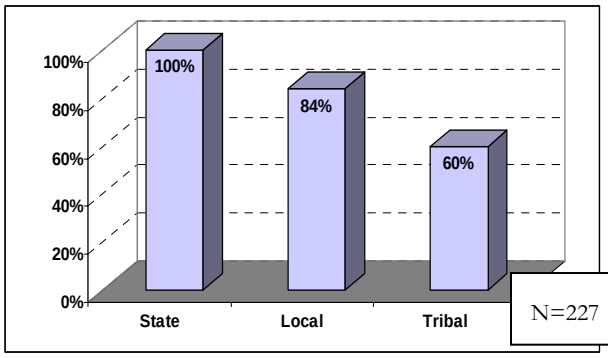
Healthy People 2010

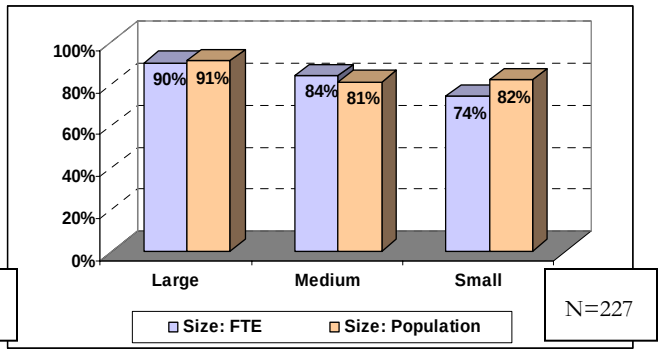
Awareness

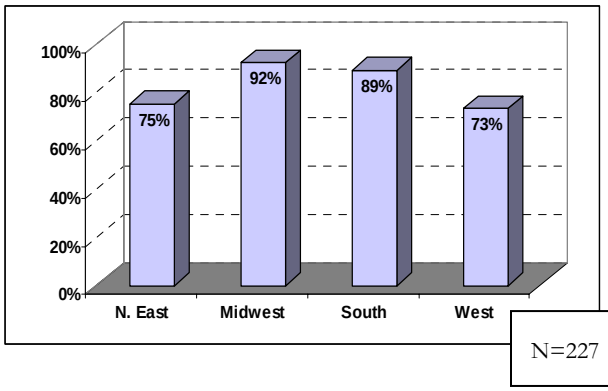
HP2010 had a high level of visibility across the responding health organizations. Overall, 83 percent of the respondent organizations were aware of the initiative. All of the responding states, 84 percent of the local health organizations, and 60 percent of the tribal health organizations reported awareness of the initiative. Tribes were statistically less likely to be aware of the initiative compared to both local and state health organizations (see Exhibit 18). Organizations with more FTEs were also more likely than smaller organizations to be aware of the initiative. This is not true when the size of the organization is measured in terms of the size of the populations served. Finally, geographical variations in the level of awareness did

exist, with health organizations in the Midwest and South reporting higher levels of awareness than those in the Northeast and West. As Exhibit 18 shows, states and tribes in the South, as well as local health organizations in the Midwest had higher levels of awareness than their counterparts in other geographical regions. Also of note, tribal health organizations in the Northeast appeared less aware of HP2010, as did local health organizations in the West.

Exhibit 18: HP2010 Awareness







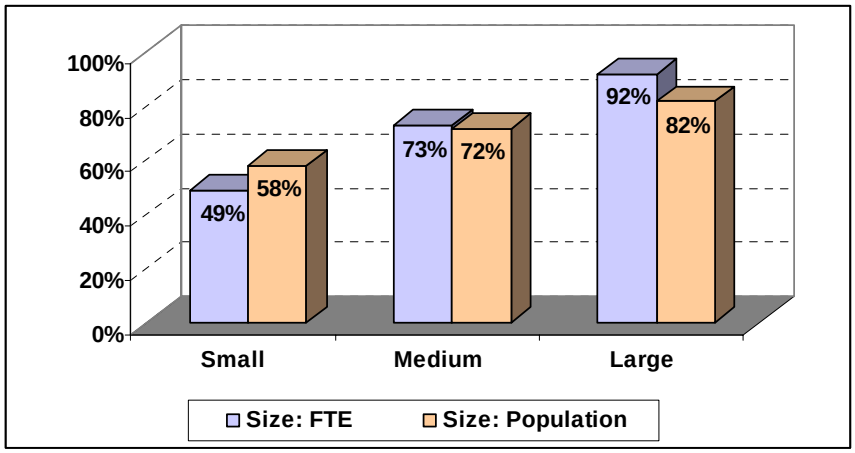
	State (n=44)	Local (n=122)	Tribal (n=21)
Proportion Aware of HP2010 in Each Census Region	%	%	%
Northeast	20	21	5
Midwest	23	42	19
South	36	22	33
West	20	15	43

Use of the Initiative

Overall, 71 percent of the 189 organizations that were aware of HP2010 reported using it in their organization. One-hundred percent of the states[12] reported using the initiative compared to 65 percent of local organizations, and 48 percent of tribes. These differences were statistically significant at the $p \leq .05$ level. In addition to the type of organization, the size of the organizations was correlated with the organization's likelihood to use HP2010, both in terms of the number of FTEs and the size of the population served. Exhibit 19 shows that larger organizations were more likely than medium and smaller organizations to use the initiative. There were no statistically significant differences among users in terms of geographic location, although there was a slightly higher proportion of users in the South (82%) compared with the West (73%), the Northeast (69%), and the Midwest (62%).

[12] One state did not provide an answer to this question; however the respondent went on to answer the HP2010 user's questionnaire, so that state is counted as a user in the analyses.

Exhibit 19: Use of HP2010 by Organizational Size



HP2010 users reported the different ways in which they use the initiative at their organization in terms of use for research, collaboration and outreach, and for internal planning. As the data presented in Exhibit 20 demonstrate, there was a significant difference between how the initiatives were used depending on the type and size of the responding organization. Tribes were less likely to use HP2010 for research purposes, and states were more likely to use the initiative for internal planning ($p \leq .05$). The organization's size, both in terms of FTE and the population served, was also correlated with the ability to utilize HP2010 for different purposes ($p \leq .05$). There were no significant geographical differences.

Specifically, over 80 percent of all respondents reported using HP2010 regularly to guide organizational priorities and as a framework for planning, goal-setting and agenda building. Over 80 percent of responding states and localities reported using HP2010 for building community partnerships, compared to only 67 percent of tribes. Ninety-one percent of states reported using HP2010 as a resource for comparison with organizational data, although less than 70 percent of localities and tribes reported using it for that purpose. Across all organization types, fewer respondents reported using HP2010 for internal spending decisions (< 56%) or for educating new staff (< 65%). See Appendix 3 for the detailed frequencies for organization type, size and census region. Eight organizations mentioned other uses for the initiative at their organization, which included using HP2010 as a model for a state-wide program (n=4), to monitor local progress compared to national figures (n=3), and to guide the organization's overall mission (n=1).

