



A GUIDE TO ALIGNING
**HEALTHY
PEOPLE 2030
AND MAPP 2.0**
TO INFORM LOCAL COMMUNITY
HEALTH IMPROVEMENT



NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS



TABLE OF CONTENTS

Acknowledgments	3
Acronyms	4
Vision for This Guide	5
Introduction	6
The Need to Work Upstream.....	6
Purpose of This Guide.....	6
Complementary Public Health Approaches	6
Overview of MAPP	6
Overview of Healthy People 2030	7
Foundational Principles.....	7
Definitions.....	8
Alignment of Healthy People 2030 and MAPP	10
Phase I: Build the Community Health Improvement Foundation	11
Overview	11
Alignment with Healthy People 2030	11
SDOH Framework	12
Phase II: Tell the Community Story	13
Overview	13
MAPP Assessments	14
Community Partner Assessment (CPA).....	14
Community Status Assessment (CSA)	14
Community Context Assessment (CCA).....	14
Healthy People 2030 Tools and Resources	15
Health Literacy	15
Social Determinants of Health (SDOH).....	16
Leveraging Healthy People to Advance Health Equity	17
Healthy People 2030 Objectives.....	18
Leading Health Indicators (LHIs)	18-20
Data Sources and Methods	20
Organizing and Analyzing Data.....	21
Data Triangulation	21
Issue Profiles.....	22
About Issue Profiles	22
How MAPP Uses Issue Profiles.....	22
How Healthy People 2030 Informs Issue Profiles	22

Phase III: Continuously Improve the Community..... 23

- Overview.....23
- Prioritize Issues for the CIP.....24
- Do a Power Analysis of Each Issue.....24
- Set Up Priority Issue Subcommittees.....24
- Create Community Partner Profiles.....25
- Develop shared Goals and Long-Term Measures27
- Select CHIP Strategies.....27
- Develop Continuous Quality Improvement Action Planning Cycles28
- Monitor and Evaluate the CHIP.....28
- Summary.....29

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The National Association of County and City Health Officials (NACCHO) represents the nation's nearly 3,000 local health departments. These city, county, metropolitan, district, and Tribal departments work every day to protect and promote health and well-being for all people in their communities. For more information about NACCHO, please visit www.naccho.org.

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ACRONYMS

CCA = Community Context Assessment

CH[N]A = Community Health [Needs] Assessment

CHI = Community Health Improvement

CHIP = Community Health Improvement Plan

CPA = Community Partner Assessment

CSA = Community Status Assessment

LHI = Leading Health Indicator

MAPP = Mobilizing for Action through Planning and Partnerships

NACCHO = National Association of County and City Health Officials

SDOH = Social Determinants of Health

VISION FOR THIS GUIDE

Public health protects and improves the health of people and communities through interventions such as sanitation, vaccinations, and food safety. However, structural and systemic inequities grow as imminent public health threats increase, shaped in part by a lack of alignment of resources and mobilization of communities to change the systems and structures that generated the inequities.

The public health community can prepare to address health inequities by using tools, resources, and processes such as Healthy People and Mobilizing for Action through Planning and Partnerships (MAPP). [Healthy People 2030](#) is the current Healthy People initiative from the HHS Office of Disease Prevention and Health Promotion. It brings a renewed focus on the nation's health and well-being through "upstream" actions that address the social determinants of health (SDOH). [MAPP 2.0](#) is the updated version of MAPP from the National Association of County and City Health Officials (NACCHO). This community-driven strategic planning process for community health improvement (CHI) spurs collective action to improve population health and equity.

To help address SDOH and advance health equity, NACCHO partnered with the HHS Office of Disease Prevention and Health Promotion to develop this guide on using Healthy People 2030 objectives and targets at the local level in CHI. This guide provides a structure for strategic alignment of MAPP and Healthy People 2030 to assist local health departments and their communities to shift CHI upstream.



INTRODUCTION

The Need to Work Upstream

In recent years, MAPP and Healthy People 2030 have strengthened their focus on health equity and SDOH. The focus on SDOH helps people identify connections between health disparities and root causes or structural/systemic determinants related to past and current injustices and power. Moreover, this shift acknowledges the role of SDOH in addressing health inequities and emerging public health challenges that reflect expanding public health priorities.

Purpose of This Guide

This guide demonstrates how Healthy People 2030, its objectives, Leading Health Indicators (LHIs), and tools and resources align with MAPP. Healthy People 2030 is a valuable resource to help build a solid foundation to inform CHI. MAPP engages the entire local public health system, which includes any organization or entity that contributes to the health or well-being of the community. To foster community ownership, MAPP involves a range of community members, groups, agencies, and organizations. Local health departments and anyone engaged in MAPP may benefit from this guide.



Complementary Public Health Approaches

To address structural and systemic issues that contribute to health inequities, it is important to understand key concepts and definitions related to the root causes of inequities that impact communities. Both MAPP and Healthy People 2030 share the goal of eliminating health disparities and advancing health equity. They also emphasize understanding and addressing key factors that shape the health status and outcomes of a community, including SDOH. It is important to explore how SDOH operate in different contexts, such as social and community environments, and across different levels of influence, such as individual knowledge, organizational rules, regulations, and public policy. MAPP and Healthy People 2030 offer unique and shared elements to help drive CHI.

