

Florida State Health Improvement Plan 2012–2015

APRIL 2012

A statewide plan for public health system partners and stakeholders to improve the health of Floridians



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Executive Summary

“Health begins with healthy communities, with safe streets, freedom from violence, and parks where kids can play. Health begins with a good education, where children learn not only how to read, write, and prepare for fulfilling, prosperous lives, but how to treat each other with dignity and respect. And health begins with safe jobs and fair wage, where people derive a sense of personal satisfaction from their work and connection to their co-workers. ...”

HEALTH IS MUCH MORE THAN HEALTH CARE.

Health starts in communities where healthy choices about what to eat, how much to exercise, or whether to smoke or bicycle or work are easy choices. Health starts where the environments in which we live—our schools, workplaces, and neighborhoods—are health enhancing.

To improve the health of all Floridians, our communities must commit to action that goes beyond “health care.” Under the leadership of the state Surgeon General, a diverse group of partners in Florida who have an interest in and impact on improving the health of the state’s residents and visitors were tasked to create a blueprint for action, culminating in this State Health Improvement Plan (SHIP).

The SHIP is a plan for the entire public health system—all stakeholders including state and local government, health care providers, employers, community groups, universities and schools, environmental groups, and many more. The SHIP enables loosely-networked system partners to coordinate for more efficient, targeted and integrated health improvement efforts.

Developing the SHIP itself has served as a catalyst for moving diverse groups and sectors of the state toward a common health agenda. The SHIP Steering Committee, a leadership group representing eight agencies and organizations, used results from four assessments to set priorities by looking for cross-cutting strategic issues. Goals, strategies, and objectives around each of the strategic issue areas comprise the SHIP.

The plan identifies high-impact strategic issues and desired health and public health system

outcomes to be achieved by the collaborative activities of the many partners who provided input. Potential partners and users of this plan include county health departments (CHDs), health districts, health planning organizations, health and social service organizations, hospitals, federally qualified health centers, partner agencies, emergency responder organizations, state and local governments, the general public, elected officials, media, chambers of congress, employers, health and social service agencies, foundations, funding organizations, the business community, and academic institutions. The plan can be used for state, regional and local community health improvement planning, regional and local community health assessment, agency strategic planning, operational planning, state, regional and local emergency preparedness, accountability, performance management, quality improvement, informing, educating, and empowering residents about Florida’s health issues, marketing, grant seeking and grant making, workforce assessment and planning, and identifying research and innovation opportunities.

The SHIP reflects a commitment of partners and stakeholders to collaborate in addressing shared issues in a systematic and accountable way. The ongoing process of implementing the SHIP will bring together these system partners on a periodic, regular basis to review progress in meeting SHIP goals. Only by working together can we make a difference.

“...No institution alone can restore a healthy America that nurtures families and communities. That will require leadership, and a partnership of business, government, and civic and religious institutions.”

Recommendations The Steering Committee reached consensus on five strategic issue areas which are detailed below. The full plan also includes goals, strategies and objectives for each.

- 1 HEALTH PROTECTION** All Floridians and visitors must be protected from infectious and environmental threats, injuries and natural and man-made disasters. The public health system should:
- Prevent and control infectious disease.
 - Prevent and reduce illness, injury and death related to environmental factors.
 - Minimize loss of life, illness and injury from natural or man-made disasters.
 - Prevent and reduce unintentional and intentional injuries.

- 2 CHRONIC DISEASE PREVENTION** Tobacco, obesity, sedentary lifestyle and poor nutrition are risk factors for numerous chronic diseases, and they exacerbate other diseases, including heart disease, hypertension, asthma and arthritis. The Florida public health system must act quickly to:
- Increase the percentage of adults and children who are at a healthy weight.
 - Increase access to resources that promote healthy behaviors.
 - Reduce chronic disease morbidity and mortality.
 - Reduce illness, disability and death related to tobacco use and secondhand smoke exposure.

- 3 COMMUNITY REDEVELOPMENT AND PARTNERSHIPS** Health care and health-related information must be provided in a manner that is culturally sensitive. Community partnerships are critical to synergizing community planning activities so that they positively change the natural and built environment and ultimately improve population health. The public health system should:
- Integrate planning and assessment processes to maximize partnerships and expertise of a community in accomplishing its goals.
 - Build and revitalize communities so people can live healthy lives.

- 4 ACCESS TO CARE** Limited access to health care services, including behavioral and oral health care, may contribute to poor health outcomes and high health care costs. The public health system should:
- Regularly assess Florida's health care access resources and service needs.
 - Improve access to primary care services.
 - Improve behavioral health services so that children, adults and families are active, self sufficient participants in their communities.
 - Enhance access to preventive, restorative and emergency oral health care services.
 - Reduce maternal and infant morbidity and mortality.
 - Meet special health care needs of children, persons with disabilities and elders.
 - Provide equal access to culturally and linguistically competent care.

- 5 HEALTH FINANCE AND INFRASTRUCTURE** Performance measurement, continuous improvement, accountability and sustainability of the public health system can help to ensure Florida's population is served efficiently and effectively. Highly functioning data collection and management systems, electronic health records and systems of health information exchange are necessary for understanding health problems and threats and for crafting policies and programs to address them. Florida's public health system should:
- Use health information technology to improve the efficiency, effectiveness and quality of patient care coordination, patient safety and health care outcomes.
 - Assure adequate public health funding to control infectious diseases, reduce premature morbidity and mortality due to chronic diseases and improve health status of residents and visitors.
 - Attract, recruit and retain a prepared, diverse and sustainable public health workforce in all geographic areas of Florida.
 - Promote an efficient and effective public health system through performance management and collaboration among public health system partners.

Introduction

Accountable and effective public health practice depends upon comprehensive and strategic health improvement planning.

At the local level, county health departments (CHDs) coordinate and work in conjunction with their local public and private sector public health partners to identify, evaluate, prioritize and address community health issues. Similarly, at the state level, the Department of Health (DOH) has identified state-level partners and stakeholders to do the same.

The Florida State Health Improvement Plan (SHIP) was developed by a broadly defined public health system—the public, private and voluntary entities that contribute to the health and well-being of the residents of Florida—to promote collaboration, coordination and efficiency. The plan identifies high-impact strategic issues and desired health and public health system outcomes to be achieved by the coordinated activities of the many partners who provided input.

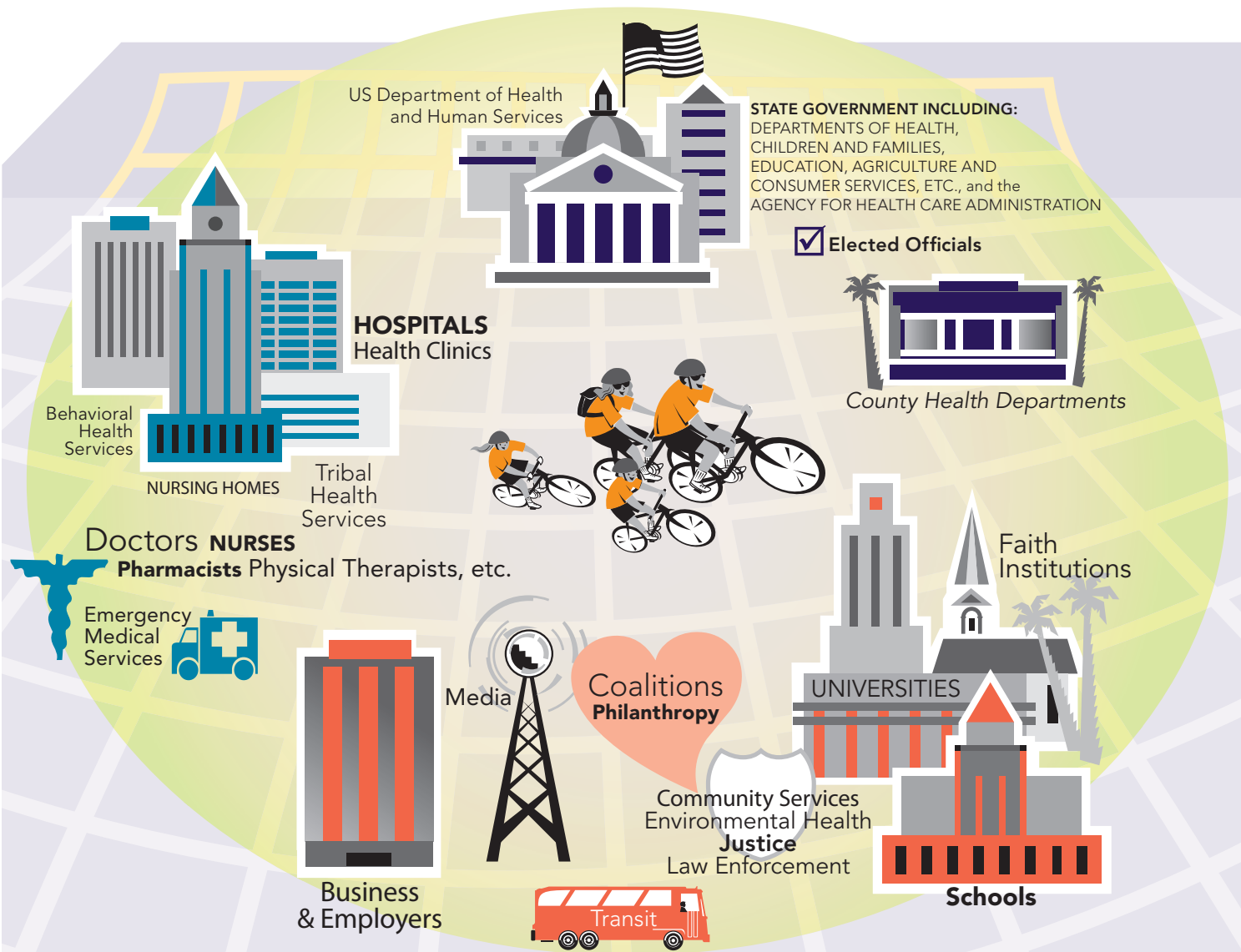
Potential partners and users of this plan include CHDs, health districts, health planning organizations, health and social service organizations, hospitals, federally qualified health centers, partner agencies, emergency responder organizations, state and local governments, the general public, elected officials, media, chambers of congress, employers, health and social service agencies, foundations, funding organizations, the business community, and academic institutions. The plan can be used for state, regional and local community health improvement planning, regional and local community health assessment, agency strategic planning, operational planning, state, regional and local emergency preparedness, accountability, performance management, quality improvement, informing, educating, and empowering residents about Florida's health issues, marketing, grant seeking and grant making, workforce assessment and planning, and identifying research and innovation opportunities.