Exhibit 20: HP2010 Types of Use by Organization Type and Size

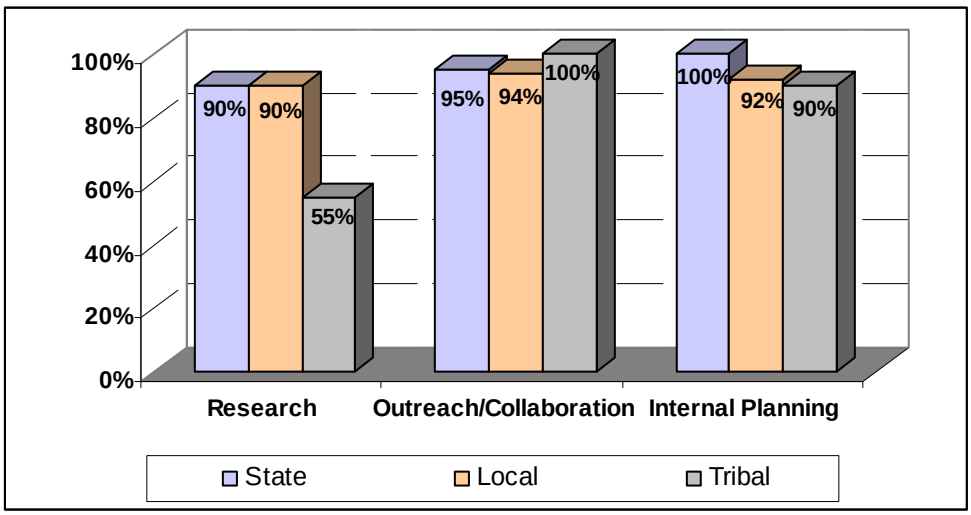
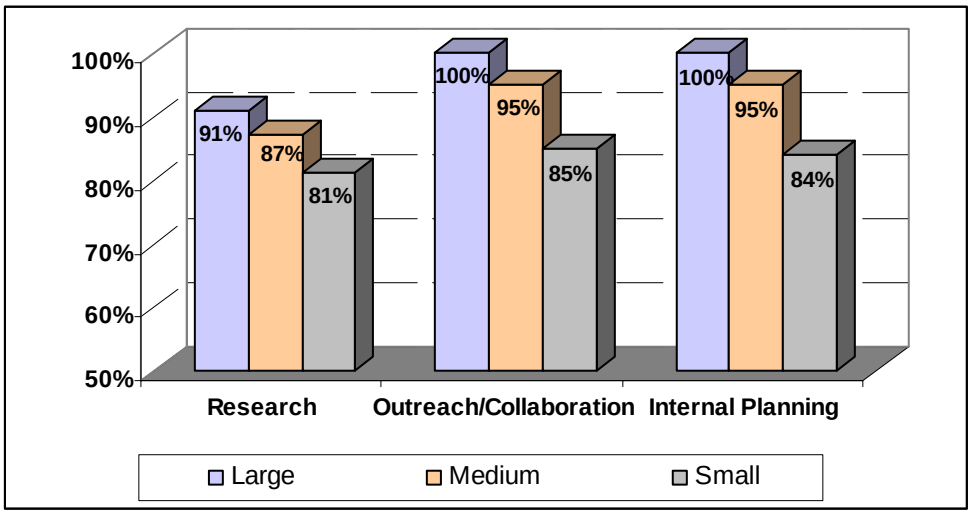


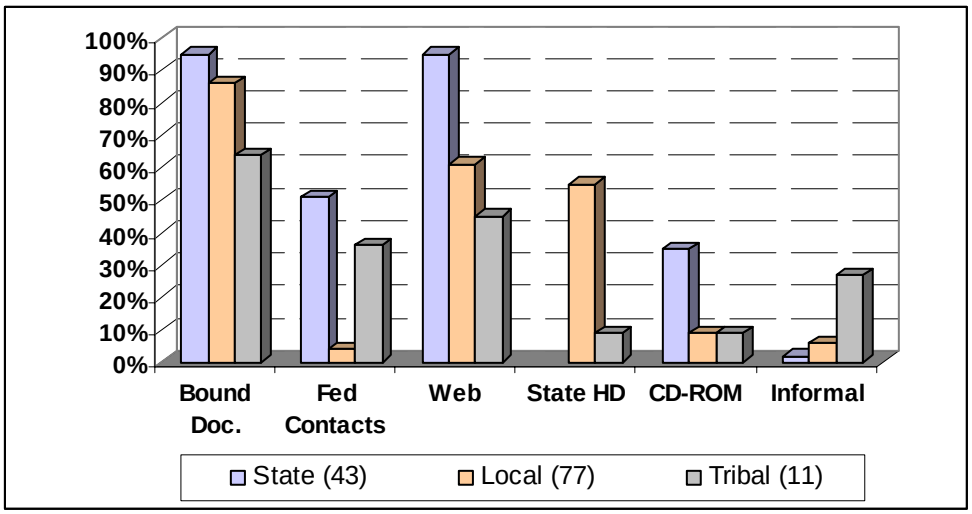
Exhibit 20: HP2010 Types of Use by Organization Type and Size (continued)



Healthy People 2010 users accessed program information in a number of different ways, as shown in Exhibit 21. Both the website and the bound HP2010 volumes were frequently accessed by users at state, local, and tribal health organizations. For localities, the state health department served as a frequently accessed source of information, while federal contacts at HHS were more often utilized by state and tribal users.

During the follow-up telephone interviews, users offered suggestions on ways to improve communications with HHS. Respondents specifically suggested that HHS maintain a HP2010 listserv for users to communicate with HHS and each other. They mentioned the inclusion of new program updates, opportunities, tools, and maybe even a "User of the Month" section to highlight different ways the program is being implemented. Some of the more policy-oriented interviewees also suggested weekly updates from HHS on various legislative and budgetary issues and decisions that could affect local HP2010 activities. Some respondents suggested greater linkages with DATA2010, email newsletters/reports, and more frequent updates of the HP2010 website. Respondents felt that articles in journals and trade newspapers about HP2010 would be useful but that they might not have time to read them. Several respondents suggested that these types of articles might do more to raise awareness than to inform or update current users.

Exhibit 21: Accessing HP2010 Information



The HP2010 initiative was viewed by users as highly relevant. As Exhibit 22 demonstrates, users across type, size, and location rated the initiative between a 3.36 and a 4.33, with a one being "Not Relevant" and a 5 being "Extremely Relevant." States reported the initiative as significantly more relevant than local or tribal organizations.

