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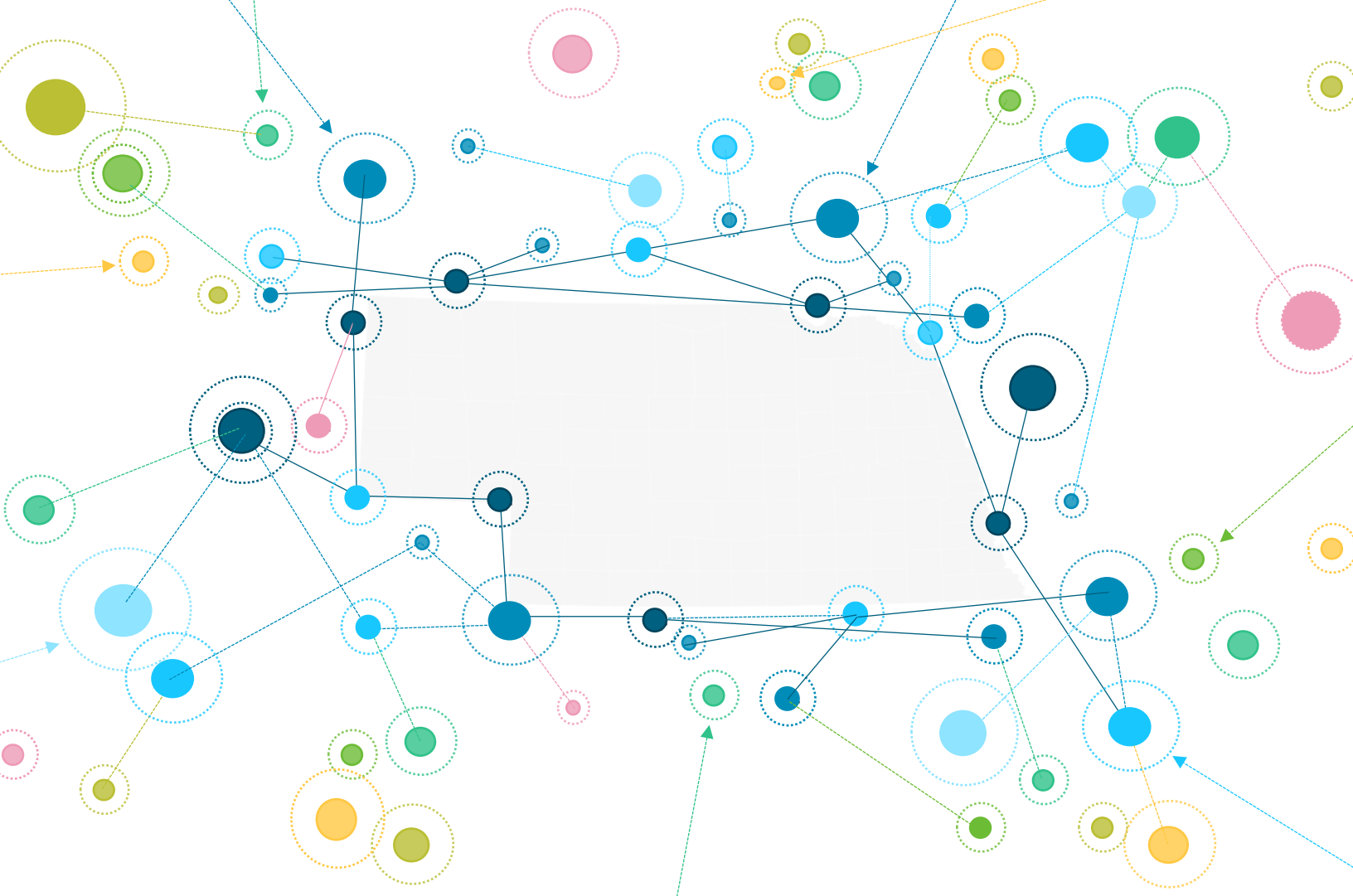
Health Status Prioritization Guide



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Partners for Insightful Evaluation

MERC

GIS & Human Dimensions Evaluation and Consulting

UNMC College of Public Health

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Introduction

In 2022, the Division of Public Health (DPH) housed under the Nebraska Department of Health and Human Services (DHHS) started redesigning how the State Health Assessment (SHA) and State Health Improvement Plan (SHIP) are conducted and implemented. A key component in redesigning the SHIP is identifying the priorities for the state. Based on input from key stakeholders, Nebraska defined two types of statewide priorities:

- **System-level priorities** are aspects that DHHS can address in collaboration with other partners and stakeholders. The intent of system-level priorities is to build public health capacity in the state. These are more over-arching topics or areas that can be addressed across the state within any health topic or program.
- **Health status priorities** are specific to health conditions. In some cases, the priority may be broad health topics, such as chronic disease, or they may be specific conditions, such as arthritis.

As an initial step in the redesign process, qualitative data gathered for the 2022 Nebraska SHA report was reviewed at several retreats with State, Tribal, and Local Health Department representatives, as well as other public health partners. The purpose was to determine priorities applicable across the public health system regardless of county size, location, or demographics. Two public health system level priorities were selected: **infrastructure** and **equity**. At subsequent retreats, eight SHIP workgroups – called the Public Health Advancement Workgroups – were formed to address key topics within those two areas (Figure 1).

Figure 1. Eight SHIP workgroups were formed in 2022 to address public health system-level priorities for infrastructure and equity

Public health infrastructure metrics	**Access to care**	**Community health workers**	**Costing assessment**
Data modernization	**Reducing health disparities**	**Communicating the value of public health**	**Workforce development**

While the system level priorities are selected, Nebraska still needs to determine how to select health status priorities. For the redesigned 2023-2027 SHIP, **Nebraska is taking an innovative approach by selecting priorities that both strengthen the public health system and benefit health status-related priorities, of which the tribal and local health departments will inform via their community health priorities**. Given the SHIP is intended to be an ever-evolving roadmap for health improvement and resource investment, Nebraska's DPH determined it would be important to have shared state health status priorities by selecting priority health issues that align with those selected by the tribal and local health departments (T/LHDs) via their Community Health Improvement Plans (CHIPs). The goal of the updated SHIP is to maximize the positive impact on the population's health by strategically elevating CHIP health status priorities and then providing support, guidance, and focus to public health departments throughout the state.

To inform the redesign, a robust evaluation was conducted by a team of researchers that included a review of literature, an analysis of other state SHIPs, and primary data collection to gather input from DPH teammates, tribal/local health departments, additional tribal entities, and other stakeholders. This guide synthesizes information from this evaluation and provides recommendations to consider as decisions are made regarding the prioritization and support of health status topics.

Purpose of this Guide

The purpose of this guide is to provide a systematic approach to determining the top health status priorities at the state level. The initial section of the guide presents key findings derived from data collected through the evaluation, highlighting successful and challenging aspects of past SHA/SHIP processes. These findings serve as the foundation for the recommendations, not only for the 2023-2027 SHA/SHIP but also for future endeavors. Each recommendation is accompanied by relevant samples or resources, along with a discussion of their respective advantages and disadvantages. It is highly encouraged that a diverse array of partners are involved in the process to determine the most suitable option(s) for Nebraska.

Methods

A mixed methods approach was utilized for the evaluation project, which also served as the basis for the prioritization guide. Most of the data collected and analyzed was primary data, meaning it was collected by the research team specifically for this project. Primary data mostly consisted of qualitative data, which was analyzed by the authors, while quantitative data from surveys were analyzed using SPSS. Literature reviews of public health research and state SHIPs were also conducted. The seven data sources included a literature review of public health research, a review of state SHIPs, interviews/focus groups with T/LHDs, a focus group with previous leadership/key stakeholders, 5 DPH focus groups, a DPH+ capacity survey, and a SHA/SHIP user survey. The methods applied to each of those data sources can be found in Appendix A.

Background

This section provides background on SHIPs from other states, primarily regarding how they determine their priorities. It also summarizes Nebraska's previous SHIP processes and how T/LHDs carry out their CHA/CHIP processes. Many have similar approaches to best meet the Public Health Accreditation Board's (PHAB) accreditation requirements. This information may provide valuable context for determining the future priority selection process in Nebraska.

Focus for State and Community Health Improvement Plans

Based on guidance from PHAB, the focus of a SHIP should be on addressing the needs of all residents within the state while a CHIP should focus on the needs of the residents within their jurisdiction. It also notes that while programs in a health department may have their own plans, those do not fulfill the purposes of a community health improvement plan. The intent with the CHIP/SHIP is to address a jurisdiction's priorities. Additionally, measurable objectives

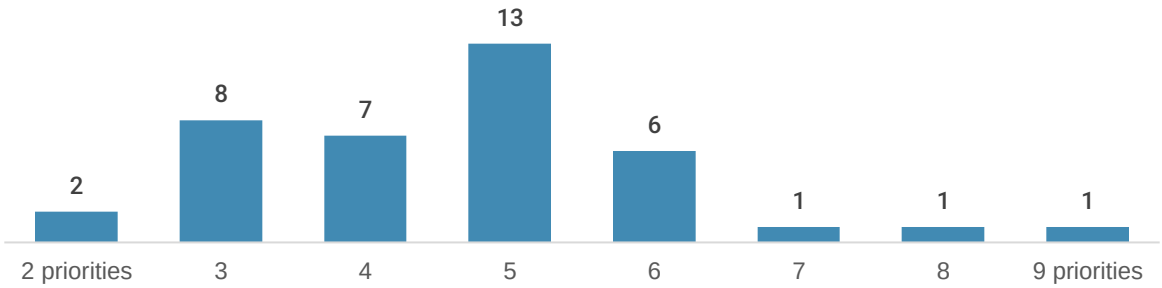
A SHIP should address the needs of all residents within the state and include at least two health priorities.

should be set for each of the health priorities to determine to what degree progress is being made on addressing those priorities.

Priority Selection among Other States

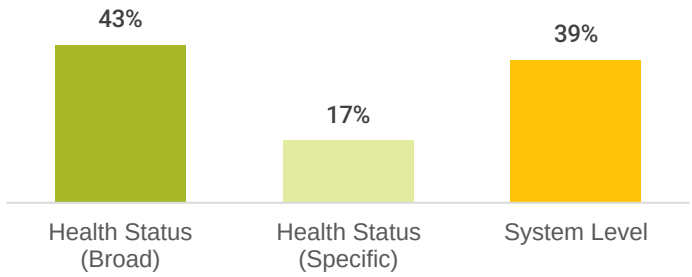
Based on a review of 39 SHIPs from states that are PHAB-accredited, there were a total of 184 priorities. States have an average of five priorities included in their SHIP, with states ranging from two to nine priorities across their SHIPs (Figure 2).

Figure 2. Among states that had a publicly available SHIP and were accredited, the average number of priorities was 5 (n=39)



The priorities among the 39 states were coded into three categories: broad health status, specific health status, and system level. Although the most common were broad health topic areas, such as chronic disease, maternal and child health, healthy eating and active living, behavioral health, and substance use disorders, it was followed closely by system level priorities (Figure 3). This includes topics such as access to care, social determinants of health, and public health infrastructure. Less than 20% of SHIP priorities were health specific, such as diabetes, opioids, smoking, birth outcomes, and Alzheimer's.

Figure 3. SHIP priorities are more likely to be system-level or broad health status rather than specific health topics (n=184)

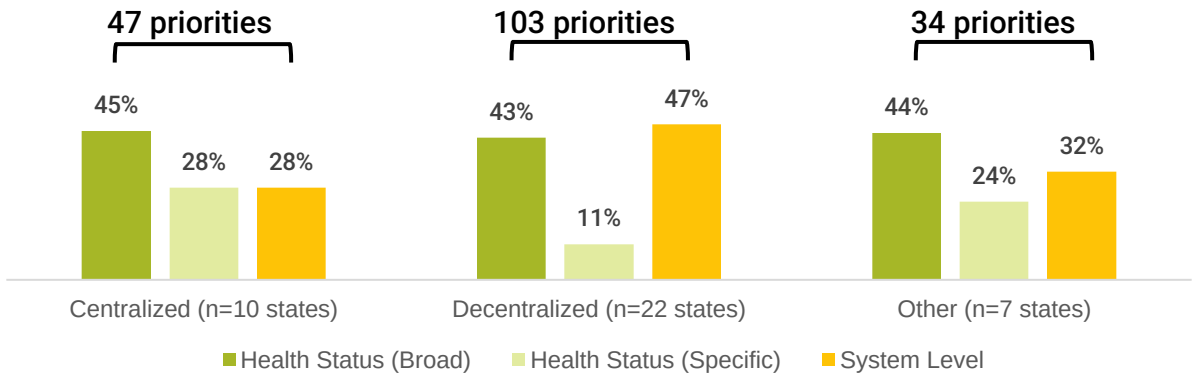


About 60% of the state SHIPs that were analyzed had two of the three types of priorities, with the most common being broad health status and system level priorities. There were five states[1] that only selected system level priorities, though they included objectives pertaining to health topics.

