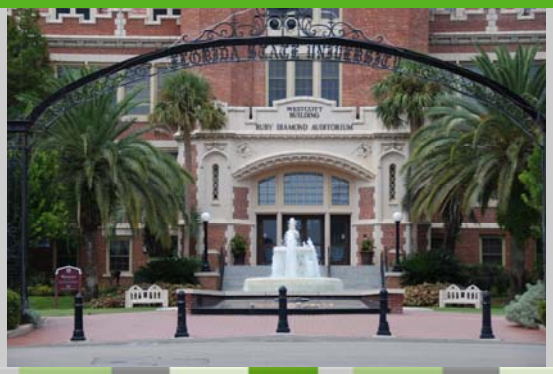
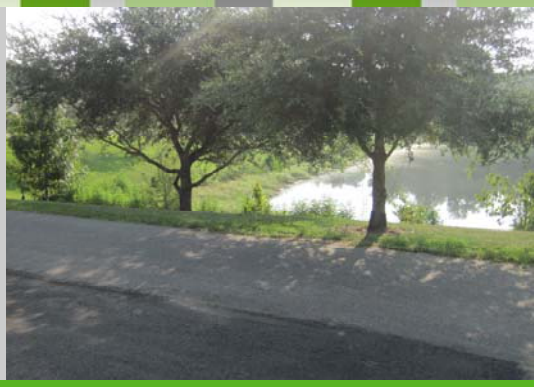
LEON COUNTY

Community Health Improvement Plan





Prepared for:
Capitol Coalition for Health

Prepared by:
Leon County Health Department

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Capital Coalition for Health

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Executive Summary

The Florida Department of Health in Leon County (LCHD), founded in 1931, provides various public health services throughout the county to ensure the health and safety of all residents. Services include vital statistics, epidemiology and disease control, environmental health services, emergency preparedness, social services, Women, Infants and Children (WIC) supplemental nutrition program, and community health promotion including tobacco and chronic disease prevention. Clinical services (provided in clinics, mobile units, and schools) include family planning; pregnancy testing; screening for sexually transmitted diseases; immunizations; cancer screenings; tuberculosis testing and prevention; dental care; and school health.

In the spring of 2011, LCHD initiated a county-wide, community health assessment that would determine public health priorities for the next three to five years. The MAPP model was chosen to guide this comprehensive effort. MAPP, the acronym for "Mobilizing for Action through Planning and Partnerships," is recommended by many national and state public health organizations including the National Association for City and County Health Officials (NACCHO) and the Florida Department of Health as a best practice for health assessment and planning. MAPP is built on principles of broad community engagement and strategic planning, which prepare community partners to act together to address prioritized health issues and improve community health.

LCHD engaged two local health councils to assist with the community health assessment process. Health Planning Council of Northeast Florida facilitated the overall assessment and community engagement processes, and Big Bend Health Council provided expertise on local health status data. To begin the process, a Core Planning Team was recruited from within the LCHD.

This group worked together throughout the year-long process to assure community involvement and to provide the public health agency perspective. A Community Kick-Off Event was held in August 2011 with over 100 participants from the community.

At this event, an overview of community health assessment and MAPP was provided, a group process was conducted to identify a vision statement and values for Leon County Community Health, and participants were recruited for the MAPP Steering Committee and various subcommittees.

Capital Coalition for Health: Forging Strong Partnerships to Promote Healthy Living
Vision: Leon County communities will distinguish themselves as collaborative, civically-engaged and accountable—communities where residents and leaders support health-based policies that ensure the healthy choice is the easy choice; where residents can live, work, and play in a safe and healthy environment; and where every resident has access to affordable and equitable health care and resources.
Values: **Leon County:**

- Will invest in the health and well-being of all residents
- Will model healthy and active lifestyles
- Will advocate for equitable and transparent health-based policies

Once the Capital Coalition for Health was established, the assessment work began. The MAPP process is comprised of four distinct assessments:

- Big Bend Health Council and Health Planning Council of Northeast Florida gathered secondary data on a variety of indicators of community health status. Leon County measures were compared to measures for the state of Florida as a whole and trends were considered to understand the how the measure has changed over time. The MAPP Steering Committee reviewed all data over the course of several meetings. Additional indicators were identified for

review and major findings were discussed. The result is a comprehensive **Community Health Status Assessment** which describes population demographics, socioeconomic characteristics, and community health status, including health care access and utilization information.

