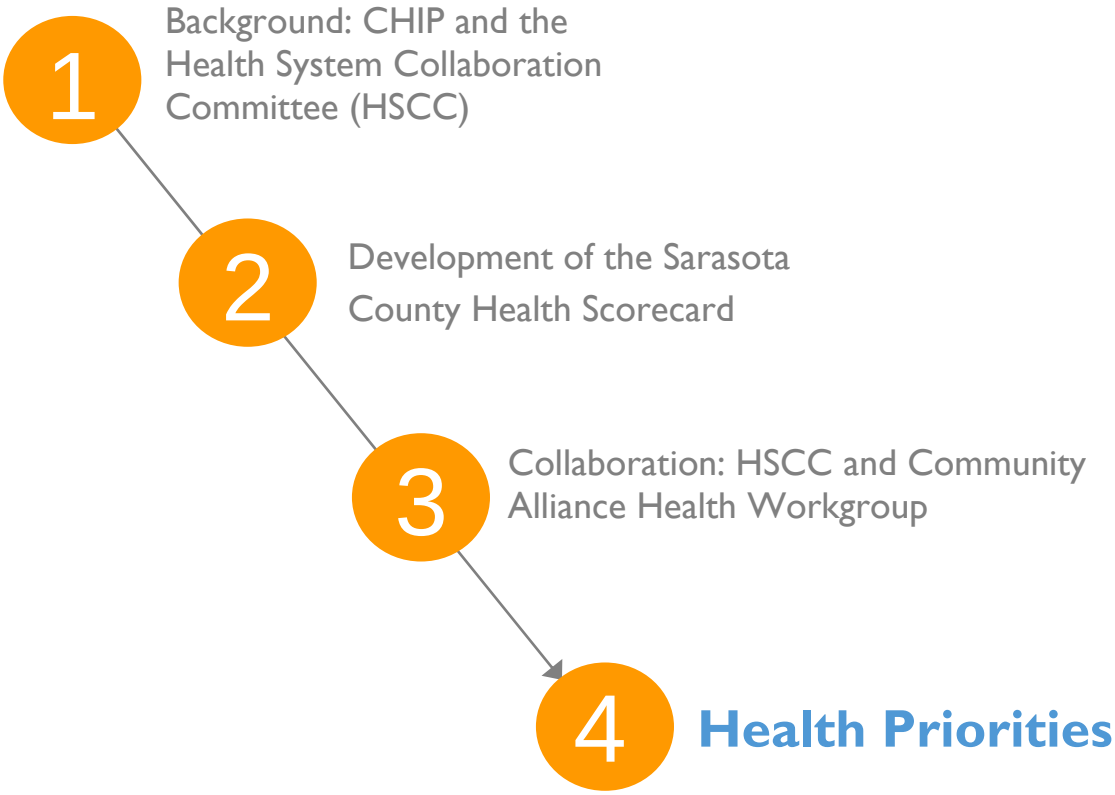
A Summary of Health Priorities for Sarasota County



CHIP
Community Health Improvement Partnership

Prepared for the Community Alliance
December 2007

1 CHIP: The Community Health Improvement Partnership

In late 2002, CHIP was formed to engage individuals, non-profit organizations, hospitals and other agencies in improving the health of Sarasota County residents. CHIP's mission is to engage and support citizens and agencies to positively impact the physical, mental, social and environmental health of their community through research, planning, implementation and evaluation.

The Health System Collaboration Committee

The Health System Collaboration Committee (HSCC) was developed by CHIP to provide a mechanism for incubating new ideas and improving communication about healthcare across the community. The HSCC includes representatives from local agencies and organizations, the health department, local hospitals, as well as community volunteers and CHIP staff.