Exhibit 22: HP2010 Relevancy

1=Not Relevant *5=Extremely Relevant*	***Type***			***Size: FTE***			***Region***			
	State (n=43)	**Local (n=83)**	**Tribal (n=11)**	**Large (n=44)**	**Medium (n=67)**	**Small (n=22)**	**Northeast (n=23)**	**Midwest (n=41)**	**South (n=41)**	**West (n=30)**
Mean	4.33	3.82	3.36	4.20	3.79	3.95	4.04	3.88	4.12	3.77
95% Confidence Interval	(4.1-4.5)	(3.6–4.0)	(2.9–3.8)	(4.0-4.4)	(3.6-4.0)	(3.5-4.4)	(3.8-4.3)	(3.6-4.2)	(3.9-4.4)	(3.4-4.1)

The initiative scored slightly lower on a similar scale for effectiveness. Depending on the type of organization, users reported a mean score between 3.09 and 3.67 on the question which asked the degree to which the HP2010 initiative affected the organization's progress toward its own disease prevention and health promotion goals (Exhibit 23). Looking at the scores across organization type, size, or location, there were no statistically significant differences between the different groups.

Exhibit 23: HP2010 Effectiveness

1=Not Effective *5=Extremely Effective*	***Type***			***Size: FTE***			***Region***			
	State (n=43)	**Local (n=83)**	**Tribal (n=11)**	**Large (n=44)**	**Medium (n=67)**	**Small (n=22)**	**Northeast (n=23)**	**Midwest (n=41)**	**South (n=41)**	**West (n=30)**
Mean	3.67	3.31	3.09	3.55	3.34	3.45	3.61	3.32	3.66	3.13
95% Confidence Interval	(3.4-3.9)	(3.1–3.5)	(2.6–3.6)	(3.3-3.8)	(3.1-3.6)	(3.0-3.9)	(3.2-4.0)	(3.0-3.6)	(3.4-3.9)	(2.8-3.5)

HP2010 users were asked to select the most useful aspect of the program to the organization. Both states and localities cited the specific health objectives as the most useful aspect, with the overarching program goals ranking second for both groups. Tribes differed significantly ($p \leq .05$), citing the participatory goal setting process more frequently than any other aspect, as seen in Exhibit 24.

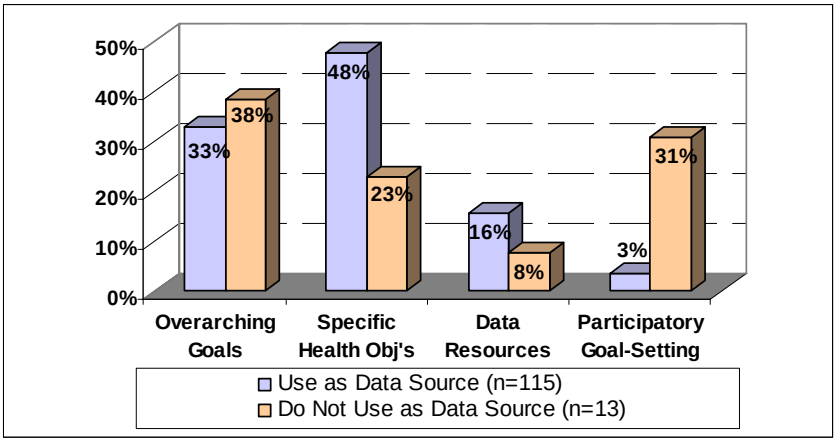
Only a minority of users contacted during the telephone follow-up were familiar with the DATA2010 website. Those who used the site characterized it as an easily used and rich data resource. A few users made some suggestions to improve the utility of the site, including more frequent updates, the ability to get regional or community/county figures, and better documentation (e.g. are all rates age-adjusted). When queried about the reasons users do not use the DATA2010 site, local respondents often said that they receive data from their state health departments or that data analysis is taken care of at the individual program offices (e.g. immunization rates in the Office of Child Health).

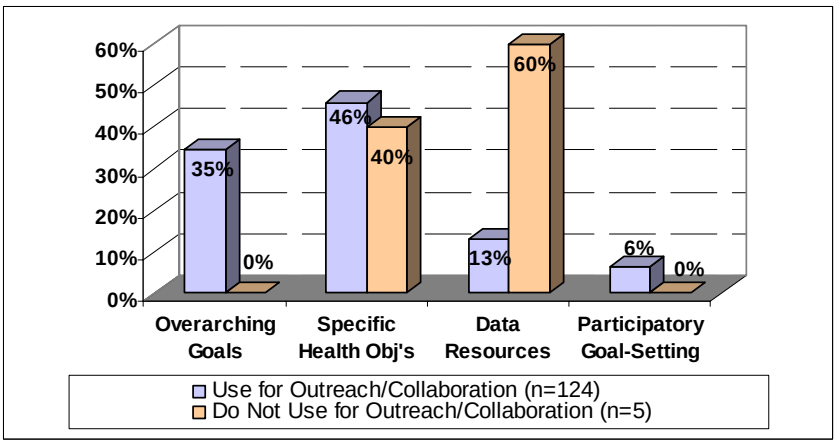
Exhibit 24: HP2010 Most Useful Aspect

	State (n=43)	Local (n=81)	Tribal (n=11)
Overarching Goals	35%	33%	27%
Specific Health Objectives	42%	46%	27%
Data Resources	12%	19%	9%
Participatory Goal-Setting Process	7%	1%	36%

Although there were no statistical differences between users based on the organization's location or size, respondents that reported using HP2010 as a data source or for collaboration and outreach differed from those respondents that do not use the initiative for those purposes. The graphs in Exhibit 25 display these differences, significant at the $p \leq .05$ level. Those reporting to use HP2010 as a data source cited the initiative's data resources and specific health objectives more frequently. Respondents that used HP2010 for outreach and collaboration valued the initiative's overarching goals more frequently, placing less emphasis on the initiative's data resources.