- Next, the coalition set out to understand what were the perceptions and opinions of community residents as part of the **Community Themes and Strengths Assessment**. A Community Survey was developed and disseminated broadly to adults via online survey posted on websites and pushed out through email contacts. Paper surveys were completed at various events and through partner organizations. Roundtable discussions began as the survey process was coming to a close. Small groups of community members participated in facilitated discussions that aimed to delve deeper into community health and quality of life issues.
- The MAPP Steering Committee developed a list of key forces that impact, or are likely to impact, the health of Leon County residents. This **Forces of Change Assessment** was completed through a group process that prioritized the top forces and then identified potential opportunities and/or threats associated with each of the top forces.
- Finally, the **Local Public Health System Assessment** was completed in a three-step process that drew on the experiences and opinions of the Core Planning Team, MAPP Steering Committee and additional community partners, and subject matter experts within the local public health system. The findings from all four assessments were synthesized and then reviewed by the MAPP Steering Committee.

Health Status Assessment

Chronic diseases (diabetes, heart, cancer)

Risk factors (obesity, hypertension)

Health disparities by SES

Motor vehicle accidents

Infant mortality

Childhood asthma

STDs and HIV/AIDS

Gang violence

Binge drinking

Influenza/pneumonia in elderly

Themes and Strengths Assessment

Chronic diseases (diabetes, obesity)
Cancer
Substance abuse
Violence
STDs

Access to care (esp. dental, behavioral health)

Quality of advanced care has low regard

Disparity in quality of life by area of town

Improved health communications

Strategic Health Issues

1. Obesity and chronic disease

2. Health disparities

3. Access to health care

Local Public Health System Assessment

Educate and empower people about health

Mobilize community partnerships

Develop policies/plans

Link to personal health services

Workforce development: Leadership

Evaluation of health services

Forces of Change Assessment

Chronic diseases and risk factors

Access to care

Transportation

Lack of partnership and cooperation

Economic crisis/child poverty increasing

Health disparities by SES

Elderly population and needs are increasing

Next, a prioritization process was conducted to further narrow the scope of the Community Health Improvement Plan in order to make substantial progress on each issue more feasible. Each Strategic Health Issue was considered, with all of its components included.

Obesity and Chronic Disease	Health Disparities	Access to Health Care
• Overweight/ obesity • Hypertension/stroke • Diabetes • Heart disease • Cancer	• HIV • STDs • Influenza/ pneumonia • Infant mortality • Cancers (mortality for breast, prostate, colorectal) • Diabetes • Access to health care	• Access to primary care for low income populations • Dental care • Mental health/counseling • Substance abuse treatment • Prescription medications

The MAPP Steering Committee used the World Café process to create an inventory of existing resources and programs devoted to each of these issue areas. Small groups rotated through each of five tables, one for each issue area. This exercise helped participants to develop a more complete picture of the needs, assets, and existing resources dedicated to addressing each issue. Finally, each member voted on his or her top issue; three were identified through the process as being the highest priority and worthy of inclusion in the Community Health Improvement Plan. Those final issues were:

- Obesity and chronic disease
- Health disparities
- Access to health care

Important strategies to employ in addressing these issues will be: 1) improve health education and communication and 2) strengthen partnerships and collaboration.

This summary represents four phases of the MAPP Community Health Needs Assessment. Phase Five of the MAPP model continues with planning through the development of goals and strategies for the key strategic issues identified. Over several months the Capital Coalition for Health divided into three teams, which met separately, each focused on a strategic issue. As a group they agreed upon goals for each strategic issue and brainstormed possible strategies to reach each goal. Through a series of further community conversations among partners and led by the Florida Department og Health in Leon County, they aligned with the state's strategies and defined the local implication of each strategy and identified the lead for each strategy. The results of this process represents the Leon County Community Health Improvement Plan.