Overview of MAPP

MAPP spurs collective action to improve population health and promote equity. Moreover, it provides a structure for communities to assess pressing population health issues and align resources across sectors for strategic action. MAPP 2.0 [has evolved](#) to align with revisions to assessments and changing community health requirements across sectors. Its updated framework and enhanced training, technical assistance, and resources for CHI planning better enable communities to improve population health. Further, to adapt to the changing public health landscape, MAPP is grounded in evolving public health needs.

MAPP sets forth a vision for CHI as a community-led process to improve population health through the **following foundational principles**:

- ▶ Equity
- ▶ Inclusion
- ▶ Trusted Relationships
- ▶ Community Power
- ▶ Strategic Collaboration and Alignment
- ▶ Data and Community-Informed Action
- ▶ Full-Spectrum Actions
- ▶ Flexible
- ▶ Continuous



Overview of Healthy People 2030

Healthy People complements MAPP because it identifies public health priorities to help people, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on the science and knowledge gained over four decades to address the latest public health priorities. The vision for Healthy People 2030 is a society in which all people can achieve their full potential for health and well-being across the lifespan.

Healthy People 2030 is unique from other national health initiatives in the following ways:

- Includes a wide [range of objectives](#) that address priority public health issues that were established with input from subject matter experts and community members; are measurable (i.e., core objectives), drive data collection (i.e., developmental objectives), and identify research opportunities (i.e., research objectives); and provide population-based data when available that highlight disparities and inequities.
- Sets specific national [targets](#) for each of the measurable objectives (e.g., core objectives) to be achieved by the year 2030. These targets are among the most unique elements of the initiative.
- Tracks progress toward achieving the targets for Healthy People 2030 objectives over time, including reporting on population data and disparities data when available.
- Features [LHIs](#), a small subset of high-priority core objectives selected to drive action toward improving health and well-being.
- Offers [evidenced-based resources](#) to guide community engagement and to incorporate into community health improvement plans (CHIPs).

Foundational Principles

Healthy People 2030 is based on the following foundational principles:

- The health and well-being of all people and communities are essential to a thriving, equitable society.
- Promoting health and well-being and preventing disease are linked efforts that encompass physical, mental, and social health dimensions.
- Investing to achieve the full potential for health and well-being for all provides valuable benefits to society.

- Achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy.
- Healthy physical, social, and economic environments strengthen the potential to achieve health and well-being.
- Promoting and achieving health and well-being nationwide is a shared responsibility across the national, state, tribal, and community levels, including the public, private, and non-profit sectors.
- Working to attain the full potential for the health and well-being of the population is a component of decision-making and policy formulation across all sectors.

Definitions

Healthy People 2030 and MAPP complement each other by outlining definitions important to understanding and addressing the root causes of inequities that impact communities, including health equity, health disparities, and SDOH. Although the language may differ in specific definitions, Healthy People 2030 and MAPP share similar concepts:

- All people should have the opportunity to achieve their full potential for health.
- Differences in health are linked with social, economic, and environmental disadvantages.
- The conditions where people are born, live, work, learn, play, and age affect health outcomes.



Resource	Definitions
	<i>Health Equity</i>
MAPP	When everyone has a fair and just opportunity to achieve optimal health. ¹
Healthy People 2030	The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities. ²

¹Braveman, P., Arkin, E., Orleans, T., Proctor, D., and Plough, A. (2017). What is health equity? And what difference does a definition make? Princeton, NJ: Robert Wood Johnson Foundation. Retrieved March 30, 2023, from www.rwjf.org/en/insights/our-research/2017/05/what-is-health-equity-.html

² Office of Disease Prevention and Health Promotion. Health equity in Healthy People 2030. Retrieved May 24, 2023, from <https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030>

	<i>Health Disparity</i>
MAPP	The difference in health outcomes or access to healthcare across populations, which results from socioeconomic, biological, and psychological factors and the behavior of individuals. This term does not account for the unequal structuring of life chances.
Healthy People 2030	A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. ³
	<i>Social Determinants of Health (SDOH)</i>
MAPP	The conditions of the environments where people are born, live, learn, work, play, worship, and age that affect their health and well-being. ⁴
Healthy People 2030	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. ⁵

Local health departments are encouraged to collaborate with community partners and reflect on these definitions and concepts. Facilitating dialogue and having a shared understanding of the importance of health equity, health disparities, and SDOH can motivate action to address them.

³ Ibid.

