

***Miami-Dade County  
Mobilizing for Action through Planning and Partnerships***



**2013-2018  
Community Health Priorities, Goals & Strategies**

***Prepared for the Florida Department of Health in Miami-Dade County by:***

***Health Council of South Florida***

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## Summary

Beginning in 2012, the Health Council of South Florida (Health Council) partnered with the Florida Department of Health in Miami-Dade County (FDOH-MDC) to provide technical assistance and implementation management to support the application of the National Association of County and City Health Officials (NACCHO) tool, Mobilizing for Action through Partnerships and Planning (MAPP) for the 2013-2018, five-year term. The Health Council began this work by organizing community health stakeholders around the MAPP strategy and reflecting on vision and past strategic action. Please refer to **Appendix A** for a matrix of existing community health improvement strategies.

After reviewing existing community health improvement efforts, especially in the area of increasing access to care, the Health Council worked with FDOH-MDC to implement the four MAPP Assessments:

- i. Local Public Health System Performance Assessment (LHPSA): The LHPSA involves bringing the public health community together to reflect on the performance of the system and identify areas of success and improvement. The National Public Health Performance Standards Program (NPHSP) LHSPA instrument is designed to examine the capacities and efficiencies of the local public health system in support of assessing and improving the delivery of services. The instrument is based on the framework of the ten Essential Public Health Services representing the spectrum of public health activities that should be available in any area. Refer to **Appendix B** for the LHPSA Report of Results.
- ii. Community Themes and Strengths Assessment (CTSA): The CTSA provides a deep understanding of the issues that residents feel are important by answering the questions: "What is important to our community?" "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?" The information gathered during this phase informed the strategic issues identification phase of the MAPP process. A Miami-Dade County CTSA meeting was held on October 5, 2012. Refer to **Appendix C** for a summary of CTSA outcomes and a list of individuals who attended the meeting.
- iii. Forces of Change Assessment (FOCA): The FOCA identifies factors such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. This answers the questions: "What is occurring or might occur that affects the health of our community or the local public health system?" and "What specific threats or opportunities are generated by these occurrences?" A Miami-Dade County FOCA meeting was held on November 14, 2012. Refer to **Appendix D** for a summary of FOCA outcomes and a list of individuals who attended.
- iv. Community Health Status Assessment (CHNA): The CHNA provides a list of core indicators (data elements) for 11 broad-based categories. Communities may also select additional indicators. By gathering data for each of these and comparing the jurisdiction's data to trend information or peer, state, and national data, health issues are identified.

For this assessment, FDOH-MDC desired to implement a community health needs assessment household survey. Health Council solicited bids from survey contractors, receiving estimates from Gallup, the local firm Bendixen and Amandi, and Professional Research Consultants (PRC). Offering the most competitive bid, as well as a nationally vetted 150-question CHNA survey tool and the ability to customize questions, PRC was selected to conduct a survey of 2,700 households in Miami-Dade County. PRC had the additional advantage of having conducted a household health survey in Miami-Dade County in 2006. The 2013 survey would breakout results at the neighborhood level, yielding 200 surveys each in 12 neighborhoods, and 300 surveys in an oversampled cluster indicating high need. Refer to **Appendix E** for the full 2013 PRC Miami-Dade County Community Health Needs Assessment Household Survey Report (Household Health Survey) and a list of individuals who attended the July 17, 2012 Technical Advisory Panel (TAP) meeting to review and enhance the list of survey questions.

The final stages of this work involved:

- a. Identification of strategic issues whereby a list of the most important issues facing the community would be itemized. Based on the results of the four MAPP Assessments, particularly the Household Health Survey, the following areas of opportunity for enhanced public health intervention were identified. The issues are listed according to rank, as established during a community health leader meeting on April 11, 2013. Sixty Miami-Dade County community health stakeholders attended, including hospital executives, public health planners, Federally Qualified Health Center (FQHC) and free clinic leaders, and academics attended the meeting and voted on leading health issues. Thirty voting devices were distributed allowing one vote per agency. Participants ranked their priorities on a scale of 1-10. Each vote was weighted using a multi-attribute utility analysis technique. The meeting was facilitated with Alexandria Douglas Bartolone of Building Community, an agency specializing in coalition-building and service partnerships. Refer to **Appendix F** for a list of individuals who attended the meeting.

<b>Final Rank</b>	<b>MAPP Community Health Priorities 2013-2018</b>	<b>Final Score</b>
1	<i>Access to Care</i>	220
2	<i>Chronic Disease and Prevention</i>	173
3	<i>Health Care Disparities</i>	154
4	<i>Primary Care and Medical Homes</i>	137
5	<i>Nutrition and Physical Activity</i>	115
6	<i>Mental Health and Mental Disorders</i>	112
7	<i>Socioeconomic Factors Impacting Health</i>	99
8	<i>Increased Interagency Coordination</i>	91
9	<i>Heart Disease and Stroke</i>	79
10	<i>HIV, STDs and Infectious Diseases</i>	59
11	Cancer	54
12	Special Needs Populations, incl. Children w/disabilities and Seniors	54
13	Substance Abuse and Excessive Drinking	53
14	Maternal and Child Health	46
15	Undocumented Populations	32
16	Cultural Competency	26
17	Workforce	25
18	Oral Health Care	23
19	Injury and Violence Prevention	20
20	Tobacco Use	17

- b. Document goals and strategies to support revision of Community Health Improvement Plans. Enclosed are issue pieces addressing the top ten public health priorities

**Benefits of MAPP**

- Results in a healthier community and a better quality of life
- Helps communities (local health systems) better anticipate and manage change
- Creates a stronger health infrastructure that leads to better services and resources coordination
- Builds leadership
- Can produce innovative, effective, and sustainable solutions to complex community problems.

# 2013-2018 MAPP Goals to Improve Health and Wellness in Miami-Dade County

The following matrix highlights challenges and opportunities for community health improvement. The results are informed by a review of the key findings from all four MAPP assessments. Refer to the appendix for more details on each of the individual assessments.

## Goals that address the top ten priority issues impacting health and wellness in Miami-Dade County:

1. Increase Access to Care
2. Address Chronic Disease and Prevention
3. Decrease Health Care Disparities
4. Increase Availability of Primary Care and Medical Homes
5. Promote Nutrition and Physical Activity
6. Address Mental Health and Mental Disorders
7. Address the Social Determinants of Health
8. Increase Interagency Coordination
9. Decrease Heart Disease and Stroke
10. Decrease HIV, STDs and Infectious Diseases

1. Increase Access to Care	
<i>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.<sup>i</sup></i>	
<b>Healthy People 2020 Goal - Adult health insurance rate: 100%<sup>ii</sup></b>	
Challenges and Barriers	Opportunities, Strategies and Partnerships
<p>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.<sup>iii</sup></p> <ul style="list-style-type: none"> <li>+ High copays/deductibles lead to underinsured</li> <li>+ Economic and political climate; policies, systems, and environmental changes present barriers, i.e.:               <ul style="list-style-type: none"> <li>+ Lack of Medicaid and KidCare coverage for immigrants and legal residents here less than 5 years; and for county employees</li> <li>+ Florida KidCare program<sup>iv</sup> is not fully funded</li> <li>+ Inadequate service for incarcerated individuals</li> <li>+ Lack of access to lower cost generic</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>+ 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.</li> <li>+ Organizations must collaborate to ensure that patients know how to access the healthcare system (including the new Health Care Exchanges).</li> <li>+ <u>Healthy San Francisco</u> model for MDC through partnerships with <b>Miami-Dade Health Access Network, South Florida Cancer Control Collaborative</b> and <b>Consortium for a Healthier M-D</b></li> <li>+ <b>American Cancer Society</b> Patient Navigator Program at Jackson Memorial Hospital</li> <li>+ <b>Catalyst Miami</b> Prosperity Campaign for comprehensive benefits assistance and navigation and Healthcare Heroes life coaching in South Dade</li> <li>+ <b>CMS</b> Health Navigators Program</li> <li>+ <b>Florida International University</b> Mobile Health Center (MHC) and NeighborhoodHELP Program</li> <li>+ <b>Health Connect in Our Schools (HCiOS)</b> school-based health and mental health services</li> <li>+ <b>Health Connect in Our Communities (HCiOC)</b></li> </ul>

<p>drugs due to Florida’s approval (beyond FDA approval)</p> <ul style="list-style-type: none"> <li>+ Lack of transport to obtain medical services</li> <li>+ Few providers accept new Medicaid patients because the reimbursement is low; those who do accept new patients the wait times are long</li> <li>+ Fewer workers have Paid Time Off/Sick Leave hampering access health care</li> <li>+ Tailored health improvement messages and interventions are necessary for diverse populations consider education-level and illiterate populations</li> <li>+ Undocumented cannot access most health services</li> <li>+ Lack of technological integration, i.e. FQHC’s utilize a Health Level 7 interface, while FLDOH clinics utilize Health Management System (HMS)</li> </ul>	<ul style="list-style-type: none"> <li>+ <b>Health Foundation of South Florida</b> initiatives</li> <li>+ <b>Healthy Start</b> 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.</li> <li>+ <b>Homestead Hospital</b> implementing Stanford model providing health navigators</li> <li>+ Greater focus on healthcare disparities based upon income, race and ethnicity and identification of unhealthy neighborhoods.</li> <li>+ Expansion of Community Health Outreach Workers (CHWs) and Community Health Fairs</li> <li>+ One-e-App would potentially provide a platform where the <b>FQHC’s</b> and the <b>FLDOH</b> clinics would speak if the HL7 interface is an added component and added screening abilities for publicly assisted programs qualifying and enrollment (Medicaid).</li> <li>+ Electronic Medical Records to coordinate care</li> <li>+ Engage the corporate sector, e.g. <b>Walgreens, CVS</b> Minute Clinic</li> <li>+ <b>National Association of Counties (NACo)</b> Prescription Drug Discount Card Program</li> <li>+ <b>OCHP</b> Health Insurance Assistance (HIA)</li> <li>+ <b>Public Health Trust</b> (Safety net for uninsured)</li> <li>+ <b>Switchboard of Miami/211</b> effort to increase usage by health care providers</li> <li>+ <b>Refugee Health Access Program</b></li> <li>+ <b>United Way of Miami’s</b> partnership with Family- Wize to provide prescription drug discount cards</li> <li>+ Use of Technology/Educational Apps/Social Media</li> <li>+ Use of Low Cost Technology to Monitor Health Status (e.g. tools for monitoring Blood Sugar)</li> </ul>
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See **Appendix G** for more “Access to Care” information from April 11 Strategies Meeting

## 2. Address Chronic Disease and Prevention

<i>Indicator</i>	<i>Miami-Dade County (CHARTS, 2011)</i>	<i>Healthy People 2020 Goal (CDC, 2011)</i>
Heart disease deaths	156.9 per 100,000	<b>100.8 per 100,000</b>
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	<b>7.8% of live births</b>
50+ who receive colorectal cancer screen	10.6%	<b>70.5%</b>
18+ women who had a Pap. in the past yr.	56.9%	<b>93.0%</b>
40+ women w/mammogram in the past 2 yrs.	64.2%	<b>81.1%</b>

<b>Challenges and Barriers</b>	<b>Opportunities, Strategies and Partnerships</b>
<ul style="list-style-type: none"> <li>- Decreased funding</li> <li>- Chronic disease self-management is a struggle</li> <li>- Conflict with work times (many are unable to take time off for medical appointments)</li> <li>- Fear of mammograms, colonoscopies and other preventive health screenings</li> <li>- Fear of serving Medicaid population given low rates of Medicaid reimbursement for treatment</li> <li>- Fragmented health services whereas not all necessary services are available in all areas</li> <li>- Funding for programs, grants are time limited</li> <li>- Inadequate attention to asthma and prevention</li> <li>- Lack of focus on prevention and motivational issues Racial and ethnic disparities in chronic disease, esp. among Non-Hispanic Black/African-Americans</li> <li>- Linguistic and cultural barriers</li> <li>- Pharmaceutical access</li> <li>- Uninsured/Underinsured</li> <li>- Shortage of Primary Care Physicians and Specialty Care Physicians</li> <li>- Transportation is an ongoing issue, esp. in So. Dade</li> <li>- Undocumented populations have limited access</li> <li>- Older population/Baby Boomers will create more need for services for patients with chronic diseases</li> </ul>	<ul style="list-style-type: none"> <li>+ Amplify advocacy using the voice of the <b>American Heart Association</b> and <b>American Cancer Society</b>.</li> <li>+ <b>Catalyst Miami's</b> Health Care Navigators, working in partnership with Homestead Hospital (BHSF)</li> <li>+ <b>Alliance for Aging</b> CMS funded-initiative assists older adults transitioning from hospital to home. Living Healthy program provides education and Diabetes Self-Management Program</li> <li>+ <b>Baptist Health South Florida</b> Follow-up Care Clinic</li> <li>+ <b>FQHCs</b> Care Management Medical Home Center grant for diabetes and other chronic conditions home visits</li> <li>+ Evidence-based strategies:               <ul style="list-style-type: none"> <li><a href="#">Cancer Screenings for Incarcerated Women</a></li> <li><a href="#">Cancer Screening Office Systems (Cancer SOS)</a></li> <li><a href="#">CDC Community Guide: Cancer Prevention</a></li> <li><a href="#">CDC Community Guide: Community-wide campaigns informational approaches</a></li> <li><a href="#">CDC Community Guide: Diabetes Prevention</a></li> <li><a href="#">Community-based Diabetes and Hypertension Program</a></li> <li><a href="#">Dana-Farber Mammography Van</a></li> <li><a href="#">Healthy Start</a></li> <li><a href="#">Increased Medicaid Reimbursements to Enhance Breast/Cervical Cancer Screening Project</a></li> <li><a href="#">Living for Health</a></li> <li><a href="#">New Moms Network</a></li> <li><a href="#">Physician-Oriented Intervention on Follow-Up in Colorectal Cancer Screening</a></li> <li><a href="#">Prevention Care Management</a></li> <li><a href="#">Prompting and Reminding at Encounters for Prevention</a></li> <li><a href="#">REACH for Wellness</a></li> <li><a href="#">Refugee Health Assessment Program</a></li> <li><a href="#">The Stanford Five-City Project</a></li> <li><a href="#">YMCA's Diabetes Prevention Program</a></li> </ul> </li> <li>+ Pharmaceutical Assistance and Medical Supplies, i.e. patients receive a free meter, but cannot afford to buy the necessary test strips</li> <li>+ Replicate the Stanford model which provides Health Care Navigators for patients who have chronic diseases. The model promotes self-advocacy</li> </ul>

See **Appendix H** for "Chronic Disease and Prevention" information from April 11 Strategies Meeting

<b>3. Decrease Health Care Disparities</b>		
<i>Indicator</i>	<i>Black/African Americans</i>	
	<i>Miami-Dade County (CHARTS, 2011)</i>	<i>Healthy People 2020 Goal (CDC, 2011)</i>
Heart disease deaths	<b>166.2</b> per 100,000	100.8 per 100,000
Diabetes deaths	33.6 per 100,000	65.8 per 100,000
Stroke deaths	<b>41.6</b> per 100,000	33.8 per 100,000
Low birth weight infants	<b>12.9%</b> of live births	7.8% of live births
18+ women who had a Pap. in the past yr.	<b>32.6%</b>	93.0%
<b>Challenges and Barriers</b>	<b>Opportunities, Strategies and Partnerships</b>	
<p>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. <b>See Appendix I</b></p> <ul style="list-style-type: none"> <li>- During the 2012 Communities Putting Prevention to Work (CPPW) project, <i>A Healthier Future: Expanding Supermarket Access in Areas of Need for Miami-Dade County</i> 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.<sup>v</sup></li> <li>- Lack of a countywide master plan to reduce cancer disparities. Efforts are not coordinated and are not sustainable while grant-funding dependent.</li> <li>- Lack of coordinated health resources</li> <li>- Lack of financial incentives for physicians to practice in need areas. Physicians may want to “give back,” but need some incentives.</li> <li>- More involvement is necessary from the decision-makers/opinion leaders such as the Mayor and County Commissioners.</li> <li>- Racial and ethnic disparities in low birth weight rates, infant mortality and chronic disease, particularly among Non-Hispanic Black/African-Americans.</li> <li>- Socioeconomic challenges</li> <li>- Transportation</li> </ul>	<ul style="list-style-type: none"> <li>+ <b>Jasmine Project</b> focuses on Opa-Locka area follows at-risk women for up to two years</li> <li>+ Evidence-based strategies: <ul style="list-style-type: none"> <li><a href="#"><u>Baltimore community navigators project</u></a></li> <li><a href="#"><u>Community Voice: Taking it to the People</u></a></li> <li><a href="#"><u>Culturally Tailored Navigator Pgm for Cancer Screening</u></a></li> <li><a href="#"><u>Harlem Children’s Zone</u></a></li> <li><a href="#"><u>Healthy Families America</u></a></li> <li><a href="#"><u>Healthy Start</u></a></li> <li><a href="#"><u>Improving Cancer Screening for Medically Underserved</u></a></li> <li><a href="#"><u>Increasing Screening Colonoscopy in Urban Public Hospitals</u></a></li> <li><a href="#"><u>Leading, Integrating, Networking for Kids (LINK)</u></a></li> <li><a href="#"><u>Let’s Move!</u></a></li> <li><a href="#"><u>The Magnolia Project</u></a></li> <li><a href="#"><u>Neighborhood Involvement Program</u></a></li> <li><a href="#"><u>Nurse Family Partnership (NFP): Palm Beach</u></a></li> <li><a href="#"><u>Open Doors to Health</u></a></li> <li><a href="#"><u>Pasadena Community Asthma Program (PCAP)</u></a></li> <li><a href="#"><u>Project PREVENT</u></a></li> <li><a href="#"><u>Provider Intervention to Improve Colorectal Cancer Screening Rates Among African American Patients</u></a></li> <li><a href="#"><u>Putnam County Early Entry into Prenatal Care-WIC</u></a></li> <li><a href="#"><u>SISTERS</u></a></li> <li><a href="#"><u>St. Joseph’s Hospital Health Center Community-Building/Vocational Services Initiative</u></a></li> <li><a href="#"><u>Targeted Outreach for Women Act</u></a></li> <li><a href="#"><u>Wellness for African Americans through Churches (WATCH)</u></a></li> </ul> </li> <li>+ <b>FQHCs</b> partner with farmer’s markets providing fresh fruits and vegetables in high-need areas</li> <li>+ Hospital volunteer programs that incentivize physicians to work in high-need areas</li> <li>+ Implement a System of Care (e.g. in Liberty City).</li> <li>+ Jay Weiss Institute for Health Equity at the Sylvester Comprehensive Cancer Center, UM Miller School of Medicine</li> <li>+ Provide Hands-On Navigators who work with neighborhood residents to remove barriers.</li> <li>+ Create “Master Cancer Plan,” as in other cities</li> <li>+ Prioritize neighborhoods, mobilize the community.</li> <li>+ Miami-Dade Health Access Network (MD-HAN) work with Mayor Jimenez, the Dade Delegation, County Commissioners</li> </ul>	
See <b>Appendix I</b> for more “Health Care Disparities” information from April 11 Strategies Meeting		

**4. Increase Availability of Primary Care and Medical Homes**

*In 2010, 78.4% of adults in Miami-Dade County had an ongoing source of care<sup>vi</sup>*

**Healthy People 2020 Goal - Adults with an ongoing source of care: 89.4%**

Challenges and Barriers	Opportunities, Strategies and Partnerships
<p>The current Medicaid rates are so low that providers are unwilling to accept new patients. Compounding the low provider reimbursement rates, there is an issue with a general lack of providers.</p> <ul style="list-style-type: none"> <li>- Care coordination: do not “shop around” for a doctor because it fragments care.</li> <li>- Maintaining patient-compliance</li> <li>- Misuse of the ER, when a patient may already be using a health clinic</li> <li>- Shortage of healthcare providers</li> <li>- Timing appointments during regular business hours when employees cannot leave work</li> <li>- Lack of knowledge of the benefit of medical homes</li> </ul>	<ul style="list-style-type: none"> <li>+ Evidence-based strategies:               <ul style="list-style-type: none"> <li><a href="#"><u>The CARES Program</u></a></li> <li><a href="#"><u>Healthy San Francisco: Medical Homes - Access To Services</u></a></li> <li><a href="#"><u>Health Connect in Our Schools (HCiOS)</u></a></li> <li><a href="#"><u>Hypertension Treatment in Barbershops</u></a></li> <li><a href="#"><u>Florida Healthy Kids</u></a></li> <li><a href="#"><u>Kids Get Care</u></a></li> <li><a href="#"><u>Latino Health Insurance Program (LHIP)</u></a></li> <li><a href="#"><u>Marion County Indigent Care Program</u></a></li> <li><a href="#"><u>Neighborhood Health Clinic</u></a></li> <li><a href="#"><u>Opportunity NYC Demonstrations- Family Rewards</u></a></li> <li><a href="#"><u>Para Su Salud</u></a></li> <li><a href="#"><u>Patient/Provider Communication Assistant</u></a></li> <li><a href="#"><u>Positive Choice: Interactive Video Doctor</u></a></li> </ul> </li> <li>+ Accountable Care Organizations</li> <li>+ As of 2014, the Affordable Care Act /Health Care Exchanges will be implemented in the State of Florida and will ensure access to health care for all eligible Miami Dade County residents, including individuals with pre-existing conditions.</li> <li>+ Community Health Workers</li> <li>+ Care coordination and joint staffing of patient care</li> <li>+ Electronic Medical Records to coordinate care</li> <li>+ <b>FQHCs</b> in Miami-Dade are nationally accredited</li> <li>+ Greater focus on primary care thanks to <b>FIU School of Medicine</b> and interdisciplinary programming</li> <li>+ <b>Jackson Memorial Hospital</b> has cadre of primary care sites, and are now going for accreditation</li> <li>+ <b>Baptist Health South Florida</b> provides 20,000 free health screenings at annual health fairs</li> <li>+ <b>MomCare</b>, administered by the Healthy Start Coalition of Miami-Dade, assured medical homes, WIC, Healthy Start enrollment and screening</li> <li>+ One-E-App (Unified Eligibility Application)</li> </ul>
<p>See <b>Appendix J</b> for “Primary Care and Medical Homes” information from April 11 Strategies Meeting</p>	

