Healthy People 2020-National Association of County and City Health Officials Partnership

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

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USING HEALTHY PEOPLE IN MIAMI-DADE COUNTY, FLORIDA

Using Healthy People 2020 at the Florida Department of Health in Miami-Dade County

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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

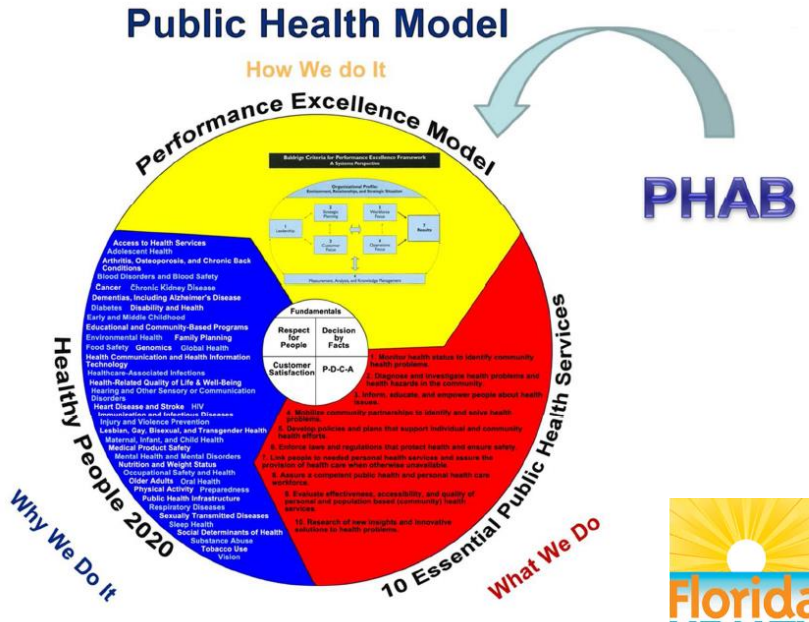
*Data provided by U.S. Census Bureau
http://quickfacts.census.gov/qfd/states/12/12086.html

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



Healthy People MAP-IT Framework

Florida HEALTH

Mobilize / Assess / Plan / Implement / Track

- **M**obilize partners and organizations
- **A**ssess the needs of your community and resources available
- **P**lan by developing a strategy and approach
- **I**mplement plan to reach Healthy People 2020 objectives
- **T**rack your community's progress

Community Health Assessment (CHA)

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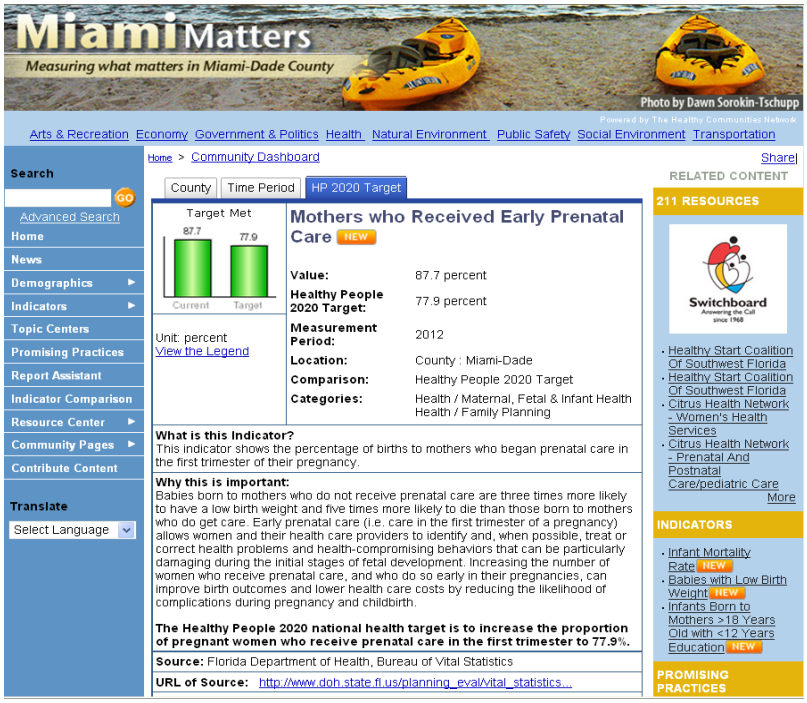
- Used to identify health needs of the community
  - Priorities, goals & strategies
- NACCHO's Mobilizing for Action through Planning and Partnerships (MAPP) model