⁴ Office of Disease Prevention and Health Promotion. Social determinants of health. Retrieved May 24, 2023, from <https://health.gov/healthypeople/objectives-and-data/social-determinants-health> [Adapted from]

⁵ Office of Disease Prevention and Health Promotion. Social determinants of health. Retrieved May 24, 2023, from <https://health.gov/healthypeople/priority-areas/social-determinants-health>

Alignment of Healthy People 2030 and MAPP

Rooted in equity, MAPP aligns with the evolution of Healthy People, which now focuses on upstream factors, including SDOH, and addresses emerging public health challenges that reflect expanding public health priorities. Healthy People 2030 naturally fits into the work of local health departments as they apply the MAPP framework for their CHI process. The following illustration shows tools and resources from Healthy People 2030 that may apply to each phase of MAPP.

Figure 1. An Overview of Healthy People 2030 Tools and Resources that may be Used during the Three Phases of MAPP



PHASE I: BUILD THE COMMUNITY HEALTH IMPROVEMENT FOUNDATION

Healthy People 2030 Tools and Resources

- SDOH Framework

Overview

MAPP's Phase I prepares organizations involved in planning and implementing MAPP to build strategic relationships and foundations with new and existing partners. This phase involves the following:

- Analyzing the power and influence of stakeholders to strategically develop leadership structures and engage stakeholders throughout the process.
- Building a shared understanding of the mission and vision of the community implementing MAPP and its foundational principles, including health equity concepts.
- Doing a Starting Point Assessment of CHI infrastructure and scoping the CHI process based on readiness and resources and evaluating and improving the CHI process and its impact on health equity over time.

Alignment with Healthy People 2030

Healthy People 2030 provides a structure to enhance Phase I in MAPP, which focuses on identifying and engaging people, organizations, and communities who are motivated to improve health and well-being to advance health equity.

Considerations

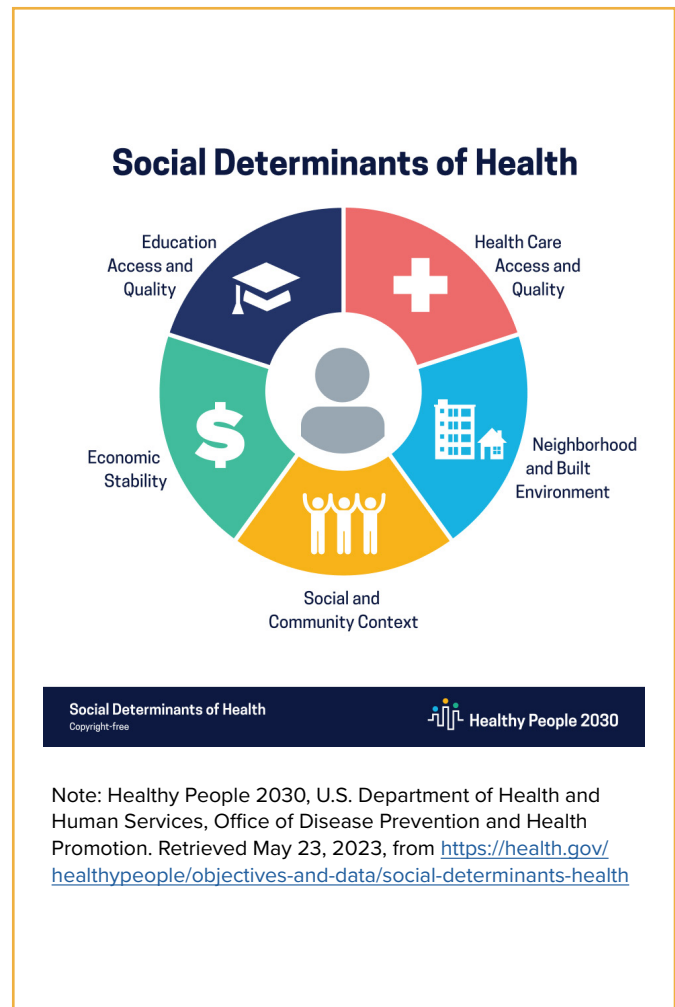
Understanding how the related tools, resources, and assessments from MAPP and Healthy People 2030 align in Phase I can help MAPP users better understand their community and measure progress through a health equity lens.



SDOH Framework

One of Healthy People 2030's five overarching goals relates to SDOH: "Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all." SDOH are conditions that influence people's health, well-being, and quality of life, such as safe housing, racism, education, access to physical activity opportunities, and literacy skills. These conditions operate through [five domains](#): economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.⁶

Communities can consider the five domains to help build diverse partnerships across sectors when assessing which partners and sectors are currently engaged in CHI and which may need to be engaged. The impact of SDOH on health disparities and inequities reinforces the need for cross-sector partners to take action to improve the conditions in people's environments. These partners contribute important knowledge of these conditions and the resources and expertise to address them.



