

Introduction

In its 1988 report, *The Future of Public Health*, the Institute of Medicine identified assessment, policy development, and assurance as the core functions of public health agencies. The fulfillment of these responsibilities is critical if we are to successfully promote conditions in which the citizens of Virginia can be healthy.

The assessment function is, by definition, the foundation upon which the other two functions must be built. It requires that public health agencies regularly and systematically collect, assemble, analyze, and make available information on the health of the communities they serve. These facts become the basis upon which a community can determine its health needs and how to use its resources to prevent and reduce disease and disability. This data-driven approach to problem-solving ensures that a scientific knowledge base undergirds efforts to improve the public's health.

To facilitate the assessment process, the U.S. Department of Health and Human Services (DHHS) established targets for the nation in its report, *Healthy People 2000*, a compilation of national health promotion and disease prevention objectives for the turn of the century. Thousands of citizens and health professionals, more than three hundred private organizations, and all state health departments spent three years developing a national consensus on health priorities.

The national report presents a vision of an increase in the span of healthy life for our nation's citizens, significantly reduced disparities in health status among the population groups in our society, and access to preventive services for all Americans. It offers a broad spectrum of health status, risk reduction, and services and protection objectives that address the multiplicity of issues faced by states and localities.

In setting forth 22 priority areas and 300 objectives in the national report, its authors were being deliberately comprehensive so that individual states and local communities could be selective in identifying the objectives which are relevant to their own most pressing needs. For the Commonwealth, this would require concentration on a limited number of priority prevention issues in order to ensure the greatest possible effectiveness in the deployment of resources.

Deciding where to focus has not been a simple task. Although all the objectives outlined in the national report are important, we wanted to choose for Virginia those which are considered the most critical given our current health status and needs. The selection process has involved the formation of a task team (see Appendix F for a list of members) in the Virginia Department of Health (VDH) which examined the original *Healthy People 2000* report as well as last year's *Midcourse Review and 1995 Revisions* and determined the key issues for Virginians. In some cases the task team identified additional objectives based on data which do not appear in the national reports. The selected targets, therefore, include national level as well as state level objectives, all of which are identified as *Virginia 2000 Objectives*.

The list of health status and health risk indicators is grouped under three separate priority goals:

- Improve Pregnancy Outcomes
- Decrease the Burden of Chronic Disease
- Protect Virginians from Communicable Diseases and Environmental Health Hazards

Under each of these goals, baseline measurements of health status and/or factors that put individuals at increased risk of premature death are stated in conjunction with specific objectives. Where the data are available for a period of years, a trend line depicts the State's progression on that measure during the given time frame. Bar graphs also show the data for a number of the measures by Health Maintenance Organization (HMO) region, in accordance with the "Commonwealth of Virginia by HMO Regions" map which appears in Appendix A. A related effort to show the linkage between the selected objectives and Health Plan Employer Data and Information Set (HEDIS) performance standards used by managed care organizations appears in Appendix C, "Relationship of Virginia 2000 Objectives and HEDIS 3.0 Measures."

In addition, the data compiled from VDH vital statistics, the reportable disease surveillance system, and the Office of Epidemiology have been presented as charts (the data source for each chart is the same as that used for the corresponding trend line and bar graph; unless otherwise indicated, the figures reflect the total population rather than just those individuals

served by the health department). These charts depict how each of Virginia's thirty-five health districts compares with the other districts, the United States and the *Virginia 2000 Objective* for the most recent year for which the figures are available. In the few instances where there are indicators for which there are no corresponding national data, we show only the most recent state figure and a *Virginia 2000 Objective*. In most cases, the latter figure targets an improvement level of 7.5% above the most recent state figure as a realizable objective by the year 2000.

When reviewing data for the health districts, rates based on a single year can be deceptive; a district's situation might be substantially different in another year based on a different set of circumstances. Publication of subsequent annual reports will establish trend lines over an extended period of time.

Segmenting of the data into quartiles provides an overview of all the health districts, in the hope that those with obvious needs might be able to replicate some of the successful approaches to problem resolution employed in comparable districts. Where districts have the same rates, they have been grouped in the higher quartile. Rates can be misleading if based on small numbers since unique events can significantly impact such rates. The reader is encouraged to check *Virginia Health Statistics 1995* and *Reportable Disease Surveillance in Virginia, 1995* for more information relating to population sizes and numbers of events or reported cases. These documents can also be used by health districts or HMOs to develop the same data for the individual counties or cities within their area.

Data from the 1995 annual Behavioral Risk Factor Surveillance System (BRFSS) are only available at the State or regional level due to sample size. Beginning with the publication of the 1997 results, the BRFSS data will also become available for many of these measures at the health district level as the survey sample size is increased.

Where the information is provided according to race, the data are presented only for "white" and "black" because of the small numbers for all other categories. To use these small numbers to calculate rates for other minorities for individual jurisdictions would result in unreliable figures. Information on the racial groups, Asians/Pacific Islanders and Native American/American Indians, and the ethnic group Hispanics/Latino is not

available for this report. To address this issue, VDH is examining ways to report information on all racial and ethnic minorities, such as collapsing smaller minority population figures at the city/county level into regional figures. The result would be denominators large enough to permit the calculation of more reliable rates. It is our goal to have such enhanced information in future VDH reports.

Based on the available information, there are often significant disparities between the health status of blacks and whites, as evidenced in the separate charts for several objectives (e.g., Infant Mortality) for these racial groupings. In spite of the disparate baseline data, the task team decided that it is important to have the same targets for all Virginians, even though it will require more effort to achieve equity when there are large differences in current rates between racial groups.

In adopting this position, the task team noted that racial and ethnic factors alone do not cause ill health. Race and ethnicity correlate with other determinants of health status, such as behaviors, access to quality health care and poverty. If we are to achieve the objectives set forth in this report, far-reaching strategies designed to improve the health and overall well-being of minorities must become a guiding priority for our efforts.

This report is designed to help focus the attention of the public, in general, and health districts, in particular, on a limited number of health-related priorities in the Commonwealth. Regular updates of the report will enable the citizens of Virginia and health care professionals to track the progress being made in their respective areas and, in concert with one another, to devise prevention-oriented approaches to local problems. The report will have served its intended purpose if it is used in this way to help promote healthy Virginia communities.