<b>5. Promote Nutrition and Physical Activity</b>		
<i>Indicator</i>	<i>Miami-Dade County (CHARTS, 2011)</i>	<i>Healthy People 2020 Goal (CDC, 2011)</i>
Adult Fruit and Vegetable Consumption	23.1%	N/A
Adult Obesity	29.3%	30.5%
Teen Obesity	12.7%	16.1%
Adult Sedentary Behavior	<b>35.4%</b>	32.6%
Teen Physical Activity	37%	N/A
<b>Challenges and Barriers</b>	<b>Opportunities, Strategies and Partnerships</b>	
<ul style="list-style-type: none"> <li>- Decreased funding</li> <li>- Corner stores in the inner city may not offer healthy fruits and vegetables.</li> <li>- In 2012, the Communities Putting Prevention to Work (CPPW) report on <i>Expanding Supermarket Access in Areas of Need for Miami-Dade County</i> determined that 250,000 Miami-Dade residents (10%) live in low-income areas that have poor supermarket access and higher death rates from diet-related causes</li> <li>- In 2010, 67.4% of MDC adults are reportedly overweight or obese; a rate that has increased from 61% in 2002</li> <li>- Inadequate access to healthy foods in schools and programs that create awareness and interest in healthy foods</li> <li>- Inadequate recreational spaces, low or free exercise programs and food deserts</li> <li>- Lack of PE and afterschool physical activity, leading to sedentary lifestyles</li> <li>- Lack of awareness of healthy food purchasing and preparation</li> <li>- Safety must be improved so that more young people can use public parks</li> </ul>	<ul style="list-style-type: none"> <li>+ Common Threads is a national nutrition education model that is now being offered to students in 3-4 Middle Schools in Miami-Dade County (replicating Chicago model)</li> <li>+ Continue the work started by CPPW into other initiatives</li> <li>+ Evidence-based strategies: <ul style="list-style-type: none"> <li><a href="#"><u>CDC COMMUNITY GUIDE: Environmental and Policy Approaches to Increase Physical Activity: Creation of or Enhanced Access to Places for Physical Activity Combined with Informational Outreach Activities</u></a></li> <li><a href="#"><u>CDC COMMUNITY GUIDE: Obesity Prevention Healthy Hoops</u></a></li> <li><a href="#"><u>Hearts N' Parks</u></a></li> <li><a href="#"><u>Let's Move!</u></a></li> <li><a href="#"><u>New York City's Phase Out of Artificial Trans Fat</u></a></li> <li><a href="#"><u>PACE+: Exercise + Nutrition Adolescent Counseling</u></a></li> <li><a href="#"><u>Preventive Nutrition Cardiovascular Disease Program</u></a></li> <li><a href="#"><u>Stepping Up To Health</u></a></li> <li><a href="#"><u>Women On the Move through Activity And Nutrition (WOMAN) Study</u></a></li> </ul> </li> <li>+ <b>Alliance for Aging</b> provides techniques on changing eating habits and improving health and fitness</li> <li>+ <b>Baptist Health South Florida</b> provides over 200 free exercise classes per month, as well as a nutritionist</li> <li>+ <b>Blue Foundation Childhood Obesity Prevention Programs in Hialeah and Opa-Locka</b></li> <li>+ <b>Centro Mater</b> grant from HFSF to fight childhood obesity</li> <li>+ <b>Consortium for a Healthier Miami-Dade</b> implementation of the evidenced-based strategies of media access, price/point of purchase/promotion and social support/services practices to decrease the obesity epidemic</li> <li>+ <b>The Children's Trust</b> promotes good eating habits</li> <li>+ <b>FQHCs</b> partner with farmer's markets providing fresh fruits and vegetables in high-need areas through CPPW funding</li> <li>+ <b>Health Foundation of South Florida (HFSF)</b> provides Healthy Aging grants focused on stretching, flexibility, balance, and low-impact aerobics</li> <li>+ <b>Miami-Dade County Public Schools</b> dietary improvements to meal plans, school health and nutrition services and healthy vending machine options implemented</li> <li>+ <b>United Way of Miami-Dade</b> funds programs that focus on youth and the importance of eating healthy and exercising</li> </ul>	
See <b>Appendix K</b> for more "Nutrition and Physical Activity" information from April 11 Strategies Meeting		

## 6. Address Mental Health and Mental Disorders

*In 2011, the age-adjusted death rate due to suicide in Miami-Dade County was 7.6 deaths per 100,000.<sup>vii</sup>*

**Healthy People 2020 Goal - 10.2 deaths per 100,000**

Challenges and Barriers	Opportunities, Strategies and Partnerships
<p>Mental disorders and substance abuse often manifest as comorbid conditions. Promising targeted preventive interventions and resilience training to identify strengths that may promote health and healing can reduce the risk for mental disorders and substance abuse and the burden of suffering in vulnerable populations.</p> <ul style="list-style-type: none"> <li>+ Inadequate availability of programming for substance abuse and mental health treatment and prevention (long waiting list, inadequate care, short-term only)</li> <li>+ Substance abuse and mental health is a widely recognized community issue, but there is little to no support for residents who require services in these areas.</li> <li>+ Lack of funding for mental health service</li> <li>+ Economic and political climate; policies and systems present barriers</li> </ul>	<ul style="list-style-type: none"> <li>+ Evidence-based strategies:               <ul style="list-style-type: none"> <li><a href="#">CDC Community Guide Home interventions reduce depression</a></li> <li><a href="#">CDC: Care for the Management of Depressive Disorders</a></li> <li><a href="#">CDC: Reducing Psychological Harm from Traumatic Events: Cognitive-Behavioral Therapy for Children and Adolescents</a></li> <li><a href="#">CDC: Interventions to Reduce Depression Among Older Adults</a></li> <li><a href="#">CDC: Therapeutic Foster Care to Reduce Violence</a></li> <li><a href="#">CDC: Interventions to Improve Caregivers' Parenting Skills</a></li> <li><a href="#">Cognitive Behavioral Therapy for Adolescent Depression</a></li> <li><a href="#">Comprehensive Homeless Access to Nontraditional Clinical Experiences (CHANCE)</a></li> <li><a href="#">The Connect Project</a></li> <li><a href="#">Coping and Support Training (CAST)</a></li> <li><a href="#">Counselors Care (CARE)</a></li> <li><a href="#">Driving and Dementia Toolkit</a></li> <li><a href="#">IMPACT</a></li> <li><a href="#">Intimate Partner Violence Intervention</a></li> <li><a href="#">Migrant Health Promotion</a></li> <li><a href="#">MoodGym and Blue Pages: Internet Depression Intervention</a></li> <li><a href="#">Pathways to Housing, Inc.</a></li> <li><a href="#">Penn Resiliency Program</a></li> <li><a href="#">Reach Out Central</a></li> <li><a href="#">Reconnecting Youth</a></li> <li><a href="#">Runaway Intervention Program (RIP)</a></li> <li><a href="#">SOS Signs of Suicide Program</a></li> <li><a href="#">Telephone Intervention for Caregivers of Stroke Survivors</a></li> <li><a href="#">Trauma-Focused Cognitive Behavioral Therapy</a></li> <li><a href="#">Youth with Disabilities Demonstration Project</a></li> </ul> </li> <li>+ <b>Alliance for Aging</b> is the convener for 2013 meetings pertinent to the behavioral health needs of older adults and cultivates partnerships for funding mental health interventions.</li> <li>+ <b>DCF Substance Abuse and Mental Health Program (SAMH)</b> works with <b>FQHCs</b> to promote integrated primary care services for medically underserved with behavioral health care needs. The DCF SAMH Managing Entity, <b>South Florida Behavioral Health Network (SFBHN)</b>, requires all of its Subcontractors to execute a Memorandum of Understanding with an FQHC.</li> <li>+ Trauma Informed Care (TIC): SFBHN and the DCF Southern Region are developing a system of care that incorporates comprehensive assessment tools that identify those affected by trauma and a system of care that meets their needs. The TIC Initiative will identify the effects of trauma on those seeking services and the provision of treatment options. As part of the TIC Initiative, SFBHN has: facilitated regional TIC meetings to develop the process to identify and respond to those affected by trauma, led regional TIC trainings, developed and implemented TIC language for all subcontractors.</li> </ul>
<p>See <b>Appendix L</b> for more “Mental Health and Mental Disorders” information</p>	

## 7. Address the Social Determinants of Health

<i>Indicator</i>	<i>Miami-Dade County</i>	<i>United States</i>
Median Household Income	\$43,957 (Census, 2011)	\$43,417 (Census, 2011)
Families Living Below Federal Poverty Level	14.6% (Census, 2011)	10.8% (Census, 2011)
Unemployed Workers in Civilian Labor Force	8.0% (US Bureau of Labor, 2012)	6.7% (US Bureau of Labor, 2012)
High School Graduation Rate	78.1% (FL DOE, 2011)	78.0% (US DOE, 2011)
Adults Age 25+ with Bachelor's Degree	26.2% (Census, 2011)	17.7% (Census, 2011)

<b>Challenges and Barriers</b>	<b>Opportunities, Strategies and Partnerships</b>
<p>The similarity of the “red zones” on the maps of ER visits for asthma, a largely preventable condition, and the household income map demonstrate a correlation between emergency care usage and socioeconomic status. <b>See Appendix I</b></p> <ul style="list-style-type: none"> <li>+ High copays and deductibles leading to underinsured</li> <li>+ Insufficient focus on integrated care that encompasses social determinants of health (including housing, income, education) leading to unsustainable solutions</li> <li>+ In 2012, the Communities Putting Prevention to Work (CPPW) report, <i>A Healthier Future: Expanding Supermarket Access in Areas of Need for Miami-Dade County</i> 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.</li> <li>+ Lack of awareness of prevention and lack of focus on motivational issues</li> <li>+ Lack of awareness of healthy food purchasing and preparation</li> </ul>	<ul style="list-style-type: none"> <li>+ Evidence-based strategies: <ul style="list-style-type: none"> <li><a href="#">Bank On San Francisco</a></li> <li><a href="#">CAMINOS</a></li> <li><a href="#">CDC: Early Childhood Development Programs: Comprehensive, Center-Based Programs for Children of Low-Income Families</a></li> <li><a href="#">CDC: Housing: Tenant-Based Rental Assistance Programs</a></li> <li><a href="#">CDC: Promoting Health Equity, Education Programs and Policies: Full-Day Kindergarten</a></li> <li><a href="#">Community Market Farms</a></li> <li><a href="#">College Track</a></li> <li><a href="#">EMERGE</a></li> <li><a href="#">The Food Trust</a></li> <li><a href="#">Fred G. Acosta Job Corps Center</a></li> <li><a href="#">Free Income Tax Assistance Program</a></li> <li><a href="#">HIRED</a></li> <li><a href="#">Interfaith Housing of Western Maryland</a></li> <li><a href="#">Janice Mirikitani Family, Youth and Childcare Center</a></li> <li><a href="#">Michigan Farmers' Market Nutrition Program</a></li> <li><a href="#">Network for Teaching Entrepreneurship (NFTE)</a></li> <li><a href="#">Parent-Child Home Program: Palm Beach</a></li> <li><a href="#">Phoenix Healthy Homes</a></li> <li><a href="#">Play Streets with Strategic Alliance for Health (SaFH)</a></li> <li><a href="#">Project for Pride in Living</a></li> <li><a href="#">See You in School</a></li> <li><a href="#">Summer Search</a></li> <li><a href="#">Wisconsin Home Energy Assistance Program (WHEAP)</a></li> <li><a href="#">Youth Opportunity Baltimore</a></li> </ul> </li> <li>+ <b>Catalyst Miami</b> Prosperity Campaign for comprehensive benefits assistance and navigation and Healthcare Heroes life coaching in South Dade</li> <li>+ Common Threads is a national nutrition education model that is now being offered to students in 3-4 Middle Schools in Miami-Dade County (replicating Chicago model)</li> <li>+ <b>Camillus House</b></li> <li>+ <b>Chapman Partnership</b></li> <li>+ <b>Habitat for Humanity</b></li> <li>+ <b>People Acting for Community</b></li> <li>+ <b>United Way of Miami-Dade</b></li> <li>+ <b>WeCare of South Dade</b></li> <li>+ Greater focus on healthcare disparities based upon income, race and ethnicity; identification of unhealthy neighborhoods</li> <li>+ Funding alone will not make a difference. A <b>totally different approach</b> is necessary that includes the community and will address the social determinants of health.</li> </ul>

See **Appendix M** for more “Social Determinants of Health” information from April 11 Strategies Meeting

## 8. Increase Interagency Coordination

Challenges and Barriers	Opportunities, Strategies and Partnerships
<ul style="list-style-type: none"> <li>- Fragmentation and lack of coordination involving separate actions undertaken by government, schools, industry and the voluntary and philanthropic sectors</li> <li>- Inadequate service to incarcerated individuals</li> <li>- Lack of utilization of electronic medical records which would allow for better coordinated and non-duplicative care.</li> <li>- Lack of technological integration – The FQHC’s utilize a HL7 interface but the FLDOH clinics utilize HMS.</li> </ul>	<ul style="list-style-type: none"> <li>+ <b>Alliance for Aging</b> working with <b>Baptist Health South Florida</b> and other hospitals on Care Transitions program</li> <li>+ <b>Catalyst Miami</b> working with <b>Baptist Follow-Up Care Clinic</b> and connecting residents to services</li> <li>+ <b>Consortium for a Healthier Miami-Dade</b> promotes collaboration and leveraging of resources, implementation of evidenced based practices, and community-focused programs and services. The group comprises governmental agencies, hospitals, businesses, foundations, schools and other entities working together to promote healthier lifestyles.</li> <li>+ <b>Department of Children and Families (DCF)</b> and <b>University of Miami Childcare Taskforce</b> work through the Consortium for a Healthy Miami-Dade</li> <li>+ <b>Health Connect in Our Schools (HCiOS)</b> and <b>Health Connect in Our Communities (HCiOC)</b></li> <li>+ <b>Healthy Start Coalition of Miami-Dade</b> is one of the strongest Healthy Start systems of care in the state. This partnership includes many private and public sector colleagues.</li> <li>+ The Miami-Dade County Hospital Preparedness Consortium works with hospitals throughout the community in order to be prepared for manmade and natural disasters.</li> <li>+ <b>United Way of Miami-Dade</b> will use the results of this MAPP process to inform their health priorities goal area.</li> <li>+ The <b>Miami-Dade Health Action Network (MD-HAN)</b> is working to bring community players together toward a better coordinated health system and toward a unified common eligibility application, or One-e-App.</li> </ul>

See **Appendix N** for more “Interagency Coordination” information from April 11 Strategies Meeting

Indicator	<i>Miami-Dade County</i> (CHARTS, 2011)	<i>Healthy People 2020 Goal</i> (CDC, 2011)
Heart disease deaths	<b>166.2</b> per 100,000	100.8 per 100,000
Stroke deaths	<b>41.6</b> per 100,000	33.8 per 100,000
High Blood Pressure Prevalence	<b>34.1%</b>	26.9%
Cholesterol Test History	67.5%	N/A

Challenges and Barriers	Opportunities, Strategies and Partnerships
<ul style="list-style-type: none"> <li>- Insufficient funding for services</li> <li>- Identifying those at-risk so that they may seek treatment</li> <li>- Individuals, workplaces and communities are not prioritizing health</li> <li>- In Miami-Dade, there has been an increase in <b>hypertensive heart disease death rate in the last decade</b> (Miami Matters, 2011)               <ul style="list-style-type: none"> <li>- Blacks have more than twice the hypertensive heart disease death rate as compared to Whites and</li> </ul> </li> </ul>	<p>Align community, non-profits with <b>Consortium for a Healthier Miami-Dade</b> to work towards one goal under proactive and enthusiastic leadership</p> <ul style="list-style-type: none"> <li>+ <b>American Heart Association (AHA)</b> “Good to Go” initiative helps patients to their own blood pressure readings; Simple Cooking with Heart in underserved neighborhoods through churches, health fairs and events; Walking Paths certification program; Fit Friendly Award recognition program for organizations that care about their employees’ health; “Get to Goal” provides blood pressure education and enrolls participants in a software program called “Heart360” which provides BP tracking and heart-healthy tips;</li> </ul>

<p>Hispanics, at 23.3, 11.2 and 9.6 per 100,000.</p> <ul style="list-style-type: none"> <li>- More work needs to be done in order to reach the <i>Healthy People 2020</i> goal</li> <li>- Physical activity levels are worsening for both adults and children; in adults, obesity levels are rising</li> <li>- Cholesterol levels are rising in both adults and children</li> <li>- High blood pressure prevalence is worsening for adults</li> <li>- The disparities are wide between cardiovascular disease (CVD)/stroke rates among Blacks, Hispanics and Whites</li> </ul>	<p>“Together to End Stroke” to raise awareness about stroke, how to prevent it, and how to recognize it using a new mobile phone app (F.A.S.T.”) among uninsured; a text health-messaging campaign focusing on heart-health, nutrition, physical activity, and general wellness</p> <ul style="list-style-type: none"> <li>+ <b>Florida Heart Research Institute</b> conducts cardiovascular risk factor screenings; a Living for Health (L4H) program that targets underserved and uninsured adults; and the PUSH CPR® public awareness campaign</li> <li>+ <b>Florida Department of Health in Miami-Dade County</b> has Community Health Action Teams (CHAT) providing blood pressure, BMI, body fat, carbon monoxide and diabetes risk screenings. The Worksite Wellness Program provides technical assistance to organizations and provides educational programs and screenings on chronic disease.</li> <li>+ Evidence-based strategies: <ul style="list-style-type: none"> <li><a href="#"><u>Heart to Heart</u></a></li> <li><a href="#"><u>The Heart Truth</u></a></li> <li><a href="#"><u>Hypertension Initiative of South Carolina</u></a></li> <li><a href="#"><u>Hypertension Treatment in Barbershops</u></a></li> <li><a href="#"><u>Internet-Based Case Management for Secondary Prevention of Heart Disease</u></a></li> <li><a href="#"><u>Million Hearts</u></a></li> <li><a href="#"><u>Living for Health</u></a>: L4H model produces statistically significant outcomes that are easily replicated</li> <li><a href="#"><u>Preventive Nutrition Cardiovascular Disease Program</u></a></li> <li><a href="#"><u>Project Health Education Awareness Research Team (HEART)</u></a></li> <li><a href="#"><u>Salud Para Su Corazón (Health for Your Heart)</u></a></li> <li><a href="#"><u>The Virginia Cardiovascular Health Program</u></a></li> <li><a href="#"><u>Worcester Area Trial for Counseling in Hyperlipidemia (WATCH)</u></a></li> </ul> </li> <li>+ <b>South Miami Heart Center</b> Screenings, free programs on heart disease risk factors, recognizing heart attack symptoms, and relationship betw. obesity &amp; heart disease</li> <li>+ <a href="#"><u>Other Local Agencies/Contributors</u></a> <ul style="list-style-type: none"> <li>One beat CPR</li> <li>Faith-based and health ministry</li> <li>Worksites and educational institutions</li> <li>Mobile-phone technology strategies include heart-healthy messaging (for example, text HEALTH to 2722 to receive weekly health tips)</li> </ul> </li> </ul>
<p>See <b>Appendix O</b> for more “Heart Disease and Stroke” information from April 11 Strategies Meeting</p>	

<b>10. Decrease HIV, STDs and Infectious Diseases</b>		
<i>Indicator</i>	<i>Miami-Dade County</i> (CHARTS, 2011)	<i>Florida</i> (CHARTS, 2011)
HIV Cases	<b>50.3</b> per 100,000	26.9 per 100,000
AIDS Cases	<b>28.5</b> per 100,000	17.4 per 100,000
Chlamydia Cases	350.0 per 100,000	401.3 per 100,000
Gonorrhea Cases	93.4 per 100,000	104.0 per 100,000
Syphilis Cases	<b>13.1</b> per 100,000	6.6 per 100,000
Tuberculosis Cases	<b>6.2</b> per 100,000	4.0 per 100,000
<b>Challenges and Barriers</b>	<b>Opportunities, Strategies and Partnerships</b>	
<p>HIV/STD Initiatives</p> <ul style="list-style-type: none"> <li>- The success of Awareness Days and Take Control Events at public schools is a challenge. STD/HIV Prevention presentations and health fair materials motivate the students and their friends to get tested, but there is not enough time or providers to meet the requests; and students do not follow-up with providers in the community to get tested.</li> <li>- There is funding to provide community partners with Chlamydia/Gonorrhea testing for young ladies but not for their partners or young males.</li> <li>- Not enough funding or staff to provide services</li> <li>- Funding for STD awareness social marketing campaign that describes signs and symptoms</li> <li>- The percentage of newly infected HIV positive individuals currently receiving care is at 65%, but should be at 80%+.</li> <li>- Physicians who have become part of the Test Miami Initiative do not always submit data making it difficult to determine HIV testing impact</li> <li>- There is a need for more initiatives targeting the men who have sex with men (MSM) community as they are most affected by HIV in Miami-Dade</li> <li>- Co-infection of STDs, specifically Syphilis, needs specific attention as it is a significant predictor in future HIV infection</li> <li>- Monitor antibiotics resistant Gonorrhea in Miami-Dade County</li> <li>- Physicians education: antibiotics resistance Gonorrhea, testing for pharyngeal and anal Chlamydia/Gonorrhea.</li> </ul> <p>Tuberculosis (TB)</p> <ul style="list-style-type: none"> <li>- Transitional Housing for TB patients</li> <li>- Administrative and engineering controls of congregate settings</li> <li>- Discharge planning for TB patients</li> <li>- Short course of treatment for Latent TB Infection</li> <li>- Lack of funding</li> <li>- Educate health care providers, patients and families</li> <li>- Patients lost to follow-up</li> <li>-</li> </ul>	<p>+ Evidence-based strategies: <b><u>AIDS Insurance Continuation Program</u></b> <u>SEXINFO: A Sexual Health Text Messaging Service for San Francisco Youth</u></p> <p>HIV/STD Initiatives</p> <ul style="list-style-type: none"> <li>+ <i>Take Control</i> was developed in 2006 through the <b>MDCHD Office of HIV/AIDS</b> Health Education Risk Reduction Program to increase the number of HIV and STD tests in non-clinical settings. Take Control community health fairs provide free information and screenings that range from glucose screenings to HIV testing in target communities. <i>Test Miami</i> promotes the CDC recommendation of integrating HIV testing in routine clinical care across healthcare settings. It aims to encourage individuals to know their HIV status and seek treatment. The campaign also seeks to eliminate perinatal transmission and has allowed for a social marketing campaign. The FDOH-MDC has been recruiting doctors for this initiative since 2010.</li> <li>+ The Enhanced Comprehensive HIV Prevention Planning (ECHPP) Project is a 3-year demonstration project funded by CDC's Division of HIV/AIDS Prevention (DHAP) for the 12 municipalities with the highest number of people living with AIDS in the United States. Targeting High Impact Prevention (HIP) ECHPP is being implemented in five areas with the highest HIV incidence in Miami-Dade. Florida Department of Health funds five new Miami-Dade County organizations to implement HIP activities including: HIV testing, prevention for positives, condom distribution, and outreach. These activities commenced in January 2013. ECHPP supports the National HIV/AIDS Strategy goals by improving program planning and implementation to: reduce new HIV infections; link people with HIV to care and treatment and improve health outcomes; reduce HIV-related health disparities, and achieve a more coordinated national response to the HIV epidemic.</li> <li>+ Development of a South Florida Men's Syphilis</li> </ul>	