The SHIP Steering Committee, a diverse leadership group representing eight agencies and organizations, set priorities by looking for cross-cutting strategic issues that emerged from a series of four assessments that together provided a comprehensive appraisal of health and quality of life in Florida. The Steering Committee reached consensus on five strategic issue areas: Health Protection, Chronic Disease Prevention, Community Redevelopment and Partnerships, Access to Health Care, and Health Finance and Infrastructure.

The process of developing the SHIP has served as a catalyst for moving diverse groups and sectors of the state toward a common health agenda. The ongoing process of implementing the SHIP will bring together these system partners on a periodic, regular basis to coordinate to meet SHIP goals. As such, this plan is meant to be a living document rather than an end point. It reflects a commitment of partners and stakeholders to coordinate to address shared issues in a systematic and accountable way.



WHAT PRODUCES OUR HEALTH? In order to effectively plan for improving health, we must understand and account for the many ways that where we live, learn, work and play contributes to our health. Most of us know that in order to stay healthy, we need to eat a balanced diet, get plenty of exercise and the recommended immunizations, avoid smoking, wash our hands and see a doctor when we are sick. What many do not know is that our health is also shaped by the social, economic and environmental conditions in which we live, such as the quality of our schooling, the cleanliness of our water, food and air, the economy in which we work and the community resources we can access. As we go forward with the SHIP for Florida, it is important to address the conditions that actually produce our health rather than only treating medical conditions after they occur.



Public Health: A Network of Partners Working for the Well-Being of Floridians

Understanding how health begins with the conditions under which people live, work and play—such as good housing, access to services, meaningful employment and clean drinking water—allows state partners to design interventions that can grow healthy people and their local economies. For example, the development of green spaces can boost residents’ physical well-being, prevent and reduce chronic disease, and improve the commercial attractiveness of an area. Similarly, healthy people have lower health care costs, fewer sick days, and are more productive—all of which are critical to economic growth. In short, what’s good for health is also good for business. We wanted to design a SHIP to leverage such synergies so that individuals and organizations who do not usually consider public health concerns can see their stake in them.

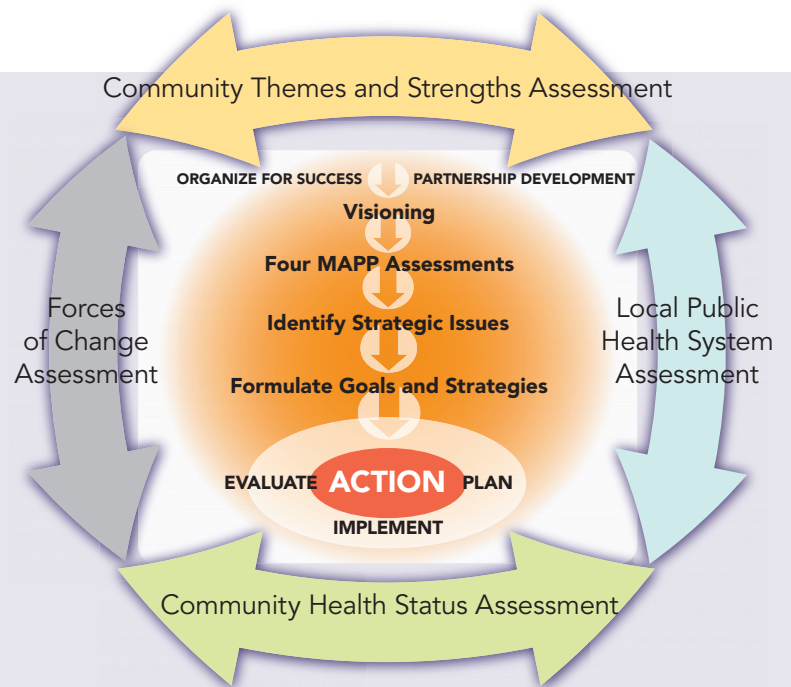
WHO CONTRIBUTES TO THE HEALTH AND WELL BEING OF THE PEOPLE OF THE STATE?

Because DOH bears statutory responsibility for protecting the public’s health, its staff initiated the SHIP and convened partners to develop it. DOH staff will also be responsible for ongoing monitoring of the SHIP. However, DOH is only one part of the public health system. Other agencies, non-governmental organizations, institutions and informal associations play critical roles in creating conditions in which people can be healthy. DOH leadership realized that government alone cannot match the collective strength of individuals, communities and various social institutions working together to improve health, so they created a collaborative state health improvement process, culminating in the SHIP. The ongoing SHIP process and the plan itself both reflect efforts of many of the key players in the public health system to promote collaboration, coordination and efficiency.

HOW WAS THIS STATE HEALTH IMPROVEMENT PLAN DEVELOPED? In November of 2011, the Florida DOH Surgeon General, H. Frank Farmer, Jr., MD, PhD, FACP, convened the SHIP Planning Team, made up of staff from the Office of Health Statistics and Assessment and the Office of Performance Improvement. The SHIP Planning Team facilitated the SHIP process through a state-level adaptation of the National Association of City and County Health Officials (NACCHO's) Mobilizing for Action through Planning and Partnership (MAPP) strategic planning model.

Florida's CHDs have been leaders for many years in MAPP-based community health assessment and health improvement planning. We follow the lead of the CHDs by designing the state process to use MAPP strategies so that the assessments and resulting plan would be as comprehensive as those at the local community health level. Furthermore, by using the same planning model as the CHDs, we hoped to align community health improvement plans and the SHIP, highlight shared priorities and point to systemwide solutions.

Subject matter experts from across a diverse group of partners conducted the four types of assessments suggested by the MAPP process (see Appendices A through D for more information on how and with whom each assessment was conducted). Individually, the assessments yielded in-depth analyses of factors and forces that impact population health. Taken together, the assessment findings contribute to a comprehensive view of health and quality of life in Florida. The four assessments, discussed below, comprise Florida's state health assessment.



The MAPP Model

The State Health Status Assessment identifies priority health and quality of life issues. Questions answered here include, "How healthy are our residents?" and "What does the health status of our state look like?"

The State Public Health System Assessment focuses on all of the organizations and entities that contribute to the public's health. The Public Health System Assessment answers the questions, "What are the components, activities, competencies and capacities of our public health system?" and "How are the Essential Services being provided to our state?"

The State Themes and Strengths Assessment identifies the important health issues as perceived by state residents. The assessment answers the questions: "What is important to the state?"; "How is quality of life perceived in the state?"; and "What assets exist that can be used to improve health in the state?"

The State Forces of Change Assessment determines forces that impact the way the system operates, including things like legislation, funding shifts, technology or other impending changes that may affect state residents or the state system. Threats or opportunities generated by these occurrences should be considered. It answers the questions, "What is occurring or might occur that affects the health of our state?" and "What specific threats or opportunities are generated by these occurrences?"

From each assessment, the Team developed findings and presented these findings to the Steering Committee. The Steering Committee comprised a diverse leadership group representing eight agencies and organizations—governmental, university, community-based and non-governmental organizations—along with representation from DOH. The Steering Committee met on November 18, 2011, and set priorities through a facilitated consensus process by looking for cross-cutting strategic issues that emerged from the four assessments. The group defined strategic issues as fundamental policy choices or critical challenges that seize on current opportunities and are important and forward thinking. The Steering Committee reached consensus on five strategic issue areas: Health Protection, Chronic Disease Prevention, Community Redevelopment and Partnerships, Access to Health Care, and Health Finance and Infrastructure.

The Steering Committee initially identified health disparities as a strategic issue area of its own.

focuses on the community-level conditions that produce health—such as the built environment, the availability of healthy food, the accessibility of opportunities to exercise, residents’ safety and the quality of their housing. The resulting community strategies will help to create the social and physical environments that allow all Floridians to have opportunities to make the choices that lead to good health.

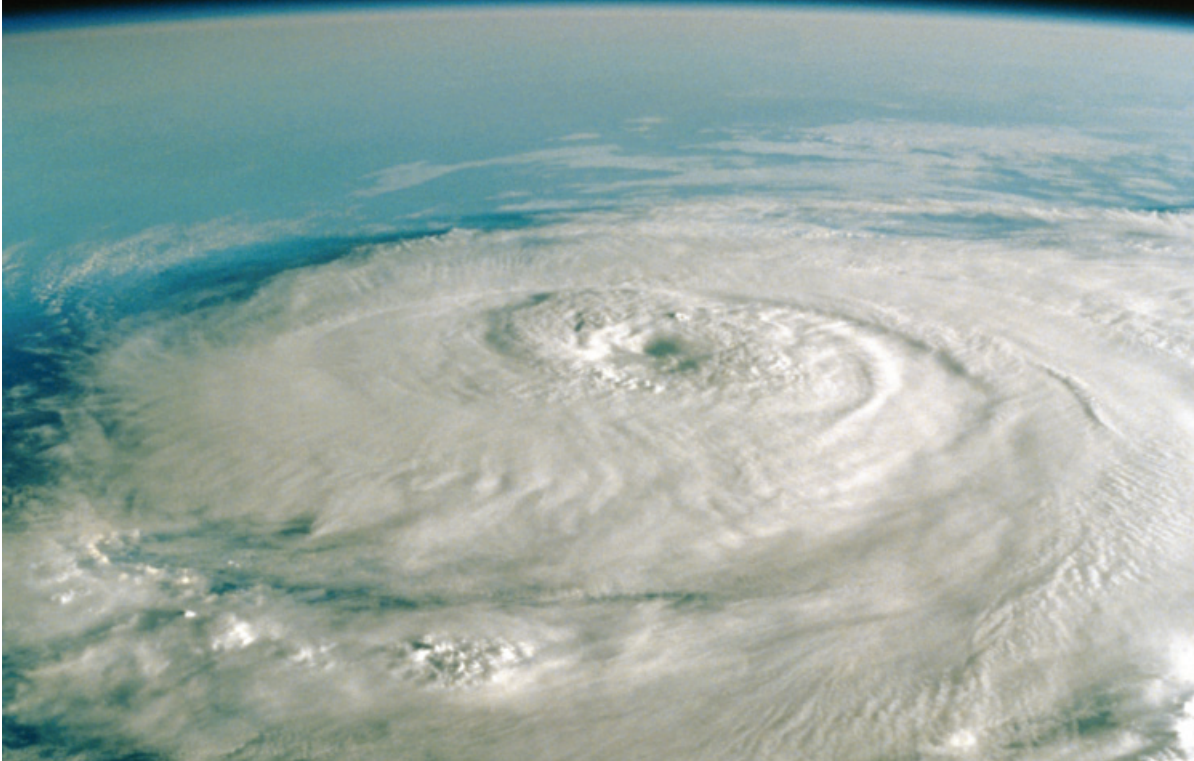
After the Steering Committee identified the strategic issues, an inter-agency workgroup of subject matter experts identified stakeholders and developed goal statements, strategies and measurable objectives. In order to align the state’s work with national objectives, workgroup members referred to Healthy People 2020, the National Prevention Strategy, the Health and Human Services Action Plan to Reduce Disparities, and the Centers for Disease Control and Prevention (CDC) Public Health Preparedness Performance Measures, and adopted or aligned with the objectives that were applicable. Additionally, when choosing strategies

