Multiple Challenges, One Solution: Using Healthy People 2020 to Enhance Your Health Department and Improve the Public’s Health

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Lakisha Thomas, MPH, Florida Department of Health in Miami-Dade County

USING HEALTHY PEOPLE IN MIAMI-DADE COUNTY, FLORIDA
Using Healthy People 2020 at the Florida Department of Health in Miami-Dade County

Presented by:
Lakisha Thomas, MPH

Objectives

• Overview of Miami-Dade County Profile
• Health Department Profile
• Why and how we use Healthy People 2020
  – Our Public Health Model
  – MAP-IT Framework
  – Community Health Assessment
  – Community Health Improvement Plan
  – Strategic Planning
  – Community and programmatic health indicators
**Miami-Dade County Profile**

- 7th largest county in the US
- Largest county in the state
  - Urban community
  - 2.5 million residents (13.5% of FL population)
  - Over 12 million annual visitors
- Race and Origin
  - Multiethnic population
  - 16.0% White Non-Hispanic, 19.3% Black Non-Hispanic and 64.5% Hispanic
  - Highest percentage of foreign-born residents, 51.2%
  - International net immigration of 42,000

*Data provided by U.S. Census Bureau
http://quickfacts.census.gov/qfd/states/12/12086.html

**Florida Department of Health in Miami-Dade County Profile**

- A part of the Florida Department of Health
  - Centralized public health system
  - 67 Counties
- Largest health department in the state
  - Population; second in budget and employees
- Consist of 850+ team members
- 2012-2013 Budget: $79 million
- Lead agency providing public health functions
  - Hospitals, clinics, planning agencies and community-based organizations
- Performance excellence driven
  - Three time FL Governor’s Sterling Award Recipient
Why we use Healthy People

- Top Leading Health Indicators and objectives reflect major national health concerns
  - Science-based
  - 10-year national objectives to improve health
  - Established benchmarks
- Encourages collaborations among communities
- Measures the impact of prevention activities
- Mechanism for health departments to monitor health and make informed decisions

Public Health Model

- How We do It

Performance Excellence Model

- PHAB

Healthy People 2020

What We Do

Florida HEALTH

10 Essential Public Health Services

Why We Do It

Florida HEALTH

Healthy People 2020
• **Mobilize partners and organizations**
• **Assess the needs of your community and resources available**
• **Plan by developing a strategy and approach**
• **Implement plan to reach Healthy People 2020 objectives**
• **Track your community's progress**

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**Community Health Assessment (CHA)**

• Used to identify health needs of the community
  - Priorities, goals & strategies
• NACCHO’s Mobilizing for Action through Planning and Partnerships (MAPP) model
Community Health Assessment (CHA)

• Collaborated with community partners
  – Technical assistance and implementation management
  – Organized community health stakeholders around MAPP strategy

• Report was developed
  – Community health priorities scored and ranked
  – Summarized health disparities within the county utilizing data
    • Assessment data
    • Household survey data
    • Miami Matters
    • Florida CHARTS (Community Health Assessment Resource Tool Set)
  • Data was compared to Healthy People 2020
1. Increase Access to Care

In 2011, 42% of people in Miami-Dade County (MDC) between the ages of 18 and 64 had no healthcare coverage, as compared to 19% of people nationwide.