	<p>Coalition beginning April 2013 to address syphilis and co-infections.</p> <ul style="list-style-type: none"> <li>+ New CDC funding PS12-1201 allows for expansion of STD testing and Program Collaboration and Service Integration</li> <li>+ <b>Sembrando Flores</b> conducts testing in South Dade</li> <li>+ <b>Thelma Gibson Health Initiative</b> – HIV Program</li> <li>+ <b>United Way</b> funds a <i>Care Connection</i> program for HIV positive individuals living in Liberty City, which has historically been a very difficult population to reach. By supporting this program, the HIV positive rate has decreased in recent years.</li> <li>+ Chlamydia/Gonorrhea screening program for young females 15 – 24 years of age involves memorandums of agreement with community partners to provide screening in non-traditional locations during non-traditional hours</li> <li>+ Active participation with community coalitions and groups such as local govt, <b>Connect to Protect, HIV Partnership</b>, Miami-Dade County Public Schools.</li> </ul> <p>Tuberculosis Initiatives</p> <ul style="list-style-type: none"> <li>+ <b>Florida DOH</b> focuses on groups at high risk of contracting the disease, such as the homeless; and reinforces the importance of timely reporting, early case detection and diagnosis through quality-assured bacteriology, IGRAs (Interferon Gamma Release Assay) testing, case management and treatment of Latent TB Infection with standardized supervision, and patient support.</li> <li>+ Application of Genotyping to Tuberculosis Prevention and Control</li> <li>+ Workplace-based Directly Observed Therapy</li> </ul>
<p>See <b>Appendix P</b> for “HIV, STDs and Infectious Diseases” information from April 11 Strategies Meeting</p>	

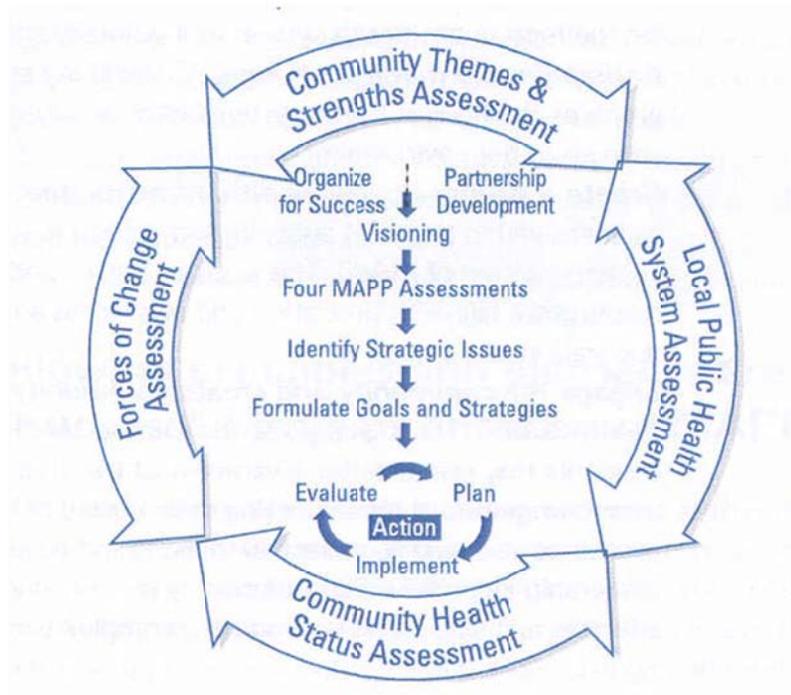
## Next Steps

The results of the MAPP assessments will be used to develop a Community Health Improvement Plan (CHIP). The CHIP will serve as the strategic plan to improve health and quality of life in Miami-Dade County.

Other reports recently published will also be considered in formulating the CHIP for Miami-Dade County, such as the state CHIP completed by the Florida Department of Health and the 2013 County Health Rankings published by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

There are many community partnerships and coalitions that have been established to improve the health of Miami-Dade County. These groups should consider the following next steps:

- Engage community groups and residents in prioritizing what is important in the four MAPP assessments and this Report of Findings.
- Collaborate to develop a new Community Health Improvement Plan (CHIP) and evaluation plan based on the findings of these four assessments and the goals and strategies herein. Target organizations and representatives to join are in **bold** on the goals matrix. These groups will help
  - identify resources for the CHIP
  - evaluate/determine the gaps and search for solutions
  - create action plans to implement best practices/promising practices
  - implement the plan
  - review/revise evaluation plan



See also process map in **Appendix Q**

## Coming Soon! Miami-Dade County Community Health Improvement Plan (MDC-CHIP)

A Community Health Improvement Plan (CHIP) is a community-wide strategic plan to improve the health and quality of life of the people who live in a community. A CHIP is a plan that helps communities:

- Ascertain and prioritize community health issues  
Utilize the priorities here in to address the most important health issues facing the community, while considering the unique circumstances and needs of Miami-Dade County.
- Address issues by identifying and aligning resources  
Facilitate a coalition of information, commitment, talents, skills, and financial resources to improve upon the health issues facing Miami-Dade County.
- Take action  
Mobilize community organizations toward strategic action to improve health outcomes.



## Endnotes

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- <sup>i</sup> U.S. Census Bureau. (2011). Income, poverty, and health insurance coverage in the United States: 2010. Retrieved from <http://www.census.gov/prod/2012pubs/p60-243.pdf>.
- <sup>ii</sup> Centers for Disease Control and Prevention (2011, April 28). Healthy people 2020. Retrieved from <http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/HP2020objectives.pdf>.
- <sup>iii</sup> Health Care for Florida Now, Talking Points provided by Florida Legal Services, Inc. Retrieved from [www.healthcareforflorida.org](http://www.healthcareforflorida.org).
- <sup>iv</sup> Annual Report and Recommendations. (2012). Florida KidCare Coordinating Council. Retrieved from <http://www.floridakidcare.org/council/reports/KCC2012report-Web.pdf>.
- <sup>v</sup> Miami-Dade County Health Department (2012). A healthier future: expanding supermarket access in areas of need for Miami-Dade County. Retrieved from [healthymiamidade.org/system/js/back/ckfinder/userfiles/files/Miami%20Dade%20Supermarket%20Access%20Report%20WEB%20FINAL.pdf](http://healthymiamidade.org/system/js/back/ckfinder/userfiles/files/Miami%20Dade%20Supermarket%20Access%20Report%20WEB%20FINAL.pdf).
- <sup>vi</sup> Florida Department of Health (2010). Florida behavioral risk factor surveillance system. Retrieved from [www.floridacharts.com](http://www.floridacharts.com).
- <sup>vii</sup> Florida Department of Health (2011). Bureau of Vital Statistics. Retrieved from [www.floridacharts.com](http://www.floridacharts.com).

Who	When	No.	What	No.	How	
Florida Department of Health Long Range Statewide Goals	2012-2017	1	Collaboration	1	Prevent and treat infectious disease of public significance	These are aligned with the Governor's Priorities: 1. Accountable budgeting 2. Reduce government spending 3. Regulatory reform 4. Focus on job growth and retention
		2	Coordination	2	Ensure FL's health & medical system achieves & maintains Nat'l preparedness	
		3	Increased access	3	Improve access to basic family health care services	
		4	Workforce development	4	Capabilities	
Miami-Dade County Health Department	2011-2014	1	Collaboration	1	a. Community assessment process b. Participate in state health improvement plan c. Maintain Hospital Preparedness Consortium	
		2	Coordination	2	a. Implement a Central Appointment system for clinical services b. Community Outreach	
		3	Integration	3	Develop and implement a systematic engagement plan across all programs	
		4	Increased access	4	a. Identify health disparities in community b. Develop contracts with HMO/PSNs for Medicaid Reform	
		5	Technology	5	a. Implement an Information Technologu Management Framework (ITIL) b. Deployment and integration of Electronic Health Records	
		6	Accountability	6	a. Policy/Procedures for third party insurance b. Policy/Procedure for health center managment	
		7	Workforce development	7	a. Analyze, plan, align and balance workfore for future b.Promote, support and train workforce and volunteers	
Miami-Dade County Health and Human Services Strategic Plan	2012	1	Collaboration	1	Develop public/private partnerships with existing programs	
		2	Coordination	2	a. Expand participation in existing programs b. Refer public health trust patients ti chronic disease management programs	
		3	Integration	3	a. Expand partnerships with community service providers b. Increase community awareness of services	
		4	Increased access	4	a. Increase access to health service through primary care medical home b. Increase patients served by Federally Qualified Health Centers c. Increase available clinical space for primary care	
		5	Technology	5	Increase enrollment into Miami Dade Blue Health Plan	
		6	Workforce development	6	Strengthen partnerships between private and public workforce agencies	
Miami-Dade County Hospital Governance Task Force	2011	1	Coordination	1	Create a Public Health Advisory Committee to ensure coordination of countywide public health	The recommendations overlap: "Recommendations should be viewed in their entirety rather than selectively; many recommendations are coupled with others."
		2	Integration	2	Create a Public Health Advisory Committee to ensure mission as safety net fulfilled	
		3	Accountability	3	Create a Public Health Advisory Committee to ensure public funds utilized fullfil mission as a safety net	
		4	Increased access Governance	4	Create a Public Health Advisory Committee to ensure mission as safety net fulfilled	
				5	a. Public Health Advisory Committee b. Implementation Committee to become the board of governance	

Who	When	No.	What	No.	How
Florida Medicaid Medical Home Task Force	2010	1	Coordination	1	Promote medical home model
		2	Collaboration	2	Work with community based networks
		3	Increased Access	3	a. Identify one rural and one urban with academic/medical school for pilot b. Include a variety of providers and community based partnerships
		4	Accountability	4	Use the National Committee for Quality Assurances standards
		5	Governance	5	Appoint a Medical Home Advisory Board
Miami-Dade County Community Health Report Card	2007	1	Maternal & Child Health	1	Children and mothers are healthy, utilize healthcare and available social services
		2	Risk Reduction	2	Adults and youth avoid risky behaviors, such as substance abuse and unprotected sex
		3	Health Promotion	3	Residents practice healthy behaviors, such as good nutrition, exercise and stress reduction
		4	Primary Care & Prevention	4	Families utilize healthcare when needed and in the most cost-effective setting
		5	Chronic Disease	5	Residents effectively prevent chronic disease and illness
		6	Access to Care	6	Residents have a wide range of health insurance options and readily access coverage
		7	Safety and Security	7	Families live in safe and supportive environments
		8	Senior health	8	Elders are healthy and utilize the healthcare system effectively and efficiently
Social Services Master Plan	2006-2008	1	Basic Needs: Poverty and Hunger	 <p>The vision is "residents have access to quality healthcare and lead healthy lives" and the goals are:</p> <p>a. Residents will know how and where to access healthcare services.</p> <p>b. Residents will have equal opportunities for access to comprehensive healthcare services.</p> <p>c. Residents will be knowledgeable and have the capability to make healthy lifestyle choices and effectively manage their health.</p> <p>d. Healthcare providers will provide culturally appropriate care to the populations they serve.</p>	
		2	Health		
		3	Children, Youth and Families		
		4	Elders		
		5	Children and Adults with Disabilities		
		6	Workforce Development for Special Populations		
		7	Criminal Justice		
		8	Immigrants and New Entrants		
		9	Special Needs (Mental Health, Substance Abuse, Homelessness, Victims of Domestic Violence or Sexual Assault)		
Miami Action Plan for Access to Healthcare	2005	1	Collaboration	1	a. Create coordinated system that facilitates appointment scheduling, referral and follow up for all levels of care b. Organize and coordinate providers to define strategies to increase access too all levels and type of care
		2	Coordination	2	a. Create coordinated system that facilitates appointment scheduling, referral and follow up for all levels of care b. Improve disease management services c. Link consumers with medical homes d. Decrease wait time for primary care and specialty services e. Follow up with consumers with chronic health problems f. Minimize duplication of services g. Streamline intake and referral process to ensure continuum of care
		3	Increased Access	3	a. Increase proportion of people with health insurance b. Insurance model of working individuals without insurance c. Advocate for changes in eligibility requirements d. Increase capacity of traditional and non-traditional providers to screen for eligibility e. Innovative ways to cover remaining uninsured (medical homes and amnesty to ineligible immigrants) f. Strategies to increase prescription drugs to uninsured

Who	When	No.	What	No.	How
Miami Action Plan for Access to Healthcare					g. Include mental health/substance abuse services into insurance coverage (no disparity between mental and physical health coverage)
					h. Improve geographic access, extend hours of operation and improve transportation system to providers
					i. Increase emphasis on school based clinic services and include preventive, mental and oral health services
					j. Decreased wait time for appointments
					k. Community dialogue about the need to improve access to primary/preventive services including mental and oral health
					l. Public education campaign
					m. Raise awareness within health profession about the need to care for uninsured and underserved
					n. Increase understanding on how to navigate the healthcare system (disseminate tools and implement media campaign)
		4	Governance	4	o. Expand efforts to include non-traditional organizations p. Create a sustainable system
		5	Integration	5	Convene and empower an independent body to monitor and evaluate the health care system for the uninsured and underserved; to determine if access to healthcare is sufficient, effective, and efficient; to report results and recommendations to the County Commission, planning boards, health care providers and community; to implement necessary changes responsive to community needs
					a. Create and utilize community wide health and human services information and referral system
					b. Increase health education and promotion programs capacity to provide community resources links
					c. Create coordinated system that facilitates appointment scheduling, referral and follow up for all levels of care
					d. Develop healthcare system that coordinates behavioral, mental and oral health programs
					e. Expand efforts to include non-traditional organizations
					f. Increase the number of psychiatrists, psychologists, mental health professionals and dentist who accept the underserved
					g. Increase emphasis on school based clinic services and include preventive, mental and oral health services
					h. Build linkages between hospitals and primary, diagnostic, specialty care centers
		6	Accountability	6	a. Educate and improve understanding of when and how to utilize emergency, primary and urgent care services
					b. Independent body created to monitor and evaluate where county funds for health care are spent
		7	Workforce development	7	a. Train community based organizations to screen for eligibility
					b. Increase the number of cultural competency and customer service training
					c. Train nurses to screen children for eligibility for insurance programs
					d. Implement cultural competency training in medical, nursing and dental school
					e. Implement or expand cultural competence training in hospitals, primary care clinics and CBO's
					f. Increased all health care providers trained to use community wide information and referral system
					g. Improve CBO capacity to link consumers to resources
					h. Implement training CBO around general public health issues
					i. Train traditional and non-traditional provider organizations to better educate about public health issues
		8	Technology	8	a. Streamline screening process
					b. Develop a uniform screening toll
					c. Place enrollment workers closer to uninsured
					d. Decrease time for transferred medical records
					e. Create appointment scheduling, referral and follow up system for all levels of care
					f. Create mechanism to streamline access for providers and patients
					g. Expand shared information system
					h. Timely transfer of medical records/sharing of records
					i. On-line referral access/website data sharing
					j. Patient tracking
					k. Improve capacity of providers to link consumers to community resources

Who	When	No.	What	No.	How
Miami Dade County Access Task Force	2003	1	Coordination	1	Improve existing delivery system/resources; ER visits to be coordinated with community-wide services; Inventory workforce/service to the poor
		2	Collaboration	2	Coordinated coalition on health care; Outreach and education to maximize enrollment
		3	Integration	3	Increase integration between mental health and substance abuse with other health programs
		4	Increased Access	4	Exploring coverage alternatives; Expanding coverage for the working uninsured; Mental health services improvement
		5	Accountability	5	Implement a countywide, ongoing process of ongoing monitoring and evaluation to certify health service quality
		6	Governance	6	Governance, planning and organization; Adequate representation and balance is necessary on the Public Health Trust Board
		7	Technology	7	Student enrollment should be combined with screening for Medicaid eligibility and enrollment



Local Public Health System  
Performance Assessment

Report of Results

Miami Dade County Health Department -Local Public Health Assessment

6/12/2012



**Local Public Health System Performance Assessment - Report of Results**  
Miami Dade County Health Department -Local Public Health Assessment  
6/12/2012



## **Table of Contents**

### **A. The NPHPSP Report of Results**

- I. Introduction
- II. About the Report
- III. Tips for Interpreting and Using NPHPSP Assessment Results
- IV. Final Remarks

### **B. Performance Assessment Instrument Results**

- I. How well did the system perform the ten Essential Public Health Services (EPHS)?
- II. How well did the system perform on specific Model Standards?
- III. Overall, how well is the system achieving optimal activity levels?

### **Appendix**

Resources for Next Steps



# The National Public Health Performance Standards Program

## Local Public Health System Performance Assessment Report of Results

### A. The NPHPSP Report of Results

#### I. INTRODUCTION

The National Public Health Performance Standards Program (NPHPSP) assessments are intended to help users answer questions such as "What are the activities and capacities of our public health system?" and "How well are we providing the Essential Public Health Services in our jurisdiction?" The dialogue that occurs in answering these questions can help to identify strengths and weaknesses and determine opportunities for improvement.

The NPHPSP is a partnership effort to improve the practice of public health and the performance of public health systems. The NPHPSP assessment instruments guide state and local jurisdictions in evaluating their current performance against a set of optimal standards. Through these assessments, responding sites consider the activities of all public health system partners, thus addressing the activities of all public, private and voluntary entities that contribute to public health within the community.

Three assessment instruments have been designed to assist state and local partners in assessing and improving their public health systems or boards of health. These instruments are the:

- State Public Health System Performance Assessment Instrument,
- Local Public Health System Performance Assessment Instrument, and
- Local Public Health Governance Performance Assessment Instrument.

This report provides a summary of results from the NPHPSP Local Public Health System Assessment (OMB Control number 0920-0555, expiration date: August 31, 2013). The report, including the charts, graphs, and scores, are intended to help sites gain a good understanding of their performance and move on to the next step in strengthening their public system.

The NPHPSP is a collaborative effort of seven national partners:

- Centers for Disease Control and Prevention, Office of Chief of Public Health Practice (CDC/OCPHP)
- American Public Health Association (APHA)
- Association of State and Territorial Health Officials (ASTHO)
- National Association of County and City Health Officials (NACCHO)
- National Association of Local Boards of Health (NALBOH)
- National Network of Public Health Institutes (NNPHI)
- Public Health Foundation (PHF)

#### II. ABOUT THE REPORT

##### Calculating the scores

The NPHPSP assessment instruments are constructed using the Essential Public Health Services (EPHS) as a framework. Within the Local Instrument, each EPHS includes between 2-4 model standards that describe the key aspects of an optimally performing public health system. Each model standard is followed by assessment questions that serve as measures of performance. Each site's responses to these questions should indicate how well the model standard - which portrays the highest level of performance or "gold standard" - is being met.

Sites responded to assessment questions using the following response options below. These same categories are used in this report to characterize levels of activity for Essential Services and model standards.

NO ACTIVITY	0% or absolutely no activity.
MINIMAL ACTIVITY	Greater than zero, but no more than 25% of the activity described within the question is met.
MODERATE ACTIVITY	Greater than 25%, but no more than 50% of the activity described within the question is met.
SIGNIFICANT	Greater than 50%, but no more than 75% of the activity described

ACTIVITY	within the question is met.
OPTIMAL ACTIVITY	Greater than 75% of the activity described within the question is met.

Using the responses to all of the assessment questions, a scoring process generates scores for each first-tier or "stem" question, model standard, Essential Service, and one overall score. The scoring methodology is available from CDC or can be accessed on-line at <http://www.cdc.gov/nphpsp/conducting.html>.

### **Understanding data limitations**

Respondents to the self-assessment should understand what the performance scores represent and potential data limitations. All performance scores are a composite; stem question scores represent a composite of the stem question and subquestion responses; model standard scores are a composite of the question scores within that area, and so on. The responses to the questions within the assessment are based upon processes that utilize input from diverse system participants with different experiences and perspectives. The gathering of these inputs and the development of a response for each question incorporates an element of subjectivity, which can be minimized through the use of particular assessment methods. Additionally, while certain assessment methods are recommended, processes can differ among sites. The assessment methods are not fully standardized and these differences in administration of the self-assessment may introduce an element of measurement error. In addition, there are differences in knowledge about the public health system among assessment participants. This may lead to some interpretation differences and issues for some questions, potentially introducing a degree of random non-sampling error.

Because of the limitations noted, the results and recommendations associated with these reported data should be used for quality improvement purposes. More specifically, results should be utilized for guiding an overall public health infrastructure and performance improvement process for the public health system. These data represent the collective performance of all organizational participants in the assessment of the local public health system. The data and results should not be interpreted to reflect the capacity or performance of any single agency or organization.

### **Presentation of results**

The NPHPSP has attempted to present results - through a variety of figures and tables - in a user-friendly and clear manner. Results are presented in a Microsoft Word document, which allows users to easily copy and paste or edit the report for their own customized purposes. Original responses to all questions are also available.

For ease of use, many figures in tables use short titles to refer to Essential Services, model standards, and questions. If in doubt of the meaning, please refer to the full text in the assessment instruments.

Sites may choose to complete two optional questionnaires - one which asks about priority of each model standard and the second which assesses the local health department's contribution to achieving the model standard. Sites that submit responses for these questionnaires will see the results included as an additional component of their reports. Recipients of the priority results section may find that the scatter plot figures include data points that overlap. This is unavoidable when presenting results that represent similar data; in these cases, sites may find that the table listing of results will more clearly show the results found in each quadrant.