After the Steering Committee identified the strategic issues, an inter-agency workgroup of subject matter experts identified stakeholders and developed goal statements, strategies and measurable objectives.

A health disparity is a difference in health status or in health services delivery that is associated with social, economic or environmental disadvantage. In other words, it is an indication that all Floridians do not have the same chance for good health. The Steering Committee ultimately decided to make health disparities a cross-cutting issue because they were a concern within so many of the strategic issue areas. Most of the strategic issue areas have disparity objectives which will be tracked according to race, gender, ethnicity and socioeconomic status when these data are available (see Appendix E for a complete list of Key Health Disparity Objectives).

Consistent with one of the overarching goals of Healthy People 2020, to “create social and physical environments that promote good health for all,” the Steering Committee wanted to have one area, Community Redevelopment and Partnerships, that

for each strategic issue, workgroup members considered CDC’s Winnable Battles (known effective strategies for improving outcomes within five years) and the recommendations from the CDC’s Community Guide. See Appendix F for strategies and objectives that align with national or state goals, objectives, or measures.



Health Protection

All Floridians must be protected from infectious and environmental threats, injuries, and man-made disasters. The public health system should:

- Prevent and control infectious disease.
- Prevent and reduce illness, injury and death related to environmental factors.
- Minimize loss of life, illness and injury from natural or man-made disasters.
- Prevent and reduce unintentional and intentional injuries.

Health Protection

Goal HP1 Prevent and control infectious disease.

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

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

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

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

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

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

Strategy HP1.2 Prevent exposure to, and infection from illness and disease-related complications from sexually transmitted diseases (STDs), tuberculosis (TB) and other infectious diseases through educational outreach, testing, behavior change, early identification and treatment and community collaboration.

OBJECTIVE HP1.2.1 By Dec. 31, 2013, reduce the bacterial STD case rate among females 15–34 years of age from 2627.3 per 100,000 (2010) to 2620 per 100,000.

OBJECTIVE HP1.2.2 By Dec. 31, 2015, increase the percentage of women diagnosed with a bacterial STD and treated within 14 days from 75% to 90%.

OBJECTIVE HP1.2.3 By Dec. 31, 2015, reduce the TB case rate from 4.4 per 100,000 (2009) to 3.5 per 100,000.

OBJECTIVE HP1.2.4 By Dec. 31, 2015, the completion of treatment rate for active TB cases will be 98%.

OBJECTIVE HP1.2.5 By Dec. 31, 2015, achieve a TB genotyping rate of 100%.

OBJECTIVE HP1.2.6 By Dec. 31, 2015, increase the percentage of TB patients completing therapy within 12 months of initiation of treatment from 90% (2008) to 93%.

OBJECTIVE HP1.2.7 By Dec. 31, 2013, reduce the enteric disease case rate per 100,000 from 59.2 (2009) to 51.7.

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



Strategic Issue Area: Health Protection

Strategy HP1.3 Prevent exposure, infection, illness and death related to HIV and AIDS through educational outreach, enhanced testing initiatives, human behavior change, and county and community collaborations with particular focus on reducing social stigma and racial disparities. ²⁰

OBJECTIVE HP1.3.1 By Dec. 31, 2015, reduce the AIDS case rate per 100,000 from 21.8 (2010) to 20.5. ²⁰ ↻

OBJECTIVE HP1.3.2 By Dec. 31, 2015, increase the percentage of HIV-infected people in Florida who know they are infected from 80% (2010 estimate) to 95%. ²⁰ ★

OBJECTIVE HP1.3.3 By Dec. 31, 2015, increase the percentage of HIV-infected people in Florida who have access to and are receiving appropriate prevention, care and treatment services from 55% (2010) to 65%. ²⁰

OBJECTIVE HP1.3.4 By Dec. 31, 2015, reduce the number of new HIV infections in Florida to be at or below the national state average per year with particular focus on the elimination of racial and ethnic disparities in new HIV infections. ²⁰

OBJECTIVE HP1.3.5 By Dec. 31, 2015, increase the percentage of currently enrolled AIDS Drug Assistant Program (ADAP) clients with suppressed viral load from 85% (2010) to 90%.

Strategy HP1.4 Conduct disease surveillance to detect, monitor and collect data for public health program planning, evaluation and policy development.

OBJECTIVE HP1.4.1 By Dec. 31, 2012, greater than 75% of selected reportable disease cases of public health significance will be reported from County Health Departments within 14 days of notification.

OBJECTIVE HP1.4.2 By Dec. 31, 2012, and annually, prepare and disseminate an annual summary of the occurrence of notifiable disease and conditions in Florida.

OBJECTIVE HP1.4.3 By Dec. 31, 2015, produce and disseminate a plan, protocols and procedures for enhanced surveillance and real-time data reporting during an event.

OBJECTIVE HP1.4.4 By Dec. 31, 2013, increase the number of laboratories electronically submitting reportable laboratory results to DOH as required by Chapter 64D-3 F.A.C. from 45 to 75.

OBJECTIVE HP1.4.5 By Dec. 31, 2013, increase the number of hospitals and urgent care centers submitting electronic information used for syndromic surveillance to Florida DOH from 170 to 185.

COORDINATING AGENCY DOH

PARTNERS AND STAKEHOLDERS

Florida: Agency for Health Care Administration; Department of Transportation; Department of Management Services; Water Management Districts; State Fire Marshall; Florida Cooperative Extensions; Department of Business and Professional Regulation; Department of Children and Families; Department of Elder Affairs; Department of Environmental Protection; Department of Agriculture and Consumer Affairs; Public Service Commission; Department of Law Enforcement; Department of Corrections; Fish and Wildlife Conservation Commission; Florida Highway Patrol; Division of Alcoholic Beverages and Tobacco; Attorney General; Department of Revenue

US: Coast Guard; Federal Communications Commission; Army Corps of Engineers; USDA Fire Service; American Red Cross; Salvation Army; Health and Human Services; Centers for Disease Control and Prevention; Air Force; Civil Air Patrol; Environmental Protection Agency; USDA; Department of Energy; Navy; Marine Corps; National Guard; Department of Defense; FBI; Department of Justice; Customs and Border Protection; FEMA; Humane Society; Disaster Center

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



Strategic Issue Area: Health Protection

Goal HP2 Prevent and reduce illness, injury and death related to environmental factors.

Strategy HP2.1 Prevent illness, injury and death related to environmental factors through educational outreach, human behavior change, and county and community collaborations.

OBJECTIVE HP2.1.1 By Dec. 31, 2014, 100% of Florida counties will complete the Environmental Public Health Performance assessment, use data to determine gaps and opportunities and create action plans.

OBJECTIVE HP2.1.2 By Dec. 31, 2015, a Protocol for Assessing Community Excellence in Environmental Health (PACE EH) process will be implemented in 34 counties (baseline: 15 counties in 2011).

Strategy HP2.2 Identify environmental threats through monitoring and surveillance from inspections, notifications from other agencies, data collection, analysis and data sharing.

OBJECTIVE HP2.2.1 By Sept. 30, 2012, and annually ensure that 90% of illness outbreaks associated with a regulated facility have an environmental assessment or inspection done within 48 hours of initial outbreak report.

OBJECTIVE HP2.2.2 By Dec. 31, 2015, increase the number of electronically submitted food complaints from 67% to 100%.

OBJECTIVE HP2.2.3 By Dec. 31, 2015, reduce the prevalence of lead poisoning among screened children less than 6 years old with blood lead levels equal to or greater than 10 micrograms per deciliter.²⁰

Strategy HP2.3 Advance programs to ensure compliance with public health standards.

OBJECTIVE HP2.3.1 By Dec. 31, 2015, ensure that 93.5% of public water systems have no significant health drinking water quality problems.²⁰

OBJECTIVE HP2.3.2 By Dec. 31, 2015, complete 90% of inspections of all other entities with direct impact on public health according to established standards.

Strategy HP2.4 Provide consultation to community planners to ensure healthy re-use of land.

OBJECTIVE HP2.4.1 By Jan. 31, 2013, DOH will offer comprehensive support and technical assistance to CHDs to perform Health Impact Assessments that will inform the decision-making process about health consequences of plans, projects and policies.

COORDINATING AGENCY DOH

PARTNERS AND STAKEHOLDERS Florida Department of Environmental Protection; Florida Department of Business and Professional Regulation; Florida Department of Agriculture and Consumer Services

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



CDC's
Community
Guide



CDC
Public Health
Preparedness



CDC's
Winnable
Battles



Healthy
People
2020



Key Health
Disparity
Objective



National
Prevention
Strategy



PAHPA
Benchmark
Measure



State Agency
Long Range
Program Plan

Strategic Issue Area: Health Protection

Goal HP3 Minimize loss of life, illness and injury from natural or man-made disasters.