Exhibit 25: HP2010 Most Useful Aspect by Type of Use



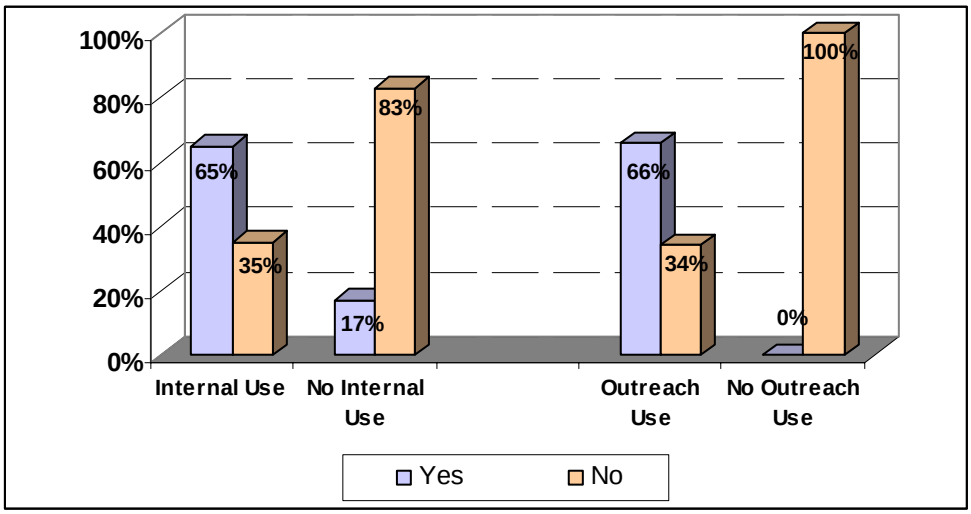


The Healthy People initiative was used for program development by 58 respondents and for program expansion by 54 respondents at all different types of organizations. The types of program activities were diverse, but varied little depending on an organization's type, size, or location. Exhibit 26 presents the different categories of program activities occurring at responding state, local, and tribal HP2010 user organizations. HP2010 respondents that reported using the initiative for internal planning or outreach and collaboration were more likely to use HP2010 for program development and expansion. This was especially true for those using HP2010 for outreach and collaboration ($p \leq .01$). Exhibit 27 displays these differences.

Exhibit 26: HP2010 Program Development and Expansion

State	Local	Tribal
20 New Programs: • 4 – Statewide HP programs/goals • 3 – Physical Activity/Obesity prevention • 3 – Addressing chronic disease management • 3 – Prevention (CVD, Diabetes, Asthma, etc) • 2 – Tobacco/Risky Behaviors • 2 – Oral Health • 1 – Community Partnerships • 1 – Child Health • 1 – Disabilities	34 New Programs: • 8 – Prevention (CVD, Diabetes, Asthma, etc) • 8 – Building community partnerships/partnering with state • 7 – Health Disparities • 5 – Physical Activity/Obesity prevention • 4 – Addressing chronic disease management • 1 – Oral Health • 1 – Women's Health	4 New Programs: • 3 – Physical Activity/Obesity prevention • 1 – Prevention (CVD, Diabetes, Asthma, etc)
22 Expanded Programs: • 5 – Addressing chronic disease management • 4 – Statewide Goals/Planning • 4 – Prevention (CVD, Diabetes, Asthma, etc) • 3 – Physical Activity/Obesity Prevention • 2 – Health Disparities • 1 – Community Partnerships • 1 – Employee Wellness • 1 – Environmental Health • 1 – Oral Health	26 Expanded Programs: • 6 – Physical Activity/Obesity Prevention • 6 – Prevention (CVD, Diabetes, Asthma, etc) • 4 – Health education • 3 – Addressing chronic disease management • 3 – Child health/immunizations • 2 – Environmental Health • 2 – Community partnerships	6 Expanded Programs • 6 – Prevention (CVD, Diabetes, Asthma, etc)

Exhibit 27: Use of HP2010 for Program Development



Sixty-five percent of state users (n=26) reported planning programs specifically around one or more of HP2010's focus areas or objectives. This was significantly higher ($p \leq .05$) than the 42 percent of local users (n=33) and 27 percent of tribal users (n=3). The states reported using HP2010 objectives as elements in the organization's strategic planning and goal-setting for various departments and program areas. Local and tribal users cited examples of program planning around focus areas more frequently than key objectives.

Along these same lines, states were significantly more likely ($p \leq .01$) to measure changes in health behaviors or outcomes related to the use of HP2010 at the organization (81%) than their local (49%) and tribal counterparts (45%). This was also true for users in the Northeast and West, who measured changes in health behaviors or outcomes related to the use of HP2010 at the organization more than users in the Midwest and South. This was especially pronounced for Northeast users who reported measuring these changes 82 percent of the time, compared to 52 percent in the Midwest, 50 percent in the South, and 66 percent in the West ($p \leq .05$). Exhibit 28 shows the different methods users were employing to measure changes in outcomes and behaviors related to the use of HP2010 at the organization. Smaller organizations were less likely to conduct new data collections, and small local organizations frequently noted (33%) that they relied on their state health department for data. Many organizations reported using the Behavioral Risk Factor Surveillance Survey as their main source of existing data at the state and local level.

Exhibit 28: Methods of Measuring Change

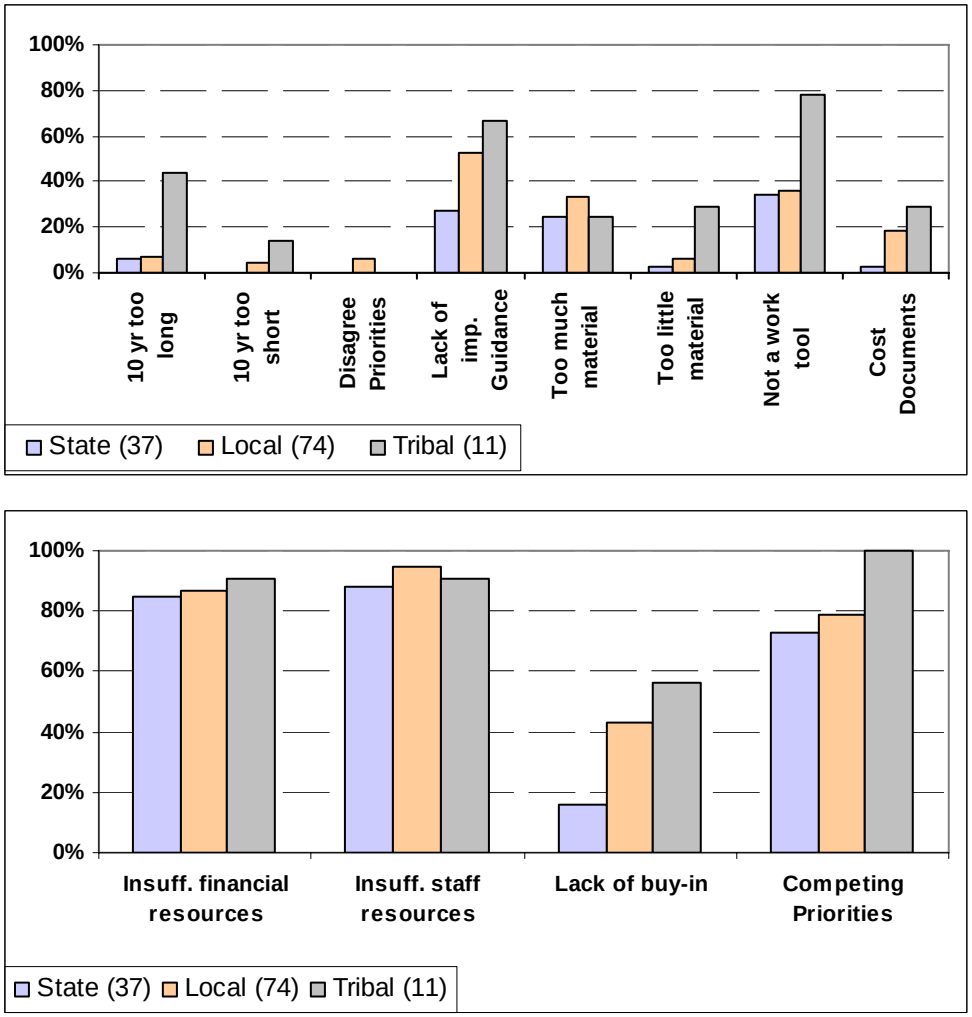
	State (n=36)	Local (n=41)	Tribal (n=6)
New outcomes data collection	64%	61%	67%
Qualitative data	33%	37%	33%
Trends in existing data	94%	76%	50%