[1] Connecticut, Kansas, Louisiana, Maryland, and Minnesota

An analysis of the 39 states found notable differences between types of governance. Decentralized states[2] are less likely to select specific health topics and are more likely to select system level priorities (Figure 4). Additionally, decentralized states are likely to have more objectives within their priority areas. Although the three types of governance used for the analysis (centralized, decentralized, and other [includes shared and mixed]) all had an average of five priorities, they varied slightly in how many objectives were specified. Centralized states had an average of nine objectives while decentralized states had an average of 14 objectives per state.

Figure 4. Decentralized states are less likely to identify specific health topics as their health status priority



Based on the coding of the SHIPs, there were at least 15 different approaches that states used in their prioritization process. The most common was reviewing results from the SHA to inform their priority selection, which is part of the Mobilizing for Action through Planning and Partnerships (MAPP) process. The MAPP process is commonly used to improve community health and health equity. There were at least eight of 39 states (20%) that specifically noted in their SHIP that they utilize the MAPP process. Two other processes utilized by 20% of the states included offering a public comment period on the priorities and utilizing some type of prioritization or ranking criteria.

Nearly all states use a combination of systems and approaches for their priority selection process. It is important to note, however, that not all states describe the specific methodology they use when selecting their priorities. One of the 39 states[3], for example, did not include any description of their methodology in their SHIP and thus is not included in that analysis. As a result, the processes discussed may be under-reported.

History of the SHIP in Nebraska

To date, Nebraska has developed four State Health Improvement Plans (SHIPs), which have evolved over time. In the most recent SHIP (2017-2021), a Collective Impact model was utilized to select priorities for the plan. Hundreds of stakeholders from across the state

[2] Defined by ASTHO (n.d.) as "local health units are primarily led by employees of local governments and the local governments retain authority over most fiscal decisions." Nebraska is classified as a decentralized state.
[3] Arkansas

participated in a structured process involving four meetings and a survey to review the SHA and select the priorities. As a result of the process, five priorities were selected (Figure 5). Each priority was championed by one of the five Co-Launch Partners[4] to provide leadership, guidance, and oversight for their respective priority area.

Figure 5. The following five priority areas were selected for the 2017-2021 SHIP

1	Integrated health system
2	Depression and suicide
3	Obesity
4	Utilization and access
5	Health equity

Utilization of the 2017-2021 SHIP

Results from the SHA/SHIP User Survey, which included T/LHDs, DHHS staff, and members of partnering organizations, suggest that the SHIP may have been under-utilized, but among those using it there was general agreement that priorities were appropriate and aligned with those of their organization. Less than half (42%) of those surveyed (n=129) reported that they had read the SHIP and know where to access it, while slightly over half were familiar with some (44%) or all (11%) of the SHIP priorities. Among those familiar with the 2017-2021 SHIP, most rated the appropriateness of the priorities favorably (92% rated as good or excellent).

The SHIP was most often used to understand what the state's priorities are, but 60% also reported using it to see where there is alignment with their local priorities and 43% used it to guide the decision-making process for their priorities. Among those who knew what the SHIP priorities were, most felt there was at least some alignment between the 2017-2021 SHIP priorities and their organization's/program's priorities, with 67% reporting the priorities are somewhat aligned and 29% believing the priorities are very aligned. However, feedback from T/LHDs suggests alignment between state and local health priorities was because of the importance of the issues in the state, rather than intentional alignment. The most common priority areas reported within their organizations were social determinants of health, behavioral and mental health, community collaborations, access to care, and chronic disease.

2017-2021 SHIP Successes

Feedback provided by individuals involved in leading the development of the 2017-2021 SHIP suggests some aspects of the process worked well, while other aspects presented challenges. The MAPP process was utilized, which most felt offered a great perspective, but also presented challenges due to the large volume of information collected. While the

[4] The five Co-Launch Partners included 1) Nebraska Department of Health and Human Services, 2) Nebraska Association of Local Health Directors, 3) Nebraska Hospital Association,4) Public Health Association of Nebraska, and 5) the University of Nebraska Medical Center: College of Public Health

quantity of data was overwhelming, most felt the data collection and review process worked well. The leaders of the SHIP also felt the gathering of partners was a success, *"Initially we had good representation from our partners, from our stakeholders. It just felt like we had a really diverse make up of our initial groups."*

Another aspect that was key to the success of the 2017-2021 SHIP was the important role the state played by involving individuals who were committed to the efforts and had time to do the work. *"What works well and continues to work well is that there are people that have dedicated time to do this."* The dedicated resources allowed for the ability to facilitate conversations, pull people together, and obtain the data easier. The concept of co-launch partners was also viewed as beneficial because of the ability to have shared leadership.

Most individuals who participated in 2017-2021 SHIP priority selection meetings and provided feedback on the User Survey felt the planning process included participatory decision-making for priority setting and resource allocation (66% agreed/strongly agreed) and that the SHIP co-launch team took special care to identify and engage stakeholders to assure the SHIP addressed social, economic, educational, and environmental determinants (63% agreed/strongly agreed). Among those involved in the next step in the process, the majority (78%) found the priority workgroups to be somewhat or very valuable, attributing the successes to having workgroup members that were diverse, knowledgeable, energetic, spirited, committed, and a skilled workgroup facilitator.

2017-2021 SHIP Challenges

While the development of the plan was overall viewed as a success, **the biggest challenge** described by those responsible for leading efforts with the 2017-2021 SHIP **surrounded implementation**. One reason the implementation of the plan did not go well was due to a **loss of momentum**, which was a challenge also described by individuals who participated in the priority selection meetings and provided feedback on the User Survey. One of the SHIP leaders acknowledged the turnover in the SHIP manager position in 2018 and the challenges around trying to revive a program that had already been struggling.

Although the initial idea was for each co-launch partner to lead one of the priorities, there was **a lack of clarity and communication**, which led to an inability for each partner to effectively manage and lead their priority area in conjunction and collaboration with the other areas. The issue of shared ownership was echoed as a substantive barrier that hindered implementation, which was exacerbated by **a lack of buy-in from DHHS leadership** and a lack of resources to fund the work.

It was also noted that **the DHHS internal process was a hindrance**, and approval for the plan was delayed, causing further delays in progress. The group shared that there was momentum in some of the early meetings, yet three months would pass without any movement. It took a year for the plan to get approved, causing a loss of trust and faith in the process. Additionally, the MAPP process was deemed too large and time-consuming to effectively carry out at the state level, and there was a scope problem with naming too many priorities that encompass *"huge things"* and that it was **not realistic to make measurable progress on all five priorities** displayed in Figure 5.

The **inability to set realistic expectations** resulted in the **loss of those involved in the SHIP development or implementation** and **their commitment to the work**. There was a desire to prioritize behavioral health, but it was not allowed due to it being under another division within DHHS, leading to a lack of connection with local efforts. There were items on the plan that the team had little ability to impact. The local efforts didn't connect, and the local health departments were already doing MAPP locally, causing redundancy and loss of buy-in from locals. Furthermore, it was noted that there was **a need for better collaboration with the local health departments**, with one previous SHIP leader noting, *"There are people on the ground doing the work that have the ability to impact that were not at the table."*

The **lack of representation in the priority meetings was identified as a barrier** by those who participated in 2017-2021 SHIP priority selection meetings and provided feedback on the User Survey. Less than half (48%) of these survey respondents agreed or strongly agreed that a representative group of people were involved in the priority selection process, and over one-quarter (28%) disagreed or strongly disagreed that the planning process included consultation and/or engagement with targeted communities and objective analysis of their needs, with an additional 21% reporting that they neither agree nor disagree.

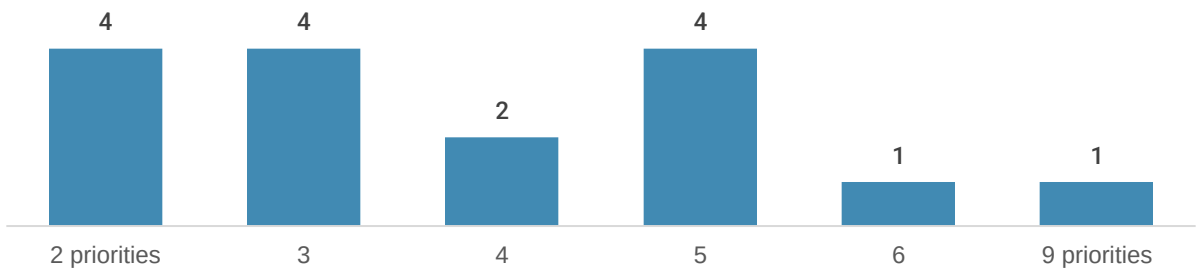
Feedback from those participating in the User Survey also alluded to **the lack of progress with implementing the plan**. Among those who knew at least some of the 2017-2021 SHIP priorities and provided a rating on progress made (37% did not rate the progress because they felt they did not know how to rate the progress), the average rating of progress was a 5.1 on a 10-point scale where 1 is no progress and 10 is significant progress, suggesting users generally felt only modest progress was made. Furthermore, it is interesting to note that users representing T/LHDs rated progress lower (4.4) than users who were not from T/LHDs (5.4).

The difficulties with implementation can be understood by better comprehending the challenges faced in the priority workgroups. Among those who participated in 2017-2021 SHIP priority workgroups and provided feedback on the User Survey, **the primary challenges** that **slowed momentum** included **limited participation among those outside of DHHS**, and **a lack of structure and communication**.

CHIP Development and Priority Selection

A review of currently available Nebraska Community Health Improvement Plans (CHIPs) in Nebraska showed that 16 of 18 local health departments had developed CHIPs since 2016. Among the 16 CHIPs, approximately 20 different priorities were selected. While some LHDs only selected two priorities, others selected as many as nine; on average, LHDs selected 4.1 priorities (Figure 6). The most common priority was behavior/mental health, which was selected as a priority in 14 of the 16 CHIPs. Other common priorities were chronic disease (selected by 7 of the 16), substance use (selected by 6 of the 16), and obesity and health disparities/health equity/access to care (both of which were selected by 6 of the 16). The document review of available CHIPs suggested that nearly all utilized a Community Health Assessment (CHA) to inform their CHIP.

Figure 6. Among regions that had a publically available CHIP, the average number of priorities was 4 (n=16)



Feedback received from LHDs and tribal organizations revealed that they **follow evidence-based practices** to conduct the CHA/CHIP and set priorities. Several of the participants from local health departments and a tribal entity indicated that they use the MAPP process. As part of the process, different assessments are conducted within the local community using both qualitative and quantitative methods (e.g., focus groups, key stakeholder interviews, surveys, etc.).

"I mean you're looking at the data, you're getting the community analysis or feedback from the community through focus groups. You're having the partners share what they're seeing, if they're in... anything healthcare related, what they're seeing. So it's really just it is layered. I mean, you're using all of the pieces of MAPP to come to your conclusions in what you should focus on." ~LHD Focus Group Participant

A tribal entity indicated that they used different evidence-based practices than the MAPP to understand and determine local priorities that are specifically designed for use in indigenous communities, while another stated they did not use an evidence-based practice.

"We just wanted something that was used in tribal communities, that way we knew that was easier to adapt to our community and how we went through the process." ~Tribal Interviewee

Several of the T/LHDs described the importance of working with local partners and stakeholders in the community to develop and conduct the CHA/CHIP. These **local partners participated in activities such as designing and conducting the health assessments, narrowing priorities, and strategic planning**. Some LHDs explained that they lead the CHIP process, while others described utilizing an external facilitator to guide the prioritization process. Regardless, all described working with local partners throughout the process in part due to the **wealth of local knowledge partners have** that can benefit the overall process. T/LHDs also expressed the **importance of using different assessments** to set priorities. For example, several LHDs mentioned using the Minority Health Assessment that was recently conducted as a starting point for the CHA/CHIP process.

The document review of current CHAs/CHIPs showed that all 18 LHDs have completed CHAs since 2015, with the majority (10 of the 18) completing their CHAs every three to four years. The next most common frequency was every five years (3 of the 18), with one LHD

conducting a CHA every year (the frequency of the remaining CHAs was unknown). The frequency of completing CHIPs was similar to their CHAs. Several LHDs explained that the **timing of their CHA/CHIP aligns with the required Community Health Assessments needed for local hospitals,** which are on a three-year cycle as stipulated by the Affordable Care Act. Conducting the CHA/CHIP in conjunction with the local hospitals helps foster local engagement, can leverage funding opportunities to cover the process, and is mutually beneficial to both the LHDs and hospitals.

Recommended Approaches for Health Status Priority Selection

Strategic and thoughtful priority selection is key to the health improvement process, providing direction for leadership, resources, and time while also increasing efficiency and efficacy of the performance of a state or program (Beitsch, 2011; Barnett, 2012). The recommended approaches outlined in this guide are based on insights from Nebraska's T/LHD leadership, Nebraska's previous and current SHIP key stakeholders, users of previous SHAs/SHIPs, members of DHHS's Division of Public Health, other states' SHIP processes (see Appendix A for description of data collection methods). It is also informed by best practices from the priority selection literature.