Strategy HP3.1 Prepare the public health and health care system for all hazards, natural or man-made.

OBJECTIVE HP3.1.1 By Dec. 31, 2013, complete After Action Reports and Improvement Plans within 30 days of exercise or real event. ⊕

Strategy HP3.2 Ensure that systems and personnel are available to effectively manage all hazards.

OBJECTIVE HP3.2.1 Annually, ensure pre-identified staff covering Public Health and Medical incident management command roles can report to duty within 60 minutes or less. ✓

Strategy HP3.3 Ensure surge capacity to meet the needs of all hazards.

OBJECTIVE HP3.3.1 By Dec. 31, 2013, achieve and maintain national Public Health Preparedness Capabilities and Standards through implementation of the Public Health and Health Care Preparedness Strategic Plan. ⚡

Strategy HP3.4 Institute appropriate and effective mitigation for the health consequences of any event.

OBJECTIVE HP3.4.1 By Dec. 31, 2013, receive a composite performance indicator of 43 from the Division of Strategic National Stockpile in CDC's Office of Public Health Preparedness and Response. ⊕

Strategy HP3.5 Detect, monitor and track, investigate and mitigate chemical, biological, radiological, nuclear and explosive (CBRNE) threats and their associated health consequences.

OBJECTIVE HP3.5.1 By Dec. 31, 2013, complete notification among CDC, on-call epidemiologist and on-call laboratorian within 45 minutes of threat. ⊕

OBJECTIVE HP3.5.2 By Dec. 31, 2013, Laboratory Response Network Biological reference laboratory completes contact with the CDC Emergency Operations Center within 2 hours during LRN notification drill. ⊕

Strategy HP3.6 Create an informed, empowered, and resilient public and a prepared health system.

OBJECTIVE HP3.6.1 By June 30, 2015, disseminate risk communications messages to the public within three hours of any incident. ⊕

OBJECTIVE HP3.6.2 By June 30, 2015, increase the number of *community sectors*, in which CHDs identified key organizations to participate in significant public health, medical, and mental or behavioral health-related *emergency preparedness* efforts or activities, from 0 to 11.

The 11 community sectors are: business, community leadership, cultural and faith-based groups and organizations, education and childcare settings, emergency management, health care, housing and sheltering, media, mental or behavioral health, social services and senior services.

Significant public health emergency preparedness efforts/activities include: development of key organizations' emergency operations or response plans related to public health,

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



CDC's
Community
Guide



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Preparedness



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Strategic Issue Area: Health Protection

medical, and mental or behavioral health; exercises containing objectives or challenges (e.g. injects) related to public health, medical, and mental or behavioral health; competency-based training related to public health, medical, and mental or behavioral health emergency preparedness and response. 


COORDINATING AGENCY Florida DOH Bureau of Preparedness and Response




PARTNERS AND STAKEHOLDERS Florida Division of Emergency Management

Goal HP4 Prevent and reduce unintentional and intentional injuries.

Strategy HP4.1 Facilitate opportunities for collaborative injury prevention efforts in traffic safety, poisoning, interpersonal violence, suicide, child maltreatment, fall-related injuries among seniors, early childhood water safety and drowning prevention and other injuries.

OBJECTIVE HP4.1.1 By Dec. 31, 2012, develop a senior falls prevention plan.


OBJECTIVE HP4.1.2 By Dec. 31, 2012, develop and implement annually thereafter a statewide early childhood (ages 1–4) safety and drowning prevention campaign. 

OBJECTIVE HP4.1.3 By Dec. 31, 2015, reduce the rate of deaths from all causes of external injury among Florida resident children ages 0–14 from 9.0 per 100,000 to 7.6 per 100,000 in those Florida counties with existing state-local injury prevention partnerships.   

Strategy HP4.2 Implement detection and surveillance through data collection, analysis and sharing.

OBJECTIVE HP4.2.1 By Dec. 31, 2012, and annually update data sources in the Florida Injury Surveillance Data System and disseminate annual injury data report.

Strategy HP4.3 Respond to injuries by ensuring treatment or follow-up, improved long-term consequences/outcomes of injuries, compliance with standards, collaboration with other agencies and communication with stakeholders.

OBJECTIVE HP4.3.1 By Dec. 31, 2015, reduce the statewide trauma mortality rate from 6.5% to meet the average U.S. trauma mortality rate of 4.4% or less. 

COORDINATING AGENCY DOH

PARTNERS AND STAKEHOLDERS Department of Elder Affairs; Florida Department of Highway Safety and Motor Vehicles; Florida Department of Transportation; Community Traffic Safety Teams; SafeKids Coalition; Agency for Health Care Administration

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Chronic Disease Prevention

Obesity, sedentary lifestyle, tobacco and poor nutrition are risk factors for numerous chronic diseases and they exacerbate others, including heart disease, hypertension, asthma and arthritis. The Florida public health system must act quickly to:

- Increase the percentage of adults and children who are at a healthy weight.
- Increase access to resources that promote healthy behaviors.
- Reduce chronic disease morbidity and mortality.
- Reduce illness, disability and death related to tobacco use and secondhand smoke exposure.


Chronic Disease Prevention

Goal CD1 Increase the percentage of adults and children who are at a healthy weight.²⁰ 

Strategy CD1.1 Assess clinician practices in documenting body mass indices (BMI) of patients and providing education and counseling on nutrition and physical activity.²⁰

OBJECTIVE CD1.1.1 By Dec. 31, 2013, develop a process and system to collect data on the number of health care providers who calculate and document body mass index of their patients.

OBJECTIVE CD1.1.2 By Dec. 31, 2013, develop a process and system to collect data on the number of health care providers that provide counseling or education related to achieving or maintaining a healthy weight for their patients.

Strategy CD1.2 Promote the use of evidenced-based clinical guidelines to assess overweight and obesity and establish principles of safe and effective weight loss. Examples may include: *The Practical Guide: Identification, Evaluation and Treatment of Overweight and Obesity in Adults*; *American Heart Association's Dietary Recommendations for Children and Adolescents: A Guide for Practitioners*; *2008 Physical Activity Guidelines for Americans*; and the *Guide to U.S. Clinical Services (includes U.S. Preventive Services Task Force recommendations)*.²⁰ 

OBJECTIVE CD1.2.1 By Dec. 31, 2014, increase by 10% the number of targeted health care providers who calculate and document body mass index of their patients.²⁰

OBJECTIVE CD1.2.2 By Dec. 31, 2014, increase by 10% the number of targeted health care providers that provide counseling or education related to achieving or maintaining a healthy weight for their patients.²⁰

Strategy CD1.3 Increase the availability of healthful food.²⁰  

OBJECTIVE CD1.3.1 By June 30, 2013, DOH will identify and disseminate model policies and practices that increase availability and consumption of healthy foods.²⁰

OBJECTIVE CD1.3.2 By June 30, 2013, DOH and the Department of Management Services will work to disseminate best practices and model policies to offer competitively priced healthy foods in vending machines in all state/public buildings.²⁰

OBJECTIVE CD1.3.3 By June 30, 2013, DOH will facilitate agreement among stakeholders on a standard data source or methodology for identifying food deserts.²⁰

OBJECTIVE CD1.3.4 By June 30, 2013, DOH will identify and disseminate model policies and practices that support food self-sufficiency.²⁰

OBJECTIVE CD1.3.5 By June 30, 2013, DOH will collaborate with the U.S. Department of Agriculture's Women, Infants and Children (WIC) and Supplemental Nutrition Assistance Program (SNAP) to expand opportunities to purchase healthy foods for users of these services.²⁰

OBJECTIVE CD1.3.6 By June 30, 2015, DOH, Department of Education and the Department of Agriculture and Consumer Services will develop model programs and policies that address the following:

- Serving healthy foods in schools and food kitchens.
- Using garden food in school cafeterias.
- Supporting edible, rather than ornamental foliage on public land.
- Expanding the Healthier U.S. School Challenge program.

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- Adopting inter-class and inter-school wellness competitions such as Team Wellness Challenge.
- Increasing the number of school gardens.
- Enhancing food and exercise related curricula such as Agriculture in the Classroom. ²⁰

COORDINATING AGENCY DOH

PARTNERS AND STAKEHOLDERS Florida Medical Association; Florida Osteopathic Medical Association; Florida Pediatric Society; Florida Convergence (a collaboration of six major health insurance companies and foundations who are coming together to develop a strategic plan targeting healthy living); insurance companies

Goal CD2 Increase access to resources that promote healthy behaviors.

Strategy CD2.1 Collaborate with partner agencies and organizations to implement initiatives that promote healthy behaviors.

OBJECTIVE CD2.1.1 By Dec. 31, 2014, implement at least three statewide initiatives that promote healthy behaviors such as obtaining healthy weight and tobacco cessation. ²⁰

OBJECTIVE CD2.1.2 By Dec. 31, 2015, decrease the percentage of adults who are overweight from 37.8% to 35.9%. ²⁰

OBJECTIVE CD2.1.3 By Sept. 30, 2012, the Departments of Health and Education will identify strategies for monitoring childhood markers of well-being including: measuring height and weight (to obtain body mass index) and individual-level physical activity. ²⁰

Strategy CD2.2 Support use of evidence-based employee wellness programs to promote healthy behaviors. ²⁰

OBJECTIVE CD2.2.1 By Dec. 31, 2013, increase by 5% the availability of employee wellness programs that address nutrition, weight management and smoking cessation counseling services in state agencies in Florida. ²⁰

OBJECTIVE CD2.2.2 By June 30, 2014, increase by 5% the availability of employee wellness programs that address nutrition, weight management and smoking cessation counseling services in workplaces other than state agencies. ²⁰

Strategy CD2.3 Implement the Alliance for a Healthier Generation's *Healthy Schools Program* or USDA's *HealthierUS School Challenge*.

OBJECTIVE CD2.3.1 By June 30, 2013, develop a process and system to collect data on the number of schools currently implementing the *Healthy Schools Program* or *HealthierUS School Challenge*.