Healthy People 2020 Goal - Adult health insurance rate: 100%

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<tr>
<th>Challenges and Barriers</th>
<th>Opportunities, Strategies and Partnerships</th>
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<tbody>
<tr>
<td>Low-income individuals suffer the health and financial consequences of not having access to health insurance. Often forced to go to the Emergency Room for needed health care, to forego critical life-saving preventive services and incur sometimes insurmountable medical debt, which factors into 62% of all bankruptcies.</td>
<td>+ As of 2014, the Affordable Care Act /Health Care Exchanges will be implemented in Florida to ensure access to care for eligible MDC residents, including individuals with pre-existing conditions.</td>
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<td>+ High copays/deductibles lead to underinsured</td>
<td>+ Organizations must collaborate to ensure that patients know how to access the healthcare system (including the new Health Care Exchanges).</td>
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<td>+ Economic and political climate; policies, systems, and environmental changes present barriers, i.e.:</td>
<td>+ Healthy San Francisco model for MDC through partnerships with Miami-Dade Health Access Network, South Florida Cancer Control Collaborative and Consortium for a Healthier M-D</td>
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<td>+ Lack of Medicaid and KidCare coverage for immigrants and legal residents here less than 5 years; and for county employees</td>
<td>+ American Cancer Society Patient Navigator Program at Jackson Memorial Hospital</td>
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<td>+ Florida KidCare program is not fully funded</td>
<td>+ Catalyst Miami Prosperity Campaign for comprehensive benefits assistance and navigation and Healthcare Heroes life coaching in South Dade</td>
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<td>+ Inadequate service for incarcerated individuals</td>
<td>+ CMS Health-Navigators Program</td>
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<td>+ Lack of access to lower cost generic drugs due to Florida’s approval (beyond FDA approval)</td>
<td>+ Florida International University Mobile Health Center (MHC) and NeighborhoodHELP Program</td>
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<td>+ Lack of transport to obtain medical services</td>
<td>+ Health Connect In Our Schools (HCiOS) school-based health and mental health services</td>
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2. Address Chronic Disease and Prevention

Indicator | Miami-Dade County (CHARTS, 2011) | Healthy People 2020 Goal (CDC, 2011)
--- | --- | ---
Heart disease deaths | 156.9 per 100,000 | 100.8 per 100,000
Diabetes deaths | 19.7 per 100,000 | 65.8 per 100,000
Stroke deaths | 28.8 per 100,000 | 33.8 per 100,000
Low birth weight infants | 8.7% of live births | 7.8% of live births
50+ who receive colorectal cancer screen | 10.6% | 70.5%
18+ women who had a Pap. in the past yr. | 56.9% | 93.0%
40+ women w/mammogram in the past 2 yrs. | 64.2% | 81.1%

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<td>- Decreased funding</td>
<td>+ Amplify advocacy using the voice of the American Heart Association and American Cancer Society</td>
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<td>- Chronic disease self-management is a struggle</td>
<td>+ Catalyst Miami’s Health Care Navigators, working in partnership with Homestead Hospital (BHSF)</td>
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<td>- Conflict with work times (many are unable to take time off for medical appointments)</td>
<td>+ Alliance for Aging CMS funded-initiative assists older adults transitioning from hospital to home. Living Healthy program provides education and Diabetes Self-Management Program</td>
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<td>- Fear of mammograms, colonoscopies and other preventive health screenings</td>
<td>+ Baptist Health South Florida Follow-up Care Clinic</td>
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<td>- Fear of serving Medicaid population given low rates of Medicaid reimbursement for treatment</td>
<td>+ FQHCs Care Management Medical Home Center grant for diabetes and other chronic conditions home visits</td>
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<td>- Fragmented health services whereas not all necessary services are available in all areas</td>
<td>+ Evidence-based strategies: Cancer Screening Office Systems (Cancer SOS)</td>
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<td>- Funding for programs, grants are time limited</td>
<td>CDC Community Guide: Cancer Prevention</td>
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<td>- Inadequate attention to asthma and prevention</td>
<td>CDC Community Guide: Community-wide campaigns informational approaches</td>
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<td>- Lack of focus on prevention and motivational issues Racial and ethnic disparities in chronic disease, esp. among Non-Hispanic Black/African-Americans</td>
<td>CDC Community Guide: Diabetes Prevention</td>
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<td>Community-based diabetes and hypertension program Dana-Farber Mammography Van</td>
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<td>Healthy Start</td>
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<td>Increased Medicaid Reimbursements to Enhance Breast/Cervical Cancer Screening Project</td>
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3. Decrease Health Care Disparities

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<th>Indicator</th>
<th>Black/African Americans</th>
<th>Healthy People 2020 Goal</th>
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<tr>
<td>Heart disease deaths</td>
<td>166.2 per 100,000</td>
<td>100.8 per 100,000</td>
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<tr>
<td>Diabetes deaths</td>
<td>33.6 per 100,000</td>
<td>65.8 per 100,000</td>
</tr>
<tr>
<td>Stroke deaths</td>
<td>41.6 per 100,000</td>
<td>33.8 per 100,000</td>
</tr>
<tr>
<td>Low birth weight infants</td>
<td>12.9% of live births</td>
<td>7.8% of live births</td>
</tr>
<tr>
<td>18+ women who had a Pap. in the past yr.</td>
<td>32.6%</td>
<td>93.0%</td>
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Challenges and Barriers