## **III. TIPS FOR INTERPRETING AND USING NPHPSP ASSESSMENT RESULTS**

The use of these results by respondents to strengthen the public health system is the most important part of the performance improvement process that the NPHPSP is intended to promote. Report data may be used to identify strengths and weaknesses within the local public health system and pinpoint areas of performance that need improvement. The NPHPSP User Guide describes steps for using these results to develop and implement public health system performance improvement plans. Implementation of these plans is critical to achieving a higher performing public health system. Suggested steps in developing such improvement plans are:

1. Organize Participation for Performance Improvement
2. Prioritize Areas for Action
3. Explore "Root Causes" of Performance Problems
4. Develop and Implement Improvement Plans
5. Regularly Monitor and Report Progress

Refer to the User Guide section, "After We Complete the Assessment, What Next?" for details on the above steps.

Assessment results represent the collective performance of all entities in the local public health system and not any one organization. Therefore, system partners should be involved in the discussion of results and improvement strategies to assure that this information is appropriately used. The assessment results can drive improvement

planning within each organization as well as system-wide. In addition, coordinated use of the Local Instrument with the Governance Instrument or state-wide use of the Local Instrument can lead to more successful and comprehensive improvement plans to address more systemic statewide issues.

Although respondents will ultimately want to review these results with stakeholders in the context of their overall performance improvement process, they may initially find it helpful to review the results either individually or in a small group. The following tips may be helpful when initially reviewing the results, or preparing to present the results to performance improvement stakeholders.

#### ***Examine performance scores***

First, sites should take a look at the overall or composite performance scores for Essential Services and model standards. These scores are presented visually in order by Essential Service (Figure 1) and in ascending order (Figure 2). Additionally, Figure 3 uses color designations to indicate performance level categories. Examination of these scores can immediately give a sense of the local public health system's greatest strengths and weaknesses.

#### ***Review the range of scores within each Essential Service and model standard***

The Essential Service score is an average of the model standard scores within that service, and, in turn, the model standard scores represent the average of stem question scores for that standard. If there is great range or difference in scores, focusing attention on the model standard(s) or questions with the lower scores will help to identify where performance inconsistency or weakness may be. Some figures, such as the bar charts in Figure 4, provide "range bars" which indicate the variation in scores. Looking for long range bars will help to easily identify these opportunities.

Also, refer back to the original question responses to determine where weaknesses or inconsistencies in performance may be occurring. By examining the assessment questions, including the subquestions and discussion toolbox items, participants will be reminded of particular areas of concern that may most need attention.

#### ***Consider the context***

The NPHPSP User Guide and other technical assistance resources strongly encourage responding jurisdictions to gather and record qualitative input from participants throughout the assessment process. Such information can include insights that shaped group responses, gaps that were uncovered, solutions to identified problems, and impressions or early ideas for improving system performance. This information should have emerged from the general discussion of the model standards and assessment questions, as well as the responses to discussion toolbox topics.

The results viewed in this report should be considered within the context of this qualitative information, as well as with other information. The assessment report, by itself, is not intended to be the sole "roadmap" to answer the question of what a local public health system's performance improvement priorities should be. The original purpose of the assessment, current issues being addressed by the community, and the needs and interests for all stakeholders should be considered.

Some sites have used a process such as Mobilizing for Action through Planning and Partnerships (MAPP) to address their NPHPSP data within the context of other community issues. In the MAPP process, local users consider the NPHPSP results in addition to three other assessments - community health status, community themes and strengths, and forces of change - before determining strategic issues, setting priorities, and developing action plans. See "Resources for Next Steps" for more about MAPP.

#### ***Use the optional priority rating and agency contribution questionnaire results***

Sites may choose to complete two optional questionnaires - one which asks about priority of each model standard and the second which assesses the local health department's contribution to achieving of the model standard. The supplemental priority questionnaire, which asks about the priority of each model standard to the public health system, should guide sites in considering their performance scores in relationship to their own system's priorities. The use of this questionnaire can guide sites in targeting their limited attention and resources to areas of high priority but low performance. This information should serve to catalyze or strengthen the performance improvement activities resulting from the assessment process.

The second questionnaire, which asks about the contribution of the public health agency to each model standard, can assist sites in considering the role of the agency in performance improvement efforts. Sites that use this component will see a list of questions to consider regarding the agency role and as it relates to the results for each model standard. These results may assist the local health department in its own strategic planning and quality improvement activities.

#### **IV. FINAL REMARKS**

The challenge of preventing illness and improving health is ongoing and complex. The ability to meet this challenge rests on the capacity and performance of public health systems. Through well equipped, high-performing public health systems, this challenge can be addressed. Public health performance standards are intended to guide the development of stronger public health systems capable of improving the health of populations. The development of high-performing public health systems will increase the likelihood that all citizens have access to a defined optimal level of public health services. Through periodic assessment guided by model performance standards, public health leaders can improve collaboration and integration among the many components of a public health system, and more effectively and efficiently use resources while improving health intervention services.



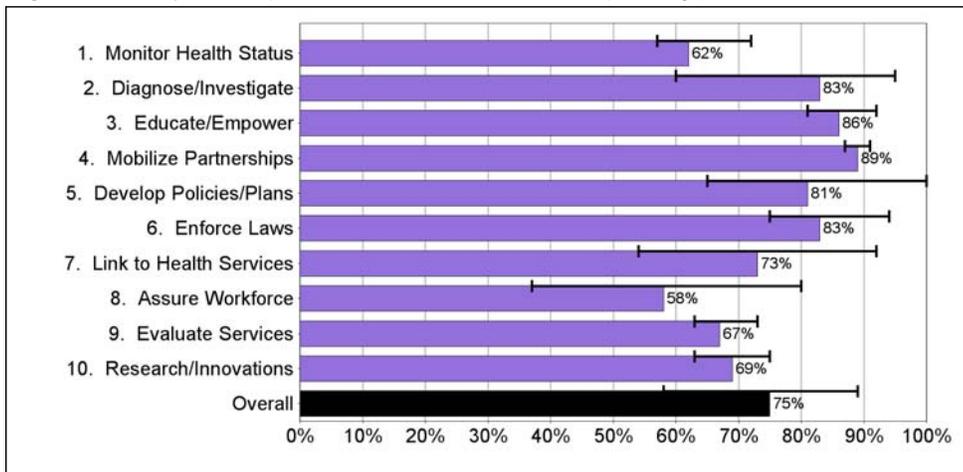
**B. Performance Assessment Instrument Results**

**I. How well did the system perform the ten Essential Public Health Services (EPHS)?**

**Table 1:** Summary of performance scores by Essential Public Health Service (EPHS)

EPHS	Score
1 Monitor Health Status To Identify Community Health Problems	62
2 Diagnose And Investigate Health Problems and Health Hazards	83
3 Inform, Educate, And Empower People about Health Issues	86
4 Mobilize Community Partnerships to Identify and Solve Health Problems	89
5 Develop Policies and Plans that Support Individual and Community Health Efforts	81
6 Enforce Laws and Regulations that Protect Health and Ensure Safety	83
7 Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	73
8 Assure a Competent Public and Personal Health Care Workforce	58
9 Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	67
10 Research for New Insights and Innovative Solutions to Health Problems	69
Overall Performance Score	75

**Figure 1:** Summary of EPHS performance scores and overall score (with range)



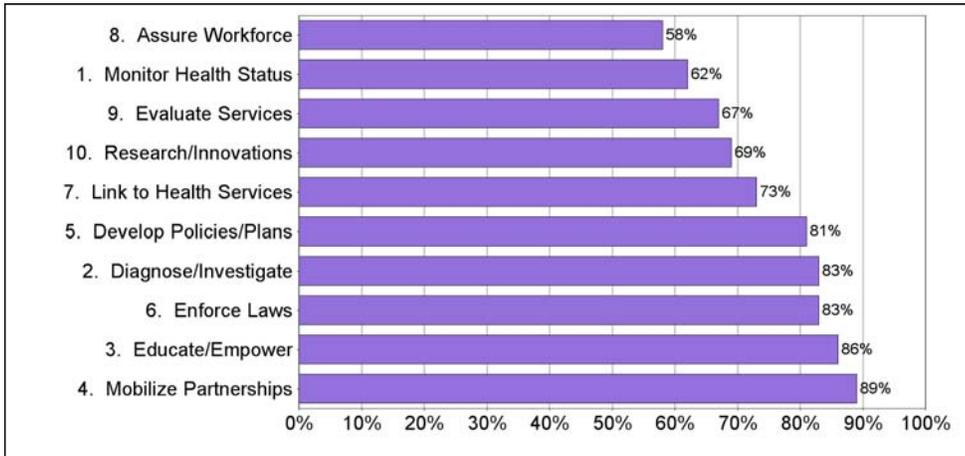
**Table 1** (above) provides a quick overview of the system's performance in each of the 10 Essential Public Health Services (EPHS). Each EPHS score is a composite value determined by the scores given to those activities that contribute to each Essential Service. These scores range from a minimum value of 0% (no activity is performed pursuant to the standards) to a maximum of 100% (all activities associated with the standards are performed at optimal levels).

**Figure 1** (above) displays performance scores for each Essential Service along with an overall score that indicates the average performance level across all 10 Essential Services. The range bars show the minimum and maximum values of responses within the Essential Service and an overall score. Areas of wide range may warrant a closer look in **Figure 4** or the raw data.

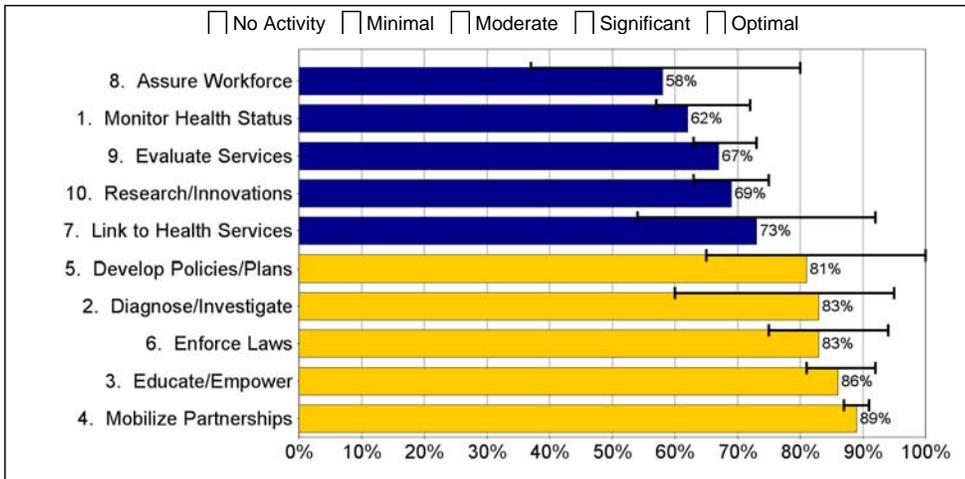
**Local Public Health System Performance Assessment - Report of Results**  
 Miami Dade County Health Department -Local Public Health Assessment  
 6/12/2012



**Figure 2:** Rank ordered performance scores for each Essential Service



**Figure 3:** Rank ordered performance scores for each Essential Service, by level of activity



**Figure 2** (above) displays each composite score from low to high, allowing easy identification of service domains where performance is relatively strong or weak.

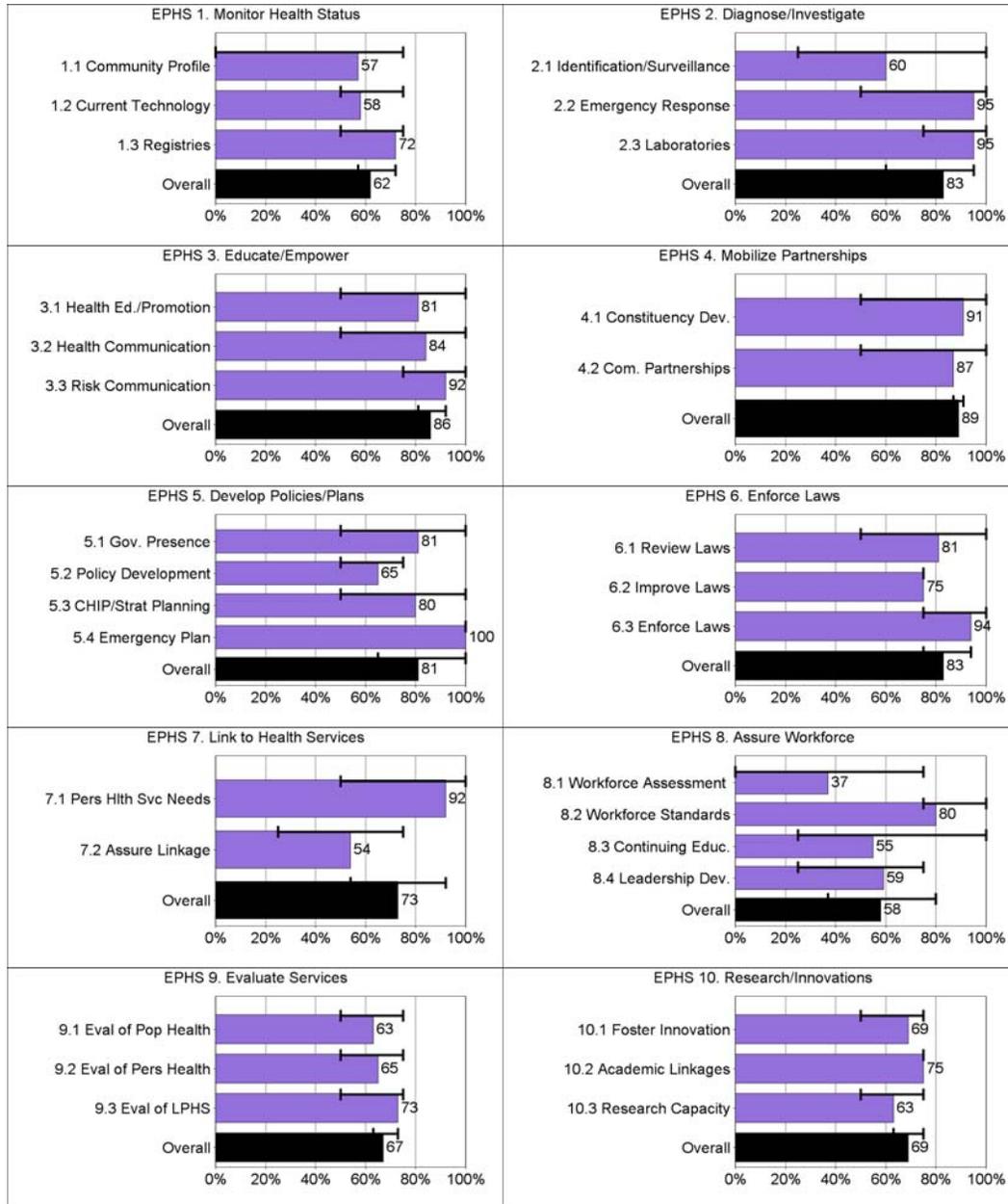
**Figure 3** (above) provides a composite picture of the previous two graphs. The range lines show the range of responses within an Essential Service. The color coded bars make it easier to identify which of the Essential Services fall in the five categories of performance activity.

**Figure 4** (next page) shows scores for each model standard. Sites can use these graphs to pinpoint specific activities within the Essential Service that may need a closer look. Note these scores also have range bars, showing sub-areas that comprise the model standard.



II. How well did the system perform on specific model standards?

Figure 4: Performance scores for each model standard, by Essential Service



**Local Public Health System Performance Assessment - Report of Results**  
 Miami Dade County Health Department -Local Public Health Assessment  
 6/12/2012



**Table 2:** Summary of performance scores by Essential Public Health Service (EPHS) and model standard

Essential Public Health Service	Score
EPHS 1. Monitor Health Status To Identify Community Health Problems	62
1.1 Population-Based Community Health Profile (CHP)	57
1.1.1 Community health assessment	69
1.1.2 Community health profile (CHP)	63
1.1.3 Community-wide use of community health assessment or CHP data	38
1.2 Access to and Utilization of Current Technology to Manage, Display, Analyze and Communicate Population Health Data	58
1.2.1 State-of-the-art technology to support health profile databases	75
1.2.2 Access to geocoded health data	50
1.2.3 Use of computer-generated graphics	50
1.3 Maintenance of Population Health Registries	72
1.3.1 Maintenance of and/or contribution to population health registries	69
1.3.2 Use of information from population health registries	75
EPHS 2. Diagnose And Investigate Health Problems and Health Hazards	83
2.1 Identification and Surveillance of Health Threats	60
2.1.1 Surveillance system(s) to monitor health problems and identify health threats	92
2.1.2 Submission of reportable disease information in a timely manner	50
2.1.3 Resources to support surveillance and investigation activities	38
2.2 Investigation and Response to Public Health Threats and Emergencies	95
2.2.1 Written protocols for case finding, contact tracing, source identification, and containment	100
2.2.2 Current epidemiological case investigation protocols	100
2.2.3 Designated Emergency Response Coordinator	100
2.2.4 Rapid response of personnel in emergency / disasters	88
2.2.5 Evaluation of public health emergency response	88
2.3 Laboratory Support for Investigation of Health Threats	95
2.3.1 Ready access to laboratories for routine diagnostic and surveillance needs	100
2.3.2 Ready access to laboratories for public health threats, hazards, and emergencies	81
2.3.3 Licenses and/or credentialed laboratories	100
2.3.4 Maintenance of guidelines or protocols for handling laboratory samples	100
EPHS 3. Inform, Educate, And Empower People about Health Issues	86
3.1 Health Education and Promotion	81
3.1.1 Provision of community health information	94
3.1.2 Health education and/or health promotion campaigns	75
3.1.3 Collaboration on health communication plans	75
3.2 Health Communication	84
3.2.1 Development of health communication plans	65
3.2.2 Relationships with media	88
3.2.3 Designation of public information officers	100
3.3 Risk Communication	92
3.3.1 Emergency communications plan(s)	100
3.3.2 Resources for rapid communications response	100
3.3.3 Crisis and emergency communications training	75
3.3.4 Policies and procedures for public information officer response	94

**Local Public Health System Performance Assessment - Report of Results**  
 Miami Dade County Health Department -Local Public Health Assessment  
 6/12/2012



Essential Public Health Service	Score
EPHS 4. Mobilize Community Partnerships to Identify and Solve Health Problems	89
4.1 Constituency Development	91
4.1.1 Identification of key constituents or stakeholders	100
4.1.2 Participation of constituents in improving community health	100
4.1.3 Directory of organizations that comprise the LPHS	63
4.1.4 Communications strategies to build awareness of public health	100
4.2 Community Partnerships	87
4.2.1 Partnerships for public health improvement activities	90
4.2.2 Community health improvement committee	95
4.2.3 Review of community partnerships and strategic alliances	78
EPHS 5. Develop Policies and Plans that Support Individual and Community Health Efforts	81
5.1 Government Presence at the Local Level	81
5.1.1 Governmental local public health presence	100
5.1.2 Resources for the local health department	93
5.1.3 Local board of health or other governing entity (not scored)	0
5.1.4 LHD work with the state public health agency and other state partners	50
5.2 Public Health Policy Development	65
5.2.1 Contribution to development of public health policies	71
5.2.2 Alert policymakers/public of public health impacts from policies	50
5.2.3 Review of public health policies	75
5.3 Community Health Improvement Process	80
5.3.1 Community health improvement process	76
5.3.2 Strategies to address community health objectives	88
5.3.3 Local health department (LHD) strategic planning process	75
5.4 Plan for Public Health Emergencies	100
5.4.1 Community task force or coalition for emergency preparedness and response plans	100
5.4.2 All-hazards emergency preparedness and response plan	100
5.4.3 Review and revision of the all-hazards plan	100
EPHS 6. Enforce Laws and Regulations that Protect Health and Ensure Safety	83
6.1 Review and Evaluate Laws, Regulations, and Ordinances	81
6.1.1 Identification of public health issues to be addressed through laws, regulations, and ordinances	75
6.1.2 Knowledge of laws, regulations, and ordinances	75
6.1.3 Review of laws, regulations, and ordinances	75
6.1.4 Access to legal counsel	100
6.2 Involvement in the Improvement of Laws, Regulations, and Ordinances	75
6.2.1 Identification of public health issues not addressed through existing laws	75
6.2.2 Development or modification of laws for public health issues	75
6.2.3 Technical assistance for drafting proposed legislation, regulations, or ordinances	75
6.3 Enforce Laws, Regulations and Ordinances	94
6.3.1 Authority to enforce laws, regulation, ordinances	94
6.3.2 Public health emergency powers	100
6.3.3 Enforcement in accordance with applicable laws, regulations, and ordinances	100
6.3.4 Provision of information about compliance	88
6.3.5 Assessment of compliance	88

**Local Public Health System Performance Assessment - Report of Results**  
 Miami Dade County Health Department -Local Public Health Assessment  
 6/12/2012



Essential Public Health Service	Score
EPHS 7. Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	73
7.1 Identification of Populations with Barriers to Personal Health Services	92
7.1.1 Identification of populations who experience barriers to care	100
7.1.2 Identification of personal health service needs of populations	100
7.1.3 Assessment of personal health services available to populations who experience barriers to care	75
7.2 Assuring the Linkage of People to Personal Health Services	54
7.2.1 Link populations to needed personal health services	50
7.2.2 Assistance to vulnerable populations in accessing needed health services	58
7.2.3 Initiatives for enrolling eligible individuals in public benefit programs	75
7.2.4 Coordination of personal health and social services	31
EPHS 8. Assure a Competent Public and Personal Health Care Workforce	58
8.1 Workforce Assessment Planning, and Development	37
8.1.1 Assessment of the LPHS workforce	50
8.1.2 Identification of shortfalls and/or gaps within the LPHS workforce	48
8.1.3 Dissemination of results of the workforce assessment / gap analysis	13
8.2 Public Health Workforce Standards	80
8.2.1 Awareness of guidelines and/or licensure/certification requirements	88
8.2.2 Written job standards and/or position descriptions	75
8.2.3 Annual performance evaluations	75
8.2.4 LHD written job standards and/or position descriptions	88
8.2.5 LHD performance evaluations	75
8.3 Life-Long Learning Through Continuing Education, Training, and Mentoring	55
8.3.1 Identification of education and training needs for workforce development	58
8.3.2 Opportunities for developing core public health competencies	63
8.3.3 Educational and training incentives	25
8.3.4 Interaction between personnel from LPHS and academic organizations	75
8.4 Public Health Leadership Development	59
8.4.1 Development of leadership skills	47
8.4.2 Collaborative leadership	50
8.4.3 Leadership opportunities for individuals and/or organizations	75
8.4.4 Recruitment and retention of new and diverse leaders	63