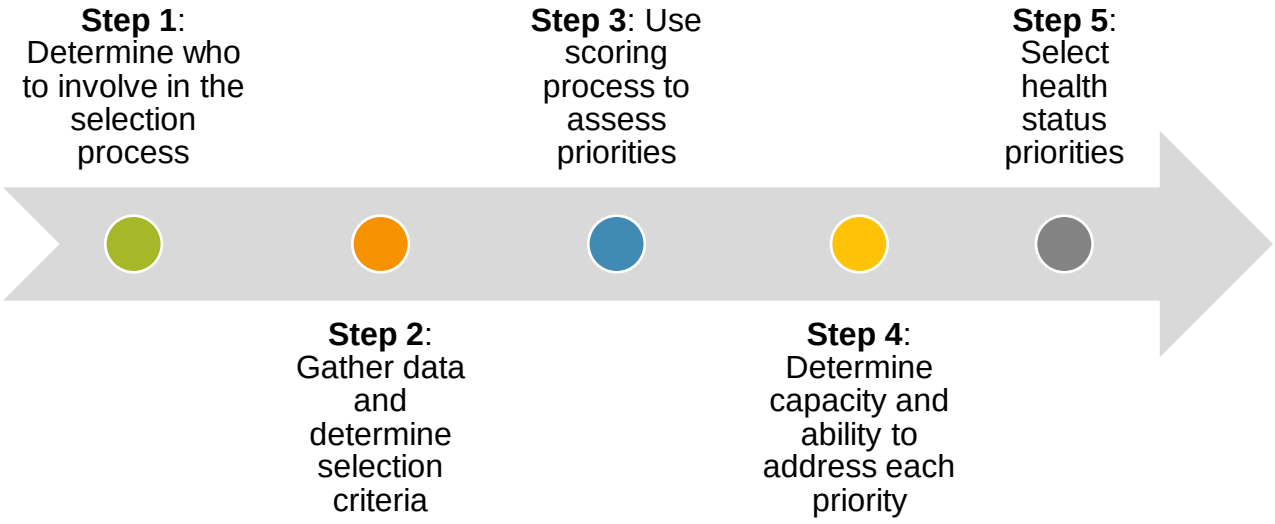
Through the data and literature, five key themes were identified as key to the priority selection projects: importance of local perspective, collaboration, transparency, resources, and utility. Each of those areas is described in Appendix C. As noted throughout the previous section of the guide, although there are strengths with the processes Nebraska has used in the past, there remain opportunities for improvement.

A systematic approach is encouraged for Nebraska to determine their health status priorities, which is outlined in five steps (see Figure 7). Each step contains a series of options to ensure the most suitable approach is used in Nebraska. These steps and the corresponding options are based on the literature and evaluation findings with the goal of creating a flexible approach for Nebraska. Insights and suggested tools are provided on how to carry out each of those steps.

Collaboration amongst a diverse range of partners is encouraged to determine the best approach for selecting the SHIP's health status priorities. To help facilitate the decision-making process, when more than one option is available, the advantages and disadvantages for each are highlighted. Findings from the evaluation project are also integrated to help inform the decision-making process. As part of this process, it may also be important to decide how to refer to health status priorities, to reduce confusion. Although with the redesign there are currently two types of priorities (system level and health status), there are other ways the health status priorities could be communicated. As an example, Rhode Island refers to them as "health focus areas" for the state.

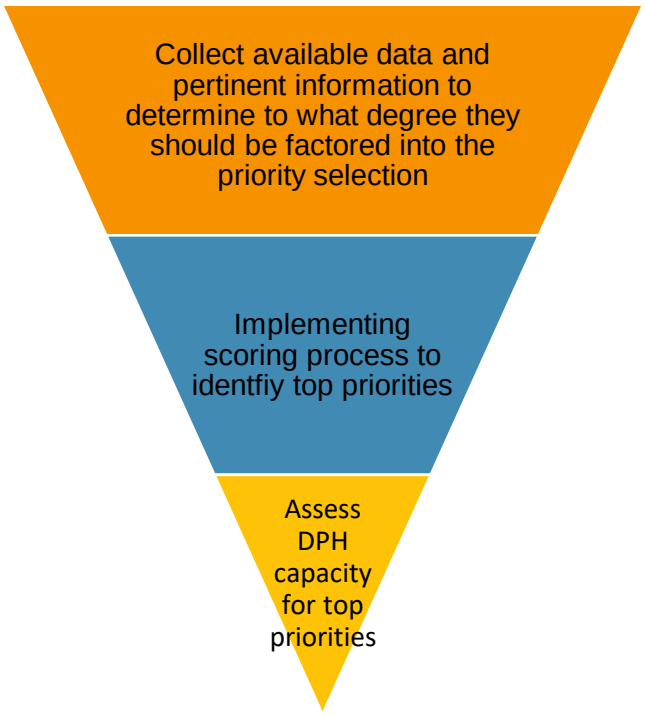
A participatory planning process with explicit criteria and processes is encouraged. The purpose of this document is to provide a structured, iterative guide that can be used for assessing statewide health issues and goals for the current and future SHAs/SHIPs.

Figure 7. The following steps are recommended for strategically determining state health status priorities



Step 1 is forming a diverse group to guide and implement the priority selection process. Although this may be led by DPH, it is important to include a range of partners that represent different agencies and geographic areas of the state. The purpose for that group is to strategically narrow down the state health priorities, as outlined in Figure 8. **Step 2** involves gathering any data or information that can complement the SHA and determining what should be included in the decision-making process. Within the guide there are a variety of data sources and documents (i.e., strategic plans, business plans, CHIPs, etc.) that may be publicly available and relevant to the project. During this stage the group should determine what data or information to include in the selection process.

Figure 8. Steps 2 through 4 are used to narrow down priorities in a systematic way



To organize and make sense of the information obtained, **Step 3** is where the health status priority selection group determines how to review, score, and/or rank that data. By implementing a scoring process, the group should be able to identify a list of top priorities. The guide outlines various approaches that could be used to help score or rank the priorities to ensure it is done in a strategic way, with samples included in Appendix D. Once

priorities have been narrowed, **Step 4** allows the group to better understand the state's capacity to address each of those priority areas. Based on that input, the group can make an informed decision about which health status priority or priorities should be chosen for the state.

Step 1: Determine who will be part of the selection process

To ensure a participatory planning process, it is important to identify and engage with a representative group of stakeholders. These stakeholders may include funding agencies, partner organizations/institutions, those who implement public health proposals, and those most impacted by community issues and inequities. Including these types of stakeholders helps promote buy-in to the prioritization process (CCHD, n.d.; Beltran, 2014).

Establish an advisory group

An advisory group may be useful to distribute the workload and provide valuable expertise for the prioritization process. **These would be separate from the eight workgroups that were established to help address the system-level priorities** outlined on page 2 of this document. Over half of respondents in the SHA/SHIP User Survey reported they were interested in participating in an advisory group for the SHIP or SHA. Other states, such as Vermont and Ohio, used Advisory Groups to inform SHIP strategy selection and/or review findings and prioritize strategies. Some advisory groups were asked to focus on specific areas, such as health equity and reducing inequities. These groups typically represented a wide variety of organizations and stakeholders. For information on constructing advisory groups, the MAPP provides guidance on assembling groups of differing sizes and goals in public health planning. The PHAB recommends involving "*at least 2 organizations representing sectors other than public health*," and "*at least 2 community members or organizations that represent populations that are disproportionately affected by conditions that contribute to health risks or poorer health outcomes"* throughout the priority selection process.

Ensure diverse engagement

According to the Center for Community Health and Development (CCHD) (n.d.), deciding the criteria and processes for **setting priorities should be driven first by those most affected by community issues and/or inequalities**.

Table 1 shows the groups across Nebraska that were identified through the SHA/SHIP User Survey as needing to be involved in addressing state priorities (organization types with >50% selection are in green). These data showed that LHDs, tribal health, and mental and behavioral health agencies were most often identified as needing to be involved in priority setting. Additionally, in discussing local health priorities, a tribal entity described ways in which to be included in the process:

"For us to be a part of either the steering committees or some sort of committee collaboration, those face-to-face meetings are very important, whether it's monthly or quarterly. That's one. Two, if the tribal councils could have a brief meeting with the DHHS leadership, it helps the tribal council of each of the tribes feel more immersed into the process. And then the final piece would be some sort of end of year synthesis that kind of shows how the information is being used. Something that's a hard copy that shows that this

is how the value of your information was used and this is why our relationship is so important." ~Tribal Interviewee

Moreover, having representatives from these groups from varying communities (i.e., rural, urban small, and urban large) across the state would help to diversify engagement in the process. Community and stakeholder buy-in may determine what priorities have the highest success, making the efforts to incorporate input from local health stakeholders that much more important (Barrett, 2012; CCHD, n.d.). Additional guidance on diverse and equitable engagement can be found in the equity section on page 16.

"We had a steering committee through the whole process that helped us with planning, guided us in the process, gave us feedback on what we were doing, maybe helped us set schedules of when things would be disseminated or shared. So, it was just very helpful because not only did we have our three hospitals involved, but we also had other influential public health stakeholders at the table that really helped. And then it made them feel part of the process because as I was mentioning before, this is a community driven process. I mean, everyone wants to point to the health department and yes, we do a lot of the heavy lifting, but it really is a community process for all … of our counties and we want them to feel that ownership." ~LHD Focus Group Participant

Table 1: Tribal health, LHDs, and mental and behavioral health were most often identified as needing to be involved to address infrastructure and equity (n=124)

	Infrastructure	Equity
Behavioral health agencies	53%	52%
Civic groups	28%	47%
Community Centers	40%	45%
Corrections	39%	42%
Elected officials	47%	48%
Employers/businesses	43%	43%
Emergency management services	51%	44%
Environmental agencies	46%	40%
Extension	37%	40%
Faith-based organizations	30%	43%
Fire departments	41%	34%
Health care providers	48%	51%
Health insurance	43%	50%
Higher education/academia	44%	51%
Hospitals	51%	49%
K-12 education	38%	44%
Law enforcement	34%	46%
Media Infrastructure	33%	48%
Mental health agencies	52%	57%
Non-profit organizations	48%	51%
Local health departments	55%	55%
Private foundations	39%	42%
Transit	38%	36%
Tribal health	55%	57%

Allow for equitable participation
Need for further development of equity in processes and stakeholder participation is an obstacle to effective implementation (Barrett, 2012). Built in flexibility may help reduce the individual burden, as well as increase engagement. An example of this would be to allow designated persons to send a representative in their place. T/LHDs noted an inability to attend meetings as a barrier to participation, with the meetings often located in Omaha or Lincoln. Utilizing alternative meeting locations across the state, as well as offering all meetings in a virtual or hybrid setting, would help offset the burden of travel for stakeholders that live far from the eastern population centers of the state, and those with fewer resources or an inability to travel (such as those with disabilities). Representation from different areas of the state is necessary, due to variations in data and resource availability that impacts decision making.

"If you are not there, you are not represented." ~DPH Focus Group Participant

"We should not be dragging people from the western part of the state all the time to these in-person meetings. You know that meme about, 'I just went to a meeting that could have been an email'? We're asking people to drive a long time for some of these meetings. Everything should have an online option to it." ~LHD Focus Group Participant

Step 2: Gather available information and determine selection criteria

Developing and utilizing explicit criteria and processes to set priorities provides a strong basis for addressing concerns around lack of transparency and communication (Gibson et al., 2004; Sibbald et al., 2009). Local T/LHDs and stakeholders want transparency and to have priority selection processes clearly communicated. Criteria typically include 1) the cost as well as the return on investment, if applicable, 2) availability of solutions, 3) impact of the problem, 4) availability of resources to solve the problem, 5) urgency of solving the problem, and 6) size of the problem (NACCHO, n.d.). Ideally, the priorities chosen will focus on what can be addressed (feasibility), where there are resources, and what will have the greatest impact.

There are several data sources, measures, and/or existing priorities that may factor into what health status priority or priorities a state ends up selecting. A key component of this effort is reviewing the SHA (which includes a compilation of statewide data), collecting other data pertinent sources that are available and determining what should be part of the decision-making process. Related to transparency in the decision-making process is the need to consider health equity, including in data, addressed in Step 3. The following information are the options that Nebraska could consider when determining priorities, including a summary of the advantages and disadvantages of each in Table 2.

As part of this step, the health status prioritization group can determine to what degree or how the data will be factored into the decision-making process. It may be decided, for example, that some sources are not taken into consideration when selecting priorities, such as funding opportunities. Although it is strongly recommended that the T/LHD priorities are part of the selection process, other sources may be up to the discretion of the priority selection group. A crosswalk was suggested by those who participated in the focus group with previous SHIP leadership to capture characteristics, similarities, and differences across CHIPs and other priorities, such as DPH priorities, governor priorities, etc.

T/LHD Priorities

The priorities of most tribal and local health department entities are outlined in their CHIPs, and most of these plans are publicly accessible. When looking across the United States, five states[5] explicitly consider tribal and local health department priorities when determining selection criteria. Another five states[6] broadly use or review CHAs and CHIPs while determining selection criteria.

In Nebraska, representatives from T/LHDs recommend taking advantage of similarities at the local and regional level, and paying attention to geographical groupings, such as rural/urban, and tribal regions. Moreover, a crosswalk was suggested by those who participated in the focus group with previous SHIP leadership to capture characteristics, similarities, and differences across CHIPs. Refer to Appendix C to see the results on Nebraska's crosswalk.