OBJECTIVE CD2.3.2 By June 30, 2014, increase by 20% the number of schools implementing the *Healthy Schools Program* or *HealthierUS School Challenge*.

OBJECTIVE CD2.3.3 By Dec. 31, 2014, 25% of schools implementing the *Healthy Schools Program* or *HealthierUS School Challenge* will achieve a Silver Level Award.

OBJECTIVE CD2.3.4 By Dec. 31, 2015, decrease the percentage of adolescents who are overweight from 13.6% to 12.9%. ²⁰

COORDINATING AGENCY DOH

PARTNERS AND STAKEHOLDERS Department of Agriculture; Department of Education; YMCA; Regional health councils; Agency for Health Care Administration; Alliance for a Healthier Generation; Action for Healthy Kids; Healthier US Challenge

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Goal CD3 Reduce chronic disease morbidity and mortality.²⁰

Strategy CD3.1 Promote chronic disease self-management education.

OBJECTIVE CD3.1.1 By Dec. 31, 2015, increase the percentage of adults with diagnosed diabetes that have ever taken a course or class in how to manage their diabetes from 55.1% to 59%.²⁰

OBJECTIVE CD3.1.2 By Dec. 31, 2015, increase the percentage of adults with diagnosed arthritis that have ever taken an educational course or class to learn how to manage problems related to arthritis or joint symptoms from 14.4% to 20%.²⁰

OBJECTIVE CD3.1.3 By Dec. 31, 2015, increase the percentage adults with diagnosed asthma that have taken a course or class to learn how to manage asthma from 10.2% to 13%.²⁰

Strategy CD3.2 Promote early detection and screening for chronic diseases such as asthma, cancer, heart disease and diabetes.

OBJECTIVE CD3.2.1 By Dec. 30, 2015, increase by 10% the percentage of women who receive a breast cancer screening based on the most recent clinical guidelines from 61.9% (2010) to 71.9%.²⁰

OBJECTIVE CD3.2.2 By Dec. 30, 2015, increase by 10% the percentage of women who receive a cervical cancer screening based on the most recent clinical guidelines from 57.1% (2010) to 67.1%.²⁰

OBJECTIVE CD3.2.3 By Dec. 30, 2015, increase the percentage of adults 50 years of age and older who receive a colorectal cancer screening (blood stool test in the past year or sigmoidoscopy or colonoscopy in the past five years) from 57% to 80%.²⁰

OBJECTIVE CD3.2.4 By Dec. 30, 2015, increase the percentage of adults who had their cholesterol checked in the past two years from 73.3% to 76.3%.²⁰

OBJECTIVE CD3.2.5 By Dec. 30, 2015, increase the percentage of adults in Florida that have had a test for high blood sugar or diabetes within the past three years from 62.6% to 65%.²⁰

OBJECTIVE CD3.2.6 By Dec. 30, 2015, increase the percentage of persons whose diabetes has been diagnosed from 10.4% to 12%. (As measured by the percentage of adults in Florida who have ever been told by a doctor they have diabetes. There are approximately 767,666 adults in Florida living with undiagnosed diabetes. Prevalence will increase until these adults are identified).²⁰

Strategy CD3.3 Promote use of evidence-based clinical guidelines to manage chronic diseases.

OBJECTIVE CD3.3.1 By Dec. 31, 2015, increase the percentage of adults with current asthma who received written asthma management plans from their health care provider from 23.2% to 25%.²⁰

OBJECTIVE CD3.3.2 By Dec. 31, 2015, DOH Health Management System (HMS) Electronic Health Record (EHR) will contain evidence based practice guidelines, decision support and patient education documentation to improve screening, treatment and referral support for patients with key chronic diseases.

OBJECTIVE CD3.3.3 By Dec. 31, 2013, assess and implement at least three effective strategies for promoting clinical practice guidelines through partner networks.

OBJECTIVE CD3.3.4 By Dec. 31, 2015, increase the percentage of Florida adults with diabetes who had two A1C tests in the past year from 75.6% to 80%.²⁰

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Strategic Issue Area: Chronic Disease Prevention

COORDINATING AGENCY DOH



PARTNERS AND STAKEHOLDERS YMCA (Diabetes Prevention Program); American Diabetes Association (Florida Affiliate); American Heart Association; American Cancer Society, National Cancer Institute; Florida Medical Association; Florida Academy of Family Physicians, Susan G. Komen for the Cure; Department of Elder Affairs; Veterans Administration



Goal CD4 Reduce illness, disability and death related to tobacco use and secondhand smoke exposure.

Strategy CD4.1 Prevent Florida's youth and young adults from initiating tobacco use.


OBJECTIVE CD4.1.1 By Dec. 31, 2015, increase the number of committed never smokers among Florida's youth, ages 11–17 from 62.6 % (2010) to 68.9 % 

Strategy CD4.2 Promote quitting among Florida's youth and adults.


OBJECTIVE CD4.2.1: By Dec. 31, 2014, reduce current smoking rates among Florida adults from 17.1% (2010) to 14.5%.  


OBJECTIVE CD4.2.2 By Dec. 31, 2015, reduce the use of other tobacco products—smokeless tobacco, snus (pouched smokeless tobacco) and cigars—among Florida adults from 5.6% (2010) to 4.76%.  

OBJECTIVE CD4.2.3: By Dec. 31, 2015, reduce current cigarette use among Florida's youth, ages 11–17 from 8.3% (2010) to 7.5%.

OBJECTIVE CD4.2.4 By Dec. 31, 2015, reduce the use of tobacco products other than cigarettes by youth, ages 11–17, from 14.1% (2010) to 12.7%. Tobacco products include: smokeless tobacco, snus, cigars, flavored cigars, bidis, kreteks, pipe tobacco, flavored tobacco and hookah. 

Strategy CD4.3 Eliminate Floridians' exposure to secondhand tobacco smoke.

OBJECTIVE CD4.3.1 By Dec. 31, 2015, reduce the percentage of Florida adults who were exposed to secondhand smoke at home during the past 7 days from 8.6% (2010) to 7.7%. 

OBJECTIVE CD4.3.2 By Dec. 31, 2015, reduce the percentage of Florida youth, ages 11–17 that were exposed to secondhand smoke in a room or car during the past 7 days from 50.3% (2010) to 45.3%. 

COORDINATING AGENCY DOH

PARTNERS AND STAKEHOLDERS American Cancer Society, American Heart Association, American Lung Association

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Community Redevelopment and Partnerships

Health care and health-related information must be provided in a manner that is culturally sensitive. Community partnerships are critical to synergizing community planning activities so that they positively change the natural and built environment and ultimately improve population health. The public health system should:

- Integrate planning and assessment processes to maximize partnerships and expertise of a community in accomplishing its goals.
- Build and revitalize communities so people can live healthy lives.
- Provide equal access to culturally and linguistically competent care.

Community Redevelopment and Partnerships

Goal CR1 Integrate planning and assessment processes to maximize partnerships and expertise of a community in accomplishing its goals. 🖐️

Strategy CR1.1 Include a public health component in community planning processes to increase awareness and opportunity for the built environment to impact healthy behaviors. 🖐️

OBJECTIVE CR1.1.1 By Dec. 31, 2013, DOH and the Florida Association of Health Planning Agencies will develop and share model health-related language for comprehensive plans. 🔄

OBJECTIVE CR1.1.2 By Dec. 31, 2014, all county health departments will have public health attendance in their community planning processes with each of the 67 county planning boards.

OBJECTIVE CR1.1.3 By Dec. 31, 2015, at least 20% of county comprehensive plans will include health components.

OBJECTIVE CR1.1.4 By Dec. 31, 2012, DOH will coordinate with the Department of Environmental Protection to incorporate health-related objectives in the update to the Plan for the Florida Greenways and Trails System. 🔄

Strategy CR1.2 Share effective strategies and messages that support the connection between the built environment and healthy behaviors. 🖐️

OBJECTIVE CR1.2.1 By Sept. 30, 2013, DOH will work with the Centers for Disease Control and Prevention and others to document evidence-based practices that support the connections between health and the built environment health. 🖐️

OBJECTIVE CR1.2.2 By Dec. 31, 2013, DOH and the Florida Association of Health Planning Agencies and other organizations will develop resources and training materials that promote health-related conversations about health benefits to communities resulting from the built environment. 🖐️

OBJECTIVE CR1.2.3 By March 30, 2014, DOH will conduct training about health benefits to communities resulting from the built environment. 🖐️

OBJECTIVE CR1.2.4 By Dec. 31, 2015, DOH will work with the Department of Transportation and the Department of Environmental Protection to increase the number of municipalities, counties and regions that have complete streets policies for implementing Section 335.065, Florida Statutes, from 13 in 2011 to 26. 🖐️

Strategy CR1.3 Maximize effective and efficient means of collecting and sharing data that is common to multiple assessment processes.

OBJECTIVE CR1.3.1 By June 30, 2014, DOH will develop guidance for inspectors to incorporate community assessment activities into their inspections/duties.

OBJECTIVE CR1.3.2 By July 31, 2013, DOH will establish a mechanism for sharing data and information about community assessment work across organizations.

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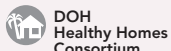
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Strategic Issue Area: Community Redevelopment and Partnerships

OBJECTIVE CR1.3.3 By March 30, 2014, DOH and the Florida Association of Health Planning Agencies and other organizations will develop recommendations and guidelines about integrating specific assessment activities including identifying commonly needed data and accepted methods by which the data may be gathered.

OBJECTIVE CR1.3.4 By Sept. 30, 2014, DOH programs will incorporate recommendations and guidelines for integrating specific assessments into its program-specific assessment requirements.

Strategy CR1.4 Provide consultation to community planners to ensure healthy re-use of land. See Health Protection Strategy HP2.4 and Objective HP2.4.1.

COORDINATING AGENCY DOH

PARTNERS AND STAKEHOLDERS Florida Association of Health Planning Agencies; Department of Environmental Protection; Department of Transportation

Goal CR2 Build and revitalize communities so people can live healthy lives.