Barriers and Recommendations

HP2010 users provided feedback about the barriers to greater implementation of the initiative at their organization. The only barrier imposed by the initiative itself was the inability to easily implement the

initiative. As Exhibit 29 demonstrates, there were several barriers where states and tribes differed significantly. More state, local, and tribal users reported organizational issues as barriers than barriers related to the HP2010 initiative itself. Over 70 percent of users at the state, local, and tribal level cited a lack of financial resources, staff resources, and competing priorities as barriers. State users differed from local and tribal users, both of whom cited a lack of buy-in from primary decision makers as a barrier ($p \leq .05$).

Exhibit 29: Barriers to HP2010



HP2010 users identified different types of technical assistance (TA) that might improve overall the organization's ability to further implement the initiative. There were a few differences between the types of TA valued by the organization depending on its size in FTEs. Despite these few differences, users were interested in opportunities for assistance with implementation and with tools for data collection and evaluation.

Exhibit 30: HP2010 Technical Assistance

	Large (n=38)	Medium (n=63)	Small (n=22)
Translating HP210 into action	74	62	77
Guidance on collecting data to track progress toward HP2010 objectives	47	44	56
Examples of how others are using HP2010	58	64	68
HHS contacts	32	35	55
Curriculum materials	53	54	59
Data collection tools	58	60	59
Data evaluation tools	74	59	59
Using HP2010 for partnering/coalition building	42	40	36
Examples of programs demonstrating progress toward HP2010's goals	61	38	50

Respondents were also given the opportunity to comment in a free-text field about other ways HHS could help users progress toward reaching the HP2010 goals. Increased funding or alternative funding mechanisms were suggested by 57 percent of the respondents. Looking beyond the provision of resources, the top suggestion, cited by twelve users in state, local, and tribal organizations, was to provide guidance on how to adapt national goals to local conditions. Along with this suggestion were several comments that access to regionally and locally tailored data needs to be improved.

Six respondents noted that HP2010 seemed to be losing visibility and that HHS should do more outreach to state and local leaders outside of the health departments, such as state legislators and mayors. This theme reemerged during the structured interviews. Some HP2010 users reported overall declines in HP2010-related activities as HP2010 reached the midpoint. Reported reasons included funding cuts, lack of regional data, and their state/locality only using HP2010 as a benchmark rather than as a long term planning aid. Other users reported HP2010 activities to be ongoing and the backbone of all of their efforts. These were typically local respondents with a strong state-based HP2010 program. One frequent HP2010 local user with a strong, active state HP2010 program stated, "Every year when we do our planning and work initiatives, we have to set up our goals and objectives; we have to show how each one directly relates to HP2010. We have to demonstrate at the end which objective each thing is addressing for HP2010 and [State] 2010." This type of requirement helped this respondent be a regular user of HP2010 as well as DATA2010 and reported sharing HP2010 information with the community agencies in the county. Another local user reported their HP2010 usage to be more inconsistent, based on need rather than regular use. The respondent stated, "I use it sporadically, in spurts. There are times when I need to look at it a lot, like when we're in the middle of community assessment work or a specific project. I normally do not use it every day or every week, but in a high-usage period, I'll use it weekly." Another local user felt that they were a more frequent HP2010 user when their locality was funded to conduct community assessments, but after funding was lost in 2002, they did not access HP2010 very often.

Non-Users of the Initiatives

Non-users of HP2010 were comprised entirely of local and tribal respondents, and they were more often from smaller organizations. These non-users were given the opportunity to describe the barriers that prevent them from using the initiative through specific answer options, as well as through free-text fields. Exhibit 31 displays the distribution of responses to a series potential barriers listed on the questionnaire. The most frequently cited barriers relate to organizational issues such as resources, competing priorities, and lack of

buy-in from decision-makers. However, a lack of implementation guidance and the amount of materials also received over a 60 percent response.

Exhibit 31: HP2010 Non-User Barriers

Insufficient financial resources	96%
Lack of buy-in	93%
Competing priorities	93%
Lack of implementation guidance	76%
Too much material	63%
Insufficient staff resources	62%
Cost of the documents	50%
10-Year timeframe too long	38%
Too little material	12%
10-Year timeframe too short	3%
Don't agree with HP priorities	3%

Funding barriers were most frequently mentioned in the free-text field (48%). However, six of the twenty-two respondents said that the state and local programs are prioritized higher than federal initiatives, and four respondents said that Healthy People 2010 is just too large of an initiative to tackle at their small local or tribal health organization. This response was further validated by respondents' answers to questions about the number of focus areas and key objectives in HP2010. Fifty-four percent of the 57 state, local, and tribal non-users had no opinion about the number of focus areas, while 30 percent said there were too many, 16 percent said it is the appropriate number, and none of the respondents reported too few focus areas. Respondents felt similarly about the number of objectives; 58 percent with no opinion, 28 percent reported too many, 14 percent said it is the appropriate number, and none of the respondents reported too few.

Twenty-one percent of the non-users said they thought HP2010 was lacking in some way. Responding specifically about how the initiative is lacking and about what HHS can do to encourage more progress toward HP2010's goals, 11 respondents said that HHS needs to do more media and public relations work to advertise the initiative to policy makers in local governments and in grassroots organizations. Another 8 respondents suggested ways for HHS to channel resources to the local and tribal health organizations so that they can implement the initiative. Specific suggestions included funding regional HP2010 planners, CBOs and grassroots organizations, and providing resources for data collection and evaluation. Seven respondents commented on the disconnect between the federal initiative and state and local priorities and programs. One respondent said, "It's just not well connected to local health department efforts." Finally, a number of non-users commented on a need for HHS to provide implementation materials that are streamlined and tailored to different types of populations. Three people commented that "you can't just give someone a book and expect them to implement a program," and another three people commented that they perceived the initiative as geared toward large, metropolitan areas.