"One thing about community health assessments, those that have been done at the local health departments is that they have had processes to get community input. So we would know that those activities and strategies and priorities have been set by getting a lot of input, both surveys and focus groups and meetings that have come from those local communities." ~DPH Focus Group Participant

Healthy People

Nine states[7] utilized Healthy People 2020 or Healthy People 2030 to determine their criteria and/or priorities. The Healthy People 2030 website[8] lists each objective and provides background information, and the DHHS dashboard for Healthy People 2020[9] shows state level performance for selected outcomes, providing a starting point to identify potential health topics. A prioritization method, which will be outlined in Step 3, could help this process. More specifically, Arizona and Connecticut referenced Healthy People 2030 for frameworks and alignment of topics, while Colorado and Indiana took leading health indicators from Healthy People 2020 into account. Maryland used 39 measures of health characteristics aligning with Healthy People 2020, and Massachusetts, Minnesota, and Montana used Healthy People 2020 objectives to guide their own state health plans.

[5] Alaska, Montana, New Mexico, Utah, and Wisconsin
[6] Alabama, Indiana, New Jersey, New York, and Pennsylvania
[7] Arizona, Colorado, Connecticut, Indiana, Maryland, Massachusetts, Minnesota, Montana, and New Mexico
[8] https://health.gov/healthypeople
[9] https://dhhs.ne.gov/Pages/Community-Health-Dashboard.aspx

Governor Priorities

Although not overly common, four states[10] also consider governor's priorities when selecting their SHIP priorities. This information should be publicly available. Along with several other resources, Colorado's Public Health Improvement Steering Committee reviewed the Governor's 2013 The State of Health: Colorado's Commitment to Become the Healthiest State when selecting priorities. In Florida's recent SHIP, their Steering Committee selected eight priorities before adding an additional ninth from their governor. Additionally, the Action Plan to Eliminate Health Disparities by the Governor's Interagency Council on Health Disparities informed the Washington SHIP, while the Governor's Healthy Equity Council recommendations executive summary informed the Wisconsin SHIP. Finding a way to consider or even align the SHIP priorities with the Governor's priorities was also noted during the DPH focus groups.

"I think getting buy-in from legislature and the governor's office around those priorities as well so that we can make sure that they're at least aware and, and hopefully can align with governor's priorities as well" ~DPH Focus Group Participant

Funding Opportunities

Feedback obtained through the data collection in Nebraska indicated that it may be helpful to select priorities based on which topic areas have state or federal funding available to support it. Many funding agencies, such as the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA), and Health Resources and Services Administration (HRSA) provide funding forecasts that can be accessed online. Utilizing this information can provide data on funding access and insight into what health focus areas may be most feasible to fund. If a state government gives little or no funding to public health, federal grants may be the next source of funding to seek out. However, this funding may be limited further if distributed at the local level.

"We at least need to take a look at what do we have funding for. Otherwise, you know, we can choose some priorities, but we won't be able to do anything towards them because we don't have any funding." ~DPH Focus Group Participant

"…it'd be nice from a state perspective, look at what funding sources do we have…we are responsible for finding those resources, but if the state has resources and puts it in those buckets, guess what, things tend to get done because there's money. It always comes down to funding people and staff and programs." ~LHD Focus Group Participant

Other State Plans & Priorities

PHAB guidance states that SHIP priorities should be reflective of the state as a whole and should not reflect a specific program's state plan. However, there are many state plans available through public health programs that can be utilized to inform the SHIP priorities. An example of this approach was implemented by Indiana, which integrated this into their process by gathering a team to meet with subject matter experts to review objectives and strategies for improving health. They reviewed planning documents from other state agencies to better understand the initiatives and strategies already being conducted or planned. In addition, they made a concerted effort to ensure that the data, activities, and

[10] Colorado, Florida, Washington, and Wisconsin

strategies in their SHA and SHIP were aligned with other local, state, and national improvement efforts. Table 2 shows some advantages and disadvantages to the data sources listed above.

"And for state, we also have our priorities for sure. For example, for cancer, we do collaborate with our state cancer control program and it's all kind of federal funding directed. We rarely, just as I mentioned, communicate with the local health department directly, you know, to figure out whether they have any priorities on cancer." ~DPH Focus Group Participant

A related consideration is reviewing the previous SHIP to see what priorities may still need to continue into the next SHIP. Rather than 'starting from scratch' every five years, some DPH staff and key partners felt it may be beneficial to continue on with SHIP priorities that need more than five years to adequately address or make progress toward.

"I think the key thing there is, and that I'm concerned about, is if we've had previous priorities that are still applicable and need to be addressed. … I wouldn't want to be jumping on and working on a lot of other things. I'd like to be figuring out why those haven't been addressed and keep working on them. Otherwise we just kind of keep jumping from thing to thing and never really fully address what still need to be addressed." ~DPH Focus Group Participant

"I think we need in our SHIP and CHIP plans to maintain priorities for longer. I know we're required to update them every 3-5 years, but I would love to see continuity. We haven't made movement on behavioral health and substance abuse in our regions – I mean, we've done what we can and we're putting efforts toward it, but the outcomes we're seeking haven't shifted as much. What if we keep those priorities for a longer period of time until we create the change we want to see? What does it mean to reassess every three to five years and then change priorities if we need to?" ~LHD Retreat Attendee

Table 2: Data sources or documents to review or consider

Data Source	Advantages	Disadvantages
T/LHD Priorities (via CHIPs)	✓ Would ensure better alignment between SHIP and T/LHD priorities ✓ Integrates feedback and needs expressed by constituents across the state as CHIPs are developed with local input ✓ Increased likelihood of issues being addressed because they are prioritized locally	× Some CHIPs may not be publicly available × There are a number of CHIP priorities to consider × Each T/LHD uses a different process and timeline to implement their CHA/CHIP × Some T/LHDs may lack access to data needed to determine state-level priorities
Healthy People	✓ Dashboard provides trend information to identify problem areas ✓ Could generate alignment with like-states	× There are 359 Healthy People objectives, which may be overwhelming to review × There is a lack of local data for many of the Healthy People objectives and measures

Governor Priorities	✓ Likely to have state-level support and resources	× May not align with what other data sources identify as priority × Priorities may change due to elections, which may produce instability of support
Funding Opportunities	✓ Potential for ensuring there are resources to do the work	× May not align with what other data sources identify as priority × Availability of funds may not be consistent or known
Other State Health Plans & Priorities	✓ There are many public resources ✓ Could create alignment within programs and organizations ✓ Could indicate that additional resources and/or capacity are available to address those priorities	× Some methodologies may not be generalizable

Health Equity

Public health focuses on the wellbeing of the entire population, to improve quality of life, and reducing human suffering (American Public Health Association 2022). The inequalities related to social determinants of health (SDOH) are counter to these goals, so public health must work to eliminate the disparities affecting populations that are underserved or otherwise marginalized (Braveman 2017). Health equity and health disparities must be taken into consideration when developing criteria. Addressing SDOH ensures the root causes of health disparities are attended to. Some researchers estimate that 80 to 90 percent of health outcomes are due to SDOH, and are becoming a public health priority (Braveman & Gottlieb, 2014; Magnan, 2017; McGinnis, Williams-Russo & Knickman, 2002). First, SDOH must be identified.

Identifying SDOH is a multi-step task. Examples of SDOH, such as lack of access to health care, environment and community conditions, housing, behavioral factors, socioeconomic status, education level, transportation, geography, discrimination, and commercial determinants of health, can be found in many sources. A greater challenge is finding data that includes useful indicators for the entire population. Which indicators are chosen may provide different insights, and impact the measurement of progress (Mangan 2017). Data must be acquired and/or collected to systematically measure outcomes for the groups affected. The results of the SHA can provide details about who is most affected by disparities, help us understand root causes (Mangan, 2017), and help focus resources to areas of greatest need (Braveman, Egerter & Williams, 2011).

Additional potential criteria relating to health disparities include severe housing problems and disconnected youth, as both indicators are backed up with recent research (Mangan 2017). Risk behaviors such as substance use and exposure to violence are correlated with this status. Furthermore, racial and ethnic minorities have a higher proportion of disconnected youth than the majority population. More factors to consider when approaching health equity include unequal distribution of resources, empowering individuals, building community capacity, and advocating for equitable policies. Resources that contain further information useful for addressing health equity include a CDC provided

toolkit for conducting the SHA, the Robert Wood Johnson Foundation, the County Health Rankings, and Healthy People 2030.

Native American Communities
Three factors that negatively affect data collection within Native American communities are underreporting and misclassification, lack of trust, and cultural sensitivity (Jim et al., 2014; Skewes et al., 2020). Underrepresentation of Native American respondents of surveys may in part be rooted in racial misclassification, ensuring results derived from inadequate and misleading data. Reluctance to participate in such surveys and research also impacts the quality of data. This reluctance stems from historic malpractice. Furthermore, lack of exhibited understanding of traditions and cultural beliefs hinders the accuracy of data collection and representation. Engaging with Native American communities and taking cultural differences into account while developing surveys are key strategies to improve inclusion. Additionally, Tribal Epidemiology Centers may function as a valuable resource for accessing tribal health data.

Step 3: Use a scoring process to assess priorities

Several stakeholders across Nebraska noted the importance of narrowing down priorities. Using an explicit prioritization method to do this increases transparency and communication of how health priorities are determined. Scoring processes can provide the structure to narrow down and analyze alternatives while supporting the alignment of T/LHD and state DPH priorities.

The following prioritization methods are derived from prioritization processes in other states and best practices from the literature. Nine states[11] use prioritization or ranking criteria in assessing potential SHIP priorities:

- The Alabama ACHIP (Alabama Community Health Improvement Plan) uses the Q-sort ranking system, which consists of all stakeholders ranking 13 selected health concerns and averaging the ranking scores to find those in highest priority.
- A weighted scoring system was used by Louisiana to identify the top three priorities.
- A weighted voting system based on a list of criteria was used by New Hampshire to identify 10 health status priority areas.
- After potential priorities were identified, the State Coordinating Council for Public Health in Maine voted on priorities based on a set of criteria.
- Ohio used stakeholder selection through regional forums and online prioritization surveys for Steering and Advisory committees.
- Pennsylvania used the Hanlon method, a formulaic system to calculate the size of problems, gravity of them, and the feasibility of solving them.
- South Carolina voted to select criteria for the Hanlon method and then used the Hanlon method to determine priorities.
- The first round of prioritization in Utah and Vermont was conducted based on a set of criteria, though their publicly available documents did not explain how they were considered.

All methods used by states and described in the literature use a scoring process that involves voting, ranking, and/or weighing to meet the needs of policy goals across criteria.

[11] Alabama, Louisiana, Maine, New Hampshire, Ohio, Pennsylvania, South Carolina, Utah, Vermont, and

Of the methods listed below (Table 3), only the prioritization matrix and Goeller scorecard use one system (ranking), while all others utilize more than one system. Using multiple systems within a prioritization methodology aims to draw on strengths of some systems while minimizing weaknesses of others (Patton et al., 2016). Regardless of which prioritization systems are used and which prioritization method is chosen, decisions are ultimately made based on implicit or explicit criteria.

Voting systems

Among state SHIPs, five states[12] explicitly utilized **voting systems** in their prioritization processes but did not provide specific details on what voting techniques they used. The nominal group technique and multi-voting technique are two voting and ranking prioritization methods that have been employed in public health settings and may be used to assist in assessing potential SHIP priorities (McMillan et al., 2016; NACCHO, n.d.).

Pros	Cons
Promotes deliberation, democratic outcomes, equitable participation, and transparency	Provides space for strategic voting and limitations of collective decision-making

Ranking and weighting systems

Ten states[13] all considered **rankings** in their prioritization process, but only three states[14] utilized explicit ranking methods, as described above. Four non-voting ranking methods are explored with the prioritization matrix and Hanlon method being currently used in state SHIPs (NACCHO, n.d.; Wolk, 2015). The Goeller scorecard and goals achievement matrix provide alternative methods to compare alternatives with the Goeller scorecard being recommended in public health settings (Luck & Yoon, 2015; Patton et al., 2016). Four states[15] used **weighting systems** in their prioritization process with two[16] utilizing the Hanlon method as an explicit prioritization process.

Pros	Cons
Structures a comparison across alternatives, as well as the potential for the inclusion of criteria and/or weights	Requires agreement on criteria or rankings used through an outside method not included in the process

The benefits and disadvantages for these options are outlined in Table 3, with examples shown in Appendix D. Additional details on how to implement each of the approaches can be obtained through the references.