Strategy CR2.1 Make it safer for people to live active, healthy lives by increasing community policing, addressing substandard housing and increasing aging-in-place opportunities. 🏠

OBJECTIVE CR2.1.1 By Aug. 31, 2012, DOH will work with the Department of Transportation's nine Commuter Services groups to support model regional transportation systems for rural communities including carpooling, commuter services and rail service and promote them at local levels. 🚗

OBJECTIVE CR2.1.2 By Oct. 31, 2012, DOH, the Florida Department of Law Enforcement and representatives of local sheriffs and police chiefs will provide model practice examples of successful partnerships and projects that reduce violence, crime, and improve safety such as community crime watches, beach patrol, compliance buys, DUI saturation patrol and other efforts.

OBJECTIVE CR2.1.3 By Oct. 31, 2012, DOH will provide county-level model rapid assessment tools for identifying substandard housing and delivering local county contact information for actions needed. 🏠

OBJECTIVE CR2.1.4 By Oct. 31, 2013, DOH will forge partnerships with HUD and other local, regional and federal funding agencies to support "Moving to Opportunity" which improves housing conditions for vulnerable populations. 🏠

OBJECTIVE CR2.1.5 By Oct. 31, 2013, DOH will report on "Healthy Homes Consortium" activities and increase interagency support (HUD, EPA) in maximizing the effects of this program. 🏠

OBJECTIVE CR2.1.6 By Oct. 31, 2014, DOH will work with the Department of Elder Affairs and other state agencies to disseminate model "Communities for a Lifetime" policies focused on improving health by "aging in place" (e.g., enabling seniors to remain at home for as long as possible). 🏠

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Strategy CR2.2 Increase access to and participation in physical activity for all members of a community.  

OBJECTIVE CR2.2.1 By Sept. 30, 2012, the Department of Education and DOH will identify and disseminate model practices and policies that promote biking, walking and using public transportation to school or work. ²⁰

OBJECTIVE CR2.2.2 By June 30, 2012, the Department of Transportation and DOH will identify strategies for measuring the number or percentage of students that walk or bike to school. ²⁰

OBJECTIVE CR2.2.3 By Dec. 31, 2015, increase the percentage of trips to work by walking from 1.6% to 3.2%. ²⁰

OBJECTIVE CR2.2.4 By Nov. 30, 2012, DOH will disseminate information about the Florida Recreation Development Assistance Program, Land and Water Conservation Fund and the Recreational Trails Program. ²⁰

Strategy CR2.3 Increase the availability of healthful food. See Chronic Disease Strategy CD1.3 and Objectives CD1.3.1–1.3.6.  

COORDINATING AGENCY DOH

PARTNERS AND STAKEHOLDERS Department of Elder Affairs; Department of Education; DOH; Department of Law Enforcement; Department of Management Services; Department of Transportation; U.S. Department of Agriculture and Consumer Services

Goal CR3 Provide equal access to culturally and linguistically competent care. ²⁰

Strategy CR3.1 Promote health in all policies to ensure that decisions and investments promote health or mitigate the negative health consequences of previous policies.

OBJECTIVE CR3.1.1 By July 31, 2013, DOH will offer systematic support and technical assistance to CHDs to perform Health Impact Assessments that will systematically inform the decision-making process about health consequences of plans, projects and policies.

Strategy CR3.2 Provide equal access to culturally and linguistically competent care. See Access to Care Goal AC7, Strategy AC7.1, Objectives AC7.1.1–7.1.4. ²⁰

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PARTNERS AND STAKEHOLDERS Department of Children and Families

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Access to Care


Limited access to health care services, including behavioral and oral health care, may contribute to poor health outcomes and high health care costs. The public health system should:

- Regularly assess Florida's health care access resources and service needs.
- Improve access to primary care services.
- Improve behavioral health services so that children, adults and families are active, self sufficient participants in their communities.
- Enhance access to preventive, restorative, and emergency oral health care services.
- Reduce maternal and infant morbidity and mortality.
- Meet special health care needs of children, persons with disabilities and elders.
- Provide equal access to culturally and linguistically competent care.


Access to Care

Goal AC1 Regularly assess health care assets and service needs.

Strategy AC1.1 Collaboratively assess and report Florida's health care access resources and needs including patterns of health care system use and barriers to care.

OBJECTIVE AC1.1.1 By Dec. 31, 2012, and every four years thereafter to coincide with the state health improvement planning process, a health resource assessment process will be conducted resulting in a written report that includes an inventory, analysis and geographic mapping of Florida's health care providers including high-volume Medicaid providers, health care needs of Florida residents, and health insurance coverage. 

OBJECTIVE AC1.1.2 By Dec. 31, 2012, and annually thereafter, review DOH Physician Workforce Shortage Annual Report and report on workforce shortage areas and patterns.

OBJECTIVE AC1.1.3 By June 30, 2014, and every three years thereafter, DOH will collect and report county-level Behavioral Risk Factor Surveillance System (BRFSS) data to assess related health behaviors and health status. 

COORDINATING AGENCY DOH

PARTNERS AND STAKEHOLDERS Association of Florida Health Planning Councils, Agency for Health Care Administration


Goal AC2 Improve access to primary care services for Floridians.


Strategy AC2.1 Reduce professional health care workforce shortages and improve geographic distribution of the professional health care workforce.


OBJECTIVE AC2.1.1 By Sept. 30, 2013, a legislative budget request will be submitted to restore funding to the Florida Health Services Corps Program to encourage qualified medical professionals to practice in underserved locations in Florida.


OBJECTIVE AC2.1.2 By Dec. 31, 2015, the percentage of primary care residency slots in Florida will increase by 10%.


OBJECTIVE AC2.1.3 By Dec. 31, 2015, an initiative will be launched to reduce or eliminate practice barriers such as scope of practice, licensure and credentialing processes and reciprocity agreements.

OBJECTIVE AC2.1.4: By Dec. 31, 2012, and every four years thereafter, DOH will assure all underserved areas in Florida maintain a Health Professional Shortage Area (HPSA) designation. 

OBJECTIVE AC2.1.5: By Dec. 31, 2012, and annually thereafter, the maximum number (30) of J-1 visa slots for health professionals in medically underserved areas in Florida will be filled. 

OBJECTIVE AC2.1.6: By Dec. 31, 2012, and annually thereafter, all National Health Services Corps site and provider applications will be processed by federal deadlines. 

OBJECTIVE AC2.1.7: By Dec. 31, 2015, the percentage of mid-level providers in primary care practice settings will increase by 10%. 


LONG-RANGE OBJECTIVE AC2.1.8 By Dec. 31, 2020, the number of primary care providers in Florida will increase by 10%. 


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Strategic Issue Area: Access to Care

Strategy AC2.2 Address health care service barriers (e.g., payment, enrollment and access impediments) for service providers and care recipients.

OBJECTIVE AC2.2.1 By Dec. 31, 2015, increase the percentage of persons who report having any kind of health care coverage, including health insurance, prepaid plans such as HMOs or government plans such as Medicare from 83% to 87%. ²⁰ 

OBJECTIVE AC2.2.2 By Dec. 31, 2015, decrease the percentage of persons who report they were unable to see a doctor during the past 12 months due to cost from 17.3% to 16.4%. 

OBJECTIVE AC2.2.3 By Dec. 31, 2015, the number of clients who receive primary care services in medically underserved areas in Florida will increase by 10%.

LONG-RANGE OBJECTIVE AC2.2.4 By Dec. 31, 2020, the percentage of primary care facilities that provide mental health treatment onsite or by paid referral will increase by 5%. ²⁰

COORDINATING AGENCY DOH

PARTNERS AND STAKEHOLDERS Florida Association of Community Health Centers, Florida Medical Association

Goal AC3: Improve behavioral health services so that adults, children and families are active, self-sufficient participants living in their communities.

Strategy AC3.1 Strengthen integration of substance abuse and mental health services with delivery of primary care. 

OBJECTIVE AC3.1.1 By Dec. 31, 2015, determine the number of primary care providers who know where to refer children and adults for early intervention and treatment of substance abuse and mental health disorders.

DEVELOPMENTAL OBJECTIVE AC3.1.2 By Dec. 31, 2015, increase the number of primary care providers who routinely screen for substance abuse and mental health disorders. ²⁰

Strategy AC3.2 Reduce barriers to substance abuse and mental health services that impact the ability of children and adults to live and participate in their communities.

OBJECTIVE AC3.2.1 By Dec. 31, 2015, the percentage of children and adults adequately prepared to achieve and maintain independence will be sustained (for example, 24% of adults with serious mental illness are competitively employed; and seriously emotionally disturbed children attended 86% of school days).

COORDINATING AGENCY Department of Children and Families

PARTNERS AND STAKEHOLDERS DOH; Florida Association of Community Health Centers; federally qualified health centers

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Goal AC4 Enhance access to preventive, restorative and emergency oral health care.

Strategy AC4.1 Revise and collaboratively implement Florida's State Oral Health Improvement Plan (SOHIP).

OBJECTIVE AC4.1.1 By Sept. 30, 2012, a revised Florida SOHIP will be published and disseminated. 🗓️

OBJECTIVE AC4.1.2 By Jan. 31, 2013, a data collection and surveillance plan for Florida's oral health indicators will be developed. 🗓️ 20

OBJECTIVE AC4.1.3 By Sept. 30, 2013, determine financial support needs to implement the data collection and surveillance plan for Florida's oral health indicators. 🗓️ 20

OBJECTIVE AC4.1.4 By Dec. 31, 2014, implement the data collection and surveillance plan for Florida's oral health indicators. 🗓️ 20

OBJECTIVE AC4.1.5 By June 30, 2014, analyze and report on costs and payment mechanisms for dental care in Florida. 🗓️

Strategy AC4.2 Promote integration between the oral health care system and other health care providers, including information sharing, education for medical providers on preventive dental health services, more effective reimbursement, and incentives for improving coordination of care to improve access to oral health services and revision of Medicaid reimbursement rules.