Obesity and Chronic Disease

Overweight and Obesity are conditions that increase the risk for a variety of chronic diseases and health concerns, including heart disease, Type 2 diabetes, certain cancers, hypertension, high cholesterol, and stroke.

The condition of overweight and obesity are determined by using a calculation called the Body Mass Index (BMI), which takes into account a person's height in proportion to his or her weight. BMI is correlated with the amount of body fat present.[15] The percentage of adults who are overweight is similar in Leon County and Florida. Black populations in Leon have a higher percent of overweight adults than White populations. Those with an income of less than $25,000 have a higher percentage of overweight adults than those with a higher income.

Approximately 17% (or 12.5 million) of children and adolescents aged 2-19 years are obese. Obese children are more likely to have high blood pressure, high cholesterol, diabetes, asthma, joint problems, gastrointestinal problems, and social/psychological problems.[16] The percentage of children age two or older who are overweight or at risk for overweight has been increasing since 2006. This percentage is slightly lower in Leon County than Florida. The percentage of Middle school students who are overweight is higher in Leon than Florida, but the percentage of overweight High school students is about the same in Leon and Florida.

Obesity and Chronic Disease Prevention

Goal OCDP1: Increase the proportion of adults and children who are at a healthy weight.

Strategy OCDP1: Standardize the documentation of body mass indices (BMI) of patients; provide education and counseling on nutrition and physical activity to their patients and the community  at large. 

Smart Objectives OCDP1.1: By December 31, 2014, increase by 10% the number of targeted health care providers that provide counseling or education related to achieving or maintaining a healthy weight for their patients. 

Activity	Lead person/ Organization	Completion Date	Evidence of Success
1. Establish designated "95210 Healthcare sites" which do the following: 1) create awareness of 95210, 2) Assess weight, 3) listen to patients and families, and 4) are a role model	Whole Child Leon	September 2013	Survey engaged practices to assess whether they are meeting the 4 components of a designated "95210 Healthcare Site"
2. Encourage nurses to document BMI measurement during vitals	Whole Child Leon	December, 2014	Decreased prevalence of obesity and incidence of chronic diseases **Policy** – BMI at every visit.
3. Physicians can prescribe physical activity and healthy habits to their patients	Whole Child Leon	December, 2014	Greater utilization of parks and recreational facilities. Demand for healthy foodstuffs.
4. Develop a recognition process for healthcare practices and/or providers to acknowledge their commitment to addressing childhood obesity	Whole Child Leon	December, 2014	Recognition process developed, approved and utilized
5. TMH will eliminate formula in Hospital bags.	Lauren Faison, TMH	December, 2014	Baby Friendly Hospital Certificate
6. Top 5% of TMH Emergency Room users are Chronic untilizers and they will work together to decrease obesity rates.	Lauren Faison, TMH	December 2014	Plan for Chronic ER users.

Obesity and Chronic Disease Prevention

Goal OCDP2: Increase access to resources that promote healthy behaviors.

Strategy OCDP2: Collaborate with partner agencies and organizations to implement initiatives that promote healthy behaviors.  

Smart Objectives OCDP2.1: By June 30, 2014, increase by 5% the availability of employee wellness programs that address nutrition, weight management and smoking cessation counseling services in workplaces. 

Activity	Lead person/ Organization	Completion Date	Evidence of Success
1. 95210 Resource Binder for use in the workplace developed	Leon County Health Department	April, 2013	Reviewed and approved Workplace Resource 95210 Binder by Working Well; Worksite representatives report what components of the 95210 Binder they are using.
2. Tallahassee/Leon County based public or private entities will develop and offer a comprehensive employee health promotion program to their employees that meets the 7 WELCOA Benchmarks and includes at least one policy and environmental change as identified through the CHANGE tool and as correlated to nutrition, weight management and/or smoking cessation.	Working Well	June, 2014	Successful program will have gained the full commitment and support of leadership and employees, fully implemented all 95210 Worksite Wellness core program elements, collected baseline data, and created a health-promoting environment that establishes an overall culture of health within the worksite **Policy** – Wellness Policy in the worksite.
3. Participate in the American Cancer Society's Great American Smokeout Observance by highlighting workplace wellness programs and policies addressing smoking cessation counseling services	Tobacco Free Leon Partnership	November, 2013	Individual local worksite efforts shall be tied into organized, annual, community employer related smoking cessation events and promoted in local media outlets.
4. Dr. Haile will work with FAMU about a Worksite Wellness	Dr. Haile		