[12] New Hampshire, Louisiana, Maine, South Carolina, and Utah
[13] Alabama, Colorado, Louisiana, Massachusetts, New Hampshire, New Jersey, New Mexico, Pennsylvania, and Utah
[14] Alabama, Pennsylvania, and South Carolina
[15] Louisiana, New Hampshire, Pennsylvania, and South Carolina
[16] Pennsylvania and South Carolina

Table 3: Prioritization methods by system

Method	Systems			Pros	Cons
	Voting	Ranking	Weighting		
Nominal groups	X	X		Utilizes a deliberative and democratic process to work through priorities	May allow for some participants to dominate the discussion, making the alternatives chosen non-representative
Multi-choice	X	X		Can narrow down a list of items quickly and through consensus, may be used with other processes to narrow down alternatives further	May encourage strategic voting rather than consensus building
Prioritization matrix		X		Allows for criteria to be compared across alternatives	Requires agreement on criteria and their importance
Hanlon method		X	X	Structures a data-driven comparison of priorities	Resource intensive to collect data, requires agreement on rankings
Goeller scorecard		X		Structures a comparison of alternatives across criteria while leaving alternatives in their natural units	Requires agreement on rankings not included in the prioritization method
Goals achievement matrix		X	X	Structures a comparison of how much alternatives meet criteria, including how important the criteria is	Requires agreement on rankings not included in the prioritization method

Step 4: Determine capacity and ability to address initial list of identified priorities

Following the scoring process, the priority selection group should have an initial list of top health priorities. Before selecting the final health status priorities, it is important to assess the state's capacity and ability to address those, as that factors into the resoruces available to impact that priority area. This section outlines the various ways that capacity and the ability to influence each of those priorities could be assessed, providing additional insight on which priority or priorities should be selected.

Conduct Survey with DHHS Staff

A survey can be used to assess the capacity – including funding, staffing, and expertise – among state health department staff, which can be used to determine the feasibility of addressing health status priorities. Many DPH staff and key stakeholders noted that it was important to select priorities that would have support from DHHS. A survey could provide an opportunity to capture timely information regarding what funding and priorities DHHS programs have.

"I think that certainly getting input across the division – asking about in what ways would you see your program or your area or your service having a strategy or ways that you could align towards this particular objective or goal?" ~DPH Focus Group Participant

This document contains some of the questions from the capacity survey used with DPH staff (administered to program managers) as part of the evaluation project as a sample (Appendix E). More information about the administration of this survey can be found in the methodology section (Appendix A).

Pros: Provides insight to what the state can feasibly address; helps identify what support may be available to help implement each priority area; provides initial sense for which areas may have more buy-in among DPH staff

Cons: Captures a point in time; hard to determine who should be surveyed; may have low response rates; time-consuming to implement and analyze

Solicit Feedback from Key Partners

In addition to assessing capacity from DHHS staff, it may also be helpful to solicit input and feedback from key partners. This may include LHDs, tribal entities, community-based organizations, universities, etc. This provides an opportunity to assess to what degree others have the capacity to assist in addressing potential health status priorities. The data collection approach may depend on what type of information would be most valuable. A survey may provide an opportunity to make comparisons with results from the DHHS staff survey, helping to identify areas of alignment or discrepancy. If more in-depth information would help inform priority selection, interviews or focus groups could be done instead of or in addition to a survey. See Appendix E for examples of survey questions on capacity.

"Be realistic to your point where the opportunities are, where there is dedicated staff, where there is money." ~ Previous SHA/SHIP Leadership

Pros: Ensures firsthand knowledge of what people see, want, and can accomplish

Cons: There can be conflicting feedback

Utilize the PEARL Test

One way of looking at the feasibility of a health priority is through applying the PEARL test. This test provides a set of questions to consider to ensure effective decision making (NACCHO, n.d.). Similar to a strengths, weaknesses, opportunities, and threats (SWOT) analysis, utilizing a method such as the PEARL test provides an opportunity for SHIP leadership to review priorities before their final selection. These may be considered in view of potential obstacles to effective implementation of prioritization such as a lack of quality data, a lack of equity in decision making processes, stakeholder fatigue, poorly understood criteria, and political dynamics (Barrett, 2012).

PEARL Test

- **P**ropriety
  - Is a program for the health problem suitable?
- **E**conomics
  - Does it make economic sense to address the problem? Are there economic consequences if a problem is not carried out?
- **A**cceptability
  - Will a community accept the program? Is it wanted?
- **R**esources
  - Is funding available or potentially available for a program?
- **L**egality
  - Do current laws allow program activities to be implemented?

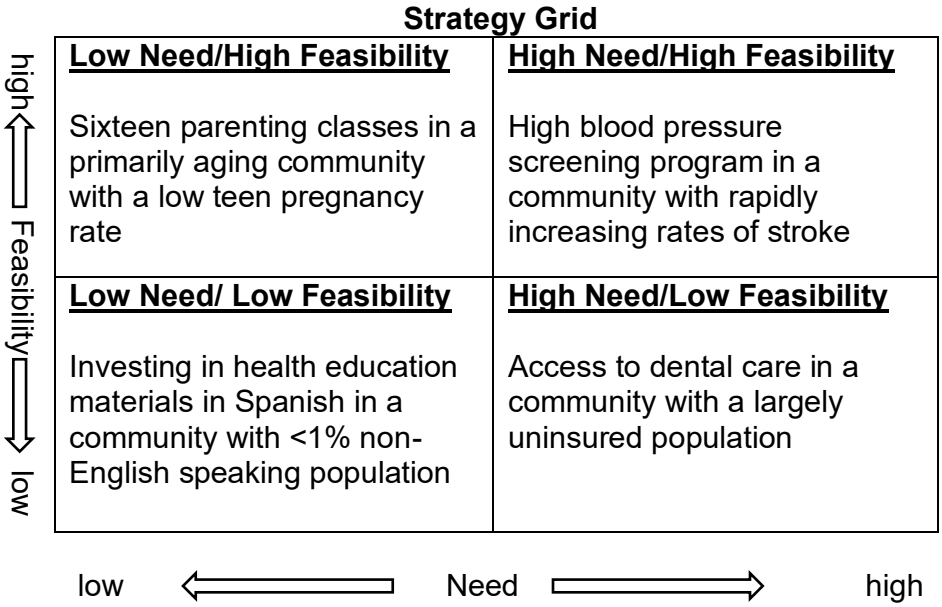
Pros: Provides a discrete and overarching list of feasibility requirements

Cons: Possibility for disagreement on whether priorities meet aspects of the test and if not, how to correct them

Strategy Grid

When resources are scarce, the usage of a strategy grid provides guidance in deciding the most resourceful plan of action (NACCHO, n.d.). Two perpendicular axes divide the grid, one representing feasibility of a task, and the other representing the gravity of the task (Figure 9). These two axes can be utilized for different criteria as well, given the need. While it can be difficult and politically straining to sort priorities in these categories, it can be a driving force in maximizing change.

Figure 9: Strategy grid example from NACCHO (n.d.)



Different categories require different plans and levels of action to be made. The most favorable outcomes may come from focusing on priorities with high need and high feasibility (NACCHO, n.d.). With priorities of low need and high feasibility, the utility of resources may need to be reassessed. While change can be made, low need may garner low investment, while high investment can be saved for greater impacts. Pursuing priorities with high need but low feasibility may threaten productivity and success should priorities be shown to be infeasible. Although these projects are deemed to have low feasibility, because of their high resources needed, they should be executed as a long-term endeavor, using increased resources stretched out over a longer period. Priorities with little need and little feasibility may be best abandoned for the greater impact of other more impactful accomplishments.

Pros	Cons
Can visualize how priorities relate between feasibility and need or capacity	Possibility for disagreement on whether priorities are feasible or not, requires an understanding of differences in feasibility and need or capacity across areas

Step 5: Select final health status priorities

The final step of the process is selecting the final health status priority or priorities. A variety of considerations should be taken when making the final section, as outlined in this section.

Select an appropriate number of health status priorities

As noted, states have an average of five priorities included in their SHIP. Nebraska has developed four SHIPs, with at least three of them having five priorities. With the 2023-2027 SHIP, there are currently two public health system-level priorities that focus on infrastructure

and equity. Given that, it is important to determine an appropriate number of health status priorities. Based on data collected as part of this evaluation, an ideal number seems to be three or less.

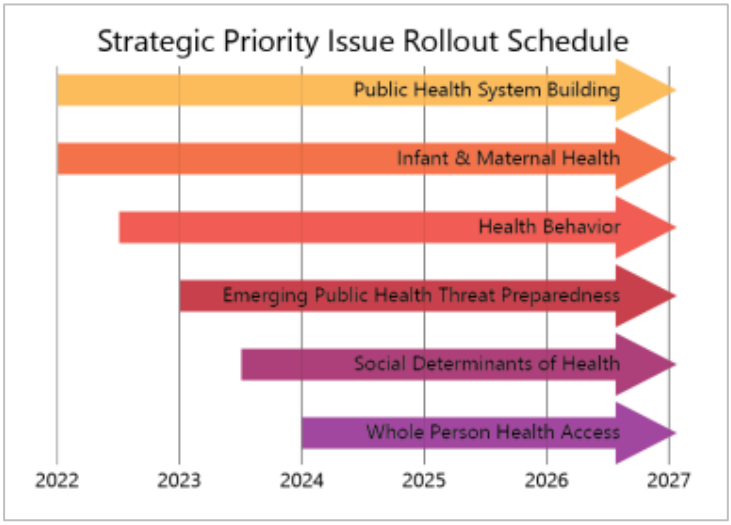
It was recommended from the data collected from the evaluation that the number of priorities selected for Nebraska's SHIP be narrowed. A respondent in the 2022 SHA/SHIP user survey recommended "*Narrowing the number of priorities and placing greater emphasis on a few."* Two other respondents suggested selecting only one or two priorities. Key stakeholders also noted that the broad scope of past priorities were overwhelming: *"There were five areas: helping the health systems integration, depression and suicide, obesity, health care utilization, and access and health equity; those are huge things."*

"I agree with prevalence. If there are two or three things that shake out as almost every health department had those in the plan, those are it." ~LHD Focus Group Participant

Consider rolling dates for addressing priorities

If it is not possible to limit the number of health status priorities, another option is to set rolling dates for addressing each priority areas. This is an approach utilized by Missouri, as shown in Figure 10. They structured their plan so that two priorities were addressed first in 2022, and then another priority would be added every six months. Furthermore, at the end of each year, annual reports contained information about progress made on each priority area during each period. They also suggested a tiered approach where a smaller set of themes is prioritized initially, with others phased in based on timelines or other criteria.

Figure 10. Missouri's SHIP utilized a rollout schedule for addressing SHIP priorities



"And if they want to have them all, maybe they need to be in a tiered approach, you know, do you know these four or five first year and then tier them in or phase them in based on timelines or, or whatever." ~LHD Focus Group Participant

Plan to continue with priorities

A SHIP typically covers a five-year period, though it was noted by T/LHDs that often more time is needed to adequately address specific health topics in that duration. Given that the 2023-2027 SHA/SHIP is being redesigned, it may not make sense to continue with the priorities previously identified. As future health status priorities are selected, however, the priority selection group may find that it is appropriate to keep the same prioritizes for more than the five-year period to allow more time for change to be made.

"So it might be something that we look at again in the future, just because it does take so much time." ~LHD Focus Group Participant

Other Considerations

Whether health status priorities are new or retained from the previous SHIP, reviewing its priorities and processes enables SHIP leadership to reassess the strengths and weaknesses of past approaches. Elements that might be reevaluated include previous priorities, capacities, and data accessibility. Such a review could also address concerns raised by key stakeholders in the previous SHIP about data accessibility for priorities. Reviewing previous SHIP priorities provides SHIP leadership with an opportunity to re-engage stakeholders, which may take place through collaborative meetings, committees or workgroups, and involving key partners. This review would foster greater buy-in for what decisions are made (AHA, 2023). Re-evaluation of final priority selection methods may be necessary to ensure the effectiveness after repeat uses. Insight from these evaluations may be put to future use, along with guidance from this document.

Obtaining Public Input

A variety of states solicit feedback and input from the public. This can be done through a public comment period or preliminary presentations of the priorities. It is essential to have buy-in, so Nebraska may want to determine at what points in the process and how it's most effective to solicit public input. Refer to the Health Equity section on page 18 for information on SDOH and groups that may be at greater risk. Involved organizations listed in the PHAB include the following: *"other governmental agencies (e.g., education, transportation, community development); not-for-profit groups, advocacy organizations, associations, or special interest groups related to health assessment priority areas (e.g., employment, housing); businesses; recreation organizations; or faith-based organizations."*

Considering Terminology

One challenge noted with the SHIP priorities – both the system level as well as the health status priorities – is the terminology. Through the priority selection process, it may be beneficial to have the workgroup determine what terminology would resonate best and/or how they should be explained. Rhode Island, for example, refers to their health status priorities as "health focus areas." Clarifying the terminology may help reinforce the purposes ssof the statewide priorities and avoid overusing the word priority.

"[It's important] for folks to know that if they're working in an area or doing something as a core service of DPH, if you're not mentioned within one of the [SHIP] priorities, you're still a priority service that we're providing and we want to do it well and support it and find ways to continue doing that. Again, some of that is just that wording and, and helping people understand what it means to be a priority and knowing that, if I'm in an area that's not mentioned within that, you're still a priority service that we're providing or program that we have within the Division. ~DPH Focus Group Participant

Appendix A: Methods

Literature Review

The team conducted a literature review of public health research, as well as applied reports and documentation, and public health organization guidance. These sources were reviewed for best practices and commonalities, which are compiled in this report and used to inform recommendations. Integrated with other data analyzed for this guide, the review of literature and data can be found in Appendix C.

Review of State SHIPs

The SHIPs from 49 states with publicly available documentation were collected and compared regarding their processes for identifying priorities, and in particular health status priorities. Ten of those states are not accredited by the Public Health Accreditation Board (PHAB), thus much of the analysis is focused on SHIPs from the remaining 39 states (see Appendix B for more information). Content from the SHIPs were coded and analyzed for similarities and differences. Conclusions from this analysis were then used to provide suggestions for best practices of priority selection based on patterns found nationwide.