By comparing preventable hospitalizations and ER visits to household income rates by ZIP code as available on Miami Matters, it is apparent that areas in the preventable hospitalizations “red zone” also have lower household incomes. The maps reveal disparities in health with the “i-95 Corridor” and in South Dade representing particularly underserved areas. Avoidable hospital admissions indicate gaps in service, lack of access, lack of insurance, and poverty. See Appendix I

- During the 2012 Communities Putting Prevention to Work (CPPW) project, A Healthier Future: Expanding Supermarket Access in Areas of Need for Miami-Dade County report determined that 250,000 Miami-Dade residents (10%) live in low-income areas that have poor supermarket access and higher than average death rates from diet-related causes.

Opportunities, Strategies and Partnerships

- Jasmine Project focuses on Opa-Locka area follows at-risk women for up to two years
- Evidence-based strategies: Baltimore community navigators project Community Voice: Taking it to the People Culturally Tailored Navigator Pgm for Cancer Screening Harlem Children’s Zone Healthy Families America Healthy Start Improving Cancer Screening for Medically Underserved Increasing Screening Colonoscopy in Urban Public Hospitals Leading, Integrating, Networking for Kids (LINX) Neighborhood Involvement Program Provider Intervention to Improve Colorectal Cancer Screening Rates Among African American Patients St. Joseph’s Hospital Health Center Community Buildings/Vocational Services Initiative FQHCs partner with farmer’s markets providing fresh fruits and vegetables in high-need areas Hospital volunteer programs that incentivize physicians to work in high-need areas Implement a System of Care (e.g. in Liberty City).

Community Health Improvement Plan (CHIP)

- MAPP assessments/CHA used to create CHIP
- CHIP serves as strategic plan to improve health and quality of life
  - Ascertain and prioritize community health issues
  - Address issues by identifying and aligning resources
  - Take action
- Healthy People 2020 strategies, goals and objectives serve as framework
- Aligned with SHIP developed by the Florida Department of Health
Strategic Priority: Access to Care

HP 2010 Goal: Improve access to comprehensive high quality healthcare services

HP 2010 Objective 1-4a: Increase the proportion of persons who have a specific source of ongoing care for all ages.

Local Strategy: An emergency room diversion clinic will be implemented at the MDCHD Health District site in order to reduce the number of patients accessing the emergency room at Jackson Memorial Hospital. The clinic will treat the patient and link them to a Federally Qualified Health Center as their medical home.

Outcome Objective: By December 31, 2013, reduce the amount of clients who seek primary care services at the Jackson Memorial Hospital Emergency Department by the daily census target.

Outcome Objective: By December 31, 2013, link clients who are referred to the Women’s Health and Preventive Services Program to primary care providers and establish clients in finding a medical home.

SHIP Goal AC2: Improve access to primary care services for Floridians.

Partners: Miami-Dade Health Action Network
Strategic planning process designed to identify priorities and meet mission and vision

Strategic plan acts as blueprint to improve health

Strategic Priorities:
- Prevention and preparedness
- Return on investment
- Service excellence

Performance indicators and deployment activities in alignment with:
- Requirements of the state Department of Health
- Healthy People 2020 health indicators

Strategic Plan Tracker
Community and Programmatic Health Indicators

- Health indicators used to track community health, manage processes and support decision making
- Methods for selecting, collecting and integrating data are dependent upon:
  - Requirements of our customers and partners
  - Healthy People 2020 goals and objectives
  - Mandates of external sources
- Indicator data maintained in Results Scorecard System
• Centralized system
  – Performance and community measures
• Aligned with strategic priorities and public health domains
• Tracks performance of program/community activities
• Includes goals, objectives and targets
• Data used to drive action planning for health improvement initiatives
Healthy People 2020 Supports Our Health Efforts

- Communicates the national health agenda, vision and strategy
- Provides overarching, national-level goals and serves as a road map
- Guidance and direction to health departments to improve health
- Partner organizations able to set priorities and assign tasks to achieve objectives
THANK YOU!

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