2 Development of the Sarasota County Health Scorecard

In early 2005, the HSCC began the process of establishing a set of key indicators which would provide a comprehensive, multi-dimensional snapshot of the health of Sarasota County. Under the leadership of Dr. Loring Wood, the ***Sarasota County Health Scorecard*** was developed to accomplish several objectives:

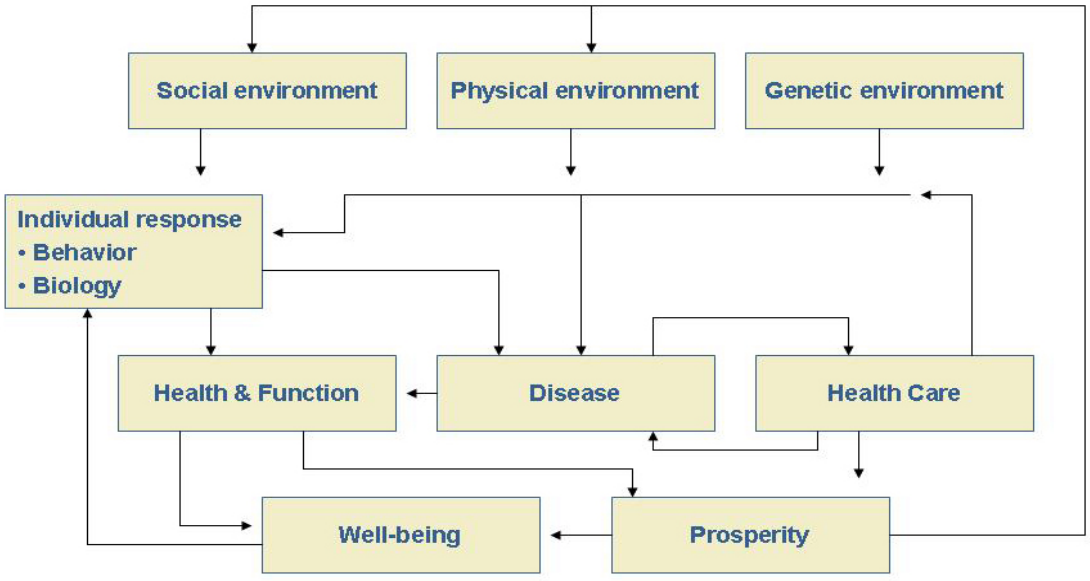
- To guide and monitor local community health trends
- To network and synergize local groups working to address similar issues
- To build a framework to move forward with health improvement strategies

The Scorecard will be updated on an annual basis, offering a tool that can be used to provide a better understanding of where we are – and where we are going – in our efforts to improve community health.

Understanding the Many Factors which Contribute to Health

Many factors impact health. CHIP's Health System Collaboration Committee used the Evans and Stoddart conceptual model of the "Patterns of Determinants of Health" [1] as a framework to select key measures for inclusion in the Scorecard. The Evans and Stoddart model defines health as a product of many influences and recognizes that these factors interact to shape the health of individuals and the community.

The model depicts health as influenced by individual response (behavior and biology), by disease, and by the social environment, the physical environment and genetic endowment. These factors create health or disease, which in turn determine the utilization of the health care system. The model includes other important outcomes such as well-being and prosperity, in addition to the absence of disease. The uniqueness of this model is the attention given to environmental and physical factors in the production of health and the inclusion of secondary outcomes, such as prosperity.



Adapted from Evans & Stoddart, "Patterns of Determinants of Health"

How were the indicators selected?

The HSCC focused on the challenging task of selecting appropriate, locally meaningful indicators to represent the Evans-Stoddart model's key categories. The committee reviewed many state and national tools to identify a long list of potential indicators. This indicator selection process took more than year, during which time the committee reviewed, discussed, and debated hundreds of measures. To narrow down that long list, a ranking process was carried out in which individual committee members scored each indicator based on three important criteria:

- **Magnitude of the Problem:** How many persons does the problem affect, either actually or potentially?

- **Seriousness of the Consequences:** What degree of disability or premature death occurs because of the problem? What are the potential burdens to the community, such as economic or social burdens?

- **Feasibility of Correcting:** Is the problem amenable to interventions (i.e., are interventions feasible scientifically as well as acceptable to the community)? What technology, knowledge, or resources are necessary to effect a change? Is the problem preventable?

The ranking scores were averaged for each indicator and discussed by the committee. Indicators receiving low scores were considered for exclusion from the list.

Another factor impacting the indicator selection process was the availability of data specific to Sarasota County. Sometimes desired indicators were excluded from the Scorecard because of a lack of local data.

Several drafts of the Scorecard were produced, discussed and reviewed before eventually arriving at the current version, which contains 34 indicators.