One aspect of the analysis was the state's governance structure. The Centers for Disease Control and Prevention (CDC) outlines the varying types of governance that states may have.[17] Centralized states indicate that the local health departments are primarily led by the state while decentralized states, such as Nebraska, indicate that local health departments are primarily led by local entities. Slightly more than half (22) of the 39 states are decentralized. Among the remaining states, eight states were centralized[18], two were largely centralized[19], three were mixed[20], three were shared[21], and one was largely shared.[22] When doing the analysis, largely centralized were grouped with the centralized.

Focus Groups with LHDs and Interviews with Tribal Entities

To better understand the perspectives of those who work for the T/LHDs, data was collected from LHD directors and staff in February 2023. LHD participants were asked to join focus groups, and three tribal health directors were requested to partake in one-on-one interviews. Four LHD focus groups were conducted virtually, with participation ranging in size from six to ten per group. A total of 24 people representing 16 of the 21 different LHDs participated in at least one focus group. This data collection opportunity captured feedback on 1) the alignment between the SHA/SHIP and local efforts and what support could be offered by DHHS and 2) how LHDs and tribal entities carry out their CHA/CHIP processes. Findings from these focus groups and interviews highlighted how DPH can support T/LHDs

[17] Health department governance. (2022). Centers for Disease Control and Prevention. https://www.cdc.gov/publichealthgateway/sitesgovernance/index.html

[18] Arkansas, Delaware, Mississippi, New Mexico, Rhode Island, South Carolina, Vermont, and Virginia

[19] Alabama and Louisiana

[20] Maine, Oklahoma, and Pennsylvania (defined as *"some local health units are led by employees of the state and some are led by employees of the local government. No one arrangement predominates the state."* (NORC University of Chicago, 2012))

[21] Florida, Georgia, and Kentucky (defined as "*local health units may be led by employees, then local government has authority to make fiscal decisions and/or issue public health orders."* (NORC University of Chicago, 2012))

[22] Maryland

health priorities, as well as how DPH can address T/LHD training, funding, and technical assistance needs.

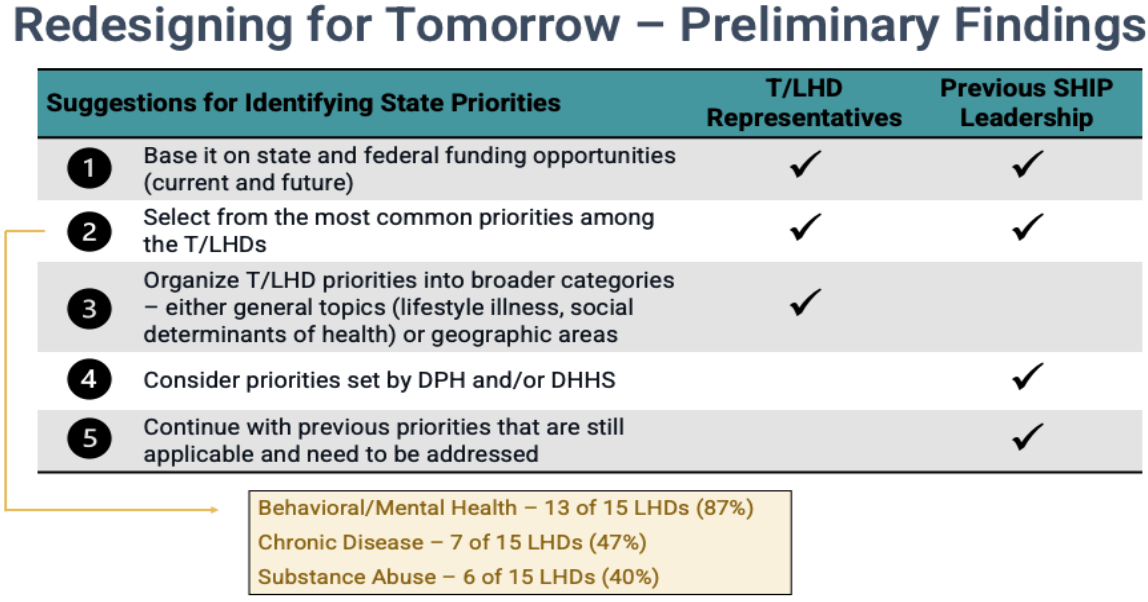
Previous Leadership/Key Stakeholders Focus Group

A virtual focus group of previous leadership and current key stakeholders was conducted with seven participants in March 2023. In total, three of the focus group participants were from DPH, two were from University of Nebraska Medical Center (UNMC), one was from a LHD, and one was from the Nebraska Association of Local Health Directors (NALHD). Although the individuals who participated primarily represented those who were in leadership roles with the 2017-2021 SHIP, some of the DPH staff represented the two new system-level priorities of infrastructure and equity. The purpose of this focus group was to capture lessons learned from the 2016 SHA/2017-2021 SHIP and gather feedback on their perspectives on the future direction of the SHA/SHIP and alignment with CHAs/CHIPs.

DPH Focus Groups

Five virtual focus groups with DPH teammates were conducted in May and June 2023 to collect feedback on how to best elevate the CHIP priorities as health status priorities for the SHIP. Results from prior interviews and focus groups with T/LHDs as well as the SHIP leadership/key stakeholders focus group were presented to the focus group participants as part of the data collection process (shown in Figure 11). This allowed for additional feedback on findings and recommendations gathered up to that point. The focus groups ranged in size from six to 12 participants, with a total of approximately 45 DPH teammates providing input.

Figure 11: The five preliminary suggestions for identifying the health status priorities for the SHIP were presented during the DPH Focus Groups



DPH+ Capacity Survey

The Capacity Survey was developed based on a literature review of public health capacity assessments and expert review from the team of SHA/SHIP Redesign researchers. The

purpose was to capture data related to the internal capacity for SHA/SHIP processes. The survey included approximately 50 questions covering topics such as adequacy of resources, current programming, support for T/LHDs and community partners, funding, health disparities, data, alignment between the SHA/SHIPs and the CHAs/ CHIPs, alignment of priorities, collaboration around the SHA/SHIP, collaboration, past experience with SHA/SHIP, recommendations for improvement, as well as training and technical assistance.

The Capacity Survey was administered to teammates of public health programs or initiatives at DHHS via the online survey platform Qualtrics. The recipient list of 70 teammates (66 unique individuals, with some answering on behalf of multiple roles) was determined based on an initial list provided by the SHIP Manager from the Office of Performance Management at DPH and input from the research team, ensuring that one person from each pertinent program was identified (typically the program manager). The list primarily included DPH teammates, but also included four teammates from the Division of Behavioral Health (DBH) whose programs align with DPH health focuses and priorities. The survey was open for a month, with two reminders sent, starting at the end of September 2022. A total of 46 individuals completed the survey for a response rate of 66%. A full report on the findings from the survey is available upon request through DPH.

SHA/SHIP User Survey

The research team developed a survey to solicit feedback from a range of users of the SHA/SHIP. A user was defined as someone who 1) indicated they have used the SHA/SHIP, 2) participated in developing the previous SHA/SHIP; and/or 3) could provide valuable insights on the SHA/SHIP based on their role or position. The SHA/SHIP User Survey asked individuals to share their opinions, experiences, and recommendations for the SHA/SHIP development process, the identified SHA/SHIP priorities, and the documents themselves. Respondents were also queried about their interest in future work focused on the two system level priorities (equity and infrastructure).

The survey was administered via the online survey platform Qualtrics using two methods: 1) direct invitations sent to those identified as users and 2) open survey links shared with LHD Directors and tribal organization leaders to share with those they felt would be qualified to provide input. Participants receiving direct invitations were intentionally selected based on their prior participation in or utilization of the SHA/SHIP or were determined to be able to provide a valuable perspective based on their position. A provisional recipient list was provided by the SHIP Manager from the Office of Performance Management at DHHS, including contacts from prior SHIP meeting attendees. This list was combined with contacts from the LHD Director list, responses from the DPH+ Capacity Survey suggesting additional contacts, and additional searches for appropriate stakeholders. The survey was open for approximately one month, opening November 1, 2022, and closing in early December. An additional 52 invitations were sent to T/LHD individual staff who were previously involved in SHA/SHIP activities in mid-November.

A total of 280 individuals (228 original invitees plus the 52 additional T/LHD individuals who were previously involved in SHA/SHIP activities) received direct invitations to participate in the SHA/SHIP User Survey. Among those, 84 responded to the survey for a response rate of 30%. In addition to these participants, 39 people participated in the survey through the

open link shared with T/LHDs and tribal organizations. Similar questions to the SHA/SHIP User Survey were also asked in the DPH+ Capacity Survey. Responses to similar questions included on that survey were merged with the SHA/SHIP User Survey, which added an additional 25 cases for those questions. Thus, a grand total of 148 responses were collected across the SHA/SHIP User Survey and respondents for like-questions from the DPH+ Capacity Survey**.** A full report on the findings from the survey is available upon request through DPH.

Appendix B: Summary of SHIPs Reviewed

Below are the State Health Improvement Plans (SHIPs) that were reviewed and coded to better understand processes for the health status priority selection. This only included health departments that were accredited by the Public Health Accreditation Board (PHAB).[23]

State	Type of Structure[24]	Year of SHIP
Alabama	Largely Centralized	2015 - 2019
Arizona	Decentralized	2021 - 2025
Arkansas	Centralized	2021 - 2025
California	Decentralized	Unknown
Colorado	Decentralized	2015 - 2019
Connecticut	Decentralized	2020 - 2025
Delaware	Centralized	2018 - 2023
Florida	Shared	2017 - 2021
Georgia	Shared	2016 - 2021
Idaho	Decentralized	2020 - 2024
Illinois	Decentralized	Unknown
Indiana	Decentralized	2018 - 2021
Iowa	Decentralized	2023 - 2027
Kansas	Decentralized	2023 - 2027
Kentucky	Shared	2017 - 2022
Louisiana	Largely Centralized	2016 - 2020
Maine	Mixed	2018 - 2020
Maryland	Largely Shared	Unknown
Massachusetts	Decentralized	Unknown
Minnesota	Decentralized	2017 - 2022
Mississippi	Centralized	2021 - 2026
Missouri	Decentralized	2022 - 2027
Montana	Decentralized	2019 - 2023
New Jersey	Decentralized	2018-2020
New Mexico	Centralized	2020 - 2022
New York	Decentralized	2019 - 2024
North Carolina	Decentralized	Unknown
North Dakota	Decentralized	2019 - 2021
Ohio	Decentralized	2020 - 2022
Oklahoma	Mixed	Unknown
Oregon	Decentralized	2020 - 2024
Pennsylvania	Mixed	2023 - 2028
Rhode Island	Centralized	Unknown
South Carolina	Centralized	2018 - 2023
Utah	Decentralized	2017 - 2020
Vermont	Centralized	2019 - 2023
Virginia	Centralized	2023 - 2027
Washington	Decentralized	2014 - 2018
Wisconsin	Decentralized	2023 - 2027

[23] Accreditation Activity. (n.d). Public Health Accreditation Board. Excel spreadsheet retrieved from website on May 16, 2023: https://phaboard.org/accreditation-recognition/accreditation-activity/?gclid=CjwKCAjwv8qkBhAnEiwAkY-ahgVfDQf3suIStwK4P8gRQa47M3MkCCC09jregMUHZeRoXaENzZNxFhoCIDsQAvD_BwE

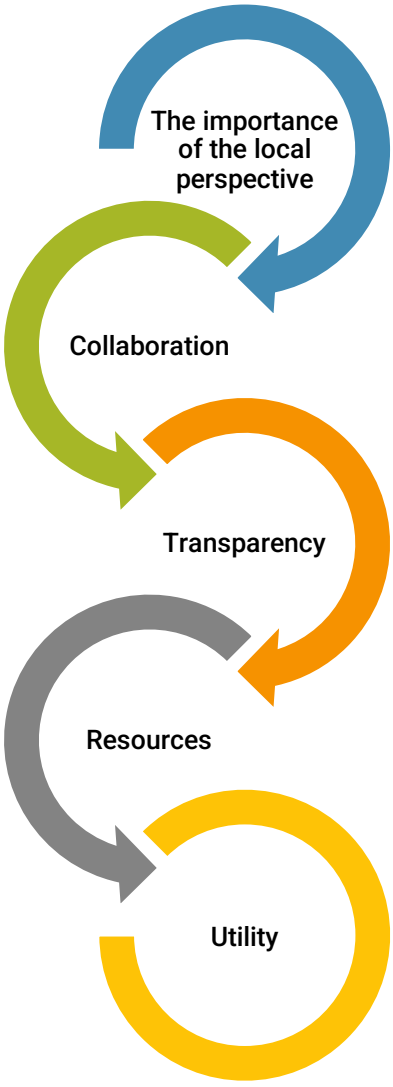
[24] Health department governance. (2022). Centers for Disease Control and Prevention. https://www.cdc.gov/publichealthgateway/sitesgovernance/index.html

Appendix C: Review of Data and Literature

Below is a review of data and literature used for recommendations in prioritization. This focuses on five themes related to prioritization found in the data and literature: the importance of the local perspective, collaboration, transparency, resources, and utility.