Conclusions

As the results from the survey and follow-up interviews demonstrate, HealthierUS and HP2010 are visible initiatives with a diverse set of users and applications for use. The findings indicate that tribes and smaller health organizations are less likely to use the initiatives, however these types of organizations are also frequently behind larger organizations on the program development continuum. This implies that while current levels of HealthierUS and HP2010 awareness and use are low among tribal and small organizations, opportunities will arise for adoption of the initiatives as the organizations continue to develop their capacity to implement programs that cross specific disease and behavior areas like HealthierUS and HP2010.

Non-users of the initiative cited a lack of information as one of the leading barriers to implementing the initiatives at their organization. HHS can improve outreach to non-users and those in the early

implementation stage by providing information on the initiatives and the work that has been conducted to date at HHS, state, local, and tribal health organizations. Findings indicate that most respondents prefer electronic information. By collaborating with state health departments, national organizations like the American Diabetes Association, and professional networks like the National Association of County and City Health Officials, HHS can ensure that links to the HealthierUS and HP2010 programs are found throughout the disease prevention and health promotion field.

Along with funding, the other commonly cited barrier by users and non-users alike was the lack of implementation materials and tools available. Without a funding stream, most key user groups lack the resources necessary to translate the initiative into action. Users expressed significant interest in a variety of methods to share best practices, tools, and implementation experiences. Tools as basic as a directory of contacts at HHS and state and local governments or as complex as media promotion templates and data collection instruments will serve the purposes of both new and experienced users. Respondents also expressed interest in seeing both formal program evaluations and basic reports of program implementation examples from state, local, and tribal users.

Both initiatives are used for a wide variety of purposes by the key user groups, including collaboration and outreach, and for internal organizational planning. Users see value in both initiatives, frequently capitalizing on the broader nature of HealthierUS to integrate the many program offices where more decentralized users are implementing activities to meet the specific health objectives put forth in HP2010. However, many users seized the opportunity in the open-ended questions on the survey and telephone interview to suggest greater integration between the initiatives. Respondents were unclear about how to prioritize the scare resources at their organizations to make progress toward meeting the disease prevention and health promotion goals housed among the different HHS initiatives.

Current users are making good faith efforts to implement the HealthierUS and HP2010 initiatives. However, they admit to needing assistance. Understanding that a direct funding mechanism may not be an option for HHS, users suggested that HHS could use its resources and influence to increase the exposure of the initiatives to other key stakeholders and potential funders. The lack of widespread awareness of HealthierUS as a new initiative, and a perceived loss of focus on HP2010 provide HHS with an opportunity for outreach to groups like the National Governors Association, state legislatures, and major healthcare organizations like HMOs and the AMA.

As the survey findings demonstrate, users appreciated the initiatives, their purpose, and their potential. These key user groups are constrained by resource shortages at their organizations, but as their responses and participation in this study demonstrate, they are also willing to work with HHS to encourage greater implementation of HealthierUS and HP2010. The results of this study provide evidence of the potential for collaboration and identify opportunities to initiate these partnerships with the key user groups.

Appendix 1: Questionnaire

See companion PDF file for use with electronic report.

Appendix 2:

Interview Protocol and Respondent Demographics

Introduction

Thank you so much for agreeing to participate. We greatly appreciate your contribution to the survey and this follow-up interview. The purpose of the Assessment is to determine the uses of HealthierUS and Healthy People 2010 by several target audiences. The goal of this interview is to determine the ways in which you exchange information with HHS. HHS offers several mechanisms to inform program users about HealthierUS and Healthy People 2010. They seek to determine the ways in which these mechanisms are being utilized at state, local, or tribal health departments.

This interview should last approximately 30 minutes. Your identity and organizational information will be kept confidential. Unless you have any questions we are ready to begin.

Section 1 – HealthierUS Users

In your responses to the initial questionnaire, you mentioned that your health organization uses the HealthierUS program. We'd like to discuss, in a bit more detail, some of the ways you receive information about the program and some possibilities for HHS to improve its communication with health organizations like yours.

- What do find to be the most useful way to access information about HealthierUS?
    - Have you ever tried to obtain information or assistance from your HHS Regional Health Administrator? Or has your RHA ever tried to contact you regarding health promotion or disease prevention activities? If yes,
        - How frequently do you obtain information from your RHA?
        - Is the information helpful?
        - Is the information you receive from the RHA tailored to the specific health challenges in your region of the country?
    - How frequently do you obtain information from non-governmental sources, like professional conferences or informal communications with colleagues?
    - Are there any other ways you access information on HealthierUS that we haven't discussed?
- Now, thinking about the ways that HHS disseminates information about HealthierUS, how would you prefer to receive up-to-date information about the program and its related activities?
    - Do you find electronic communication effective?
    - What about HHS placing articles in public health or other professional newspapers and journals?
    - Are there any other ways HHS could disseminate information about the program that you would find useful?
- Do you have any suggestions for ways that HHS can improve its communications with HealthierUS users?
    - Are there specific kinds of information that you'd like to receive that aren't available to you at this time?
    - Would you be interested in a report or area of the website devoted to highlighting the ways other health organizations are using the initiative?

Section 2 – HP2010 Users

In your responses to the initial questionnaire, you mentioned that your health organization uses the Healthy People 2010 program. We'd like to discuss, in a bit more detail, some of the ways you receive information about the program and some possibilities for HHS to improve its communication with health organizations like yours.

- What do find to be the most useful way to access information about HP2010?
    - Do you use the hardcopy documents?
    - What about electronic resources such as the Healthy People 2010 web site or the CD-Rom?

        - How frequently do you access Healthy People 2010 information on the web? Do you find it useful?
        - How frequently do you use the Healthy People CD-ROM? Do you find it useful?
    - Are there specific times when you choose to access the hardcopy version rather than the electronic resources, or vice versa?
    - Have you ever tried to obtain information or assistance from your HHS Regional Health Administrator? Or has your RHA ever tried to contact you regarding health promotion or disease prevention activities?
        - How frequently do you get information from your RHA?
        - Is the information helpful?
        - Is the information you receive from the RHA tailored to the specific health challenges in your region of the country?
    - How frequently do you obtain information from non-governmental sources, like professional conferences or informal communications with colleagues?
    - Are there any other ways you access information on HP2010 that we haven't discussed?
- Thinking generally, do you consider HP2010 as a valuable data source? Why or why not?
    - HHS supports the DATA2010 website. Are you aware of this site?
        - Do you utilize this data source at your organization?
        - Can you describe how you use it? / Why don't you use it?
        - Is there anything HHS could do to [make it more useable/make it worth using] at your organization?
- Now, thinking about the ways that HHS disseminates information about HP2010, how would you prefer to receive up-to-date information about the program and its related activities?
    - Do you find electronic communication effective?
    - How about reports or quarterly Newsletters?
    - What about HHS placing articles in public health or other professional newspapers and journals?
    - Are there any other ways HHS could disseminate information about the program that you would find useful?
- Do you have any suggestions for ways that HHS can improve its communications with HP2010 users?
    - Are there specific kinds of information that you'd like to receive that aren't available to you at this time?
    - Would you be interested in a report or area of the website devoted to highlighting the ways other health organizations are using the initiative?