OBJECTIVE AC4.2.1 By Dec. 31, 2014, increase the percentage of adults who report having visited a dentist or dental clinic in the past year from 64.7% to 67%. 🗓️ 20 ★

OBJECTIVE AC4.2.2 By Dec. 31, 2014, reduce the percentage of adults who report having permanent teeth removed because of tooth decay or gum disease from 53% to 51%. 🗓️ 20

OBJECTIVE AC4.2.3 By Dec. 31, 2014, increase the percentage of adults who report having had their teeth cleaned in the past year from 60.9% to 64%. 🗓️

OBJECTIVE AC4.2.4 By Dec. 31, 2015, increase the percentage of the targeted low-income population receiving dental services from a county health department from 9.8% to 18.64%. 20 🗓️

Strategy AC4.3 Assess current and future practitioner needs via re-licensure surveys of dentists and dental hygienists to ascertain geographic distribution of practitioners and types of practice.

OBJECTIVE AC4.3.1 By Dec. 31, 2013, reduce the percentage of dentists with active Florida licenses who currently do not practice in Florida from 19.1% (2011) to 15%.

OBJECTIVE AC4.3.2 By Dec. 31, 2015, increase the percentage of children and adolescents who have received dental sealants on their molar teeth. 20

LONG-RANGE OBJECTIVE AC4.3.3 By Dec. 31, 2020, increase the percentage of federally qualified health centers (FQHCs) that have an oral health component from 75% to 83%. 20



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Strategic Issue Area: Access to Care

Strategy AC4.4 Promote innovative oral health care delivery practice models.

OBJECTIVE AC4.4.1 By Dec. 31, 2013, health access settings will be reimbursed for preventive care provided by dental hygienists without a dentist having to be in attendance.

OBJECTIVE AC4.4.2 By Dec. 31, 2013, secure funding to conduct an educational campaign focused on the benefits of community water systems with fluoridated water, and develop strategies in partnership with communities that have evidence of changing perceptions and motivating change.  

OBJECTIVE AC4.4.3 By Dec. 31, 2014, all county health departments providing dental services will have electronic dental records. 

OBJECTIVE AC4.4.4 By Dec. 31, 2015, increase the percentage of the Florida population served by community water systems with optimally fluoridated water from 78.7% (2008) to 90.5%.  




DEVELOPMENTAL OBJECTIVE AC4.4.5 By Jan. 1, 2014, increase the number of Medicaid physicians providing fluoride varnish and education in their offices by 25%.


COORDINATING AGENCY Oral Health Florida Coalition

PARTNERS AND STAKEHOLDERS Florida Public Health Institute, Florida DOH, Florida Association of Community Health Centers, federally qualified health centers, Florida Dental Association


Goal AC5 Reduce maternal and infant morbidity and mortality.


Strategy AC5.1 Raise awareness among providers and consumers on the importance and benefits of being healthy prior to pregnancy.

OBJECTIVE AC5.1.1 By Dec. 31, 2015, increase the percentage of women having a live birth, who prior to that pregnancy received preconception education and counseling regarding lifestyle behaviors and prevention strategies from a health care provider from 19.7% to 80%.   



OBJECTIVE AC5.1.2 By Dec. 31, 2015, reduce the rate of maternal deaths per 100,000 live births from 20.5 to 12.2. 





Strategy AC5.2 Raise the awareness of Medicaid Family Planning Waiver services for all women who lost full Medicaid services within the last two years to potentially eligible women.

OBJECTIVE AC5.2.1 By Dec. 31, 2015, decrease the percentage of births with inter-pregnancy intervals of less than 18 months from 36.9% (2010) to 36%. 

OBJECTIVE AC5.2.2 By Dec. 31, 2015, decrease the percentage of women with unplanned or unwanted pregnancies from 47.4% (2008) to less than 45%. 

Strategy AC5.3 Utilize positive youth development sponsored programs to promote abstinence and reduce teen sexual activity.

OBJECTIVE AC5.3.1 By Dec. 31, 2015, decrease the percentage of teen births, ages 15–17, that are subsequent (repeat) births from 9% (2010) to 8.5%.  

OBJECTIVE AC5.3.2 By Dec. 31, 2015, reduce live births to mothers aged 15–19 from 32.8 (2010) to 31.6 per 1000 females.    

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Strategic Issue Area: Access to Care

Strategy AC5.4 Partner with Department of Children and Families to initiate an educational health care provider and consumer campaign on safe sleep.

OBJECTIVE AC5.4.1 By Dec. 31, 2015, increase the percentage of infants sleeping on their backs from 58.6% to 61.5%. ²⁰

OBJECTIVE AC5.4.2 By Dec. 31, 2015, increase the percentage of infants not bed-sharing from 36.2% to 37.1%.

OBJECTIVE AC5.4.3 By Dec. 31, 2015, reduce the infant mortality rate from 6.5 (2010) to 6.1 per 1000 live births. ²⁰  

OBJECTIVE AC5.4.4 By Dec. 31, 2015, reduce the black infant mortality rate from 11.8 (2010) to 10.9 per 1000 live births. ²⁰  


OBJECTIVE AC5.4.5 By Dec. 31, 2015, increase the percentage of women who are exclusively breastfeeding their infant at 6 months of age from 9.9% (2007) to 12%. ²⁰

COORDINATING AGENCY DOH


PARTNERS AND STAKEHOLDERS AHCA; Florida Association of Healthy Start Coalitions; March of Dimes; Florida OB/GYN Society (FOGS)/Florida American College of Obstetricians and Gynecologists (ACOG); Florida Chapter of the American College of Nurse Midwives (ACNM); Association of Women's Health; Obstetric and Neonatal Nurses (AWHONN); Federal Office of Population Affairs (OPA); Florida Hospital Association; Child Abuse Death Review Committee

Goal AC6 Meet special health care needs of children, persons with disabilities and elders.


Strategy AC6.1 Children's Medical Services staff will collaborate with Department of Children and Families and the community-based organizations for children in out-of-home (foster) care who are enrolled in the Children's Medical Services Network to ensure the provision of health care services and care coordination services.

OBJECTIVE AC6.1.1 By June 30, 2013, 100% of the Children's Medical Services area offices will collaborate with the Department of Children and Families in the provision of care coordination services for children in out-of-home care who meet the clinical eligibility criteria for the Children's Medical Services Network. ²⁰ 

Strategy AC6.2 Children's Medical Services-approved primary care providers will assist in locating adult primary care providers and transferring the care for children with special health care needs.

OBJECTIVE AC6.2.1 By June 30, 2013, 100% of the Children's Medical Services Primary Care Projects will be providing assistance to primary care providers in locating adult primary care providers and transferring care for children with special health care needs. 

Strategy AC6.3 Children's Medical Services will work collaboratively with Children's Medical Services-approved primary care providers to provide health care transition education for children with special health care needs and their families to prepare the child and family for a successful health care transition process.

OBJECTIVE AC6.3.1 By June 30, 2013, 100% of the Children's Medical Services primary care projects will be providing transition education and activities for children with special health care needs who are transitioning from child-centered to adult-oriented health care systems. ²⁰ 

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Strategic Issue Area: Access to Care

Strategy AC6.4 Maintain safe environments for people living in public developmental disabilities centers.

OBJECTIVE AC6.4.1 By Dec. 31, 2015, reduce the annual number of significant reportable incidents per 100 persons with developmental disabilities living in developmental disabilities centers from 30 to 24. 

Strategy AC6.5 Increase provider network capacity to serve persons age 60 and older, their families and caregivers.

OBJECTIVE AC6.5.1 By Dec. 31, 2015, maintain the percentage of elders at imminent risk of nursing home placement who are served with community-based services at 90% (2004). 




OBJECTIVE AC6.5.2 By Dec. 31, 2015, increase the percentage of caregivers (of persons aged 60 and older served by Department of Elder Affairs programs) whose ability to continue to provide care is maintained or improved after service intervention from 87% (2003) to 90%. 




COORDINATING AGENCY DOH (Strategies 6.1–6.3); Agency for Persons with Disabilities (Strategy 6.4); Department of Elder Affairs (Strategy 6.5)




PARTNERS AND STAKEHOLDERS Department of Children and Families

Goal AC7 Provide equal access to culturally and linguistically competent care.

Strategy AC7.1 Develop, implement and promote strategic plans that outline mechanisms to provide culturally and linguistically appropriate services, conduct self-assessments of culturally and linguistically appropriate services (CLAS), and ensure that individual client records include race, ethnicity and spoken and written languages

OBJECTIVE AC7.1.1 By September 30, 2015, DOH and the Department of Children and Families will identify or include objectives in agency strategic plans that address providing culturally and linguistically appropriate services.   

OBJECTIVE AC7.1.2 By June 30, 2013, DOH will facilitate development of a self-assessment of CLAS that can be used across many provider settings.   

OBJECTIVE AC7.1.3 By June 30, 2014, DOH and other social services agencies will distribute and implement use of a CLAS self-assessment tool.   

OBJECTIVE AC7.1.4 By June 30, 2013, DOH will facilitate a multi-agency assessment of how data systems collect race, ethnicity and spoken and written languages, and will develop a plan that addresses gaps in information gathering and reporting.

COORDINATING AGENCY DOH

PARTNERS AND STAKEHOLDERS Department of Children and Families

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Health Finance and Infrastructure

Performance measurement, continuous improvement, accountability and sustainability of the public health system can help to ensure Florida's population is served efficiently and effectively. Highly functioning data collection and management systems, electronic health records and systems of health information exchange are necessary for understanding health problems and threats, and crafting policies and programs to address them. Florida's public health system should:

- Use health information technology to improve the efficiency, effectiveness and quality of patient care coordination, patient safety and health care outcomes.
- Assure adequate public health funding to control infectious diseases, reduce premature morbidity and mortality due to chronic diseases and improve health status of residents and visitors.
- Attract, recruit and retain a prepared, diverse and sustainable public health workforce in all geographic areas of Florida.
- Promote an efficient and effective public health system through performance management and collaboration among public health system partners.

Health Finance and Infrastructure

Goal HI1 Use health information technology to improve the efficiency, effectiveness and quality of patient care coordination, patient safety and health care outcomes for all Floridians.


Strategy HI1.1 Connect providers and electronic health record systems in a network that consists of a State-Level Health Information Exchange, Direct Secured Messaging and local health information exchanges and gateways.  

OBJECTIVE HI1.1.1 By Jan. 1, 2013, no less than 1,500 health care providers will be registered to exchange data by using direct secured messaging.