Obesity and Chronic Disease Prevention

Activity	Lead person/ Organization	Completion Date	Evidence of Success
Plan			
5. Develop a centralized location for all 95210 efforts	John Cowell		95210 Main Website
6. TMH will work on a Marketing Plan to promote this MAPP CHIP for Obesity and Chronic Disease.	Warren Jones		95210 Markrting Plan

Strategy OCDP3: 100% participation of every Leon County School in the Alliance for a Healthier Generation's Healthy Schools Program 

Smart Objectives OCDP3.1: By October 2012, every school in Leon county will have completed and submitted an online inventory for their school and identified 2-3 areas for improvement.

Smart Objectives OCDP3.2: By December 2012, every school will have submitted an Action Plan to address how identified areas of need will be improved upon.

Smart Objectives OCDP3.3: By May 2013, identify schools that have achieved levels of success as determined by the Alliance criteria.

 - Healthy People 2020

 - CDC Winnable Battles

 - State Health Improvement Plan

Access to Healthcare

Access to health care services is an important determinant of health status and continues to be a central focus for health
policy in Florida. Uninsured persons experience reduced access to health care and are less likely to have a regular source of care or use preventive services. As a result, uninsured persons are more likely to require avoidable hospitalizations and emergency hospital care.

The Department of Health and Human Services (HHS) has designated the low-income population in Leon County to be a Medically Underserved Population (MUP). In addition, Leon County is designated a Health Professional Shortage Area (HPSA) for the low income population in the areas of Primary Care, Dental Care, and Mental Health. Bond Community Health Center, the Federal Correctional Institution-Tallahassee, and North Florida Medical Centers are currently funded to address health care access needs of the low income population.

Primary care is typically the first point of entry into the health care system for non-emergent services. Primary care providers (PCPs) give routine medical care for the diagnosis, treatment, and prevention of common medical conditions. PCPs refer patients requiring additional care to specialists for treatment and play an important role in the coordination of care in the managed care environment. Leon County has a lower rate of licensed physicians than the state of Florida overall with 256.8 licensed physicians per 100,000 in Leon and 336.3 per 100,000 in Florida during 2010-2011.

During 2010-2011, the rate of licensed dentists per 100,000 population was much lower in Leon County than the state. Generally, access to dental care declines as income declines. The percentage of low income persons with access to dental care in Leon County is half the percentage of persons with access in Florida. While the state rate has been gradually increasing since 2006, the rate has remained low and relatively constant in Leon County.

Access to Healthcare

Goal AC1: Improve access to primary care services for low income populations.

Strategy AC1.1: Address health care service barriers (e.g., payment, enrollment and access impediments) for service providers and care recipients.

Smart Objectives AC1: By December 31, 2015, decrease the percentage of persons who report they were unable to see a doctor during the past 12 months due to cost from 17.3% to 16.4%

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Activity	Lead person/ Organization	Completion Date	Target Organization(s)	Evidence of Success
1. TMH and 211 staff will work with the Health Access Team to develop a marketing approach in the distribution of a resource guide to improve health access.	TMH	August, 2013	All community partners and the public in general	Marketing Plan for 211 Big Bend
2. TMH will utilize their list of providers (800) and have staff call to assess the following information: a. If they take Medicaid, Medicare, of if they have a Sliding Fee Scale b. If they require a referral c. If they are accepting new patients	TMH	August, 2013	Leon County Government	Updated 211 Directory
3. 211 will update their directory to include TMH and Leon County information. This will include key information based on the MAPP Assessment.	211 Big Bend	August, 2013	All community partners and the public in general	Updated 211 Directory
4. Distribute Leon County healthcare resource guide to targeted communities and populations.	211 Big Bend	October, 2013	All community partners and the public in general	Updated 211 Directory
5. Train FSU students that will	211 Big Bend	Decmber, 2013	All community partners and the	Trained students

Access to Healthcare

Activity	Lead person/ Organization	Completion Date	Target Organization(s)	Evidence of Success
be providing or having direct contacts with the low-income population on the services provided by 211.			public in general	
6. 211 will train staff of community agencies to improve effectivness of 211 in linking access to the population	211 Big Bend	Decmber, 2013	All community partners and the public in general	Trained staff

Goal AC2: Enhance access to preventive, restorative and emergency oral health care services for children and low income populations.