► *Examples of Efforts to Address SDOH*

Across the United States, people and organizations at the local, state, territorial, Tribal, and national levels are working to improve health and reduce health disparities by addressing SDOH. [Learn more about what Healthy People 2030 users are doing.](#)



⁶ Office of Disease Prevention and Health Promotion. Social determinants of health. Retrieved May 24, 2023, from <https://health.gov/healthypeople/priority-areas/social-determinants-health>

PHASE II: TELL THE COMMUNITY STORY

Healthy People 2030 Tools and Resources



- Health Literacy
- SDOH Framework
- Leveraging Healthy People to Advance Health Equity
- Objectives
- LHIs
- Data Sources and Methods



Overview

MAPP's Phase II results in a comprehensive community health [needs] assessment (CH[N]A) and emphasizes the need for a complete, accurate, and timely understanding of community health and well-being based on data and information from several views, including qualitative and quantitative sources. Combining demographic and public health data can help communities identify differences in health outcomes and where to focus efforts. Phase II includes three assessments, which highlight health inequities, forces of change, community members' lived experiences, and opportunities to strengthen partnerships. Each assessment uses a different data collection method. The Community Status Assessment (CSA) uses quantitative methods, the Community Context Assessment (CCA) uses qualitative methods, and the Community Partner Assessment (CPA) uses mixed methods.



MAPP Assessments

MAPP's three assessments present opportunities to align a variety of data collected with Healthy People 2030 metrics and indicators. Communities can apply Healthy People 2030 tools and resources across the assessments to inform CHI efforts.

COMMUNITY PARTNER ASSESSMENT (CPA)

Replacing the Local Public Health System Assessment from the prior version of MAPP, this assessment provides a structure for all community partners to look critically at their (1) individual systems, processes, and capacities; and (2) collective capacity as a network of community partners to address health inequities. The CPA identifies current and future actions to address health inequity at individual, systemic, and structural levels.

Alignment with Healthy People 2030 Tools and Resources: SDOH Framework, Health Literacy, Leveraging Healthy People to Advance Health Equity

COMMUNITY STATUS ASSESSMENT (CSA)

This assessment collects quantitative data on the status of a community such as demographics, health status, and SDOH. The CSA helps a community move upstream and identify inequities beyond health behaviors and outcomes, including association with SDOH and systems of power, privilege, and oppression. This foundational community-driven assessment will reveal both data gaps and issues and inequities to explore further through other assessments.

Alignment with Healthy People 2030 Tools and Resources: Data Sources and Methods, LHIs, Objectives, Leveraging Healthy People to Advance Health Equity

COMMUNITY CONTEXT ASSESSMENT (CCA)

This assessment is a qualitative tool to assess and collect data through the following three domains: (1) community strengths and assets; (2) built environment; and (3) forces of change. It collects the insights, expertise, and views of people and communities affected by social systems to improve the functioning and impact of those systems. The CCA centers people and communities with lived experiences and lived expertise. It focuses on the views, insights, values, cultures, and priorities of those experiencing inequities firsthand. Communities may tailor the domains based on their context.

Alignment with Healthy People 2030 Tools and Resources: SDOH Framework, Health Literacy, Leveraging Healthy People to Advance Health Equity

Healthy People 2030 Tools and Resources

Health Literacy

Health literacy is a central focus of Healthy People 2030 and is defined on both personal and organizational levels.

According to Healthy People 2030:

- Personal health literacy is “the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.”
- Organizational health literacy is “the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.”

These definitions have evolved. They now emphasize how health information is used rather than simply understood, focus on the ability to make “well-informed” rather than “appropriate” decisions, include a public health view, and acknowledge the role and responsibility of organizations in addressing health literacy.

Communities can use these definitions to elevate health literacy throughout the C[H]NA, CHI process, and MAPP assessments. For example, communities may explore local needs related to health literacy on a personal and organizational level. Communities may also consider including one or more of the following Healthy People 2030 objectives related to health literacy in the CSA and CCA:

- Increase the proportion of adults whose health care provider checked their understanding—[HC/HIT-01](#) (core objective).
- Decrease the proportion of adults who report poor communication with their health care provider—[HC/HIT-02](#) (core objective).
- Increase the proportion of adults whose health care providers involved them in decisions as much as they wanted—[HC/HIT-03](#) (core objective).

- Increase the proportion of people who say their online medical record is easy to understand—[HC/HIT-D10](#) (developmental objective).
- Increase the proportion of adults with limited English proficiency who say their providers explain things clearly—[HC/HIT-D11](#) (developmental objective).
- Increase the health literacy of the population—[HC/HIT-R01](#) (research objective).



Spotlight: Akron-Summit County Public Library and Healthy People 2030

One example of how a community can improve health literacy comes from Ohio’s Akron-Summit County Public Library, whose mission to provide resources that “support, improve, and enrich individual, family, and community life” closely aligns with Healthy People 2030.

The library provides numerous services to meet community needs, including services that ensure the health of community members by providing accurate health information. In particular, the popular Books in Boxes program helps schools access evidence-based health information. [Learn more.](#)





Social Determinants of Health (SDOH)


Communities can apply the SDOH Framework and objectives from Healthy People 2030 in the following ways:

- To identify and build cross-sector partnerships to assess and address SDOH, which can help to emphasize SDOH in the CPA and CSA.
- To include SDOH in the CPA and CSA, which can help to explore upstream factors impacting community health status.