Section 3 – Tribal Users

HHS and the Office of the Assistant Secretary for Planning and Evaluation are particularly interested in learning ways to improve the initiatives for use by tribal health entities.

- Can you give us a little background about the organization you work in?
    - Is it part of a larger health system?
    - In addition to health promotion and disease prevention activities, what are your other responsibilities?
- How did your organization make the decision to use the HealthierUS or HP2010 initiatives?
    - What were the reasons?
    - Who were the key players?
- Can you tell me a little bit about how you use HealthierUS and/or HP2010 at your organization?
    - [IF USE BOTH FEDERAL INITIATIVES] How does your organization coordinate its HealthierUS and Healthy People 2010 activities?

- Do you feel like the use of the initiatives has a positive impact on the health promotion and disease prevention goals for the tribe? Why or why not?
- What could HHS do to make it easier for tribal health organizations to use these initiatives?

Section 4 – State and Local Users

We are also interested in learning about activities occurring at your organization surrounding the Healthy People 2010 or HealthierUS initiatives.

- [IF USE BOTH FEDERAL INITIATIVES] How does your organization coordinate its HealthierUS and Healthy People 2010 activities?
- Does your region, state, or locality have its own version of a HealthierUS or HP2010 program?
    - Can you describe the program and/or its related activities?
    - Do you participate in the program?
        - [IF YES] Do you find it more or less applicable than the Federal-level initiatives?
        - Is there any funding available through the local level program?
    - When was the program first implemented?
    - [FOR HEALTHIERUS PROGRAMS] Did this local level HealthierUS program evolve out of a local level Healthy People initiative?

Wrap-up

That is all that we had planned to ask you. We very much appreciate your time and effort. Before we end, is there anything else that you would like to tell us – any additional thoughts or insights about the HealthierUS or Healthy People 20210?

Interview Respondent Demographics

Phone Interview Respondent Characteristics n=26	
Type	
State	12 (46%)
Local	10 (39%)
Tribal	4 (15%)
Census Region	
Northeast	3 (12%)
Midwest	7 (27%)
South	9 (35%)
West	7 (27%)
Healthy People Use	
Yes	26 (100%)
No	0 (0%)
HealthierUS Use	
Yes	16 (62%)
No	10 (38%)

Appendix 3: Frequencies of Use

Uses of HealthierUS: Organization Size by FTE

	Large		Medium		Small	
	N	**%**	**N**	**%**	**N**	**%**
Internal Planning	**19**	**79**	**23**	**82**	**5**	**71**
Use as a guide to set spending priorities	9	43	7	27	2	29
Use as a framework for planning, goal-setting, or decision making	15	71	22	81	5	71
Collaboration/Outreach	**22**	**92**	**26**	**96**	**6**	**86**
Guide priorities for the organization	16	73	18	72	4	57
Mechanism for building community partnerships for promoting health	19	83	24	92	5	71
Learning tool for new staff	9	43	16	64	4	57
Raise public awareness	19	83	23	88	5	71
Improve the quality of medical care by educating medical community	8	36	12	48	3	43
Tool to promote utilization of preventive services	16	67	22	81	4	57

Uses of HealthierUS: Organization Size by Population Served

	Large		Medium		Small	
	N	%	N	%	N	%
Internal Planning	**12**	**63**	**30**	**90**	**5**	**71**
Use as a guide to set spending priorities	5	28	11	38	2	29
Use as a framework for planning, goal-setting, or decision making	11	61	27	87	4	67
Collaboration/Outreach	**16**	**89**	**32**	**97**	**7**	**100**
Guide priorities for the organization	10	59	24	80	4	57
Mechanism for building community partnerships for promoting health	14	79	28	90	6	86
Learning tool for new staff	9	53	16	55	5	71
Raise public awareness	16	89	27	87	5	71
Improve the quality of medical care by educating medical community	7	41	14	47	2	29
Tool to promote utilization of preventive services	11	61	28	85	4	57

Uses of HealthierUS: Organization by Census Region

	Northeast		Midwest		South		West	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Internal Planning	**9**	**75**	**13**	**81**	**17**	**81**	**7**	**70**
Use as a guide to set spending priorities	3	25	4	27	8	44	2	22
Use as a framework for planning, goal-setting, or decision making	9	75	13	81	14	74	6	67
Collaboration/Outreach	**10**	**90**	**15**	**88**	**19**	**95**	**10**	**100**
Guide priorities for the organization	8	74	11	73	13	68	5	56
Mechanism for building community partnerships for promoting health	9	83	12	80	17	85	9	90
Learning tool for new staff	6	55	10	71	7	37	6	67
Raise public awareness	9	83	13	87	19	95	6	60
Improve the quality of medical care by educating medical community	4	36	9	60	7	37	3	33
Tool to promote utilization of preventive services	7	64	12	71	15	75	8	80

Uses of HP2010: Organization by Type

	State		Local		Tribal	
	N	%	N	%	N	%
Research Data Source	**40**	**91**	**72**	**90**	**6**	**55**
Collaboration/Outreach	**42**	**95**	**74**	**94**	**11**	**100**
Guide priorities for the organization	42	95	66	86	9	82
Mechanism for building community partnerships for promoting health	35	81	62	83	6	67
Learning tool for new staff	28	65	39	52	4	44
Internal Planning	**44**	**100**	**72**	**92**	**10**	**91**
Resource for comparison with organizational data	39	91	54	70	7	64
Use as a guide to set spending priorities	16	40	24	33	5	56
Use as a framework for planning, goal-setting, or decision making	41	93	65	84	9	82
Use as a model for participatory building of organization's health agenda	27	64	45	63	7	78

Uses of HP2010: Organization Size by FTE

	Large		Medium		Small	
	N	%	N	%	N	%
Research Data Source	**40**	**89**	**55**	**87**	**19**	**83**
Collaboration/Outreach	**42**	**98**	**62**	**95**	**20**	**91**
Guide priorities for the organization	38	88	58	92	18	83
Mechanism for building community partnerships for promoting health	35	88	49	80	16	73
Learning tool for new staff	22	54	37	62	10	45
Internal Planning	**44**	**100**	**61**	**95**	**18**	**86**
Resource for comparison with organizational data	38	88	46	74	14	64
Use as a guide to set spending priorities	17	43	17	30	10	48
Use as a framework for planning, goal-setting, or decision making	42	95	54	87	17	77
Use as a model for participatory building of organization's health agenda	29	73	34	59	13	62