Strategy AC2.1: Promote innovative oral health care delivery practice models.

Smart Objectives AC2.1: By December 31, 2015, increase the percentage of children and adolescents who have received dental sealants on their molar teeth.

Activity	Lead person/ Organization	Completion Date	Target Organization(s)	Evidence of Success
1. Identify partner(s) who can assist the health department in reaching out to the schools	Dr. Zapert/Health Department Dental Program	March 31, 2013	Elementary Schools (second and third grades)	Meeting planned with Courtney Atkins (WCL) and Peggy Youngblood (LCS) Elementary Lead.
2. Work with school partner to plan a timeline for the sealant program in the schools	Dr. Zapert	April – May 2013		
3. Identify low performing schools for pilot.	Peggy Youngblood	June – July, 2013		
4. Present plan to School Board for approval	Peggy Youngblood/Dr. Zapert	August 2013		
5. Implement the pilot plan in identifed low perfoming schools	Dr. Zapert	September 2013		

Access to Healthcare

Activity	Lead person/ Organization	Completion Date	Target Organization(s)	Evidence of Success
6. Evaluate schools' performance after program implementation	Peggy Youngblood	June – July 2014		FCAT Scores
7. Present results to the School Board	Dr. Zapert/ Peggy Youngblood	August 2014		
8. Full implementation in all Elementary schools	Dr. Zapert/ Peggy Youngblood	September 2014		

Goal AC3: Regularly assess Leon County's health care access resources and service needs.

Strategy AC3.1 Address health care service barriers (e.g., payment, enrollment and access impediments) for service providers and care recipients. 

Smart Objectives AC3.1: By December 31, 2012, Capital Coalition for Health will utilize the results of a DOH health resource assessment process that includes inventory, analysis, and geographic mapping of Florida's health care providers including high volume Medicaid providers, health care needs of residents and health insurance coverage for planning purposes. 

Activity	Lead person/ Organization	Completion Date	Target Organization(s)	Evidence of Success
1. Develop Community Health Improvement Plan (CHIP)	Capital Coalition for Health	12/31/12	Capital Coalition for Health (CCH) Various	The CHIP has been completed.
2. Present CHIP to County Government Officials	Capital Coalition for Health			Presentation to the County has been conducted.
3. Present CHIP to City Government Officials	Capital Coalition for Health			Presentation to the City has been conducted.
4. Present CHIP to School Board	Capital Coalition for Health			Presentation to the School Board has

Access to Healthcare

				been conducted.
5. Review CHIP Status and Update as necessary CHIP	Capital Coalition for Health			CCH has reviewed and updated the CHIP.
6. Review for alignment with the State Health Improvement Plan (SHIP)	Capital Coalition for Health			CCH has reviewed status and updated CHIP.
7. Communicate CHIP to the public via various media outlet.	Capital Coalition for Health			Number of Hit on the MAPP Website

 - State Health Improvement Plan

 - Healthy People 2020

 - Key Health Disparities objectives

Health Disparities

Infant mortality refers to the death of an infant less than one year old (0 to 364 days). The overall infant mortality rate has steadily declined in the United States over the past several decades, but drastic disparities remain between certain racial and ethnic groups in many areas. Infant mortality in Leon County was notably higher that the state average in the earliest time frame, but has since been decreasing. Black populations experience a nearly threefold higher rate at 13.1 deaths per 1,000 births compared to 4.6 deaths per 1,000 births in White populations.

Low birth weight babies are at increased risk for intellectual disabilities, learning problems, cerebral palsy, vision and hearing loss, and even death.[1] The low birth weight rate in Leon County is higher than the rate in Florida overall (Figure 66) and the disparity by race is substantial, with almost twice as many Black infants born with low birth weight (13.0%) as White infants (6.3%).