Healthy People 2030 highlights the importance of addressing upstream factors in reducing health disparities and improving health and well-being. As such, many Healthy People 2030 objectives address SDOH and are organized by domain on the website. In addition, the SDOH Framework summarizes the latest research related to SDOH and the five domains (refer to Table 1). These [literature summaries](#) provide a foundational overview of SDOH and related upstream root causes, which can help communities understand how SDOH may play a role in community health outcomes and disparities and apply SDOH concepts to the MAPP assessments.

Table 1. SDOH Framework Domains in Healthy People 2030

DOMAIN AND OBJECTIVES	GOAL	LITERATURE SUMMARIES BY DOMAIN
 <u>Economic Stability</u>	Help people earn steady incomes that allow them to meet their health needs.	Employment Food Insecurity Housing Instability Poverty
 <u>Education Access and Quality</u>	Increase educational opportunities and help children and adolescents do well in school.	Early Childhood Development and Education Enrollment in Higher Education High School Graduation Language and Literacy
 <u>Health Care Access and Quality</u>	Increase access to comprehensive, high-quality health care services.	Access to Health Services Access to Primary Care Health Literacy
 <u>Neighborhood and Built Environment</u>	Create neighborhoods and environments that promote health and safety.	Access to Foods That Support Healthy Dietary Patterns Crime and Violence Environmental Conditions Quality of Housing

 <p>Social and Community Context</p>	<p>Increase social and community support.</p>	<p>Civic Participation Discrimination Incarceration Social Cohesion</p>
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Leveraging Healthy People to Advance Health Equity

Advancing health equity is central to MAPP. Health equity has been a focus of Healthy People since the initiative began in 1980. Each decade, Healthy People evolves to reflect the current science and address the latest public health priorities, including a strengthened focus on health equity. Healthy People 2030’s focus on health equity is closely linked to its focus on health literacy and SDOH. Healthy People 2030 outlines health equity as a priority area and includes recommendations for how to leverage Healthy People 2030 to advance health equity using tools for action, including the following:

Leveraging Healthy People to Advance Health Equity

Health Equity is the attainment of the highest level of health for all people.

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and social determinants of health — and to eliminate disparities in health and health care.





Objectives

Identify priorities by browsing **Leading Health Indicators and other objectives**

Compare **population-level progress** to national targets



Data

Use **Healthy People data** to track health disparities and inform program and policy development



Resources

Find inspiration by consulting **evidence-based resources** to use in your community

Review **Healthy People in Action stories** to learn how others are addressing health equity



Frameworks

Use the **Healthy People 2030 framework** as a model for program planning

Use the **social determinants of health framework** to build **partnerships across sectors** and communicate root causes of health disparities



Definitions

Use the definitions of **health equity and health disparities** to promote a shared understanding and identify areas for collaborative action to improve health for all

Leveraging Healthy People to Advance Health Equity
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Communities can explore how these recommendations and tools for action can guide Phase II of MAPP and help people, organizations, and communities committed to improving health and well-being advance health equity.

Healthy People 2030 Objectives

Healthy People 2030 includes a range of objectives developed by [workgroups](#) comprised of federal subject matter experts in specific topics. Although most objectives measure progress toward a target over time, some are not measurable. **There are three types of objectives: core, developmental, and research.**

- **Core Objectives** have valid, reliable, nationally representative data, including baseline data from no earlier than 2015. Data are provided for core objectives for at least three time periods throughout the decade. Data sources used to track progress toward achieving objectives are summarized as "baseline only", "target met or exceeded", "improving", "little or no detectable change", or "getting worse".
- **Developmental Objectives** represent high-priority public health issues that are associated with evidence-based interventions but do not yet have reliable baseline data. Some developmental objectives will become core objectives when reliable data become available.
- **Research Objectives** represent public health issues with a high health or economic burden or significant disparities between population groups—but they are not yet associated with evidence-based interventions. Research objectives may be added throughout the decade to address emerging public health issues.

Communities can use the Healthy People 2030 objectives and the MAPP assessments to identify needs and priority populations, build partnerships, and explore priority areas. In particular, the objectives can help communities do the following:

- Describe SDOH and track health disparities.
- Explore critical public health topics that address SDOH impacting the community and have a major impact on public health outcomes.

- Use national data to assess and measure community health indicators.

For example, Healthy People 2030 focuses on promoting health and safety in [community settings](#), so communities can benchmark community status data with national baseline and targets. While there are no national data sources for research or developmental objectives, state or local data sources may exist. Communities can also explore community research partnerships that focus on developmental or research objectives. In addition, communities can review national goals to improve health that might inform the three MAPP assessments. When applicable, communities can use the objectives and data available to identify and understand groups affected by health disparities and inequities.



Leading Health Indicators (LHIs)

[LHIs](#) are a small subset of high-priority Healthy People 2030 objectives selected to drive action toward improving health and well-being. LHIs cover the life span and are organized by life stage. All LHIs are core objectives; focus on upstream measures; address issues of national importance and high-priority public health issues; are modifiable in the short-term through evidence-based interventions and strategies; address SDOH, health disparities, and health equity; and have new data available periodically.