3 Collaboration: HSCC and Community Alliance Health Workgroup

In the summer of 2006, the Health System Collaboration Committee was asked by the Community Alliance to spearhead a process of selecting 3 to 5 health priorities for Sarasota County. In tandem with the Alliance's Health Workgroup, a collaborative process to identify priorities was undertaken.

Suggested Approach for Priority Selection Process

Given that the HSCC had already completed a process of selecting key health indicators to be monitored for Sarasota County, the collective group already had an important tool with which to work. It was suggested that the data to be reviewed for the priority selection process for the Community Alliance focus on two key items: the Health Scorecard and survey data from CHIP's Community Health Survey. The Community Health Survey was a mail survey conducted in the fall of 2006; 2,325 surveys were returned by Sarasota County households. Of particular relevance to this process were questions which asked residents to identify the most important local health concerns as well as the issues most important for a healthy community.

What three items do you believe are the most important health concerns in your community?

	Percent
Aging problems (arthritis, Alzheimer's, etc.)	60
Chronic disease	43
Alcohol & other drug abuse	38
Poor diet / lack of exercise	25
Lack of access to healthcare	24
Child abuse / neglect	18
Motor vehicle crashes	16
Homelessness	15
Tobacco use	15
Mental health issues	12
Domestic violence	11
Sexually Transmitted Diseases	4
Teenage pregnancy	4
Infectious diseases	3
Rape / sexual assault	2
Firearm-related injuries	1
Homicide	1
Suicide	<1

What three items do you believe are most important for a healthy community?

	Percent
Low crime / safe neighborhoods	48
Access to healthcare & other services	41
Good schools	33
Good jobs and healthy economy	31
Affordable housing	30
Strong family life	29
Healthy behaviors and lifestyles	25
Religious or spiritual values	22
Community involvement	21
Clean environment	21
Parks and recreation	8
Low level of child abuse	7
Tolerance for diversity	7
Arts and cultural events	4
Low death and disease rates	2

1. Data from the 2007 CHIP Community Health Survey
2. Percentages add up to greater than 100 because individuals had the option of selecting more than one response.

Armed with these two key data tools, the group began the process of identifying three priorities. As the grouped looked at the Scorecard and the survey data, congruencies emerged between the “hard” data of the scorecard and the community input captured in the survey results. After some discussion, **three priority issues** were identified, along with focus areas under each main category.

PRIORITIES IDENTIFIED

Improve Chronic Disease Management

Encourage Healthy Behaviors and Active Lifestyles

Increase Access to Healthcare

These items are summarized on the following pages.

4 Health Priorities

The following priorities have not been ranked in terms of importance.

Priority: Improve Chronic Disease Management

What does this mean?

Chronic disease management is an approach to health care that emphasizes helping individuals maintain independence and keep as healthy as possible through prevention, early detection, and management of chronic conditions, such as congestive heart failure, asthma, diabetes, and other debilitating illnesses.

Chronic conditions impose challenges for those affected, their families and care providers. A patient's ability to follow medical advice, accommodate lifestyle changes, and access resources are all factors that influence successful management of an ongoing illness.

Why is this a priority?

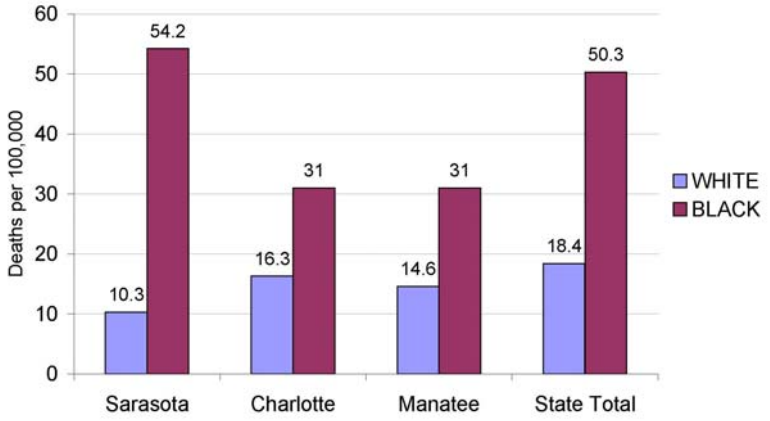
- Chronic diseases—such as heart disease, cancer, and diabetes—are the leading causes of death and disability in the United States. Chronic diseases account for 70% of all deaths in the U.S. – about 1.7 million each year. These diseases also cause major limitations in daily living for almost 1 out of 10 Americans or about 25 million people. Although chronic diseases are among the most common and costly health problems, they are also among the most preventable.[1]

- Without adequate clinical care, education and self-management skills, those with chronic diseases are more likely to endure preventable complications of the diseases.