Uses of HP2010: Organization Size by Population Served

	Large		Medium		Small	
	N	%	N	%	N	%
Research Data Source	**39**	**91**	**55**	**87**	**21**	**81**
Collaboration/Outreach	**40**	**100**	**62**	**95**	**22**	**85**
Guide priorities for the organization	38	95	57	90	19	73
Mechanism for building community partnerships for promoting health	31	82	52	87	19	73
Learning tool for new staff	23	59	34	57	12	48
Internal Planning	**41**	**100**	**61**	**95**	**21**	**84**
Resource for comparison with organizational data	36	88	43	70	19	73
Use as a guide to set spending priorities	18	46	20	36	7	29
Use as a framework for planning, goal-setting, or decision making	39	98	55	87	18	69
Use as a model for participatory building of organization's health agenda	27	71	38	67	13	52

Uses of HP2010: Organization by Census Region

	Northeast		Midwest		South		West	
	N	%	N	%	N	%	N	%
Research Data Source	**20**	**87**	**36**	**88**	**36**	**90**	**24**	**83**
Collaboration/Outreach	**23**	**100**	**38**	**95**	**38**	**95**	**27**	**93**
Guide priorities for the organization	21	95	36	90	35	90	24	83
Mechanism for building community partnerships for promoting health	18	82	30	79	33	92	21	72
Learning tool for new staff	16	70	21	57	22	61	11	38
Internal Planning	**23**	**100**	**40**	**98**	**36**	**92**	**26**	**93**
Resource for comparison with organizational data	16	70	33	83	29	78	21	72
Use as a guide to set spending priorities	10	48	11	31	13	37	11	38
Use as a framework for planning, goal-setting, or decision making	22	100	35	85	32	84	25	86
Use as a model for participatory building of organization's health agenda	14	64	20	56	26	74	18	64

Appendix 4: Emerging HealthierUS Programs

Since the development of HealthierUS, many health departments have incorporated The President's Recommendations for Improving Physical Fitness and Nutrition, Prevention and Avoiding Risky Behaviors into their health promotion activities. Some programs have used HealthierUS to supplement HP2010 activities while other programs have incorporated HealthierUS as a stand-alone intervention. For this appendix, NORC has conducted a literature review to identify emerging HealthierUS and HP2010 programs (besides Steps grantees) and report on their activities.

For this task, we analyzed verbatim responses from HP2010 and HealthierUS users, conducted an extensive review of published and gray literature regarding the initiatives, searched state health department websites, conducted a broad internet search using google.com, and studied posters and presentations of recent public health conferences in order to identify emerging HealthierUS initiatives. Users who received follow-up telephone interviews also were probed regarding new HealthierUS-related initiatives for this appendix.

Texas (State Health Department) is incorporating both Steps as well as the HealthierUS School Challenge in their chronic disease prevention, cardiovascular wellness, and obesity prevention activities. The Texas Department of Agriculture's Square Meals program encourages schools to actively participate in the HealthierUS School Challenge in order to improve nutrition and physical activity among Texas elementary school children. Texas incorporates Steps principles through its Building Healthy Families initiative which encourages families to work together to improve nutrition and physical fitness. The Building Healthy Families Initiative is a collaborative program between the health department, Blue Cross/Blue Shield, The Texas Hospital Association, The American Heart Association, the Texas Hospital Association and HEB. Though this initiative does not receive Steps funding, Texas has been able to use a Steps model to include community organizations and stakeholders in contributing to this healthier lifestyle program.

Camden Country, NJ (Local Health Department) is using the HealthierUS program as a guideline for health education work with their community coalitions as well as their adolescent health and tobacco control programs. HealthierUS also provides insight into their programs for children, specifically through a nutrition program for toddlers aimed at preventing obesity and encouraging good nutrition. Though not a funded Steps grantee, Camden County draws upon both the healthierus.gov site as well as neighboring Philadelphia's Steps program for guidance. Staff indicated a strong desire to build from Philadelphia's Steps program wherever possible and hoped for feedback and collaborations with Philadelphia's Steps staff. Camden County also extensively uses DATA2010 for HealthierUS and HP2010/New Jersey 2010-related activities and actively shares DATA2010 output with community groups for prevention and planning purposes.

Cold Springs Rancheria Indian Health Project (Tribal Organization) has used HealthierUS to develop a physical fitness initiative targeted towards all age groups. The 10,000 Steps a Day program is an intervention which encourages walking and provides incentives based on each 25-mile increment walked. The 10,000 Steps

a Day program runs four times a year in 3-month increments. This intervention supports HealthierUS's obesity-prevention and fitness plan and is an effective way to promote exercise in this high-risk population. They also consult HealthierUS to develop activities for local children, with a focus on outdoor activities.

Ohio (State Health Department) has incorporated both HealthierUS and Healthy People 2010 into their Healthy Ohioans program (www.healthyohioans.org), a key initiative of Governor Bob Taft. Healthy Ohioans promotes nutrition, fitness, tobacco management, and cardiovascular health through school-based and community initiatives. One such program is a competition for all schools to compete for having the best health and wellness programs. Healthy Ohioans also has strong corporate partners and a Healthy Ohioans Business Council. Governor Taft has convened an advisory council on physical fitness, wellness and sports, comprised of legislators, athletes, and fitness experts. The Healthy Ohioans program also funds local health departments with Healthy Ohio grants for cardiovascular health programs. Staff indicate that the driving power for this initiative is the strong support of the Governor who has made this initiative a hallmark of his administration. This program stands out from other non-funded HealthierUS users because of the funding opportunities and the political backing of the initiative. This suggests that strong government buy-in can allow for wide dissemination.

Utah (State Health Department), Division of Aging and Adult Services and the **Eau Claire County, WI** Department of Health have adopted the "Steps to Healthy Aging" program developed by the National Center on Nutrition and Aging as a complement to the Steps to a HealthierUS initiative. This program educates older adults on physical fitness and nutrition and serves as a complement to their health promotion activities for older adults. As this initiative increases in visibility through the support of the Administration on Aging, we anticipate further visibility of Steps to a HealthierUS and greater adoption of HealthierUS goals within health departments as well as community-based agencies.

As current Steps grantees are able to report results of their initiatives to the public, it can be expected that local, state and tribal health departments will be able to utilize lessons learned to implement or expand their own HealthierUS initiatives. These unfunded programs indicate the potential for implementing HealthierUS without necessarily needing Steps funding. For example Ohio has been able to create a statewide initiative incorporating both HealthierUS and HP2010 through the strong commitment of their governor, who has made the initiative one of the hallmarks of his term. Programs such as Utah and Eau Claire Country have been able to adapt toolkits designed for HealthierUS with considerable ease. As these types of specific HealthierUS programs are made more available, HealthierUS may be utilized in a different way than HP2010.