Healthy People 2030 Leading Health Indicators (LHIs)



LHIs by life stage

All ages*

Children, adolescents, and adults who use the oral health care system (2+ years)
Consumption of calories from added sugars by persons aged 2 years and over (2+ years)
Drug overdose deaths
Exposure to unhealthy air
Homicides
Household food insecurity and hunger
Persons who are vaccinated annually against seasonal influenza
Persons who know their HIV status (13+ years)
Persons with medical insurance (<65years)
Suicides

*Except where otherwise noted

Infants

Infant deaths

Children and adolescents

4th grade students whose reading skills are at or above the proficient achievement level for their grade
Adolescents with major depressive episodes (MDEs) who receive treatment
Children and adolescents with obesity
Current use of any tobacco products among adolescents

Adults and older adults

Adults engaging in binge drinking of alcoholic beverages during the past 30 days
Adults who meet current minimum guidelines for aerobic physical activity and muscle-strengthening activity
Adults who receive a colorectal cancer screening based on the most recent guidelines
Adults with hypertension whose blood pressure is under control
Cigarette smoking in adults
Employment among the working-age population
Maternal deaths
New cases of diagnosed diabetes in the population

Note: Adapted from Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved April 30, 2023, from <https://health.gov/healthypeople/objectives-and-data/leading-health-indicators>

Communities can use LHIs and the MAPP assessments in the following ways:

- Explore LHIs in the CSA and CCA to focus on upstream measures and factors that impact death and disease in the community.
- Use LHIs as a benchmark to identify and compare locally relevant indicators to explore community status in the CSA.
- Use LHIs to inform the CCA and explore community context regarding the factors that impact death and disease in the community.

Data Sources and Methods

Healthy People 2030 relies on high-quality data from more than 80 data systems to measure progress toward meeting national objectives. [Population data](#) are available for many objectives, including customizable charts and tables that display the data. The data template includes age group, country of birth, disability status, educational attainment, family income, gender identity, geographic location, health insurance status, marital status, race/ethnicity, sex, sexual orientation, and veteran status. When data are available, they may include many specific types of disparities among different groups. Users can further filter data by years and or by topics of interests. Communities may use the data alone or in combination with local data to inform CHI efforts and monitor progress toward specific targets.





When using population data to inform the MAPP assessments, communities may do the following:

- Review the data sources and methodology and identify opportunities to collect data in the CSA.
- Review the Healthy People 2030 [target-setting methods](#) and [download tools](#) to set targets.
- Use the Healthy People 2030 data to identify and track health disparities in the community through the CSA.
- Import data charts and data tables into local reports.
- Download one or more data sets from Healthy People 2030 to compare analytical methods locally and nationally.

Organizing and Analyzing Data

Organizing and analyzing data is a major step in the MAPP assessments. Communities may find it helpful to organize data by overarching Healthy People 2030 SDOH domains as described earlier. Reviewing the Healthy People 2030 data template and the population groups can be an opportunity to disaggregate data. For example, communities may assess whether the local data set includes gender identity or veteran status. Communities may also use the SDOH Framework to guide data collection and analysis within and across each domain. The SDOH Framework can help planners identify data partners in other sectors, such as transportation or housing. The SDOH Framework can also help communities organize and share results and deepen understanding of specific determinants within the community.

Data Triangulation

Figure 3 shows the process of data triangulation in MAPP, which informs the development of issue profiles. Data triangulation includes the following steps:

- Summarizing raw data from the CPA, CSA, and CCA.
- Using guiding questions to identify themes from the assessment data.
- Developing issue statements based on themes.

This process informs the issue profiles, which can be organized around Healthy People 2030 SDOH domains. Communities can look across the three assessments to identify cross-cutting themes related to the Healthy People 2030 SDOH domains.



**DATA FROM
ASSESSMENTS**



THEMES



**ISSUE
STATEMENTS**



**ISSUE
PROFILES**

Figure 3. MAPP Process for Developing Issue Profiles

Issue Profiles

About Issue Profiles


Issue profiles are brief documents that explore each public health topic and corresponding issue statement through a root cause analysis. They include potential strategies to improve the community’s health and well-being related to a specific issue.

How MAPP Uses Issue Profiles

- During Phase II: Issue profiles are used in the CH[N]A to share the story of the community.
- During Phase III: Issue profiles are used when prioritizing which issues will be the focus of the CHIP and when creating community partner profiles for the chosen priority issues.

How Healthy People 2030 Informs Issue Profiles

- Communities may build a [custom list](#) of Healthy People 2030 objectives to use in their work and to inform issue profiles. For example, if an issue profile highlights “healthy aging,” a [custom list](#) could be created or edited with any relevant Healthy People 2030 objectives and added to the issue profile.
- The issues outlined in the issue profiles are explored through a root cause analysis. Through this analysis, communities may consider how Healthy People 2030 SDOH domains contribute to or are affected by the issue. It may also be helpful to measure the root

Considerations 

- When applicable, select the parts of Healthy People 2030 that apply most to the community and issue profiles identified in the CHA.
- Consider access and availability of data when identifying priorities.
- Identify and develop shared goals and long-term measures that align MAPP and Healthy People 2030.