- Age is a major risk-factor for chronic diseases. Among Counties with at least 10,000 people, Sarasota County ranks seventh nationally among counties with the highest proportion of the aged. Based on 2006 figures from the U.S. Census, 29.4 percent of the population in Sarasota County is 65 or above.

- Many chronic diseases disproportionately affect certain racial and ethnic groups. For example, African Americans, Hispanic/Latino Americans, and American Indians are at particularly high risk for developing type 2 diabetes. Race is another significant risk factor for chronic diseases. Data available from the Florida Department of Health provides compelling evidence to support the strengthening of efforts to address racial disparities in diabetes in Sarasota County. As indicated in Figure 1, the diabetes death rate for African Americans in Sarasota County is more than five times the rate for Caucasians.

Figure 1: 3-Year Age-Adjusted Diabetes Death Rate (02-04)



What are some ideas or examples of best practices?

- Many health programs are turning to community health workers (CHWs) for their unique ability to serve as "bridges" between community members and health care services. Recognition of the roles, skills, and contributions of CHWs; support for programs, including stable funding, technical assistance, and evaluation; and continuing education are needed to respectfully and effectively integrate these workers into the health care delivery system. An emerging body of literature appears to support the unique role of these community workers and advocates in strengthening existing community networks for care, providing community members with social support, education, and facilitating access to care and communities with a stimulus for action.[2] In Sarasota County, a CHW program is currently active in Newtown.

- Manatee County's Closing the Gap program seeks to facilitate the improvement of health outcomes and the elimination of health disparities in the area of diabetes. The project aims to provide self-management skills to a minimum of 100 Manatee County minorities diagnosed with diabetes by linking these individuals to care and education. To enhance access to services for low income, uninsured diabetics, the Manatee County Health Department partners with Eye Associates for free diabetic eye exams and with West Coast Podiatry for free foot exams. Another main objective of the program is to provide diabetes prevention education to a minimum of 400 individuals in our target areas.[3]

- In Richland County, Montana, a collaboration between the Richland County Commission on Aging, Richland County Health Department, and the Sidney Health Center, created the Richland County Community Diabetes Project, which aimed to provide a support system for persons with Type 2 diabetes. During its first year the project developed a Diabetes Advisory Board, conducted community and health care provider focus groups, and tested four pilot projects (a diabetes support group, walking clubs, a weight loss group, and a community diabetes resources book). The Project has created a formal, community-supported diabetes education program at the local hospital, recruited community sites for free indoor walking, developed linkages with the local Literacy Volunteers of America Program and Migrant Health, added social activities and collaborative goal setting to its projects,

and has developed plans to advocate for policy changes supporting chronic disease self management. By the end of its first 10 months of its implementation phase, the project has impacted the lives of at least 13% of the estimated local diabetic population.[4]

- The Diabetes Shared Medical Appointment Pilot Project (DSMAPP) was created in Suffolk County, New York, to develop, implement and evaluate a collaborative system/chronic care model approach and offer shared medical appointments, or group visits, in a primary care setting to improve the management of diabetes. Objectives included demonstration of improvement in provider compliance with American Diabetes Association (ADA) clinical practice recommendations and patient achievement of ADA goals, and demonstration of increase in patients' sharing of personal experiences and coping techniques with other patients who have diabetes.[5]

Helpful Resources

- The Community Guide to Preventive Services
  Evidence-based recommendations for programs and policies to promote population health.
  www.thecommunityguide.org