Pre-term babies are more likely to be premature, placing them at risk for newborn health complications such as breathing problems and even death. Pre-term births have been declining since 2002 in Leon County and the rates are lower than in Florida overall. There is a disparity by race in Leon County, with Black populations experiencing a higher rate of pre-term births than White populations. The majority of teen pregnancies are unintended.

In 2009, the live birth rate to mothers aged 15-19 was 39.1 per 1,000 women in this age group in the United States. In Leon County, the birth rate to teen mothers is much lower than the state. However, there is a significant disparity by race with the birth rate to Black teens more than three times the birth rate to White teens in Leon County.

Women with short interpregnancy intervals, or time between births, are at nutritional risk and are more likely to experience adverse birth outcomes such as low birth weight. Over forty percent of births in Leon County are to women with an interpregnancy interval of less than 18 months.

Health Disparities

Goal OCD1: Reduce maternal and infant morbidity and mortality by achieving health equity, eliminating disparities, and improving the health of all groups 

Strategy 1: Raise awareness among providers and consumers on the importance and benefits of being healthy prior to pregnancy 

Smart Objectives 1: By Dec. 31, 2015, work with community partners to increase the percentage of women having a live birth, who prior to that pregnancy received preconception education and counseling regarding lifestyle behaviors and prevention strategies from a health care provider from **19.7% to 80%.** 

Activity	Lead person/ Organization	Completion Date	Target Organization(s)	Evidence of Success
1. Work with Healthy Start to identify the number of community partners with a focus on infant mortality.	DOH/Healthy Start Kristina Abernathy	12/30/13	Health Education Working Group	Program with consistent messaging reaching multiple diverse populations
1.a Healthy Start Provider Group will develop educational materials for the community. **1.b** Develop a step by step map that will illustrate what pregnant women need to do to get care. **1.e** Improve current website to improve navigation and improve access, also include other helpful websites. **1.d** Provide list of providers to be included in the MAPP Access to Care website and other sites	Jo Deeb Jo Deeb Betty Healthy Start Staff Jo L.	June 19 Ongoing TBD June 19 TBD TBD	Agencies and Organizations that serve women of childbearing age	Create new educational materials Rotary funding Clients able to access Healthy Start Services Updated website Increase hits on the website Healthy start resources included in other public sites for easy access
2. Provide Preconception Health Conference to raise awareness among	LCHD/Whole Child Leon	June 2014	Healthcare Provider Organizations	Conference on Preconception Health to Primary Care

Health Disparities

providers and consumers on the importance and benefits of being healthy prior to pregnancy.				physicians and pediatricians
2.a Create Planning Committee for Preconception Health Event **2.b** Develop a plan including a Marketing plan **2.c** Develop a budget **2.d** Identify Partners to sponsor the event **2.e** Invite speakers **2.f** Work with AHEC for CME and CEUs and paticipant registration **2.g** Draft policy change for Preconception Health recommended practice for healthcare providers.	Preconception Health Planning Team	August, 2013	Healthcare Provider Organizations	The number of Commitment forms signed by Primary Care physicians /Pediatricians to provide preconception care to women of child bearing age
3.Support DOH and Healthy Start's Preconception Health Training	Health Education Working Group	ongoing	DOH and Healthy Start	Public Awareness of the role of stress on pregnancy and infant mortality
3.a Link Healthy Start staff to primary care groups in the community **2.b**Meet with primary care provider groups to introduce Preconception Health in their practice **3.c** Healthy start will provide videos and other printed materials to doctors offices to share with the their clients.	Leon County Health Department Healthy Start Healthy Start	2013-14	Physician Provider Groups	Meeting with Primary Care Groups Number of Primary Care partners Healthy Start education and information provided to primary care clients
4. Recruit Volunteer Health Educators	Healthy Start, CMS	ongoing	FSU Med School, Nursing School, CMS Alliance	Routine and Frequent high quality programs delivered at multiple venues.

Health Disparities

 - State Health Improvement Plan

 - Healthy People 2020,

 - National Prevention Strategy

 - State Agency Long Range Program Plan