- causes of or contributors to an issue.
- Issue profiles can be organized around each Healthy People 2030 SDOH domain. For example, what are factors related to social and community context in communities that are disproportionately affected by community and/or police violence? What are the factors in the neighborhood and built environment in communities with limited or no affordable housing?
- Communities may align Healthy People 2030 objectives and LHIs within each issue profile. For example, communities can use data to determine important topics and issues, then use [evidence-based resources](#) to inform action to address those issues.

PHASE III: CONTINUOUSLY IMPROVE THE COMMUNITY

Healthy People 2030 Tools and Resources



- Leveraging Healthy People to Advance Health Equity
- Community Stories
- Data Sources and Methods
- Evidence-Based Resources
- LHIs
- Objectives
- Partnership Stories
- Target-Setting Tools



Overview

MAPP's Phase III maintains the emphasis on addressing upstream priorities but offers structured steps to advance health equity through both transactional and transformational approaches. With an emphasis on strategic partnerships for sustained action, this phase integrates power analyses and community partner profiles to appropriately engage those best positioned to address the root causes of inequity as they relate to each CHI goal. This phase also uses methods of continuous quality improvement and rapid cycle improvement to promote sustained, data-driven action. This allows for building an evidence base through small-scale improvements on existing strategies and small-scale testing of new, innovative strategies. Further, this phase provides a structure for partners to establish shared measures to monitor and evaluate the short- and long-term impact on priority issues.

The following section outlines Phase III of the MAPP process to guide CHI. Each step includes considerations for using key Healthy People 2030 tools and resources to deepen understanding of community priorities and support implementation of strategies to improve health and well-being. Here are some ways communities can use Healthy People 2030 throughout Phase III:



Prioritize Issues for the CHIP

- Identify priority issues for the CHIP and opportunities to advance health equity. Refer to [Leveraging Healthy People to Advance Health Equity](#) for recommended tools for action to help improve health and well-being centered on advancing health equity.
- Consider [evidence-based resources](#) with interventions to help achieve the objectives, such as those listed in Healthy People 2030, including resources related to each SDOH domain. After selecting priority areas of focus, consider the suggested interventions to plan for action with partners and target SDOH for a wider impact on the conditions that shape health.
- Use LHIs and [objectives](#) to set priorities for the CHIP that align with Healthy People 2030 priorities.
- Connect state priority issues to Healthy People 2030 priority areas.
- Refer to Healthy People 2030 objectives for selecting indicators for the CHIP.

Do a Power Analysis of Each Issue

- A power analysis is used to assess how priority issues are influenced by people and institutions, including the factors that cause or lead to the issue. [Explore Healthy People in Action](#) for inspiration through Community Stories when doing a power analysis of each priority issue in MAPP. These stories demonstrate how communities across the United States are addressing Healthy People 2030 topics and objectives.

Set Up Priority Issue Subcommittees

- For each priority issue, create a subcommittee that is responsible for developing the action plan

and assigning the implementation process for selected strategies. Engage community partners whose efforts and resources align with LHIs and objectives. Diverse representation of community partners on the subcommittees can contribute to a deeper understanding of priority issues informed by MAPP and Healthy People 2030. It also helps to advance CHI upstream.

► *Inspiration and Practical Tools*



Explore public health topics that matter to your community.

Learn more about important topics in Healthy People 2030's comprehensive [evidence-based resources](#), which is a collection of published reviews and studies in categories such as health conditions, health behaviors, and systems and settings.

Use Healthy People 2030 evidence-based resources in your work.

Evidence-based resources can support and inform CHI efforts. [Learn](#) about practical ways that evidence-based resources can help improve community health and well-being in your work.

Create Community Partner Profiles

- Explore [Healthy People in Action](#) Partnership Stories when creating and analyzing community partner profile worksheets in MAPP. These stories highlight the work of Healthy People 2030 Champions. The stories demonstrate how Champions are working across sectors to achieve shared goals of health equity and well-being across the lifespan.
- Use community partner profiles with Healthy People 2030 objectives to help identify community partners who are best positioned to impact a priority issue and streamline the process to develop, implement, and evaluate strategies by community partners. Not only are Healthy People 2030 objectives evidence-based and vetted, they also represent a variety of topics that community partners can address. Moreover, Healthy People 2030 provides a framework to drive multi-sector collaboration through the MAPP process.

Table 2 provides an example of how communities may align their goals with activities across partners. In this example, education access and quality is the priority, and improving high school graduation rates is the goal. The selected partners represent different sectors with shared values and goals. Using their available resources and programmatic efforts can address service gaps, strengthen cross-sector relationships, and help communities achieve goals.