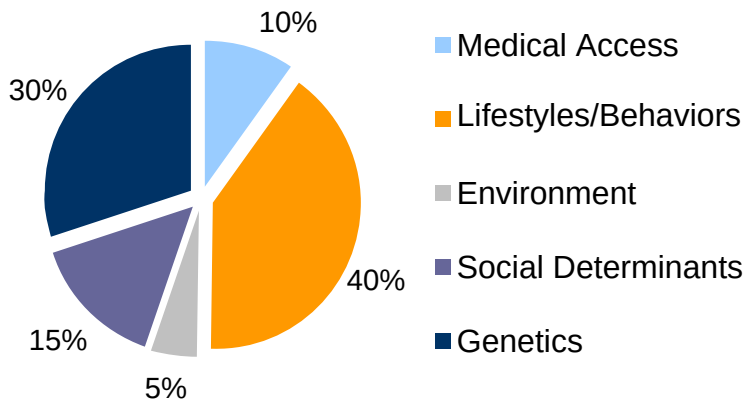
- National Association for County and City Health Officials (NAACHO)
  NAACHO maintains a Model Practice Database, an online, searchable collection of practices across public health.
  http://archive.naccho.org/modelPractices/

Priority: Encourage Healthy Behaviors and Active Lifestyles

What does this mean?

It has been estimated that behavior and lifestyle choices account for 40% of premature deaths.[6] Our behaviors and lifestyle choices are bigger predictors of health than medical access, genetics, or the social conditions in which we live.

Predictors of Premature Mortality



Healthy lifestyles include eating a healthy diet, maintaining a healthy weight, exercising regularly, quitting smoking (or not starting), and minimizing stress. Efforts should be made to promote healthy lifestyle behaviors, foster social connectedness, and create an environment which encourages healthy choices.

Why is this a priority?

- Since the mid-seventies, the prevalence of being overweight or obese has increased sharply for both adults and children. Based on data from CHIP's 2006 health survey, more than 30 percent of local residents are overweight and 19 percent are obese. [7]
- Increasing obesity rates raise concern because of their implications for Americans' health. Being overweight or obese increases the risk of many diseases and health conditions.
- Many Americans fail to make the connection between undertaking healthy behaviors today and the impact of these choices later in life. Studies by the National Institute of Aging indicate that healthy eating, physical activity, mental stimulation, not smoking, active social engagement, moderate use of alcohol, maintaining a safe environment, social support, and regular health care are important in maintaining health and independence.[8]
- Efforts need to be made to ensure that our physical environment makes healthy choices easy choices. The Institute of Medicine has underscored that

it is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change. But when these forces support health, it pays off. An average 150 pound person living in a activity friendly environment could lose 0.85 to 1.75 pounds per year, which approximates the average adult weight gain in the U.S.[9]

What are some ideas or examples of best practices?

- In Louisville, Kentucky, the 300-Mile Club is a walking program designed to encourage lifestyle changes that promote healthier living for individuals who lack knowledge about nutrition and the effects of obesity and who cannot afford to join health clubs. The program will achieve its goal by introducing walking as a form of exercise by educating participants about good nutrition and by providing pertinent health information through literature and speakers. Northwest Louisville's total population is 10,155, with an African American population of 9,664. The 300-Mile Club reached approximately 2 percent of African Americans and approximately 25% of that total population. The key elements of this program are a coordinator to organize activities, media coverage, data collection, incentives to encourage participation, and a newsletter for educational and promotional purposes.[10]

- The Land Use and Health Team is a collaborative effort in the tri-county, mid-Michigan area that involves planners, university faculty, business and public health. The purpose of the Team is to educate and engage the community regarding impacts of community design on health, and facilitate improvement through refinement and promotion of a health impact assessment tool. The Team has increased public engagement in regional planning by increasing awareness of local land use trends and health impacts. The Team is refining and promoting use of a health impact assessment tool to encourage discussion among planners and developers and others about health impacts of proposed developments. http://CACVoices.org

Resources

- Presentation on Healthy Living and Active Lifestyles by Tyler Norris. A DVD copy of this presentation is available through CHIP. http://app.idph.state.il.us/iphi/docs/Tyler%20Norris.pdf

- The Community Guide to Preventive Services
  Evidence-based recommendations for programs and policies to promote population health.
  www.thecommunityguide.org

- National Association for County and City Health Officials (NAACHO)
  NAACHO maintains a Model Practice Database, an online, searchable collection of practices across public health.
  http://archive.naccho.org/modelPractices/

Priority: Increase Access to Healthcare

What does this mean?