**Local Public Health System Performance Assessment - Report of Results**  
 Miami Dade County Health Department -Local Public Health Assessment  
 6/12/2012

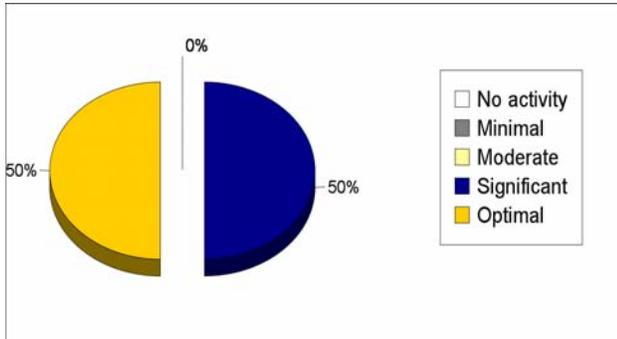


Essential Public Health Service	Score
EPHS 9. Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	67
9.1 Evaluation of Population-based Health Services	63
9.1.1 Evaluation of population-based health services	75
9.1.2 Assessment of community satisfaction with population-based health services	53
9.1.3 Identification of gaps in the provision of population-based health services	75
9.1.4 Use of population-based health services evaluation	50
9.2 Evaluation of Personal Health Care Services	65
9.2.1. In Personal health services evaluation	75
9.2.2 Evaluation of personal health services against established standards	75
9.2.3 Assessment of client satisfaction with personal health services	63
9.2.4 Information technology to assure quality of personal health services	63
9.2.5 Use of personal health services evaluation	50
9.3 Evaluation of the Local Public Health System	73
9.3.1 Identification of community organizations or entities that contribute to the EPHS	75
9.3.2 Periodic evaluation of LPHS	71
9.3.3 Evaluation of partnership within the LPHS	75
9.3.4 Use of LPHS evaluation to guide community health improvements	72
EPHS 10. Research for New Insights and Innovative Solutions to Health Problems	69
10.1 Fostering Innovation	69
10.1.1 Encouragement of new solutions to health problems	50
10.1.2 Proposal of public health issues for inclusion in research agenda	75
10.1.3 Identification and monitoring of best practices	75
10.1.4 Encouragement of community participation in research	75
10.2 Linkage with Institutions of Higher Learning and/or Research	75
10.2.1 Relationships with institutions of higher learning and/or research organizations	75
10.2.2 Partnerships to conduct research	75
10.2.3 Collaboration between the academic and practice communities	75
10.3 Capacity to Initiate or Participate in Research	63
10.3.1 Access to researchers	75
10.3.2 Access to resources to facilitate research	75
10.3.3 Dissemination of research findings	50
10.3.4 Evaluation of research activities	50



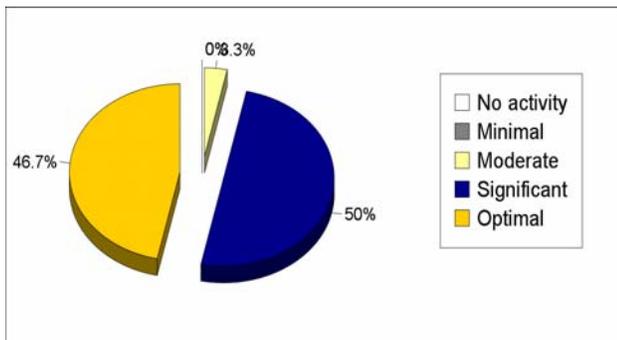
**III. Overall, how well is the system achieving optimal activity levels?**

**Figure 5:** Percentage of Essential Services scored in each level of activity



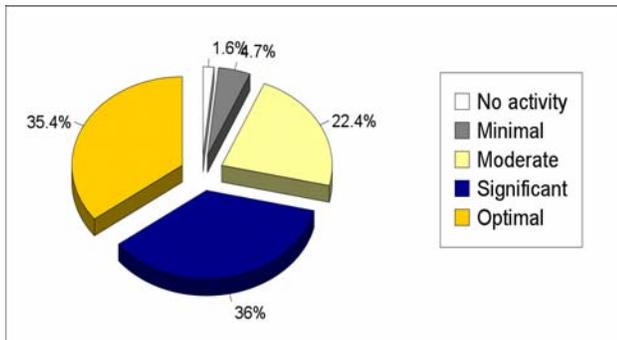
**Figure 5** displays the percentage of the system's Essential Services scores that fall within the five activity categories. This chart provides the site with a high level snapshot of the information found in **Figure 3**.

**Figure 6:** Percentage of model standards scored in each level of activity



**Figure 6** displays the percentage of the system's model standard scores that fall within the five activity categories.

**Figure 7:** Percentage of all questions scored in each level of activity



**Figure 7** displays the percentage of all scored questions that fall within the five activity categories. This breakdown provides a closer snapshot of the system's performance, showing variation that may be masked by the scores in **Figures 5** and **6**.



### **APPENDIX: RESOURCES FOR NEXT STEPS**

The NPHPSP offers a variety of information, technical assistance, and training resources to assist in quality improvement activities. Descriptions of these resources are provided below. Other resources and websites that may be of particular interest to NPHPSP users are also noted below.

- **Technical Assistance and Consultation** - NPHPSP partners are available for phone and email consultation to state and localities as they plan for and conduct NPHPSP assessment and performance improvement activities. Contact 1-800-747-7649 or [phpsp@cdc.gov](mailto:phpsp@cdc.gov).
- **NPHPSP User Guide** - The NPHPSP User Guide section, "After We Complete the Assessment, What Next?" describes five essential steps in a performance improvement process following the use of the NPHPSP assessment instruments. The NPHPSP User Guide may be found on the NPHPSP website (<http://www.cdc.gov/NPHPSP/PDF/UserGuide.pdf>).
- **NPHPSP Online Tool Kit** - Additional resources that may be found on, or are linked to, the NPHPSP website (<http://www.cdc.gov/NPHPSP/generalResources.html>) under the "Post Assessment/ Performance Improvement" link include sample performance improvement plans, quality improvement and priority-setting tools, and other technical assistance documents and links.
- **NPHPSP Online Resource Center** - Designed specifically for NPHPSP users, the Public Health Foundation's online resource center ([www.phf.org/nphpsp](http://www.phf.org/nphpsp)) for public health systems performance improvement allows users to search for State, Local, and Governance resources by model standards, essential public health service, and keyword.;
- **NPHPSP Monthly User Calls** - These calls feature speakers and dialogue on topic of interest to users. They also provide an opportunity for people from around the country to learn from each other about various approaches to the NPHPSP assessment and performance improvement process. Calls occur on the third Tuesday of each month, 2:00 - 3:00 ET. Contact [phpsp@cdc.gov](mailto:phpsp@cdc.gov) to be added to the email notification list for the call.
- **Annual Training Workshop** - Individuals responsible for coordinating performance assessment and improvement activities may attend an annual two-day workshop held in the spring of each year. Visit the NPHPSP website (<http://www.cdc.gov/nphpsp/annualTrainingWorkshop.html>) for more information.
- **Public Health Improvement Resource Center at the Public Health Foundation** - This website ([www.phf.org/improvement](http://www.phf.org/improvement)) provides resources and tools for evaluating and building the capacity of public health systems. More than 100 accessible resources organized here support the initiation and continuation of quality improvement efforts. These resources promote performance management and quality improvement, community health information and data systems, accreditation preparation, and workforce development.
- **Mobilizing for Action through Planning and Partnerships (MAPP)** - MAPP has proven to be a particularly helpful tool for sites engaged in community-based health improvement planning. Systems that have just completed the NPHPSP may consider using the MAPP process as a way to launch their performance improvement efforts. Go to [www.naccho.org/topics/infrastructure/MAPP](http://www.naccho.org/topics/infrastructure/MAPP) to link directly to the MAPP website.

Miami-Dade County Health Department  
**Mobilizing for Action through Planning and Partnerships (MAPP)**

**Visioning and  
Community Themes and Strengths Assessment Results**

Prepared by the Health Council of South Florida  
December 2012

**BACKGROUND: VISIONING AND COMMUNITY THEMES AND STRENGTHS ASSESSMENT**

The Miami-Dade County Health Department and the Health Council of South Florida facilitated a Vision and Community Themes and Strengths Assessment on **October 5<sup>th</sup>, 2012** with MAPP stakeholders invited from the community. The following themes arose:

1. High risk behavior
2. Increased coordination between agencies and across sectors
3. Maximizing resources; i.e., making best use of limited in resources
4. Promoting individual and organizational stewardship and accountability
5. Affordable Care Act and the undocumented population/understanding Medicaid
6. Health Disparities, incl. inequity based on income and race in current built environment
7. Gainful Employment
8. Obesity
9. Work force/Service Learning
10. Awareness of resources

A summary of the visioning and themes assessment is provided below.

**VISIONING**

Participants were split into three groups and asked to answer the following questions:

1. What does a healthy Miami-Dade County mean to you?
2. How do you envision the Miami-Dade County community in 10-15 years?
3. What are important characteristics of a healthy community for all who live, work, and play here?

The session included a hands-on activity in which each group was asked to illustrate their vision for an ideal community of the future. Participants envisioned Miami-Dade County in 10-15 years as a community with adequate access to primary care that is affordable, wherein ER visits for treatable conditions are reduced. The vision put forth by the participants included healthy living throughout the lifespan (e.g., breastfeeding, access to healthy foods, primary care, wellness programs) and engaging the community at every level. Participants indicated this envisioned community would possess environmental assets that motivate residents to make healthy choices. Sound planning for the modification of the existing infrastructure was a stated necessity.

Key vision words highlighted by the group were:

Life cycle/Span	Continuity	Coordination/Collaboration
Access (to Health Resources)	Prevention	Wellness
Outreach	Promotion	Connectivity (location and transportation)
Education	Medical Home	Social responsibility
Literacy	Design/re-Design	Nutrition/ Affordable Food
Cultural norms	Participation	Continuity of care
Empowerment	Partnerships	Choice
Safety and Prevention	Equity	Physical Activity

### Picturing and Envisioning an Ideal Community

The themes for the groups were similar focusing on the “journey of life” from birth to death and the assets required to maintain a healthy community with intergenerational, quality, comprehensive care. A wellness model for delivering healthcare would be followed; not a disease model. Thus, participants drew paths with themes along the way, such as a mother and her baby; families; a playground, church/temple; trees and homes; someone on a bicycle; a fresh market, which addresses the nutrition component; a wellness center; hospitals and clinics. One group connected to a clinic/urgent care or a wellness center (ER → urgent care facility) with the hospital portrayed as the last resort, as the place where one is born (the beginning), and arrows protruding from it leading to different centers. Participants also portrayed the importance of financial stability; this aspect is crucial, according to participants, to the reduction of stressors; as well as collaboration (people in the community being involved) and social interaction, which is portrayed by people sitting together at a table, conversing. Location of every item in the drawing was crucial, emphasizing the need for an efficient transportation system, according to participants.



Figure 1: Group 1



Figure 2: Group 2



Figure 3: Group 3

Throughout the discussion, participants emphasized the importance of health education, in conjunction with widely accessible health resources and health information, as crucial components enabling community members to make healthy choices. According to participants, health education should start as early as in Kindergarten, so that children would understand the importance of eating fruits and vegetables and daily physical activity. Participants added that health education would allow the mental and physical dimensions of health to be met. They also emphasized the need for health organizations to implement employee health and wellness programs. For example, many health employees exhibit the same chronic health conditions as the rest of the community; therefore, the self-management component needs to be addressed in the aforementioned wellness programs for health sector employees and the community in general. In addition, participants discussed the importance of equal access to health resources; as well as the availability of health information that is comprehensive and culturally-sensitive. This would allow the public to be informed about where to access pertinent health resources.

Health education would allow not only the mental and physical dimensions of health to be addressed but also the spiritual (i.e. the three elements that encompass the ten dimensions of health). By educating faith-based professionals on what it means to be healthy, they may share information with their congregations. Participants believe that those who are hurting, whether physically or mentally, seek out their respective churches or temples; thus, health professionals must involve faith-based professionals. In general, participants propose a holistic approach to healthy living.

#### COMMUNITY THEMES AND STRENGTHS

Participants were informed that the information gathered during this phase will feed into the Identify Strategic Issues Phase of the MAPP process (the other three assessments will also provide important sources of information). This assessment provides a deep understanding of the issues that the community feels are important by answering the following questions: "What is important to our community?" "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?" Participants were guided on the tenants of an asset-based versus a needs-based discussion (proactive vs. reactive).

Needs Based	Asset Based
Focus on deficits	Focus on assets
Problem response	Opportunity identification
Charity orientation	Investment orientation
Programs are the answer	People are the answer
More services	Less services
Grants to agencies	Grants, loans, contracts, investment, leverage dollars
High emphasis on government agencies	Emphasis on associations, business, agencies, churches, etc.
Focus on individual	Focus on community or neighborhood
See people as "clients"	See people as "citizens"
	Develop potential
<i>Source: United Way of Metro Atlanta in MAPP Sourcebook</i>	

Participants highlighted the following key issues and strengths

Community Needs/Issues	Community Strengths or Solutions	Challenges
<b>1. High risk behavior</b>	<ul style="list-style-type: none"> <li>• Increased capacity for cross-sector community-based prevention work (CPPW, CTG, Health Foundation funded initiatives)</li> </ul>	<ul style="list-style-type: none"> <li>• Balance between preserving autonomy and responsibility;</li> <li>• Identifying cause and effect</li> </ul>
<b>2. Increased coordination between agencies and across sectors</b>	<ul style="list-style-type: none"> <li>• Collaboration</li> <li>• Media</li> <li>• Established partnerships</li> <li>• Existing coalitions (Consortium for a Healthier Miami-Dade, Miami-Dade Health Action Network, Florida Association of Free Clinics)</li> </ul>	<ul style="list-style-type: none"> <li>• Egos</li> <li>• Competition</li> <li>• Duplication</li> <li>• Funds</li> </ul>
<b>3. Maximizing resources i.e. making best use of limited in resources</b>	<ul style="list-style-type: none"> <li>• Community programs</li> </ul>	<ul style="list-style-type: none"> <li>• Outreach and Education</li> </ul>
<b>4. Promoting individual and organizational stewardship and accountability</b>	<ul style="list-style-type: none"> <li>• Extensive health promotion capacity (Consortium, community based organizations)</li> </ul>	<ul style="list-style-type: none"> <li>• Holding people/health organizations accountable for the resources they are receiving</li> </ul>
<b>5. Affordable Care Act impact on the undocumented population/ understanding Medicaid</b>	<ul style="list-style-type: none"> <li>• Florida Association of Free Clinics</li> <li>• Volunteers/sovereign immunity</li> <li>• Empathy and organized supports</li> <li>• Health Advocacy</li> <li>• Individual and political advocacy to navigate through needed resources</li> <li>• Community Health Workers/Patient Navigators (more training needed on health disparities, affordable care act, accessing benefits)</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of funding</li> </ul>
<b>6. Health Disparities including inequity based on income and race in current built environment</b>	<ul style="list-style-type: none"> <li>• Funding opportunities</li> <li>• Recognition of the issue</li> <li>• Foundation for organizing structure in place</li> <li>• Knowledge</li> <li>• Media outreach</li> <li>• Academic health centers</li> <li>• Funding, i.e. diabetes programs</li> <li>• Trust of faith-based organizations</li> <li>• Switchboard Miami referrals</li> </ul>	<ul style="list-style-type: none"> <li>• Gaps between the “haves” and “have nots”</li> <li>• Lack of empathy and understanding</li> <li>• Changing the built environment</li> <li>• Cultural differences</li> <li>• Lack of trust</li> <li>• Positive behavior changes Linguistic/education</li> </ul>
<b>7. Gainful Employment</b>	<ul style="list-style-type: none"> <li>• Large and qualified workforce</li> <li>• Workforce programs</li> <li>• Good educational system</li> <li>• Reserved programs</li> </ul>	<ul style="list-style-type: none"> <li>• Hiring bias against unemployed</li> <li>• Age discrimination</li> <li>• Not enough program to retrain workforce</li> </ul>

Community Needs/Issues	Community Strengths or Solutions	Challenges
<b>8. Obesity</b>	<ul style="list-style-type: none"> <li>• Prevention programs</li> <li>• Media campaign</li> <li>• Agriculture</li> <li>• Strong community leaders</li> <li>• Funding</li> </ul>	<ul style="list-style-type: none"> <li>• Built environments</li> <li>• Cultural issues</li> <li>• Economic</li> <li>• Perception</li> <li>• Knowledge transfer</li> <li>• Diabetes epidemic</li> <li>• Comfort food</li> </ul>
<b>9. Work force/Service Learning</b>	<ul style="list-style-type: none"> <li>• Higher education</li> </ul>	
<b>10. Awareness of resources</b>	<ul style="list-style-type: none"> <li>• Switchboard Miami; 311; Alliance of Aging Elder Health Line; and ECHPP, which has centralized the information that would benefit those afflicted with HIV/AIDS</li> <li>• Partnerships with medical schools in the community</li> <li>• Yearly conferences where health professionals share the types of projects they are involved in, leading to collaboration; and types of data available</li> <li>• The Florida Health Data Warehouse</li> </ul>	<ul style="list-style-type: none"> <li>• The absence of a centralized system</li> </ul>

# FORCES OF CHANGE ASSESSMENT RESULTS

## Miami-Dade County Health Department Mobilizing for Action through Planning and Partnerships (MAPP) Forces of Change Assessment Results

Prepared by the Health Council of South Florida  
December 2012

### BACKGROUND: FORCES OF CHANGE ASSESSMENT

The HCSF is implementing the Mobilizing Action through Planning and Partnerships (MAPP) process on behalf of the MDCHD as the five-year follow-up to the 2007-2008 MAPP process, which resulted in the Miami-Dade Disparities Report and Action Plan. Two of the four assessments, the Local Public Health System Assessment and the Community Themes and Strengths Assessments have been completed. On **November 14<sup>th</sup>, 2012**, MAPP Stakeholders came together to complete the Forces of Change Assessment. Karen Weller of the Miami-Dade County Health Department introduced the session and the role of the MAPP Process in supporting the MDCHD's Community Health Improvement Planning Process. Shelley-Anne Glasgow-Wilson, from the Health Council of South Florida, described the purpose and format of the Forces of Change Assessment in identifying the key factors that are impacting or will impact community health planning in the coming years.

The intended result of the Forces of Change Assessment is a comprehensive, but focused, list that identifies key influences and describes their impact. It answers the questions:

1. "What is occurring or might occur that affects the health of our community or the local public health system?"
2. "What specific threats or opportunities are generated by these occurrences?"

Identifying and addressing forces of change is a form of environmental scanning. It ensures that the MAPP process: is relevant and timely, builds upon opportunities, and responds to potential threats. The identification of forces illuminates some of the "givens" under which the public health system operates or will need to operate. If these forces are not fully considered, the strategies developed later in the MAPP process may be less effective.

Forces are a broad all-encompassing category that includes trends, events, and factors defined as:

- Trends are patterns over time, such as migration in and out of a community or a growing disillusionment with government.
- Factors are discrete elements, such as a community's large ethnic population, an urban setting, or the jurisdiction's proximity to a major waterway.
- Events are one-time occurrences, such as a hospital closure, a natural disaster, or the passage of new legislation.

Participants identified a variety of trends, factors, and events that shape the public health landscape in Miami-Dade County. Using this framework, and guided small group discussions facilitated by the Health Council team, MAPP Stakeholders identified Forces of Change, Opportunities, and Threats to improving community health in the county.

# FORCES OF CHANGE ASSESSMENT RESULTS

## Results

Four key forces were identified by the breakout groups:

- ◆ **Affordable Care Act:** changes to Medicaid and Medicare, private insurance market and managed care privatization
- ◆ **Shifting Demographics:** aging population and workforce, immigration and birth trends
- ◆ **Social Inequities:** evolving ethnic make-up of the community, underrepresented communities, the cost of care for un- and underinsured, and environmental justice issues
- ◆ **Technological Advances:** relating to Electronic Health/Medical Records, the role of social media and technology in data collection

Specific topics identified are shown in Table 1.