Importance of the local perspective

"*At the local health department level, we are the boots on the ground. We're doing the specific programs that need to occur in our communities to address those health priorities. So we know the issues and it can't just be a cookie cutter approach or the state's telling us, 'Well, you need to focus on these issues*.'"
~LHD Focus Group Participant



According to the Center for Community Health and Development (CCHD) (n.d.), deciding the criteria and processes for setting priorities should be driven first by those most affected by community issues and/or inequalities. Data from T/LHD representatives indicated the importance of working with local stakeholders to develop their CHAs/CHIPs. Community and stakeholder buy-in may determine what priorities have the highest success (Barrett, 2012; CCHD, n.d.). As a T/LHD representative said, "*But when I think of the local level and finding resources, it's not always money, it's more like political will or cooperation, collaboration, that kind of thing*." Which makes the efforts to incorporate local public health stakeholders that much more important.

Access to resources was a common topic in the data and literature, including things like time and money, as well as what supports are available at the local level. For many T/LHDs in Nebraska, their access to resources is linked to their geography and distance from population centers. The access to resources for the state as a whole were discussed by T/LHDs. Not only the existence of health services, but how to get to them: "*[T]he challenges that are faced by our rural health districts are vastly different from an urban health area. … So transportation is not a barrier anymore in Lincoln or in Omaha, but it's a tremendous amount of barrier for everyone else.*" What works in larger population centers will not be effective statewide. Some issues are more relevant in different geographic areas, as T/LHDs point out. They use this as an

example of something to pay attention to for the prioritization process, but it should also be noted that this also reflects issues of health disparities and health equity.

There is also a substantial gap in available data for many rural areas, where data may not be available due to data privacy issues. The T/LHDs pointed out that most data coming from the state is only available at the state level, which is useful for benchmarks, but isn't useful for their local partners or gaining community buy-in. "*[County level data] would be amazing. But we know that county level data is really hard to get, especially minority county level data because, in a rural area, I should say, most of our data is per our total jurisdiction*." Staff at DPH also report providing state level data most often. Instead, many T/LHDs rely solely on the data they collect themselves.

Many T/LHDs conduct their own MAPPs and collect data in their own communities. According to T/LHD representatives and key stakeholders, being asked to participate in state-level MAPP processes seem redundant to them. Further, as related decisions were being made, they were not involved. With access to T/LHDs' CHAs/CHIPs, T/LHDs don't understand why there is a separate process at the state level developing priorities that do not match what their local data is saying.

Identifying where existing focal areas for T/LHDs and the state overlap would be beneficial for prioritization. Feedback from T/LHDs noted that existing alignment between their priorities and state priorities is most likely coincidental: "*just because those are big issues in Nebraska. I don't think there was any purposeful alignment*." Taking advantage of similarities at the local or regional level would allow T/LHDs to share resources and maximize efforts. Relatedly, T/LHDs noted a need for flexibility when applying state objectives at the local level; sometimes they will not align but will still address the same priority.

Figure 12. Prioritization Considerations

- Existing and potential community assets
  - What resources do you already possess or may soon gain?
- Social determinants of priorities
  - What socio-economic and environmental conditions could be impacting each priority?
- Existing and potential alignment of priorities
  - Could resources be shared across efforts?
- The ability of increased resources to impact the priorities
  - Will increased resources affect change?

When evaluating priorities, it is useful to consider the issues listed above in Figure 12 (CCHD, n.d.; McKnight, 2017). An assessment of the existing assets is sometimes called an ecological approach and may lead to increased buy-in and engagement and a better understanding of the foundations for the work ahead. Considering the social determinants may lead to greater understanding of what can be changed. The alignment of priorities may reduce the workload and/or increase available resources. And finally, consider whether applying more resources to the issue will produce change towards the desired outcomes.

In order to get a grasp on current trends of local priorities, a crosswalk was conducted in which 16 CHIPs based in Nebraska were compiled. Of the priorities in these CHIPs, Behavioral/Mental Health Care was the most commonly selected at 14 times, while Chronic Disease was selected 7 times, and Substance Abuse and Health Disparities/Equity &

Access to Care were both selected 6 times. The following Table (4) lists priorities and their frequency of selection.

Table 4. Commonly Selected Health Priorities in Nebraska Crosswalk

Community Health Improvement Plan	Frequency
Behavioral/ Mental Health Care	14
Substance Abuse	6
Suicide Prevention	4
Obesity	5
Chronic Disease	7
Health Disparities, Health Equity, & Access to Care	6
Increase Social Supports	2
Physical Wellness	4
Motor Vehicle Crashes & Deaths	3
Local Public Health System Collaboration	3
Housing Conditions	2
Cancer	3
Environmental Health	2
Early Childhood Care & Education	2

Collaboration

Effective engagement between T/LHDs and DPH staff supports Nebraska's goals of improving infrastructure and equity at a statewide public health system level. The collaboration between state and local entities can lead to many positive outcomes, such as greater alignment of processes, increased momentum and trust, and maximizing resources. As of September 2022, 37% of surveyed DPH teammates (n=38) had no collaboration with any T/LHDs, and 21% worked with all Nebraska T/LHDs.

The alignment of processes provides an opportunity to reduce workloads, increase local engagement, and leverage funding opportunities. The timelines between state and local health assessments are often not aligned. Some T/LHDs note this is because of local needs, such as their hospitals needing community health assessments every three years.

"*I mean, wouldn't it be great if Nebraska made a concerted effort to sync all of those timeframes, because we're all doing these surveys. So the power of the financial support that DHHS could put into very comprehensive surveys if we were all doing them at the same time and asking a bank of similar questions, and then it can expand out in our areas. But imagine the power of that data if it was all one effort*." ~LHD Focus Group Participant

Alignment could also increase the use of CHAs/CHIPs at the state level – over two-thirds of the surveyed DPH staff (69%) did not use CHAs/CHIPs, and most did not know where to access them.

Collaboration can also lead to increased momentum and trust, but can also hinder them. These are linked through past experiences. Some T/LHDs noted that the COVID-19 pandemic produced some successful communication and collaboration between T/LHDs

and the state, which made them optimistic about future work. However, there are many challenges in the data component that can undermine momentum and trust: staff turnover, slow approval processes, and the sometimes-bulky logistics of collaboration. Key stakeholders and SHA users both talked about how the lack of realistic expectations derailed past collaboration, such as not providing clarity in how much work was required.

Maximizing resources is a benefit of collaboration, in large part due to the sharing of knowledge and exposure to different ideas and perspectives. The public health workforce of Nebraska already collaborates in many ways, such as with workgroups (as shown in Figure 1 found on page 1), statewide coalitions, and communities of practice. The T/LHD representatives advocated for communities of practice around the priorities, which would allow them to learn from each other, increase their resources, and engage with the state and peers across the state. This would increase collaboration, accountability, and trust between T/LHDs and the state. State teammates who participated in statewide coalitions and workgroups were more likely to work with T/LHDs already, and believed that strong partnerships facilitated greater understanding, identification, and addressing of health disparities.

Transparency

When done effectively, prioritizing builds a consensus on how resources will be allocated, clarifies the expectations for resource allocation, creates a timeframe and focus area, and lays out the responsibilities for stakeholders (Barnett, 2012). However, those involved in the prior SHIP and T/LHDs discussed the lack of clarity when it came to the prioritization process. Developing and utilizing explicit criteria and processes to set priorities provides a strong basis for addressing concerns of a lack of transparency and communication (Gibson et al., 2004; Sibbald et al., 2009). Nebraska has a history of engaging stakeholders in the SHIP creation process. Even so, previous efforts to involve stakeholders led to perceptions of lessened leadership and ownership of the SHIPs priorities due to a seeming lack of communication between stakeholders. A representative from the LHDs discussed the lack of transparency in who is making the decisions, and confusion about the prioritization process:

> *"So if they already decided the priority, then the state is telling the locals that, 'Okay. This is our priority. Now, fall in line.' Is that the message they're sending us?"* ~LHD Representative

> *"I never heard anything about, 'We have decided priorities for the SHIP.'"* ~T/LHD Representative

In other collaborative events, T/LHDs described a lack of follow-through by the state due to a lack of communication after participation, reducing T/LHD confidence in their collaboration. T/LHD representatives had a general lack of knowledge about current SHA/SHIP priorities.

They also discussed how state requirements may not be defined or described in ways that are understandable or actionable at the local level. Those working at the local level would like to have common definitions and standard metrics, so that progress can be measured collectively.

> "*We're not moving the needle on anything when we're doing it 12 different ways. To move the needle in Nebraska, all of those metrics should be the same, and the state should say, 'What's the goal for these districts?'" And then support that goal so that we can show them needle moving instead of 12 different ideas on what the data or what the goal should look like.*" ~T/LHD Representative

> "*Well, I think maybe they need to come to us honestly, like it's been mentioned before, but there's more that to Nebraska than just Omaha and Lincoln. They can come kind of see who we are, who we serve, see why we have the priorities we do, and then hopefully collaborate*." ~T/LHD Representative

Suggestions that arose from focus groups with T/LHD representatives were to use prevalence to select priorities, as well as making a greater effort to collect information from local voices across the state. T/LHDs would like to see site visits or in-person data collection in not just metropolitan areas, but also rural areas of the state, and intentional pursuit of new voices.

Resources

At the local level, there is a desire for the state to provide infrastructure and resources to help meet local goals and priorities. *"[I]n considering what the locals have as their priority areas in the CHA and CHIP, then the SHA and SHIP then can build on that and determine what resources they can provide*." According to key stakeholders, the SHIP needs to fill gaps for communities to fulfil their goals. Specific resources to support prioritization described by participants and respondents included two related categories: infrastructure to support T/LHD and training and technical assistance (T/TA).

Under infrastructure, the largest topic was data and dashboards. Data was described as overwhelming by key stakeholders, T/LHDs, and DPH teammates, particularly when describing the MAPP process. As noted under the local perspective, there are gaps in available data due to rurality, but there are also issues of accessibility that apply to all T/LHDs, as well as DPH teammates. Only one in four DPH teammates said they have access to data for all areas of the program to identify health disparities. Some T/LHDs pointed out data that they know exists, but was not released to them for unknown reasons. They would also like to know how to deal with data from the most rural areas and data access issues. In general, there is a desire for an online system, such as repository or dashboard. A public system would be nice, but they also need access to raw data for their programming and reports. The dissemination of data to the public was noted as a challenge by DPH teammates. Key stakeholders discussed how important sustainable data delivery systems are for prioritization and progress towards goals. Gaps in data were seen as the greatest challenge to SHA users.

Relevant literature indicated that the prioritization process is time sensitive and time intensive, showing that this resource is key. Time is a fundamental concern at multiple stages of the prioritization process: defining goals (Thesenvitz et al., 2011), prioritization criteria (NACCHO, n.d.), and processing of outcomes (Gibson et al., 2004). Key stakeholders noted the success of past SHAs was due in part to the time commitment given by those involved: "*What works well and continues to work well is that there are people that have dedicated time to do this*." Time was also the primary barrier identified by DPH staff in providing support to T/LHDs.

Training and technical assistance were a focus in the T/LHD focus groups. They discussed the importance of taking resources and geography into account when providing T/TA. They recognized how some topics for T/TA are more successful in different modes, but also discussed the logistical struggles based on population distributions. Specifically, those traveling many hours to the eastern population centers, as well as dealing with staff turnover and varying schedules. They suggested, if possible, that trainings be bundled if travel is required. In the user survey, Zoom was the most frequently desired method to receive T/TA, although only about half preferred it. According to the capacity survey, T/TA is provided to T/LHDs more than funding by DPH, although those surveyed felt more able to provide T/TA to community partners than T/LHDs.

Utility

The prioritization process sheds a light on different parts of the priority setting process, including data collection, stakeholder participation, resources, time, and decision making (Thesenvitz et al., 2011). This is tied to how the SHA/SHIP will be utilized – its usefulness to its users. Part of this is based on the logistics of prioritization, such as the number of priorities selected and on the dynamics of doing the work. Is addressing health disparities built into the process? How responsive is it to change? How much do the T/LHDs use it? These are also part of the feasibility of the SHA/SHIP.

The number of priorities identified are a primary concern for everyone involved. Looking at the literature, the number of recommended priorities varies, from two (Wolk, 2015) up to as many as six (AHA, 2023): five main priorities and one with three sub-priorities (Wisconsin, 2023). How they are chosen varies, with some focusing on community or "sub-state stakeholders," and others recommending a pool of local, state, and national priorities from which to choose (AHA, 2023; Beltran, 2014; Washington, 2014; Wisconsin, 2023; Wolk 2015). Nebraska T/LHDs suggested grouping priorities into "buckets" that have common frameworks or underlying causes to reduce infrastructure needs. As mentioned earlier, T/LHDs recommended using simple prevalence to choose priorities, but the DPH teammates noted how difficult it was to narrow down the needs. The key stakeholders advocate for looking beyond the numbers to the scope of the priorities: "*There were 5 areas: helping the health systems, integration, depression and suicide, obesity, health care utilization and access, and health equity; those are huge things*." ~Key Stakeholder

Addressing issues like access and health equity require understanding health disparities. Both the capacity survey and the user survey included questions about health disparities. Most respondents understood and are able to identify disparities, but addressing them is described as a challenge. As noted earlier, data is a challenge for identification of issues.