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%

Challenges and Barriers	Opportunities, Strategies and Partnerships

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.
+ High copays/deductibles lead to underinsured
+ Economic and political climate; policies, systems, and environmental changes present barriers, i.e.:
  + Lack of Medicaid and KidCare coverage for immigrants and legal residents here less than 5 years; and for county employees
  + Florida KidCare program is not fully funded
  + Inadequate service for incarcerated individuals
  + Lack of access to lower cost generic drugs due to Florida's approval (beyond FDA approval)
  + Lack of transport to obtain medical services
	+ 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.
	+ Organizations must collaborate to ensure that patients know how to access the healthcare system (including the new Health Care Exchanges).
	+ 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**
	+ **American Cancer Society** Patient Navigator Program at Jackson Memorial Hospital
	+ **Catalyst Miami** Prosperity Campaign for comprehensive benefits assistance and navigation and Healthcare Heroes life coaching in South Dade
	+ **CMS** Health Navigators Program
	+ **Florida International University** Mobile Health Center (MHC) and NeighborhoodHELP Program
	+ **Health Connect in Our Schools (HCiOS)** school-based health and mental health services
	+ **Health Connect in Our Communities (HCiOC)**
	+ **Health Foundation of South Florida** initiatives
	+ **Healthy Start** services for pregnant women, infants and children up to age three, incl. care coordination, counseling, parenting education, breastfeeding education, nutrition counseling, tobacco cessation, home visits and outreach.
	+ **Switchboard of Miami/211** effort to increase usage by health

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**%

Challenges and Barriers	Opportunities, Strategies and Partnerships

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

3. Decrease Health Care Disparities		
Indicator	***Black/African Americans*** *Miami-Dade County* (CHARTS, 2011)	*Healthy People 2020 Goal* (CDC, 2011)
Heart disease deaths	**166.2** per 100,000	100.8 per 100,000
Diabetes deaths	33.6 per 100,000	65.8 per 100,000
Stroke deaths	**41.6** per 100,000	33.8 per 100,000
Low birth weight infants	**12.9%** of live births	7.8% of live births
18+ women who had a Pap. in the past yr.	**32.6%**	93.0%

Challenges and Barriers	**Opportunities, Strategies and Partnerships**
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.	+ **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 (LINK) Neighborhood Involvement Program Provider Intervention to Improve Colorectal Cancer Screening Rates Among African American Patients St. Joseph's Hospital Health Center Community-Building/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

Florida Health Status Assessment **SELECTED INDICATORS** **STATE RANKINGS:** 1=most favorable; 51=least favorable among 50 states and Washington, D.C ‡ Ranking is among the 25 Prenatal Risk Assessment and Monitoring System (PRAMS) participating states	Year	Healthy People 2020 Goals	State Rank *	US Rate	Florida Rate
CHRONIC DISEASES					
Hypertension Prevalence[C]	2009	26.9%	42	28.7%	32.1%
Heart Disease Age-Adjusted Death Rate[SE]	2008		10	186.5	154.6
Stroke Age-Adjusted Death Rate[DE]	2007	33.8	4	42.2	30.3
Cervical Cancer Age-Adjusted Death Rate[ABE]	2007	2.2	22	2.4	2.5
Colorectal Cancer Age-Adjusted Death Rate[ABE]	2007	14.5	12	16.7	14.2
Breast Cancer Age-Adjusted Death Rate[ABE]	2007	20.6	13	22.8	20.8
Diabetes Age-Adjusted Death Rate[DE]	2007		15	22.5	19.1
People Who Have Been Told by a Doctor They Have Diabetes[C]	2010		43	8.7%	10.4%
Asthma Hospitalizations (per 100,000)[N]	2009			672.8	769.7
TOBACCO					
Adults Who Currently Smoke[C]	2010	12%	24	17.3%	17.1%
OVERWEIGHT, OBESITY AND PHYSICAL INACTIVITY					
Adults Who are Overweight (BMI >25)[C]	2010		45	36.2%	37.8%
Adults Who are Obese (BMI >=30)[C]	2010	30.6%	24	27.6%	27.2%
Adults Who Engaged in Any Physical Activity During the Past Month[C]	2009		34	76.2%	75.3%
Adults Who Eat Five Servings of Fruits and Vegetables per Day[C]	2009		20	23.4%	24.4%
UNINTENTIONAL INJURY					
Unintentional Injury Age-Adjusted Death Rate[EF]	2007	36	32	40	42.6
Motor Vehicle Accident Age-Adjusted Death Rate[ES]	2007	12.4	35	14.4	13.6
Fall Death Rate, Ages 65+[DE]	2007	45.3		45.3	44.7

Strategic Issue Area:

Health Protection

Goal HP1 Prevent and control infectious disease.