<b>Table 1: Force of Change Results</b>		
<b>Forces of Change (Trends, Factors, Events)</b>	<b>Opportunities (Prospects, Responses)</b>	<b>Threats (Barriers, Challenges)</b>
<p><b>The Patient Protection and Affordable Care Act (ACA)</b></p> <ul style="list-style-type: none"> <li>• i.e. Healthcare Reform: Medicaid, Medicare, private insurance, managed care privatization</li> </ul>	<ul style="list-style-type: none"> <li>• “The angel is in the details” of ACA: education and awareness on what it means to communities</li> <li>• Focus of preventative care and health across the life span with holistic, integrated and coordinated care and follow-up.</li> <li>• Increase access to coverage</li> <li>• Access to care despite pre-existing conditions</li> <li>• Improve health outcomes</li> <li>• Increase job opportunities</li> <li>• Innovation and economic growth associated with ACA</li> <li>• Education for professional shortage areas</li> <li>• Loan forgiveness</li> <li>• Funding for community-based initiatives</li> <li>• Fosters partnership and collaboration</li> </ul>	<ul style="list-style-type: none"> <li>• “The Devil is in the details;” misinformation</li> <li>• Uncertainty with Medicaid e.g .small businesses are not expanding due to the unknown</li> <li>• Changes in state program that may cause higher costs or reduced services</li> <li>• Political resistance at state level to federal funding and other political challenges faced within the state</li> <li>• Financial impact on business</li> <li>• Consolidation threatens local control / autonomy</li> </ul>

## FORCES OF CHANGE ASSESSMENT RESULTS

<b>Table 1: Force of Change Results</b>		
<b>Forces of Change</b> (Trends, Factors, Events)	<b>Opportunities</b> (Prospects, Responses)	<b>Threats</b> (Barriers, Challenges)
<p><b>Shifting Demographics:</b></p> <ul style="list-style-type: none"> <li>i.e. Increased Hispanic population, Aging Population (baby boomers), Birth Trends, an aging workforce</li> </ul>	<ul style="list-style-type: none"> <li>Recognition of needs</li> <li>Increase education and create targeted messages for different demographics</li> <li>Increase partnerships</li> <li>Grow the medical and public health workforce, using expertise of qualified immigrant population</li> <li>Increased jobs associated with care for the elderly</li> <li>Miami-Dade can be a model for caring for the undocumented and older adults</li> </ul>	<ul style="list-style-type: none"> <li>Increased cost of living associated with aging population</li> <li>Loss of expertise as seniors retire</li> <li>Chronic disease prevalent in older residents</li> <li>Health disparities faced in certain ethnic populations</li> <li>Younger people not seeking preventive care</li> <li>Lack of Primary Care across the lifespan</li> <li>Increased ER use</li> <li>Societal ageism</li> <li>Lack of infrastructure to accommodate growing populations</li> <li>Quality to meet demand for services</li> <li>Funding for higher quality services</li> <li>Shortage of prepared medical and public health workforce</li> <li>Cultural competency</li> <li>Misinformation</li> <li>Generation gap/trust</li> <li>Depletion of the system</li> </ul>
<p><b>Social Inequities:</b></p> <p>i.e. changes in ethnic make-up of the community, underrepresented communities, the cost of care to the un- and underinsured and issues of environmental justice</p>	<ul style="list-style-type: none"> <li>Support medically underserved</li> <li>Funding for health disparities</li> <li>Increase collaboration across sectors</li> <li>Increase education with regards to environmental influences on health</li> <li>Increase the number of agencies focusing on environmental conditions</li> </ul>	<ul style="list-style-type: none"> <li>Barriers to access/information</li> <li>Increasing health and socioeconomic disparities</li> <li>Lack of individual/personal responsibility</li> <li>Unsanitary conditions</li> <li>Not enough cross-agency collaboration</li> </ul>

## FORCES OF CHANGE ASSESSMENT RESULTS

**Table 1: Force of Change Results**

<b>Forces of Change</b> (Trends, Factors, Events)	<b>Opportunities</b> (Prospects, Responses)	<b>Threats</b> (Barriers, Challenges)
<p><b>Technological Advances</b></p> <ul style="list-style-type: none"> <li>i.e. Electronic Medical/Health Records (EHR/EMR). Social media; Data</li> </ul>	<ul style="list-style-type: none"> <li>Strengthening community based services</li> <li>Resource sharing</li> <li>Improved coordination of care</li> <li>Reduces medical error</li> <li>Tailored/targeted health communication messages</li> <li>Job growth/innovation</li> <li>Tele-health improves access to care</li> <li>Consumer choice improvement</li> <li>Integration of information</li> <li>Increased evidence based approach</li> <li>Better outreach/education on available resources</li> <li>Better health outcomes</li> </ul>	<ul style="list-style-type: none"> <li>Validity</li> <li>HIPPA compliance</li> <li>Standardization of EHR/EMR</li> <li>Security breach of EMRs</li> <li>Speed of Innovation, some cannot catch-up – lack of capacity</li> <li>Cost association with implementation</li> <li>Fraud/Identity Theft</li> <li>Data interpretation w/o knowledge</li> <li>Data validity</li> </ul>
<p><b>Workforce development</b></p> <ul style="list-style-type: none"> <li>i.e better utilization of existing resources. Training and education, funding for education</li> </ul>	<ul style="list-style-type: none"> <li>Targeted learning</li> <li>Retraining of unemployed</li> <li>Recruitment expand the use of students and the National Health Service Corps; partnering with higher education</li> <li>Matching trained professionals to areas of concern or need</li> <li>ACA offers funding for education</li> <li>Messaging –community awareness</li> </ul>	<ul style="list-style-type: none"> <li>Cultural competency</li> <li>High school drop-out rates</li> <li>Gaps in needs</li> <li>Cost of education (loan debt)</li> <li>Lack of cross-training between public health and health care</li> </ul>
<p><b>Immigration</b></p> <ul style="list-style-type: none"> <li>i.e. services to the undocumented and uninsured</li> </ul>	<ul style="list-style-type: none"> <li>Easily targeted for messaging</li> <li>Funding information to educate on available resources</li> <li>Increase available services</li> </ul>	<ul style="list-style-type: none"> <li>Improper use of hospitals and clinics</li> <li>Undocumented cannot get health insurance</li> <li>Limited resources to undocumented in general</li> <li>Privatization of Jackson</li> </ul>

## FORCES OF CHANGE ASSESSMENT RESULTS

<b>Table 1: Force of Change Results</b>		
<b>Forces of Change</b> (Trends, Factors, Events)	<b>Opportunities</b> (Prospects, Responses)	<b>Threats</b> (Barriers, Challenges)
<b>Improving Wellness</b> i.e. health education, Physical Activity, sedentary lifestyles, nutrition, mental health	<ul style="list-style-type: none"> <li>• Utilizing parks and green space</li> <li>• Early education</li> <li>• “Make Healthy Happen” initiative</li> <li>• Increasing Physical Education in schools</li> <li>• Increase farmers markets in low income areas</li> <li>• Diminished cost/taking advantages of group wellness programs</li> </ul>	<ul style="list-style-type: none"> <li>• Increase in chronic disease Healthcare delivery</li> <li>• High rate of obesity and chronic disease</li> <li>• Diminished health education in low income populations</li> </ul>
<b>Reduced funding</b> i.e., bureaucratic issues between organizations; struggling economy	<ul style="list-style-type: none"> <li>• Hope for a stronger economy; increased awareness of the issues faced by average person</li> <li>• Decreased unemployment rate</li> <li>• More efficiency within programs; more collaboration</li> <li>• Higher awareness of public health</li> </ul>	<ul style="list-style-type: none"> <li>• People becoming sicker; cost of care is rising</li> <li>• Fraud</li> <li>• Social determinants of health</li> <li>• Reduced funding to social programs</li> <li>• High cost of living; lack of jobs</li> </ul>
<b>Political Climate</b>	<ul style="list-style-type: none"> <li>• Compromising /find solutions</li> <li>• Educating population on their right to vote</li> <li>• Educate legislators/decision-makers</li> <li>• Legislators to focus on issues and find solutions</li> </ul>	<ul style="list-style-type: none"> <li>• Resistant to change/lack of compromise</li> <li>• Confused/disengaged population</li> <li>• Misuse of resources which creates lost opportunities</li> </ul>

At the end of the meeting, there was consensus that addressing uncertainties presented by the ACA and focusing on wellness and social inequities should be the core strategic priorities of the Community Health Improvement Action Plan in Miami-Dade County.

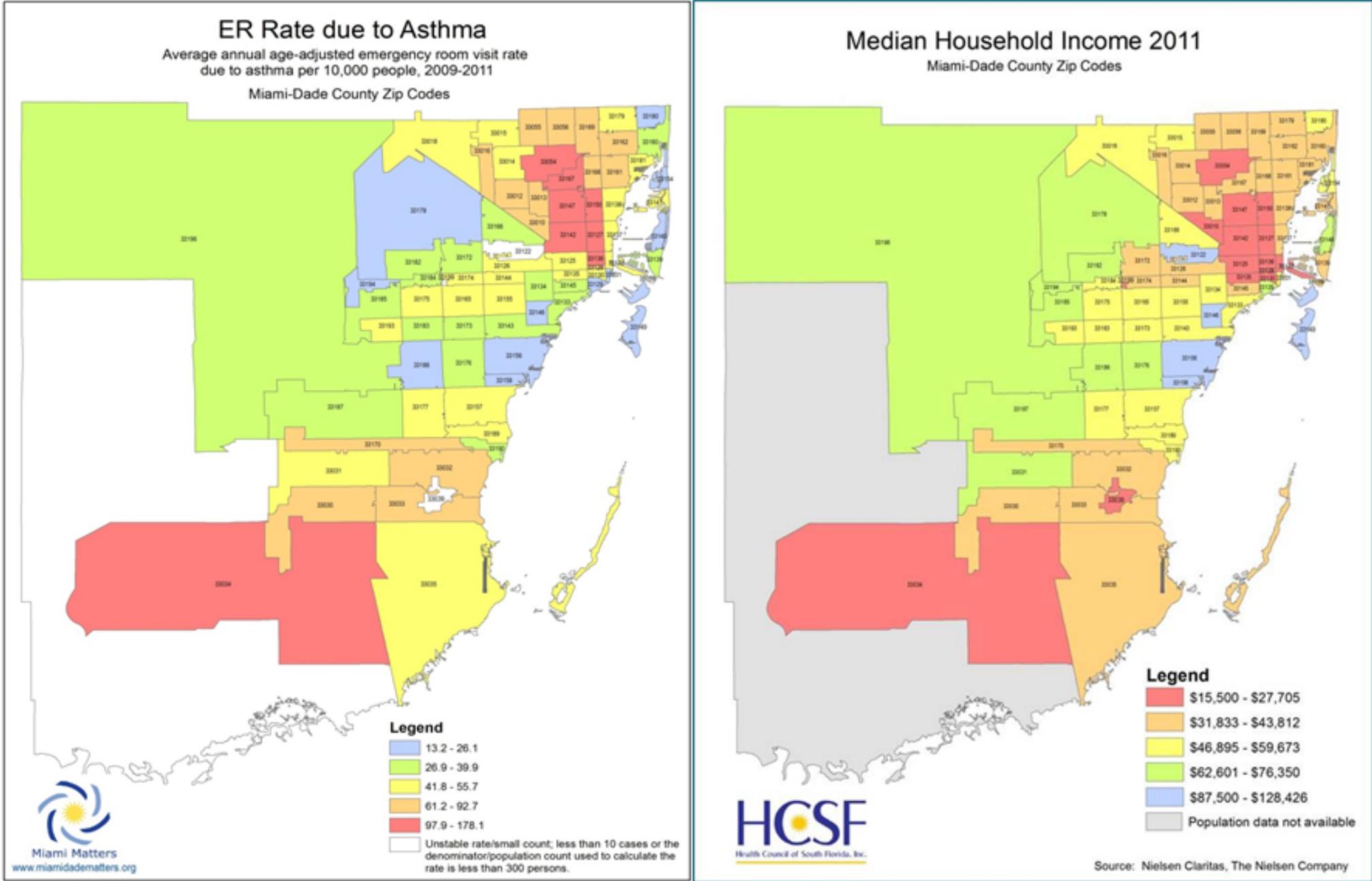
**MAPP 2013-2018 Community Health Priorities Goals & Strategies**

Thursday April 11, 2013

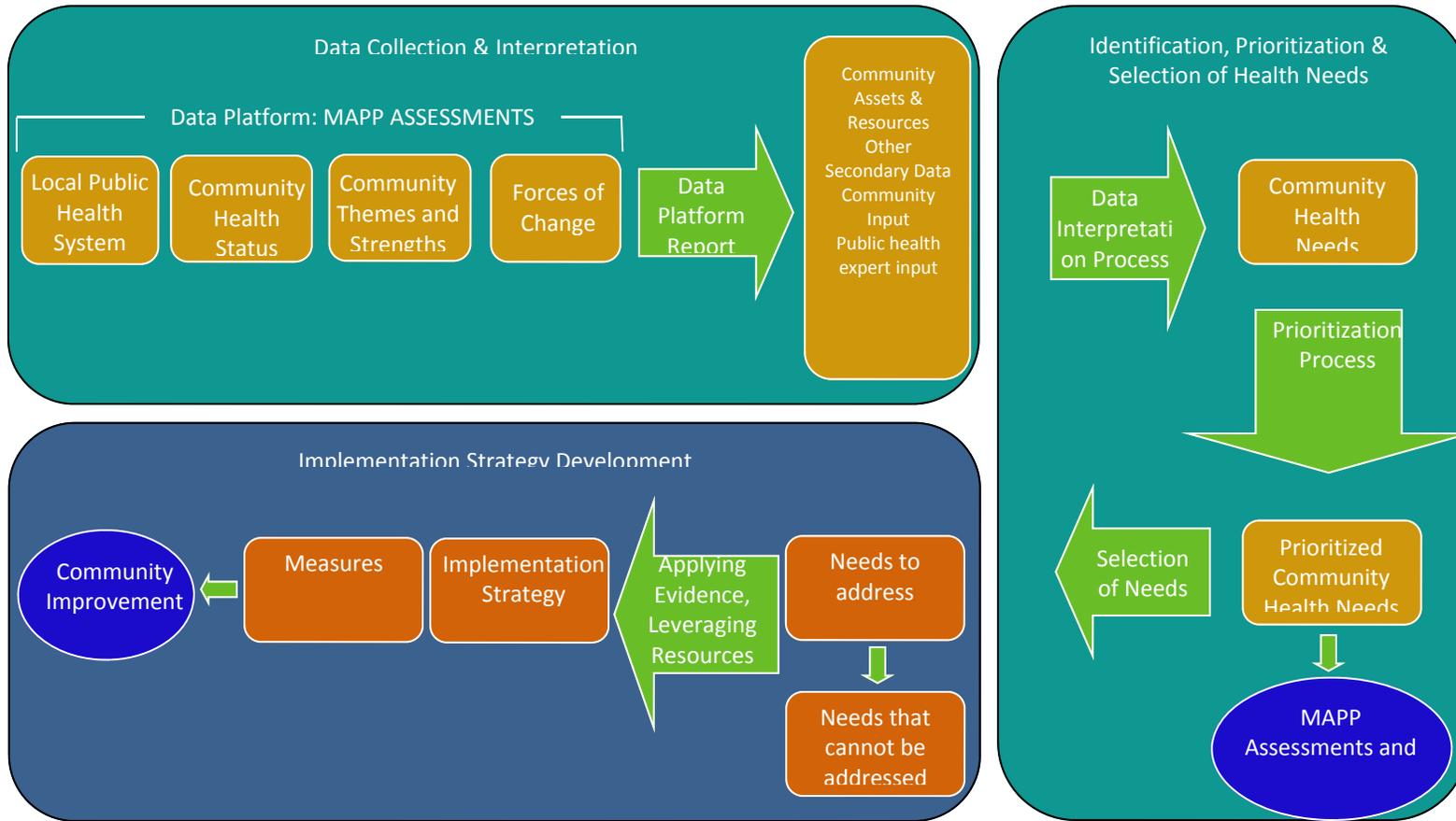
<b>Last Name</b>	<b>First Name</b>	<b>Degree</b>	<b>Title</b>	<b>Organization</b>
Acomulada	Lorna			Community Health Of South Florida, Inc.
Anyamele	Clarinda		Rehabilitative Service Supervisor	Miami-Dade County
Bello	Lauren		Program Coordinator	Urban Health Partnerships
Brasher	Mike		Strategic Business Development, Employer a	Healthways, Inc.
Brehm	Roxana			Community Health Of South Florida, Inc.
Campbell	Tom	MBA	Assistant Executive Director, Director of Plan	Health Choice Network
Crudele	Jeffrey		Executive Vice President & Chief of Strategy	Jackson Health System
Dietz	Gayle	MS, RD, LD/N	Community and Civic Registered Dietitian	Nutridietz
Donworth	Mary		Group Vice President, Community Investme	United Way
Douglas-Bartolone	Alexandra	MA	Faciliator	Building Community
Duval	Ruth			Jessie Trice Community Health Center, Inc.
Edwards	Trudy	MBA	Grant Writer	Miami Beach Community Health Center
Fermin	Manuel		CEO	Healthy Start Coalition of Miami-Dade
Goldsmith	Silvia		Executive Vice President /COO	Jewish Community Services of South Florida, Inc.
Gonzalez	Vanessa	PhD	Senior Associate for Health Data and Quant	Miami-Dade County OCHP
Hawley	Jeff		Program Officer	United Way
Howard	Melissa	PhD, MPH, MCH	Clinical Assistant Professor	FIU College of Public Health & Social Work
James	Terisa	MSW	Executive Vice President of Programs and Fu	Health Choice Network
Johnson	Suzanne	RN, MBA	Sr. Community Health Nursing Supervisor	Florida Department of Health in Miami-Dade Co.
Johnson-Cobb	Latavea		Victim of Crime Act Supervisor I	Miami-Dade County
Jordahl	Lori	MBA, HA	Senior Human Services Program Manager S	Florida Department of Health in Miami-Dade Co.
Krasovic	Trudy		Crisis Counselor/Trainer	Switchboard of Miami
LaBoeuf	Jackie		Administrative Project Analyst	Homestead Hospital
Losa	Marisel	MHSA	President and CEO	Health Council of South Florida
Martinez	Maria	MPH, CHES	Community Health Educator, CHAMPS	Baptist Health South Florida
Masters	Melissa		Director of Program Planning	Jackson Health System
Meagher	Katy		Affiliate Manager	Susan G. Komen for the Cure
Medina	Angie		Manager of Community Health	Baptist Health South Florida
Mendijar	Sorangely		SVP of Patient Services	Miami Beach Community Health Center
Mogul	Harve		President and CEO	United Way
Moore-Ramos	Morneque	MPH	Research & Evaluation Analyst	The Children's Trust

Moxam	Michael		Social Service Administrator	Miami-Dade County
Neasman	Annie		President & Chief Executive Officer	Jessie Trice Community Health Center, Inc.
Perez-Stable	Alina	MSW	Director, Academic Support Services	FIU College of Medicine
Rabinowitz	Mark			MBCHC
Riley	Akeemia			Community Health Of South Florida, Inc.
Rios	Berta	PHD	Patient Services Manager Florida Division	American Cancer Society, Inc.
Rivera	Lillian	RN, MSN, PhD	Director	Florida Department of Health in Miami-Dade Co.
Rivera	Nancy		Founder / Executive Director	Sembrando Flores
Rodriguez	Marlene	RD	Nutrition Projects Coordinator	Florida Heart Research Institute
Rodriguez	Abilio	PhD	Program Administrator	Centro Mater West
Rodriguez	Brendaly			UM
Rodriguez-Loddo	Amelinda	BS		Florida Department of Health in Miami-Dade Co.
Schotthoefer	Linda		Director of Community Initiatives	United Way
Schwartz	Robert	MD	Professor & Chair	UM, Dept of Family Medicine & Community Health
Scott	Tangier		Social Service Supervisor I	Miami-Dade County
Scotto	Maria	MS	Director of Healthy Aging Programs	Alliance for Aging, Inc.
Serle	Christiana		Volunteer	Florida Department of Health in Miami-Dade Co.
Soto	Nilda	MD	Medical Director	Open Door Health Center
Souto	Islara	MPH	Regional Director	American Heart Association
Stock	Fred		President & CEO	Miami Jewish Home & Hospital
Tran	Thao	MD, MPH		Health Council of South Florida
Tucker	Susan		Executive Director of Community Initiatives	YMCA
Tuero	Cristina		Senior Health Planning Services Coordinator	Health Council of South Florida
Villamizar	Kira	BS, MPH	Health Manager	Florida Department of Health in Miami-Dade Co.
Waddell	Charlotte		Executive Board Liaison	Florida Department of Health in Miami-Dade Co.
Watkins	Jessica	MSW	Director of Community Health	Catalyst Miami
Watson	Shanika		Children Issues Liaison	Florida Department of Health in Miami-Dade Co.
Weinger	Jessica	MPH, CHES	Health Educator	Florida Department of Health in Miami-Dade Co.
Weller	Karen	RN BSN MBA-HSN	Assistant Community Health Nursing Director	Florida Department of Health in Miami-Dade Co.
Williams	Jenelle			Florida Department of Health in Miami-Dade Co.
Wood	Peter	MPA	Vice President of Programs and Community	Health Foundation of South Florida
Wyatt	Belita			Jessie Trice Community Health Center, Inc.
Zaharatos	Julie	MPH	Senior Community Health Specialist	Health Council of South Florida
Zweig	Ilene		Consultant	IHCM

**Appendix I:** By comparing preventable hospitalizations and emergency room (ER) visits to household income rates by ZIP code, it is apparent that areas in the preventable hospital visits “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.