DPH teammates describe having buy-in at all levels as a facilitator for addressing health disparities. A barrier to this process is the lack of a shared definition for disparities.

Ideally, the process of evaluation and the resulting priorities are flexible enough to handle change. A T/LHD representative talked about changing meanings and terminology, such as the phrase “access to care.” Others noted the potential need for less change. Key stakeholders mentioned not needing to start from scratch every time, but instead, start with the last SHA and see what needs to be continued first. In contradiction, Barrett (2012) warns against the inertia of existing priorities. Whether health status priorities are new or retained from the previous SHA/SHIP, reviewing previous SHA/SHIP priorities and processes enables SHA/SHIP leadership to reassess the strengths and weaknesses of past approaches.

The SHA/SHIP has not consistently been relevant to T/LHDs. In the past, resources towards state priorities did not always reach T/LHDs doing similar work: *“there really wasn't a lot of advocacy at the state level to help us with any of our priorities.”* In the User Survey, respondents from T/LHDs did not find the SHA/SHIP as useful as those who were not part of T/LHDs. The T/LHDs and key stakeholders discussed how important it is to keep goals achievable when setting priorities. To be relevant, this must be true at all levels.

Feasibility is a key component of achieving any goals identified in the prioritization process. Related prioritization criteria should include 1) the cost as well as the return on investment, if applicable, 2) availability of solutions, 3) impact of the problem, 4) availability of resources to solve the problem, 5) urgency of solving the problem, and 6) size of the problem (NACCHO, n.d.). Key stakeholders recommended several needs related to feasibility: focus on the resources needed to address changes in health outcomes; understand where change can be made; and finally, be strategic about how the priorities are identified, thinking about capacity and opportunities. As one stakeholder said, *“Be realistic to your point where the opportunities are, where there is dedicated staff, where there is money.”*

Appendix D: Prioritization Method Examples

This appendix provides examples of the prioritization methods explored in Step 3 and in Table 2. Additional resources on how to utilize these methods can be found online, with the nominal group technique, multi-voting technique, prioritization matrix, and Hanlon method in NACCHO (n.d.), and another example of the prioritization matrix in Colorado's SHIP (Wolk, 2015). The goals achievement matrix is available on CDS (City Development Strategy) (n.d.) and the Goeller scorecard in Luck & Yoon (2015).

Nominal Group Technique

Table 5: Nominal Group Technique from NACCHO (n.d.)

Priority Health Indicator	1st Choice Score = 3	2nd Choice Score = 2	3rd Choice Score = 1	Total Score
Improve communication and coordination between divisions and programs within health department	4	6	6	40
Engage policymakers and community to support health department initiatives	1	6	3	18
Promote understanding of public health in general and health department as an organization among stakeholders (may include internal and external stakeholders)	3	1	6	17
Better utilize data and best practices to inform health department program decisions and understanding of the health department's role and contribution to public health	2	4	6	20
Establish a health department presence and recognition at a level comparable to other major city departments	4	5	5	27

Multi-voting Technique

Table 6: Multi-voting Technique from NACCHO (n.d.)

Health Indicator	Round 1 Vote	Round 2 Vote	Round 3 Vote
Collect and maintain reliable, comparable, and valid data	✓✓✓✓	✓✓	
Evaluate public health processes, programs, and interventions	✓✓✓✓✓	✓✓✓✓	✓✓✓✓✓
Maintain competent public health workforce	✓✓		
Implement quality improvement of public health processes, programs, and interventions	✓✓✓✓	✓✓	
Analyze public health data to identify health problems	✓✓		
Conduct timely investigations of health problems in coordination with other government agencies and key stakeholders	✓✓		
Develop and implement a strategic plan	✓✓✓✓✓	✓✓✓✓	✓✓
Provide information on public health issues and functions through multiple methods to a variety of audiences	✓✓		
Identify and use evidence based and promising practices	✓✓		
Conduct and monitor enforcement activities for which the agency has the authority	✓✓		
Conduct a comprehensive planning process resulting in a community health improvement plan	✓✓✓✓✓	✓✓✓✓	✓✓
Identify and implement strategies to improve access to healthcare services	✓✓✓	✓✓	

Red = Round 1 Elimination
Green = Round 2 Elimination
Blue = Round 3 Elimination

Hanlon Method

Table 7: The Hanlon Method: Sampling Criteria Rating (NACCHO et al. (n.d.))

Rating	Size of Health Problem (% of population w/ health problem)	Seriousness of Health Problem	Effectiveness of Interventions
9 or 10	> 25% (STDs)	Very serious (e.g. HIV/AIDS)	80% - 100 % effective (e.g. vaccination program)
7 or 8	10% - 24.9%	Relatively serious	60% - 80% effective
5 or 6	1% - 9.9%	Serious	40% - 60% effective
3 or 4	.1% - .9%	Moderately Serious	20% - 40% effective
1 or 2	.01% - .09%	Relatively Not Serious	5% - 20% effective
0	< .01% (Meningococcal Meningitis)	Not Serious (teen acne)	< 5% effective (access to care)
Guiding considerations when ranking health problem against the 3 criteria	• Size of health problem should be based on baseline data collected from the individual community	• Does it require immediate attention? • Is there public demand? • What is the economic impact? • What is the impact on quality of life? • Is there a high hospitalization rate?	• Determine upper and low measured for effectiveness and rate health problems relative to those limits • For more information on accessing effectiveness of interventions, visit https://www.communityguide.org to view CDC's Guide to *Community Preventative Services.*

Prioritization Matrices

Table 8: Prioritization Matrix from Wolk (2015)

	Low Priority-Frequency	Colorado Winnable Battle	Governor's Policy	CDC Winnable Battle	HP 2020 Leading Health Indicators Topics	EPA Priority
Obesity	43	■	■	■	■	
Mental Health	27	■	■		■	
Substance Abuse	22	■	■		■	
Clean Water	14	■				■
Safe Food	13	■				
Clean Air	12	■			■	■
Access to care	11		■		■	
Unintended Pregnancy	8	■		■	■	
Oral Health	6	■	■		■	
Injury Prevention	5	■		■	■	
Tobacco	5	■		■	■	
Infectious Disease Prevention	1	■		■	■	
Maternal and Child Health	1				■	

Table 8: Prioritization Matrix from NACCHO (n.d.)

	Evaluative Criteria					
Proposed Area for Improvement Based on LHD Self-Assessment	Linkage to Strategic Vision (.25)	Do we need to improve this area? (.25)	What change is there that changes we put into place will make a difference? (.5)	Likelihood of completion within the timeframe we have (.5)	Importance to Customer (customer is the one who would benefit, could be patient or community) (.75)	Total Score
Media Strategy & Communications to raise public health awareness	3 X (.25)	4 X (.25)	4 X (.5)	3 X (.5)	3 X (.75)	7.5
Work within network of stakeholders to gather and share data and information	2 X (.25)	3 X (.25)	2 X (.5)	1 X (.5)	1 X (.75)	3.5
Continuously develop current information on health issues that affect the community	4 X (.25)	2 X (.25)	3 X (.5)	1 X (.5)	2 X (.75)	5

Table 9: Goeller Scorecard Prioritization Matrix from Patton et al. (2016)

Simplified Goeller Scorecard	Prospective Jobs			
Criteria	1	2	3	4
Salary	$50,000	$54,000	$60,000	$47,000
Days of sunshine	175	240	200	180
Minutes of Commute	35	30	20	40
Job Challenge	VB	VI	I	B
Advancement Possibilities	None	Good	Poor	None

Key: VB = Very Boring, B = Boring, I = Interesting, VI = Very Interesting

Note: These data were collapsed in the previous example to specify the mathematical computation

Table 10: Goal Achievement Matrix Scorecard Prioritization Matrix from Patton et al. (2016)

Goal Achievement Matrix – Scoring						
	Goal a: Weight = 2			Goal b: Weight = 1		
	Group			Group		
	Weight	Plan A	Plan B	Weight	Plan A	Plan B
Group z	3	+6	-6	3	-3	0
Group y	1	-2	+2	2	0	-2
		+4	-4		-3	-2

Plan A's Score = +4-3=1

Plan B's Score = -4-2 = -6

Therefore, Plan A is preferable to Plan B

Appendix E: Example Questions for Surveying on Capacity

The following survey questions were utilized as part of the data collection for the SHIP redesign evaluation project. These are meant to be used as a starting point for administering capacity surveys related to the SHIP in the future. Each can be altered to gather parallel information about the SHA as well.

Introduction: This survey is meant to gather feedback to help identify health status priorities as part of the State Health Improvement Plan (SHIP).

For the purposes of this survey, capacity is defined as sustainable skills, organizational structures, resources, and commitment to health improvement in health and other sectors to prolong and multiply health gains many times over.

You have been selected to complete this survey on behalf of [INSERT PROGRAM NAME]. Throughout this survey, please reference [INSERT PROGRAM NAME] whenever a question is asked about your program.

Please indicate your level of agreement with the following statements.

	Strongly disagree (1)	*Disagree (2)*	*Neither disagree nor agree (3)*	*Agree (4)*	*Strongly agree (5)*
1. When fully staffed, the amount of staff employed in our program is adequate to implement our work.					
2. Overall, our program staff have adequate qualifications, training, experience, knowledge, and skills to implement our work.					
3. Program staff have adequate time allocated to implement our work.					
4. Program staff have adequate technology resources to implement our work.					
5. Our program has adequate funding to implement our work.					
6. Program staff have adequate support from leadership to implement our work.					
7. Our program has effective processes and structures in place that help us carry out work (i.e., subawards, contract management).					

Thinking about the **current** capacity of your program, how able is your program to provide the following services?

	Not at all able (1)	*Not very able (2)*	*Somewhat able (3)*	*Very able (4)*	*N/A (5)*
1. Training to Tribal and/or Local Health Departments (T/LHDs)					
2. Technical assistance to T/LHDs					
3. Funding to T/LHDs					
4. Data to inform planning at the community level					
5. Training to other community partners/stakeholders					
6. Technical assistance to other community partners/stakeholders					
7. Funding to other community partners/stakeholders					

What barriers prevent your program from being able to provide training, technical assistance, funding, or data to LHDs/THDs or other community partners/stakeholders? (Select all that apply)

- ☐ Lack of program staff
- ☐ Lack of relationships with T/LHDs or other community partners/stakeholders
- ☐ Lack of skills/expertise
- ☐ Lack of support from leadership
- ☐ Lack of funding
- ☐ Lack of time
- ☐ Unaware of what is needed
- ☐ Other (specify): _____

Over the next five years, does your program anticipate increasing, decreasing, or maintaining the same funding that is awarded externally to T/LHDs and other community partners/stakeholders?

- ☐ Increasing
- ☐ Decreasing
- ☐ Maintaining the same
- ☐ I don't know

How proactive is your program in applying for funding?

- ☐ Very proactive (1)
- ☐ Somewhat proactive (2)
- ☐ Not very proactive (3)
- ☐ Not at all proactive (4)

Which of the following factors prevented your program from applying for a grant/funding opportunity over the past 12 months? (Select all that apply)

- ☐ Misalignment with our program's strategic plan or priorities identified within our program
- ☐ Lack of staffing capacity to develop the application
- ☐ Inadequate time to develop the application
- ☐ Lack of staffing capacity to conduct the work if funded
- ☐ Determining the length of the funding opportunity was too short
- ☐ Lack of being able to provide the programming or services required by the funding
- ☐ Lack of alignment with statewide needs/priorities
- ☐ Lack of alignment with community needs/priorities
- ☐ Other (specify) _____

Over the next five years, does your program anticipate increasing, decreasing, or maintaining the same funding that is awarded externally to T/LHDs and other community partners/stakeholders?

- ☐ Increasing
- ☐ Decreasing
- ☐ Maintaining the same
- ☐ I don't know

Do you have the capacity to collect your targeted Healthy People 2030 indicators?

- ☐ Yes, for all of our targeted indicators
- ☐ Yes, but only for some of our targeted indicators
- ☐ No
- ☐ I don't know

How well do you feel the funding your program receives aligns with the priorities and needs of T/LHDs and other community partners/stakeholders?

- ☐ Very well
- ☐ Somewhat well
- ☐ Not very well
- ☐ Not at all well
- ☐ I don't know

How much does your program utilize Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs)?

- ☐ A lot
- ☐ Somewhat
- ☐ Not very much
- ☐ Not at all

Do you know if Tribal and/or Local Health Departments (T/LHDs) have identified your program's health topics as a priority?

- ☐ Yes, I know this for all T/LHDs
- ☐ Yes, I know this for some T/LHDs
- ☐ No

Please describe any facilitators (e.g., personal relationships) or barriers (e.g., lack of funding) that impact your program's engagement with T/LHDs.

Facilitators: _____

Barriers: _____

Please describe any facilitators (e.g., personal relationships) or barriers (e.g., lack of local data) that impact your program's engagement with other community partners/stakeholders

Facilitators: _____

Barriers: _____

Appendix F: References

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