ALIGNED NATIONAL & STATE: GOALS, OBJECTIVES & MEASURES— SEE APPENDIX F

- CDC's Community Guide
- CDC Public Health Preparedness
- CDC's Winnable Battles
- Healthy People 2020
- Key Health Disparity Objective
- National Prevention Strategy
- PAHPA Benchmark Measure
- State Agency Long Range Program Plan

Strategy HP1.1 Prevent disease, disability and death through immunization by advancing programs including Florida State Health Online Tracking System (Florida SHOTS), Vaccines for Children Program, Vaccine Preventable Disease Surveillance activities, assessment of immunization coverage levels among target populations, and operational reviews or program compliance visits among health care providers.

OBJECTIVE HP1.1.1 By Dec. 31, 2015, increase the percentage of two-year-olds who are fully immunized from 86.6% (2005) to 90%.

OBJECTIVE HP1.1.2 By Dec. 31, 2015, increase the percentage of adults aged 65 and older who have had a flu shot in the last year from 65.3% to 75%.

OBJECTIVE HP1.1.3 By Dec. 31, 2015, increase the percentage of two year old CHD clients fully immunized from 94% (2011) to 95%.

OBJECTIVE HP1.1.4 By Dec. 31, 2015, the number of confirmed cases of measles in children under 19 will be 0.

OBJECTIVE HP1.1.5 By Dec. 31, 2015, the number of confirmed cases of Haemophilus influenzae type B in children under 19 will be 0.

Strategic Planning

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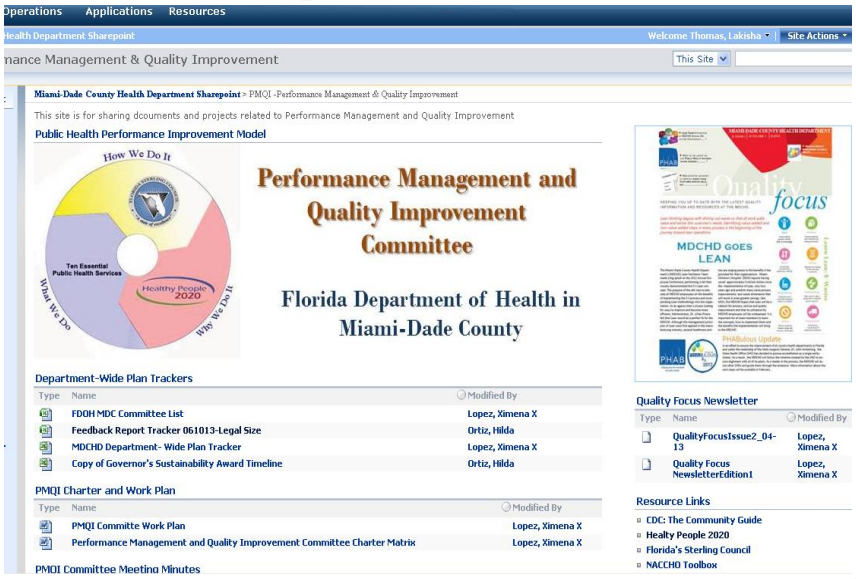
- Strategic planning process designed to identify priorities and meet mission and vision
- Strategic plan acts as blueprint to improve health
- Strategic Priorities:
  - Prevention and preparedness
  - Return on investment
  - Service excellence
- Performance indicators and deployment activities in alignment with:
  - Requirements of the state Department of Health
  - Healthy People 2020 health indicators
- Strategic Plan Tracker

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

Results Scorecard

- 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

Expand All | Collapse All

Scorecards: Community Health & Planning

Population Results

Name	Prior Period	Current Value	Change
CH&P: Babies are born healthy			
CH&P: Mothers who receive early prenatal care	85.0%	86.4%	3
CH&P: Babies born with low birth weight	9.0%	9.1%	1
CH&P: Infant mortality rate	5.8	4.4	1
CH&P: Caesarean rates	47.0%	48.5%	2
CH&P: Youth have healthy behavior			
CH&P: Teens who are overweight (HP2020)	28.0%	26.4%	1
CH&P: Teens who engage in regular physical activity (HP2020)	26.9%	36.0%	1
CH&P: Teen fruit and vegetable consumption	23.6%	24.9%	2
CH&P: Teens who smoke (HP2020)	11.2%	13.9%	1
CH&P: Pediatric asthma hospitalization rate	19.8	22.0	1

Healthy People 2020 Supports Our Health Efforts

Florida HEALTH

- 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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