COMMUNITY PARTNER PROFILE EXAMPLE	
<p>CHI Priority Issue: Education Access and Quality</p> <p>CHI Goal: Improve high school graduation rates by providing effective and early interventions long-term.</p> <p>Healthy People 2030 Indicators: Proportion of high school students who graduate within 4 years—AH-08</p> <p>Outcome Metric: Percent of public high school students who graduate with a regular diploma 4 years after starting 9th grade</p>	
PARTNER 1: DEPARTMENT OF EDUCATION	PARTNER 2: COMMUNITY MENTAL HEALTH SERVICES
Description of Current Programs, Services, and Interventions Related to Priority Issue	Description of Current Programs, Services, and Interventions Related to Priority Issue

<ul style="list-style-type: none"> • Assesses students twice each year for risk factors associated with drop out. • Can contract with community mental health centers to provide mental health and social services. 	<ul style="list-style-type: none"> • Employs mental health and social service providers in public high schools. • Provides counseling sessions and support services to students beginning in 9th grade.
SHARED GOAL(S)	
<p>Improve high school graduation rates by providing effective and early interventions long-term</p>	
ASSOCIATED OBJECTIVES	ASSOCIATED OBJECTIVES
<ul style="list-style-type: none"> • By XX date, the Department of Education will hire and place at least two mental health and social service providers from community mental health services in each public high school. • By XX date, a standardized policy will be developed for all public high schools to provide mentorship appointments before, during, and after school hours. • By XX date, public high schools will receive an annual report on students repeating school years to link high-risk students to services. • By XX date, public high schools will increase the rate of students graduating within four years by 5% compared to the rate in XX year. 	<ul style="list-style-type: none"> • By XX date, community mental health centers will select at least two mental health and social service providers per public high school to provide services to students. • By XX date, community mental health centers will provide annual training to public high school counselors and staff on risk factors for drop out and resources to prevent drop out. • By XX date, mental health and social service providers in public high schools will provide at least 200 hours of sessions for students at risk of drop out.
OUTCOME METRIC	
<p>Percent of public high school students who graduate with a regular diploma 4 years after starting 9th grade</p>	

PROCESS METRICS	
<ul style="list-style-type: none"> • # of providers hired per public high school • # of public high schools with hours and policies allowing for counseling sessions before, during, and after school hours 	<ul style="list-style-type: none"> • # of mental health and social service providers receiving annual training on assessing for risk of drop out • # of hours of counseling sessions provided to students per month • # of students receiving counseling sessions monthly
ORGANIZATIONAL RESOURCES	
<ul style="list-style-type: none"> • Funding to support student mental health and social services • Access to student data for ongoing monitoring and evaluation • Policy/advocacy skills • Physical space to support school-based mental health and social services • Teacher/staff in-service days to provide training on assessing the risk of drop out 	<ul style="list-style-type: none"> • Funding to support community mental health and social services • Trained and licensed providers to deliver mental health and social services • Relationships with multiple community partners (e.g., schools, clinics, hospitals, non-profits) • Staff time to provide training on assessing the risk of drop out and prevention strategies

Develop Shared Goals and Long-Term Measures

- To help identify needs and priority populations, browse [Healthy People 2030 objectives](#) to learn about national goals to improve health.
- Consider how [Healthy People 2030 national goals](#) align with MAPP priority areas.
- Identify opportunities to enhance focus on groups affected by health disparities in the CHIP.

Select CHIP Strategies

- To help identify evidence-based strategies for the CHIP, browse [Healthy People 2030 evidence-based resources](#).

Develop Continuous Quality Improvement Action Planning Cycles

- Develop an action plan including objectives, measures, timelines, and a Plan-Do-Study-Act (PDSA) cycle that details the needed milestone steps and responsibilities of the partners. Consider using Healthy People 2030 [target-setting methods](#) to monitor data and progress toward meeting goals and objectives. Tools are available to monitor improvement, trends, and differences across population groups. Healthy People 2030 data tools also assess changes in health disparities to help identify priority populations.

Monitor and Evaluate the CHIP

- Use Healthy People 2030 to identify targets and monitor indicators. Communities may consider using data from Healthy People 2030 LHIs as a benchmark for monitoring and evaluating local change. This could involve monitoring local progress toward achieving Healthy People 2030 objectives or comparing progress at the community level to Healthy People 2030 national data. Although Healthy People 2030 provides targets for national objectives and the United States overall, setting local targets contributes to national success.
- Reference the baseline and targets for each objective to compare community data to the national targets. When appropriate, use Healthy People 2030 data to inform local policy and program planning and development.
- Share data and information when working with community partners and to sustain relationships and progress. MAPP provides tools to support monitoring and evaluation, including reporting to different audiences using data visualization, reports, and more. Browse [Healthy People in Action](#) to learn how partners and communities are sharing their work related to achieving health equity and community well-being across the lifespan.

Considerations



Integrate Healthy People 2030 objectives and targets into data visualization tools within the CH[N]A to help track progress on objectives and targets identified.



Summary

Healthy People 2030 and MAPP provide a foundation to improve population health and advance health equity. These approaches offer helpful tools and resources to support CHI efforts and align those efforts to the unique characteristics of communities. Where possible, communities may use these approaches to identify opportunities for all people to attain optimal health and well-being.



Healthy People 2030

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