**Appendix Q: Mobilizing for Action through Planning and Partnerships (MAPP) Process Map**





## **MAPP Goal:** ***Improving Access to Care***

### **A. Existing Approaches/Strategies Underway in Miami-Dade County to address this MAPP Goal**

- American Cancer Society Patient Navigator Program at Jackson Memorial Hospital
- Catalyst Miami's Prosperity Campaign (comprehensive benefits application assistance and navigation) and Campaign for Earned Sick Leave
- Catalyst's Healthcare Heroes life coaching in South Dade with Baptist Health
- CMS Health Navigators Program
- Charity Care (Private Hospitals and Health Care Providers)
- Community Health Outreach Workers/Patient Navigators (MD-HAN, CHW and SFCCC)
- Corporate health industry, i.e. flu shots at Walgreens
- Faith-based Organizations/Health Ministries, Church-based health communities
- Fast Track Clinic
- Florida International University Mobile Health Center (MHC) launched in August 2012.
- FIU Neighborhood HELP Program
- Florida Kid Care (Healthy Start/S-CHIP)
- Florida Department of Health in Miami-Dade County clinics offering Family Planning services; tuberculosis, STD and HIV screening
- Federally Qualified Health Centers (FQHCs)
- Free Clinics
- HealthConnect in Our Schools (HCiOS) - The Children's Trust's partnership with Miami-Dade County Public Schools and Miami-Dade County Health Department offering school-based health and mental health services to students
- HealthConnect in Our Community (HCiOC) – The Children's Trust's initiative to assist families with determining eligibility and applying for low-cost health insurance to access health services for their children and themselves
- Healthy Start services available to pregnant women, infants and children up to age three include care coordination to assure access to a medical home and needed services; Psychosocial counseling; Parenting education and support; Childbirth education; Breastfeeding education and support; Nutrition counseling; Tobacco education and cessation counseling; Home visiting; and Outreach
- Health Foundation of South Florida's initiatives
- Homestead Hospital (BHSF) partnership with Catalyst to implement the Stanford model which provides Health Care Navigators for patients who have chronic diseases. The model promotes self-advocacy.
- Liga Contra el Cancer
- Miami-Dade Health Access Network (MD-HAN) "mobilizing" neighborhoods toward utilizing best practices to promote access to care
- National Association of Counties (NACo) Prescription Drug Discount Card Program

- Office of Countywide Healthcare Planning (OCHP) Expanding Health Insurance Coverage Partnership with Blue Cross Blue Shield of Florida for Miami-Dade Blue (MDB)
- OCHP Health Insurance Assistance (HIA) – premium assistance
- Public Health Trust (Safety Net for Uninsured)
- Refugee Health Access Program
- Social/technological advancements, including educational smart phone applications.
- Text campaign for Health—Text: “Health” to “12722”
- Uniform Common Eligibility Screening/Technology (i.e., One eApp)
- United Way of Miami’s partnership with FamilyWize to provide prescription drug discount cards available to uninsured/underinsured
- United Way of Miami-Dade supports the use of "health navigators" or "community health workers" to connect individuals in the community to healthcare.
- United Way funds a "care connection" program for HIV positive individuals living in Liberty City, which has historically been a very difficult population to get into care. By supporting this program, the HIV positive rate has decreased in recent years
- Others: \_\_\_\_\_

## **B. Measurable Results/Positive Impacts since 2008**

- In 2011, KidCare enrollment increased 3.9% and its Medicaid component by 4.4%. KidCare currently provides health care to more than 2 million and Medicaid to 1.7 million. Despite the millions enrolled in KidCare or Medicaid, “nearly 400,000” are still uninsured<sup>i</sup>.
- HClOS is in 157 M-DCPS schools attended by 140,000 students (out of a total of 360 non-charter M-DCPS schools with a student population of 305,000). In 2011-12, HClOS health suites served 76,000 students with 275,000 visits, of which 84% of students returned to class, provided state-mandated BMI and vision screenings for 43,000 students and provided 73,000 referrals for additional health services.
- HClOC health navigators assisted 2,056 uninsured adults and 9,072 uninsured children to obtain health insurance (8,679 through Medicaid and 393 through KidCare) in 2011-12.
- The Public Health Trust provides care Miami-Dade County residents who have no insurance, or whose insurance coverage is not sufficient to cover the cost of their treatment.
- 102,229 Uninsured Individuals (including 36,337 children) received free or low cost health care, on a sliding fee scale from FQHCs in 2012 (Data Source: Uniform Data System Reports, 2012)
- Free Clinics serve over 76,187 uninsured individuals in Miami-Dade County, 2011
- United Way’s partnership with FamilyWize has already saved Miami-Dade residents over \$1 million on the cost of their prescription
- 650 households served through FIU in-home comprehensive and follow-up care community medicine program in the following communities: North Miami-Dade County: the City of Miami Gardens, the City of Opa-Locka, a portion of Unincorporated Northwest Dade County, City of Hialeah, City of Miami Lakes, City of North Miami, City of North Miami Beach, and Little Haiti. This program is made possible through the Green Family Foundation NeighborhoodHELP™ program delivering care through interprofessional teams of medical, nursing, social work, and law; or through the FIU Community Outreach Team.

- Florida International University Mobile Health Center (MHC) currently offers three sessions each week (and up to four in the next few months). Through April 4, 2013: 109 patients seen in 250 encounters.
- MDB and MDB-associated insurance products led to more than 10,000 being insured in Miami-Dade County, raised \$1 million for Premium Assistance
- National Association of Counties (NACo) Prescription Drug Discount Card Program free card will give discounts on prescriptions for residents who are uninsured, underinsured, seniors and pet owners in the county. 2,025 residents have utilized the card since 2011, saving an average of 24% on prescriptions
- 147 individuals financially qualified for premium assistance; 711 completed on-line survey; 123 enrolled in HIA
- Anticipated program end on 12/31/13 as Affordable Care Act (ACA) is implemented
- Others: \_\_\_\_\_

### **C. Challenges Encountered/Enhancements Needed in 2013-2018**

- A lack of providers in MDC taking new Medicaid patients and for those who do accept the wait times are too long
- Chronic disease self-management is a struggle for many
- Co-payments for patients with Medicaid / Share of cost
- Co-payments at Jackson Memorial Hospital
- Connecting people to care
- Economic and political climate, policies, systems, and environmental changes present barriers
- Education-level and how to engage illiterate populations
- Ensuring access for populations that do not read or write
- Ensuring that patients know HOW to access the healthcare system (including the new Health Care Exchanges)
- Fear of mammograms, colonoscopies and other preventive health screenings
- Fewer workers have Paid Time Off/Sick Leave which allows them to access health care
- Financial assistance for cancer patient medical needs
- The Florida KidCare Coordinating Council, responsible for making the program's implementation and operation recommendations, identified a single priority for 2012: "Fully fund the Florida KidCare program..."<sup>ii</sup>
- High copays and deductibles leading to underinsured
- Hospitals who do not want to serve Medicaid or uninsured patients
- In 2012, as part of the Communities Putting Prevention to Work (CPPW) grant, a report on *Expanding Supermarket Access in Areas of Need for Miami-Dade County* 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.
- Inadequate service to incarcerated individuals
- Lack of Medicaid and KidCare coverage for immigrants (even legal residents here less than 5 years), lack of KidCare for employees of state government workers
- Lack of access to lower cost generic drugs due to Florida's high bar for approval even beyond FDA approval
- Lack of transport to obtain medical services
- Lack of awareness of prevention and lack of focus on motivational issues

- Lack of technological integration – The FQHC’s utilize a HL7 interface but the FLDOH clinics utilize HMS.
- Linking patients to health care providers
- Many low-income individuals suffer from the health and financial consequences of not having access to health insurance. They are often forced to go to the Emergency Room for needed health care, forego critical life-saving preventive services, and incur sometimes insurmountable medical debt (which factors into 62% of all bankruptcies).<sup>iii</sup>
- Miami-Dade County requires interventions and health improvement messages that are tailored to the specific needs of its diverse populations.
- Shortage of healthcare providers
- Transportation is a major issue; i.e., even for STS (\$3 one-way/day). Not all can afford \$6 roundtrip
- Undocumented populations cannot access most health services
- Others: \_\_\_\_\_

#### **D. Emerging Opportunities**

- As of 2014, the Affordable Care Act /Health Care Exchanges will be implemented in the State of Florida and will ensure access to health care for all eligible Miami Dade County residents, including individuals with pre-existing conditions
- Community Health Fairs
- Community Outreach Workers
- Electronic Medical Records
- Engage the Corporate Sector, (e.g. Walgreens, CVS Minute Clinic)
- Evidence-Based Approaches that could be replicated in Miami Dade County
- Greater focus on healthcare disparities based upon income, race and ethnicity; identification of unhealthy neighborhoods
- Expansion of Community Health Workers (CHWs)
- One-e-App (Unified Eligibility Application) would potentially provide a platform where the FQHC’s and the FLDOH clinics would speak if the HL7 interface is an added component and added screening abilities for publicly assisted programs qualifying and enrollment (Medicaid)
- Switchboard of Miami/211 effort to increase usage by health care providers
- Use of Technology/Educational Apps
- Use of Social Media
- Use of Low Cost Technology to Monitor Health Status (e.g. tools for monitoring Blood Sugar)
- Others: \_\_\_\_\_

#### **E. Access to Care Embraced as a Priority for Miami-Dade County’s MAPP 2013-2018**

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i Menzel, Margie. (2012). Kidcare for state workers still a possibility. The News Service of Florida

ii Annual Report and Recommendations. (2012). Florida KidCare Coordinating Council.

<sup>iii</sup> Health Care for Florida Now, Talking Points provided by Florida Legal Services, Inc. Downloaded on April 8, 2013 from

[www.healthcareforflorida.org](http://www.healthcareforflorida.org).



## **MAPP Goal: Chronic Disease and Prevention**

### **A. Existing Approaches/Strategies Underway in Miami Dade County to address this MAPP Goal**

- Florida Department of Health in Miami Dade County Initiatives:
  - Community Health Action Team (CHAT): Provides blood pressure, BMI, body fat, carbon monoxide and diabetes risk screenings. Also provide educational class on cardiovascular health, nutrition and other health topics.
  - Consortium for a Healthier Miami-Dade: Community initiative made up of several organizations working together on projects that promote policies, systems and environmental changes that will have an impact on chronic disease.
  - Worksite Wellness Program: Program provides technical assistance to organizations wishing to implement a program. Staff also provides educational programs and screenings on chronic disease.
- Community clinics – Good News Care Center, Open Door Health Center, San Juan Bosco (free healthcare for the indigent population)
- 7 FQHC's have received funding from the GE Foundation to provide "Care Management Medical Home Center" (Diabetes, and other chronic conditions). Program includes home visits.
- Alliance for Aging's (CMS funded) initiative assists Older Adults who are transitioning from the hospital to home. The Alliance has built a partnership with nine area hospitals and community based providers who provide the home based care.
- Alliance for Aging's Living Healthy/*Tomando Control de su Salud* Program: Provides techniques on changing eating habits, improving health, communicating with healthcare providers, managing sleep and fatigue, using medication correctly and reducing the use of hospital services.
- Alliance for Aging's Diabetes Self-Management/*Manejo Personal de su Diabetes* Program: This program is geared towards helping older adults learn to manage their symptoms and blood glucose (sugar) better, learn about and adopt healthy eating and physical activity habits, strategies for preventing complications, coping with anxiety, anger and stress, and managing their day-to-day activities.
- American Heart Association Initiative ("Good to Go") assists patients to take their own Blood Pressure readings (prevention orientation)
- Baptist Health Follow-up Care in Homestead – Advanced Registered Nurse Practitioners, diabetes nurse educators and social workers address our patients' healthcare needs and social determinants of health. The team also helps transition patients to a permanent medical home
- Baptist Health South Florida offers free educational programs, exercise classes, support groups and health screenings to inform and inspire the community to live a healthier lifestyle. Services include: heart disease, cancer, nutrition, back pain, diabetes and

other educational programs. Exercise classes include zumba, pilates, yoga, Tai Chi-style and aerobics. Screenings include blood pressure, BMI, bone density, cholesterol, breast cancer. Support groups include Al-Anon, Lupus, Diabetes, Addiction, Allergy, Arthritis, Cancer, Digestive disorders/gluten-free diet, Heart Disease and more.\**Many support groups are also offered in Spanish.*

- Baptist Health Congregational Health Dept – Wellness Fairs & Workshops in the Faith Communities – Free health screenings conducted annually to promote health education programs that match the health profile of the community. Services include: cholesterol, glucose, bone density, BMI, blood pressure. Cooking demonstrations and community resources.
- Baptist Health Congregational Health Dept – Faith and Health Support Groups – Integration of spirituality and health model for health promotion and disease management. Themes include: Cancer survivors’ group, Exercise/Fitness groups, Seniors health.
- Community Health of South Florida, Inc. (CHI) P.A.M.P.E.R. program
- CHI provides free transportation for its clients
- Community Health Workers provide education about self-management
- Florida Heart Research Institute conducts biometric screenings in the community, including the underserved and uninsured populations and in the workplace. Participants are coached on healthy lifestyle changes, as needed.
- Health Foundation of South Florida Initiatives
- Healthy Aging Regional Collaborative
- Hypertension awareness and monitoring project: “Get to Goal” teaches self-management of chronic conditions such as hypertension.
- Jessie Trice Economic Opportunity Health Center
- The Living for Health (L4H) grant-funded program followed participants referred to FQHCs for care and looked at the match rate. L4H participants also received coaching phone calls at 1, 3, 6 and 12-months on positive lifestyle behavior change.
- Thelma Gibson Health Initiative – HIV Program
- “Together to End Stroke” is a program of the American Heart Association to prevent and raise awareness of cardiovascular disease and stroke among uninsured populations
- United Way funds a "care connection" program for HIV positive individuals living in Liberty City, which has historically been a very difficult population to get into care. By supporting this program, the HIV positive rate has decreased in recent years
- YMCA
- Others:

## **B. Measurable Results/Positive Impacts since 2008**

- The FDOH CHAT team has seen over 3,000 clients for the 2012-2013 fiscal year through outreach activities. Staff have participated in over 80 health fairs and health promotion activities during this same time period
- The Consortium for a Healthier Miami-Dade implemented a media campaign called *Make Healthy Happen Miami* in three languages. Awareness of the campaign with statistics is available through FDOH-Miami-Dade County
- 70 recipients of worksite wellness program in Miami-Dade County

- Alliance for Aging’s Chronic Disease Self-Management/Evidence-Based Programs are offered at community centers and faith-based organizations, and target seniors 60 years and older, free of charge in English and Spanish. 1,050 older adults completed these programs in 2012. Data analysis for the 2008-2012 Healthy Aging Regional Collaborative participants in Broward, Miami-Dade and Monroe Counties indicate the following outcomes: Enhanced Fitness participants improved their fitness function by 66% overall; A Matter of Balance participants self-reported an overall 38% increase in self-efficacy skills and a 23% increase in exercise frequency; and Stanford Self-Management Programs participants self-reported an overall 20% increase in ability to use specified skills to manage their chronic disease and a 47% increase in activity frequency.
- Others:

### **C. Challenges Encountered/Enhancements Needed in 2013-2018**

- Fragmented Services—not all needed services are available in all areas
- Racial and ethnic disparities in chronic disease, particularly among Non-Hispanic Black/African-Americans.
- Inadequate attention to asthma treatment and prevention
- Decreased funding
- Fear of mammograms, colonoscopies and other preventive health screenings
- Pharmaceutical Access
- Uninsured/Underinsured
- (Physicians’) Fear of Serving Medicaid Population (low rates of Medicaid reimbursement for treatment)
- Linguistic and cultural barriers
- Conflict with work times (many are unable to take time off for medical appointments)
- Funding for Programs—Time Limited Grants
- Lack of Primary Care Physicians
- Lack of Specialty Care Physicians
- Transportation (especially in South Dade—NOTE that this is an ongoing issue)
- Access for Undocumented Populations
- Baby Boomer-Older Populations will create more need for services for patients with chronic diseases
- Others:

### **D. Emerging Opportunities**

- Evidence-Based Approaches that could be replicated in Miami-Dade County
- Catalyst’s Health Care Navigators, working in partnership with Homestead Hospital (BHSF)
- Pharmaceutical Assistance and Medical Supplies (for example, where patients get a free meter, but cannot afford to buy their medical supplies)
- Replicate the Stanford model which provides Health Care Navigators for patients who have chronic diseases. The model promotes self-advocacy (Homestead Hospital, in partnership with Catalyst Miami, is replicating this model)
- Use the voice of the local American Heart Association and American Cancer Society to leverage and amplify advocacy

- Others:

**E. Chronic Disease & Prevention Embraced as a Priority for Miami-Dade County's MAPP 2013-2018**



## **MAPP Goal: Reducing Health Care Disparities in Miami-Dade County**

### **A. Existing Approaches/Strategies Underway in Miami-Dade County to address this MAPP Goal**

- The Jasmine Project, which is overseen by the University of Miami's Starting Early Starting Smart Program, is a federal project focusing on three specific zip codes: 33054, 33055 and 33167 and provides intense services to at-risk women and follows them for up to two years.
- FQHCs in Miami-Dade County address disparities by promoting health and access at the neighborhood level
- Communities Putting Prevention to Work (CPPW) priority outcome objective include:
  - Addressing the health prevention needs of childcare centers in low-income, underserved, minority communities.
  - Supporting farmers markets in low-income, underserved, minority communities.
  - Researching and determining the location of "food deserts" in Miami-Dade County
  - Safe Routes to School program focusing on low-income, underserved, minority communities.
- Consortium for Healthier Miami-Dade works on prevention through education, support of policy, systems and environmental changes to reduce health disparities, through provision of educational forums, programs and screenings.
- Diabetes collaborative focused on Hispanics in Hialeah
- "Get to Goal," "Together to End Stroke," and "Go Red Por Tu Corazon" teach self-management of chronic conditions in underserved populations such as the African American, Hispanic and Caribbean American community
- Alliance for Aging partners with community organizations, health care providers and faith-based centers, to offer evidence-based programs to older adults. A Diabetes self-management workshop is offered free-of-charge to seniors in English (Diabetes Self-Management) and Spanish (Manejo Personal de la Diabetes). This program helps older adults with diabetes learn to manage their symptoms and blood glucose; appropriate use of medication and healthy eating and exercise to maintain and improve strength and endurance. In 2012, the Alliance for Aging partnered with Citrus Health and provided Diabetes Self-Management (Spanish) workshops in Hialeah. In 2013, the Alliance for Aging has a partnership with Community Medical Group of Hialeah to provide Diabetes Self-Management (Spanish) at their medical center in Hialeah.
- Jay Weiss Institute for Health Equity at the Sylvester Comprehensive Cancer Center, University of Miami Miller School of Medicine

- United Way funds a "care connection" program for HIV positive individuals living in Liberty City, which has historically been a very difficult population to get into care. By supporting this program, the HIV positive rate has decreased in recent years
- Others:

## **B. Measurable Results/Positive Impacts since 2008**

- In June of 2010, 21.5% of students in the City of Miami reported that they walk to and from school. 33.4% take a school bus and 41.3% ride in a car to school.

## **C. Challenges Encountered/Enhancements Needed in 2013-2018**

- Fragmentation/Lack of coordination of health care resources
- In 2012, as part of CPPW, *A Healthier Future: Expanding Supermarket Access in Areas of Need for Miami-Dade County* 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.
- Lack of a countywide master plan to reduce cancer disparities. Efforts exist, but they are not coordinated and they are not sustainable (grant funding dependent)
- Lack of financial incentives for physicians to practice in need areas. There are MDs who want to "give back" who are willing to work in these areas, but we need financial incentives.
- Need to have the decision-makers/opinion leaders involved, i.e. the Mayor, Commissioners, etc.
- Racial and ethnic disparities in low birth weight rates, infant mortality and chronic disease, particularly among Non-Hispanic Black/African-Americans.
- Socioeconomic challenges
- Transportation
- By comparing preventable hospitalizations and ER visits by ZIP code, 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 particularly underserved areas demanding our attention. These areas are located in the "I-95 Corridor" and in South Dade. Avoidable hospital admissions indicate gaps in service, lack of access, lack of insurance, and poverty. The similarity of the "red zones" on the maps of ER visits for asthma, a largely preventable condition, and the household income map demonstrate a correlation between emergency care usage and socioeconomic status.

## **D. Emerging Opportunities**

- As of 2014, the Affordable Care Act /Health Care Exchanges will be implemented in the State of Florida and will ensure access to health care for all eligible Miami-Dade County residents, including individuals with pre-existing conditions
- Create Financial Incentives for Physicians who would be willing to work in these areas
- Need a System of Care (e.g. in Liberty City).

- Provide Hands-On Navigators who work with neighborhood residents to remove barriers.
- Funding alone will not make a difference. A **totally different approach** is necessary that includes the people who live in these communities—and will address the social determinants of health.
- “Master Cancer Plan” should be created, as in other metropolitan areas
- MD-HAN is seeking to prioritize neighborhoods, and mobilize the community.
- Miami-Dade could focus in on a specific goal area—shared focus. We have done it before, and right now we have the momentum.
- MD-HAN has moved to a new level with support from Mayor Jimenez, key members of the Dade Delegation and the Board of County Commissioners
- Evidence-Based Approaches that could be replicated in Miami-Dade County
  - Need to explore other communities in the U.S. that are successfully reducing Health Care Disparities (e.g. Baltimore, Maryland, which has been organizing at the community level with NAVIGATORS.).
  - “Benchmark” Miami-Dade County against other counties that are most like our community/national counterparts.
  - Implement solutions that come from within the community, like Harlem Children’s Zone—where they worked on improving outcomes in a limited geographic area, “block-by-block”
- Others:

**E. Reduction of Health Care Disparities Embraced as a Priority for Miami-Dade County’s MAPP for 2013-2018**



## **MAPP Goal: *Increasing Access to Primary Care and Medical Homes***

### **A. Existing Approaches/Strategies Underway in Miami Dade County to address this MAPP Goal**

- Community clinics – Good News Care Center, Open Door Health Center (free healthcare for the indigent population)
- FQHCs in Miami Dade County are already nationally accredited
- Jackson has a cadre of primary care sites, and are now going for accreditation
- MomCare, administered by the Healthy Start Coalition of Miami-Dade, works to assure a medical home, WIC and Healthy Start enrollment, and screening for approximately 22,000 pregnant women on expanded Medicaid, up to 185% of FPL. Overseen by AHCA and Florida Department of Health.
- Healthy Start's goal is universal screening and a medical home for all pregnant women and infants born in the state of Florida. These strategies improved maternal, infant and child outcomes (i.e., decreased rates of low birth weight babies, pre-term birth and infant mortality)
- Baptist Health 20,000 free screenings for cholesterol, blood pressure, body composition and osteoporosis at our annual health fairs
- Baptist Health – Men's Health Day – free annual seminar, health screening and lectures such as physical fitness, prostate health, and stress reduction
- Baptist Health – Women's Health Day – day of free health screening, lectures, cooking & fitness demonstrations, and discussions with medical experts on a broad range of topics
- Baptist Health Follow-up Care in Homestead – Advanced Registered Nurse Practitioners, diabetes nurse educators and social workers address our patients' healthcare needs and social determinants of health. The team also helps transition patients to a permanent medical home
- Others:

### **B. Measurable Results/Positive Impacts since 2008**

- Office of Countywide Healthcare Planning (OCHP) Strategic Investing in Primary Care Expansion: leveraging \$25 million in Government Obligation Bonds (GOB) funds to expand the primary care delivery capacity of the County's Federally Qualified Health Centers (FQHCs). 64% of planned GOB projects have an approved agreement. Approved agreements represent 18,100sf operational clinic space and 35,414sf of clinical space in various stages of completion.
- Others:

**C. Challenges Encountered/Enhancements Needed in 2013-2018**

- The current Medicaid rates are so low that providers are unwilling to accept new patients. Compounding the low provider reimbursement rates, there is an issue with a general lack of providers.
- Maintaining the patient-compliance and also ensuring patients do not “shop around” for doctors, and end up fragmenting their care.
- Care Coordination
- Misuse of the ER, when a patient has been using a Department of Health clinic
- Timing of Appointments—when workers are unable to leave work
- People do not know what a medical home is and how they would benefit from it
- Others:

**D. Emerging Opportunities**

- As of 2014, the Affordable Care Act /Health Care Exchanges will be implemented in the State of Florida and will ensure access to health care for all eligible Miami Dade County residents, including individuals with pre-existing conditions
- Accountable Care Organizations
- Community Health Workers
- Care Coordination (Joint Staffing of patient care)
- Electronic Medical Records
- Evidence-Based Approaches that could be replicated in Miami-Dade County, such as San Francisco, where safety net patients get a card and are assigned a “medical home.” The card is connected to a stipend. The patient can request to change to a different medical provider, but it must go through the system.
- Greater focus on primary care thanks to FIU School of Medicine and interdisciplinary programming
- One-E-App (Unified Eligibility Application)
- Others:

**E. Primary Care and Medical Homes Embraced as a Priority for Miami-Dade County’s MAPP 2013-2018**



## **MAPP Goal: Nutrition and Physical Activity Promotion to Reduce Obesity**

### **A. Existing Approaches/Strategies Underway in Miami-Dade County to address this MAPP Goal**

- Alliance for Aging's Living Healthy/*Tomando Control de su Salud* Program: Provides techniques on changing eating habits, improving health, communicating with healthcare providers, managing sleep and fatigue, using medication correctly and reducing the use of hospital services.
- Alliance for Aging's Enhance Fitness Program: This group exercise program focuses on stretching, flexibility, balance, low-impact aerobics, and strength training.
- Healthy Aging Grant from the Health Foundation of South Florida to focus on enhanced fitness for seniors in the North Dade Community
- Baptist Health South Florida (BHSF) and some insurers provide free exercise classes. BHSF nutritionist provides free educational programming twice a week
- Blue Foundation Childhood Obesity Prevention Programs in Hialeah and Opa-Locka
- The Children's Trust promotion of good eating habits, particularly afterschool snacks
- FQHC Partnership with Farmer's Markets, providing fresh fruits and vegetables
- Miami-Dade Public Schools-Dietary Improvements, Fresh Fruit, Vending Machines, Exercise)
- An integral part of school health services are nutrition services. Health Screening and health appraisals conducted by the school nurse help to identify students at nutritional risk who need follow up for further diagnosis and treatment. Florida Statute 64F.6.003 mandates that students receive specific Health Screening Services annually. Growth & Development (G&D) Screenings are conducted on students using Body Mass Index (BMI), in grades 1, 3, 6 (at minimum), and optionally grade 9 in public schools based on available resources and parental notification with the choice to opt-out. (Florida Statue 381.0056(4)(a)(9), F.S Ch. 64F-6.003(3), F.A.C.) Nutrition education is provided. Students with nutrition-related problems are referred to a health care provider or other related resources.
- Centro Mater grant from the Health Foundation to help fight childhood obesity
- Communities Putting Prevention to Work (CPPW) implemented programming through the Consortium for a Healthier Miami-Dade to (1) Increase number of high-level community leaders who enact and support evidence-based policies; (2) Raise awareness of healthy eating and promote healthy food choices and physical activity; (3) Increase access to healthy food and beverages, require daily activity, and limit screen time; (4) Improve access to healthy foods and reimbursable meals in public schools; (5) Increase physical activity in public schools; (6) Increase community access

to healthy and affordable foods; (7) Increase access to healthy foods, fruits, and vegetables through farmers' markets; (8) Increase breastfeeding practices and breastfeeding friendly facilities; (9) Increase active transportation and recreation through the built environment; (10) Increase sustainable Safe Routes to School initiatives; and (11) Increase the number of worksite wellness programs that implement nutrition policies and physical activity.