Even for healthy community members, having a regular healthcare provider and more advanced medical services and resources available has real value. These healthcare relationships and resources enhance the quality of our lives and peace of mind. Lack of access to healthcare results in adverse economic, social, and health consequences for uninsured persons and their families.[11]

The number of people without health insurance has increased steadily since the beginning of the century, now totaling about 47 million Americans. As a community, we must find ways to expand coverage and provide access to affordable care for those without insurance.

Why is this a priority?

- Working-age Americans without health insurance are more likely to receive too little medical care and receive it too late; be sicker; and receive poorer care when they are in the hospital. Research has shown that uninsured individuals have a 25% higher mortality than those who are insured; the Institute of Medicine estimates that 18,000 lives are lost annually as a consequence of gaps in coverage.[12]
- In Sarasota County, based on 2006 population estimates, 47,388 are uninsured. [7]
- CHIP's 2007 Community Health Survey found that a high proportion of residents (41 percent) cite access to healthcare as an important characteristic of a healthy community, and nearly one-fourth of respondents noted lack of access to healthcare as a priority health concern. [7]
- Among children in Sarasota County (age 18 and under), 13.4 percent are uninsured. In Florida, 11.8 percent of children are uninsured. [7]
- Though employers serve as a primary link to coverage, employment alone doesn't ensure access to health insurance. Among Sarasota County's uninsured, 95 percent have a family member with some form of employment. Twenty-two percent of the uninsured are employed full time, 22 percent are self-employed, and 18 percent are employed part-time. An additional 11 percent are unemployed and 7 percent are retired. [7]
- Thirty-eight percent of uninsured Sarasota County residents report that they delayed or did not get needed medical care in the past year. Among those with insurance, 7.2 percent reported the same. [7]
- More than 12 percent of Sarasota County residents report that their health status is fair or poor. When compared to those with insurance, the uninsured are about twice as likely to report fair or poor health.[7]

What are some ideas or examples of best practices?

- Alachua County, Florida has implemented the Community Health Offering Innovative Care and Educational Services (CHOICES) program. The program, funded by a 1/4-cent sales tax, provides direct healthcare (primary care, pharmacy, dental) and disease management & health education to working, low-income residents (150% FPL). Participants are required to pay a $10 co-pay for each visit. www.acchoices.org

- Sarasota Healthcare Access is a referral system for people who need healthcare, but lack health insurance. The purpose of Sarasota Healthcare Access is to increase access to primary care, specialty care and dental services for uninsured individuals in Sarasota County. The program targets uninsured patients with a history of avoidable hospitalization or emergency department utilization. Case managers help patients establish a medical home, thereby decreasing reliance on hospitals for routine care.

- Project Access is a partnership between county government, county physicians, service agencies, the hospital, and pharmacists. The Health Department could handle primary care needs but specialty care had always been a problem until Project Access. The community doctors wanted to do their share but not get "slammed." Through Project Access 90% of practicing physicians in Buncombe County (over 600) now see 10-20 individuals referred into their program with no expectation of payment. The County provides seed money, the Medical Society runs the program, and the hospital absorbs patient costs. Access to primary care services has been raised from 78% in 1995 to an astounding 93% in the year 2000.[13]

- The Hampshire Health Connect Method recruits physicians to see a limited number of uninsured patients for a sliding scale fee. Contracts are used to formalize agreements. Fees range from $5-30 for standard office visit and from 10-40% of normal cost for other procedures. The program is available to those who are uninsured and unable to get health insurance from another source.

Resources

- CHIP. *Uncovered: Health and the Uninsured in Sarasota County* (Report and Video, available at www.chip4health.org and www.GetSarasotaInsured.com)

- CHIP. Summary of Best Practices - Health Provocateur Meeting Manual, April 6, 2006. Contact CHIP staff at 941.861.2987 for a copy.

- *Improving Access to Health Care*. A Manual Based on Experiences from the Robert Wood Johnson Foundation's Communities in Change Initiative, January 2005.

- Florida Health Insurance Study. Available at http://ahca.myflorida.com/Medicaid/quality_management/mrp/Projects/fhis2004/reports.shtml

- www.CovertheUninsured.org

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