- Consortium for Healthier Miami-Dade works on prevention through education, support of policy, systems and environmental changes that encourage healthy living, provision of educational forums, programs and screenings,
- Food Policy Council (promoting healthy, local food and farmers markets),
- Baptist Health Community Programs – more than 12,000 have attended free educational lectures, with topics ranging from diabetes & nutrition, weight control and children's topics *\*Many lectures are also offered in Spanish*
- Baptist Health Congregational Health Dept – Wellness Fairs & Workshops in the Faith Communities – Free health screenings conducted annually to promote health education programs that match the health profile of the community. Services include: cholesterol, glucose, bone density, BMI, blood pressure, cooking demonstrations and community resources.
- Baptist Health – Women's Health Day – day of free health screening, lectures, cooking & fitness demonstrations, and discussions with medical experts on a broad range of topics
- Baptist Health Congregational Health Dept – Faith and Health Support Groups – Integration of spirituality and health model for health promotion and disease management. Themes include: Cancer survivors' group, Exercise/Fitness groups, Seniors health.
- South Miami Heart Center Screenings, free programs on heart disease risk factors, recognizing heart attack symptoms, and relationship between obesity and heart disease
- United Way of Miami-Dade currently funds three promising programs that work with youth, teaching them about the importance of eating healthy and getting enough physical activity. These are all in traditionally underserved communities. This is especially important given that physical education is not offered in most public schools.
- Youth Organizations, e.g. YMCA – promote physical activity and healthy living
- Others:

## **B. Measurable Results/Positive Impacts since 2008**

- Alliance for Aging's Enhance Fitness program has shown the following results as reported by the Healthy Aging Regional Collaborative for 2008-2012:
  - 69% improved the number of chair stands they were able to complete in 30 seconds.
  - 71% improved the number of arm curls they were able to complete in 30 seconds.
  - 60% reduced the number of seconds needed to complete an eight-foot walk.
  - 99% self-reported that they would take the class again.
  - 84% self-reported that they were extremely likely to recommend the class to a friend.
  - 99% self-reported they were very satisfied with the program.

- 38% self-reported that they engaged in physical activity that is about as hard as EF 3 or more days a week after 16 weeks of participation in an EF class.
- In 2011, 27.7% of high school students in Miami-Dade were overweight or obese; a rate that has decreased slightly from 28.2% in 2003
- In 2011, 37% of Miami-Dade high school students engaged in regular physical activity for at least 60 minutes on five or more days of the week; a rate that has improved significantly from 26.9% in 2005.
- Results of student BMI screens include the percent of students referred with abnormal BMI results (Underweight and Obese). In 2010-2011 the rate was 22.47%; 2009-2010: 24.04%; and 2008- 2009: 24.49%
- Thirty (30) CPPW outcome objectives were implemented, with 77% of outcome objectives being met

### **C. Challenges Encountered/Enhancements Needed in 2013-2018**

- Inadequate recreational spaces, low or free exercise programs and food deserts
- Safety must be improved so that more young people can use public parks
- Corner stores in the inner city may not offer healthy fruits and vegetables.
- Lack of PE and afterschool physical activity, leading to sedentary lifestyles
- Lack of awareness of healthy food purchasing and preparation
- Inadequate access to healthy foods in schools and programs that create awareness and interest in healthy foods
- In 2012, as part of the Communities Putting Prevention to Work (CPPW) grant, a report on *Expanding Supermarket Access in Areas of Need for Miami-Dade County* 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.
- In 2010, 67.4% of adults in Miami-Dade were reportedly overweight or obese; a rate that has increased from 61% in 2002
- Decreased funding

### **D. Emerging Opportunities**

- Common Threads is a national nutrition education model that is now being offered to students in 3-4 Middle Schools in Miami-Dade County (replicating Chicago model)
- Continue work started by CPPW into other initiatives.
- Evidence-Based Approaches that could be replicated in Miami Dade County
- Others:

### **E. Nutrition and Physical Activity Embraced as a Priority for Miami-Dade County's MAPP 2013-2018**



## **MAPP Goal: *Mental Health and Mental Disorders***

All too often, mental disorders and substance abuse manifest as comorbid conditions. Promising targeted preventive interventions and resilience training to identify strengths that may promote health and healing can reduce the risk for mental disorders and substance abuse and the burden of suffering in vulnerable populations.

### **A. Existing Approaches/Strategies Underway in Miami-Dade County to address this MAPP Goal**

- The Department of Children and Families Substance Abuse and Mental Health Program Office (SAMH) have the following initiatives that demonstrate the linkage between behavioral health and improved health outcomes:
- Federally Qualified Health Centers (FQHC): The DCF Southern Region promotes the integration of primary care services to the medically underserved that also have behavioral health care needs.

The DCF SAMH Managing Entity, South Florida Behavioral Health Network (SFBHN), requires all of its Subcontractors to execute a Memorandum of Understanding (MOU) with a FQHC. All subcontractors of SFBHN have an executed MOU with a FQHC.

- Trauma Informed Care (TIC): Many individuals with behavioral health issues have experienced trauma that affects their development and adjustment and the research suggests this has an impact on primary health. SFBHN and the DCF Southern Region are committed to developing a system of care that incorporates comprehensive assessment tools that identify those affected by trauma and a system of care that meets their needs. It is the goal of the TIC Initiative to identify the effects of trauma on those seeking services and the provision of treatment options. As part of the TIC Initiative, SFBHN has: facilitated the regional Trauma Informed Care meetings to develop the process for identifying and responding to those affected by trauma, coordinated regional trainings regarding Trauma Informed Care, and developed and implemented TIC language for all subcontractors.

### **B. Measurable Results/Positive Impacts since 2008**

### **C. Challenges Encountered/Enhancements Needed in 2013-2018**

- Inadequate availability of programming for substance abuse and mental health treatment and prevention (long waiting list, inadequate care, short-term only)
- Substance abuse and mental health is a widely recognized community issue, but there is little to no support for residents who require services in these areas.

**D. Emerging Opportunities**

- The Alliance for Aging, Inc., is hosting a number of meetings in 2013 to bring Miami-Dade and Monroe community organizations together to discuss issues pertinent to the behavioral health needs of older adults. (Meeting #1 was January 18, 2013; Meeting #2 is scheduled for May 15, 2013.) Depression and other mood disorders in elders are under-recognized and under-treated, and are frequently co-morbid with physical illness (such as diabetes, cancer, and other chronic conditions). The Alliance is meeting with community organizations to share information regarding local resources to address the mental health needs of older adults, to discuss the need for education to recognize the signs of depression and other mental illnesses, and encourage collaboration among community providers to provide preventative intervention services. The next scheduled meeting will focus on evidence-based interventions to address the behavioral health needs of older adults, as well as possible partnerships to seek funding opportunities for the provision of mental health interventions.



## **MAPP Goal: Socioeconomic Factors Impacting Health**

### **A. Existing Approaches/Strategies Underway in Miami-Dade County to address this MAPP Goal**

- Catalyst Miami's Prosperity Campaign (comprehensive benefits application assistance and navigation)
- Campaign for Earned Sick Leave
- Catalyst's Healthcare Heroes life coaching in South Dade with Baptist Health
- Common Threads in school home economic training
- 5000 Role Models of Excellence
- Camillus House
- Chapman Partnership
- Dress for Success
- Habitat for Humanity
- People Acting for Community
- United Way of Miami-Dade
- WeCare of South Dade
- Women's Fund of Miami-Dade

### **B. Measurable Results/Positive Impacts since 2008**

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### **C. Challenges Encountered/Enhancements Needed in 2013-2018**

- High copays and deductibles leading to underinsured
- Lack of awareness of prevention and lack of focus on motivational issues
- Lack of awareness of healthy food purchasing and preparation
- Insufficient focus on integrated care that encompasses social determinants of health (including housing, income, education) leading to unsustainable solutions

### **D. Emerging Opportunities**

- Evidence-Based Approaches that could be replicated in Miami-Dade County
- Others:

### **E. Need to Improve Socioeconomic Factors Impacting Health Embraced as a Priority for Miami-Dade County's MAPP 2013-2018**



## **MAPP Goal: *Promoting Increased Coordination Between Agencies and Across Sectors***

### **A. Existing Approaches/Strategies Underway in Miami Dade County to address this MAPP Goal**

- Alliance for Aging working with Baptist Health on Care Transitions program
- Catalyst Miami working with Baptist Health on Follow-Up Care Clinic and connecting residents to services
- Consortium for Healthier Miami-Dade promotes collaboration and leveraging of resources, implementation of evidenced based practices, and community-focused programs and services. The group comprises governmental agencies, hospitals, businesses, foundations, schools and other entries working together to promote healthier lifestyles.
- Health Connect in Our Schools (HCIOS) and Health Connect in Our Communities (HCIOC)
- Healthy Start Coalition is one of the strongest Healthy Start systems of care in the state. This partnership includes many private and public sector colleagues.
- Hospital Preparedness Consortium: Works with hospitals throughout the community in order to be prepared for manmade and natural disasters.
- United Way will use the results of this MAPP process to inform their health priorities goal area.
- The Miami-Dade Health Action Network (MD-HAN) is working to bring community players together toward a better coordinated health system.
- One-e-App
- Others:

### **B. Measurable Results/Positive Impacts since 2008**

- The Alliance for Aging has partnered with nine area hospitals, six community-based agencies, and Walgreens Pharmacy to form the Greater Miami Coalition to Prevent Unnecessary Re-hospitalizations (GMCPUR). The GMCPUR has implemented a Community-based Care Transitions Program (CCTP) to provide eligible Medicare fee-for-service patients with a coaching intervention to assist with a successful transition from hospital to home and reduce hospital readmissions. Funding for this project is provided by the Center for Medicare and Medicaid Services (CMS).
- CCTP implements an adaptation of the Eric Coleman model (Care Transitions Intervention) which addresses re-admission drivers with components such as medication management, nutrition education, physician/specialist follow-up care, completion of a personal health

record, and education regarding “red flag” indicators or warning signs which indicate the patient should contact their doctor. In addition, GMCPUR’S transition intervention includes the additional components of meals for those in need, and linkage to home and community-based resources through the ADRC (Aging and Disability Resource Center).

- Thirty (30) Communities Putting Prevention to Work (CPPW) outcome objectives were implemented, with 77% of outcome objectives being met
- The Consortium for a Healthier Miami-Dade helped implement the CPPW project. As a result the following success were achieved:
  - Over 650 Child Care Centers and Child Care Family Programs were trained by the University of Miami in the areas of nutrition, physical activity and screen time standards established with CPPW resources; within these trainings, over 1,700 child care center and child care family programs employees were trained. An estimated 100,000 children will benefit from these trainings. Additionally, Consulting Registered Dietitians have reached out to 485 child care centers and child care family programs and as a result, there was a 70% participation in having their menus revised to include healthier food and drink items.
  - Miami-Dade County Public Schools (MDCPS) Food & Nutrition department has worked closely with celebrity chefs to design a menu for reimbursable vending machines. As of Thursday, April 28<sup>th</sup>, 2011, there have been 16 reimbursable vending machines installed in 16 Miami-Dade County Public High Schools with an average of two machines being installed per week and a goal of 23 machine installations by May 16th, 2011. The vending machines avail USDA approved meals to students as an option over lower nutritive items from competitive foods. Throughout the month of March and the first week of April, over 2,800 meals were served in the vending machines. An estimated 10,000 reimbursable meals will be provided to 99,636 high school students when all machines are installed.
  - Hospital Designation Miami-Dade, FL: Baby Friendly and Worksite Lactation Policy: 10 out of 14 birthing centers in Miami-Dade County have agreed to move forward and take steps towards Baby-Friendly Designations and the implementation of a Worksite Lactation Policy. Four of those hospitals have moved to the second pathway (out of four pathways) to Baby-Friendly Designation. An estimated 11,227 mothers will be impacted by the Baby Friendly Hospital Initiative. South Florida Hospital and Healthcare Association (SFHHA) passed a resolution supporting SFHHA’s provision of services associated with the Miami-Dade County Health Department Communities Putting Prevention to Work initiative.
- The GMCPUR partnership plans to serve approximately 8,000 Medicare fee-for-service patients per year, and expects to provide successful post-discharge support to eligible patients, thereby reducing the re-admission rate. Early results indicate the program may reduce unnecessary re-admissions by as much as 46%.

### **C. Challenges Encountered/Enhancements Needed in 2013-2018**

- Fragmentation and lack of coordination involving separate actions undertaken by government, schools, industry and the voluntary and philanthropic sectors
- Inadequate service to incarcerated individuals

- Lack of utilization of electronic medical records which would allow for better coordinated and non-duplicative care.
- Lack of technological integration – The FQHC’s utilize a HL7 interface but the FLDOH clinics utilize HMS.

**D. Emerging Opportunities**

- Department of Children and Families (DCF) and University of Miami Childcare Taskforce work through the Consortium for a Healthy Miami-Dade
- Evidence-Based Approaches that could be replicated in Miami Dade County
- Miami-Dade Health Access Network (MD-HAN) initiatives including One-E-App and Electronic Medical Records
- Others:

**E. Need to Increase Coordination Across Agencies and Sectors Embraced as a Priority for Miami-Dade County’s MAPP 2013-2018**



## **MAPP Goal: Reducing Heart Disease & Stroke in Miami-Dade County**

### **A. Existing Approaches/Strategies Underway in Miami-Dade County to address this MAPP Goal**

- Community Health Action Team (CHAT): Provides blood pressure, BMI, body fat, carbon monoxide and diabetes risk screenings. Also provide educational class on cardiovascular health, nutrition and other health topics.
- Consortium for a Healthier Miami-Dade: Community initiative made up of several organizations working together on projects that promote policies, systems and environmental changes that will have an impact on chronic disease.
- Worksite Wellness Program: Program provides technical assistance to organizations wishing to implement a program. Staff also provides educational programs and screenings on chronic disease.

#### Florida Heart Research Institute (FHRI)

- Cardiovascular Risk Factor Screening started in 2001
- Living for Health (L4H) started in 2008 - is a cardiovascular community health program that targets underserved and uninsured adults throughout Miami-Dade County
- PUSH CPR® started in 2011 - PUSH CPR® is a public awareness campaign educating the public about bystander-continuous chest compression CPR.

#### American Heart Association

- American Heart Association (AHA) targeting three major prevention issue areas:
  1. Healthy Diet & Nutrition Education
  2. Physical Activity
  3. Blood Pressure awareness and self-management of chronic hypertension
- AHA Simple Cooking with Heart demonstrations and heart-healthy nutrition information taken directly into underserved neighborhoods through churches, health fairs, events, etc.;
- AHA new certification program for Walking Paths;
- AHA Fit Friendly Award recognition program for organizations that care about their employees' health;
- AHA "Get to Goal" Program to educate communities about blood pressure and to enroll participants in a unique software program called "Heart360" which provides BP tracking and heart-healthy tips;
- AHA "Together to End Stroke" to raise awareness about stroke, how to prevent it, and how to recognize it using a new mobile phone app (F.A.S.T.);

- AHA Text health-messaging campaign focusing on heart-health, nutrition, physical activity, and general wellness
- South Miami Heart Center Screenings, free programs on heart disease risk factors, recognizing heart attack symptoms, and relationship betw. obesity & heart disease  
Other Local Agencies/Contributors
- One beat CPR

## **B. Measurable Results/Positive Impacts since 2008**

- FHRI Cardiovascular Risk Factor screening on-site and off-site total participants 46,624
- L4H alone screened 9,453 individuals of which 5,571 were referred for medical follow-up. 2,787 were referred to an FQHC; of those 1,889 were new patients. HCN follow-up data showed 201 or 11% were matched to a medical home.
- PUSH CPR® - 7263 people have been trained and taken our pledge to act with PUSH CPR® if they see someone collapsed who is not breathing

In Miami-Dade County, ***the stroke death rate has improved significantly in the last decade:***

- In 2009, the age-adjusted death rate due to stroke in Miami-Dade was 29.5 deaths per 100,000 people; down from the 2003 rate of 38.4 deaths per 100,000 and is better than the statewide average of 30.3 deaths per 100,000.
- In Miami-Dade County, Blacks continue to have a higher death rate than Whites and Hispanics during the same year at 40.6, 26.5, and 25.2 per 100,000 people, respectively. (Source: Miami Matters, 2010)
- Mortality rates from CVD & stroke have steadily declined over the last three years, dropping by 6.1%.
- There were more than 32,000 fewer age-adjusted deaths from CVD and stroke in 2009 than in 2007 (last years for which data is available).
- Rates of non-smoking and decreased blood sugar levels are improving.
- Improvements are being seen among children in body-weight (by BMI-for-age).
- Blood pressure levels are dropping.

## **C. Challenges Encountered/Enhancements Needed in 2013-2018**

- Insufficient funding for services
- Getting people identified as at-risk to seek treatment
- Individuals, workplaces & communities not prioritizing health
- In Miami-Dade, there has been an increase in ***hypertensive heart disease death rate in the last decade*** (Source: Miami Matters, 2010)
  - In 2009, the age-adjusted death rate due to hypertensive heart disease in Miami-Dade was 13.4 deaths per 100,000; a rate that **increased** from 12.9 in 2003, and is worse than the statewide rate of 9.7 per 100,000.
  - Blacks have more than twice the hypertensive heart disease death rate as compared to Whites and Hispanics, at 23.3, 11.2 and 9.6 per 100,000.

More work needs to be done in order to reach the Impact Goal for 2020, including:

- Physical activity levels are worsening for both adults and children; in adults, BMI levels (obesity levels) are rising.
- Cholesterol levels are rising in both adults and children.
- Blood pressure is worsening for adults
- The disparity gaps still are wide between CVD/stroke rates among Blacks, Hispanics and Whites.

#### **D. Emerging Opportunities**

- Programs and services listed above under Section A are opportunities to reduce CVD and stroke rates in Miami-Dade County, particularly among underserved populations.
- Faith-based and health ministry partnerships are being fostered by AHA, as well as at worksites and educational institutions
- In the Miami-Ft Lauderdale AHA, there are renewed and aggressive efforts to promote heart-health messaging, recruit volunteers, develop a cadre of Ambassadors, raise funding for community interventions and research, and apply evidence-based approaches to community interventions (for example, the Get to Goal program).
- Many opportunities exist to collaborate and partner with the AHA -- not only to decrease CVD and stroke in our area, but to improve overall health, as well.
- One area of great opportunity is the advocacy component, with AHA serving as the “voice” for governmental and other groups with limited advocacy capacity.
- Another area is mobile-phone technology, which is emerging as:
  - a vehicle for heart-healthy messaging (for example, text HEALTH to 2722 to receive weekly health tips).
  - a delivery mechanism for applications, such as the F.A.S.T. Campaign to raise awareness about strokes.
- L4H is a community health model that produces statistically significant outcomes that is easily replicated
- Focus on outcomes measurements
- Economies of scale: aligning with health dept.’s Consortium for a Healthier Miami-Dade, community, non-profits to work towards one goal under proactive and enthusiastic leadership

#### **E. Heart Disease & Stroke Prevention Strategies Embraced as a Priority for Miami-Dade County’s MAPP 2013-2018**