OBJECTIVE HI1.1.2 By Dec. 31, 2012, at least 50% of the participants active in direct secured messaging will have sent a transaction at least one time in the last month.


OBJECTIVE HI1.1.3 By Jan. 1, 2013, no less than 10 organizations will be data sharing and no less than eight organizations will be actively sharing data daily through the Florida Health Information Exchange.

Strategy HI1.2 Promote provider adoption of certified electronic health record software. **20**

OBJECTIVE HI1.2.1 By Dec. 31, 2012, at least 50% of the hospitals which are eligible will complete their registration and receive initial Incentive payments using the Florida Medicaid Electronic Health Record Incentives Program. 

OBJECTIVE HI1.2.2 By Dec. 31, 2012, at least 25% of estimated eligible professionals will receive initial Medicaid incentive payments.

OBJECTIVE HI1.2.3 By Jan. 1, 2013, 25% of DOH prescriptions will be transmitted electronically.

OBJECTIVE HI1.2.4 By Dec. 31, 2012, at least 10% of eligible professionals (those clinicians who meet the criteria for meaningful use as established by the Federal Office of National Coordination) will be using a certified electronic health record. 

OBJECTIVE HI1.2.5 By Dec. 31, 2012, DOH will launch a certified electronic health record for county health departments.


OBJECTIVE HI1.2.6 By Dec. 31, 2013, county health department clinical providers in all 67 counties will be using DOH certified electronic health records in accordance with criteria established by the Federal Office of National Coordination.

Strategy HI1.3 Use public health information technology and systems to efficiently track reportable diseases and conditions of public health significance, and to support public health disease prevention programs and epidemiological activities.  

OBJECTIVE HI1.3.1 By Dec. 31, 2013, increase the number of laboratories electronically submitting reportable laboratory results to DOH (as required by FAC 64D-3) from 45 to 75.

OBJECTIVE HI1.3.2 By Jan. 1, 2013, increase the percentage of reportable disease case reports where the department received electronically submitted laboratory reports to 65%.

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 Electronic Health Record Incentive Program

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Strategic Issue Area: Health Finance and Infrastructure

OBJECTIVE HI1.3.3 By Dec. 31, 2013, increase the number of hospitals and urgent care centers submitting electronic information used for syndromic surveillance to DOH from 170 to 185.

OBJECTIVE HI1.3.4 By Jan. 1, 2015, DOH will be using the statewide health information exchange to support public health case reporting and epidemiological case follow-up.

COORDINATING AGENCY/OFFICE Agency for Health Care Administration

PARTNERS AND STAKEHOLDERS DOH (CHDs), Bureau of Clinic Management and Informatics, Bureau of Epidemiology, Division of Disease Control; Florida Regional Extension Centers; Regional Health Information Organizations; Florida Medical Association; Florida Hospital Association

Goal HI2 Assure adequate public health funding to control infectious diseases, reduce premature morbidity and mortality due to chronic diseases, and improve the health status of residents and visitors.

Strategy HI2.1 Maintain an adequate level of Medicaid and other third party revenue to help county health departments and Children's Medical Service providers to retain the infrastructure necessary to meet the public health needs of their community.

OBJECTIVE HI2.1.1 By July 1, 2012, DOH will establish workgroup members and team leaders and distribute contact information to CHDs for a managed care technical assistance group to provide support to public health and safety net providers who are working to establish business relationships with managed care organizations.

OBJECTIVE HI2.1.2 By Jan. 1, 2014, increase the percentage of Medicaid recipients served by CHDs who are enrolled in managed care organizations from 15.2% (2011) to 30.0%.

OBJECTIVE HI2.1.3 By Oct. 1, 2012, a revised Medicaid reduction methodology for cost-based providers will be implemented in the General Appropriations Act and DOH efficiency standards will be applied to CHD rates.

OBJECTIVE HI2.1.4 By Dec. 1, 2015, the CHD Health Management System Billing Redesign Project to automate all major billing functions and establish 100% electronic interaction with health care plans will be implemented.

OBJECTIVE HI2.1.5 By April 30, 2013, Children's Medical Services will have implemented a third-party billing administrator function to automate billing functions.

Strategy HI2.2 Update public health program office Legislative Budget Request funding methodologies in preparation for budget requests to replace reimbursement for public health services previously embedded in Medicaid Cost Based Reimbursement.

OBJECTIVE HI2.2.1 By Sept. 30, 2012, DOH programs for high priority service areas will complete sample budget requests in the standard legislative budget format. These programs include infectious disease control and epidemiology services; family health services to uninsured persons seeking selected clinical services and evidence-based, population-based risk reduction services; and services such as community hygiene, arbovirus surveillance, rodent and arthropod control and other environmental health services that are non-fee generating.

OBJECTIVE HI2.2.2 By Jan. 1, 2013, DOH will increase the absolute dollar amount from competitive grants for public health and safety net activities.

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Strategy HI2.3 Routinely review and update fee policies and fee schedules.

OBJECTIVE HI2.3.1 By Sept. 30, 2012, DOH Central Office will implement the rule revision recommendations from the CHD Fee Workgroup to allow the enhanced ability to assess and collect fees from clinical patients who have the ability to pay.

OBJECTIVE HI2.3.2 By Dec. 1, 2012, all CHDs will have documented a fee analysis or fee adjustment process to better align fees with actual cost.

OBJECTIVE HI2.3.3 By Sept. 30, 2012, all non-clinical DOH program offices will have documented a fee analysis or fee adjustment process to better align fees with actual cost.

COORDINATING AGENCY/OFFICE DOH

PARTNERS AND STAKEHOLDERS CHDs; DOH Information Technology; DOH Children's Medical Services; Central Office Programs; DOH Deputy Secretary for Health; DOH Environmental Health; DOH Medical Quality Assurance

Goal HI3 Attract, recruit and retain a prepared, diverse and sustainable public health workforce in all geographic areas of Florida.

Strategy HI3.1 Facilitate collaboration between state agencies and universities to provide trainings and other resources that support and develop existing public health employees, particularly in the area of core competencies for public health professionals.

OBJECTIVE HI3.1.1 By July 30, 2013, DOH and the Florida Public Health Training Centers will produce the next workforce development needs assessment for public health professionals.

OBJECTIVE HI3.1.2 By Dec. 1, 2013, DOH and Florida Public Health Training Centers will produce a plan to collaboratively address identified training gaps, using data from the needs assessment.

Strategy HI3.2 Ensure that students graduating from colleges of public health have mastered the core competencies for public health professionals and have applied them through an internship. ²⁰

OBJECTIVE HI3.2.1 By July 30, 2013, DOH and the Florida Colleges of Public Health will establish baseline data on the percentage of public health masters and doctoral students who are certified in public health (CPH) and create a new objective for improvement if appropriate.

OBJECTIVE HI3.2.2 By Dec. 30, 2012, DOH and the Florida Colleges of Public Health will develop a plan to increase opportunities for graduate students to develop practical application skills through structured internships and other strategies that increase mastery of core competencies.

OBJECTIVE HI3.2.3 By June 30, 2014, the Office of Medical Quality Assurance will make online applications available for all providers to quickly license all health care professionals who meet statutorily-mandated minimum standards of competency.

Strategy HI3.3 Increase understanding of public health among the population of Florida in order to promote an interest in public health careers.

OBJECTIVE HI3.3.1 By Jan. 31, 2013, DOH Office of Workforce Development, the Florida Public Health Institute and the public health training centers will develop a marketing plan to increase visibility and understanding of the field of public health.

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Strategy HI3.4 Promote the development of workforce development plans for public health system partners who address current and future training and resource needs.

OBJECTIVE HI3.4.1 By July 1, 2012, DOH will have an approved workforce development plan that is shared throughout the Department and with public health system partners.

OBJECTIVE HI3.4.2 By July 1, 2013, DOH will achieve a minimum of two objectives in each of the goal areas of the Workforce Development Plan.

OBJECTIVE HI3.4.3 By Feb. 1, 2013, establish employee mentoring and succession planning programs to encourage professional advancement.



OBJECTIVE HI3.4.4 By July 1, 2014, the percentage of employees who have had an Employee Development Plan completed during their performance appraisal will increase from 19.5% to 30%.



COORDINATING AGENCY DOH

PARTNERS AND STAKEHOLDERS DOH Office of Health Statistics and Assessment; DOH Bureau of Human Resource Management; Florida International University; University of Puerto Rico; University of South Florida; Florida Public Health Institute; Florida Public Health Association; Florida Colleges of Public Health


Goal HI4 Promote an efficient and effective public health system through performance management and collaboration among system partners.

Strategy HI4.1 Implement and link health improvement planning at state and local levels.

OBJECTIVE HI4.1.1 By Dec. 31, 2013, 100% of counties will have produced a current (within the past 3–5 years) community health improvement plan.  

OBJECTIVE HI4.1.2 By Dec. 31, 2015, 100% of community health improvement plans will be aligned with the goals and strategies in the State Health Improvement Plan.  


Strategy HI4.2 Coordinate with public health system partners to monitor the State Health Improvement Plan.

OBJECTIVE HI4.2.1 By Jan. 31, 2013, State Health Improvement Plan partners will convene to discuss progress of plan implementation. 

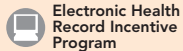
Strategy HI4.3 Collect, track and use performance data to inform business decisions and support continuous improvement.

OBJECTIVE HI4.3.1 By Dec. 31, 2015, the state public health system assessment (using the National Public Health Performance Standards tool) will show results indicating moderate to significant activity in mobilizing partnerships.

OBJECTIVE HI4.3.2 By Dec. 31, 2015, the state public health system assessment (using the National Public Health Performance Standards tool) will show results indicating moderate to significant activity related to assessment and assurance that programs to educate, empower and inform are effective.

OBJECTIVE HI4.3.3 By Feb. 2015, at least 67% of CHDs will have produced current (in the past four years) prerequisite documents (e.g., Health Status Assessment, Health Improvement Plan and Strategic Plan) for accreditation. 

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Strategic Issue Area: Health Finance and Infrastructure

OBJECTIVE HI4.3.4 By Jan. 31, 2015, 31 CHDs will be accredited by the Public Health Accreditation Board. ²⁰

OBJECTIVE HI4.3.5 By Dec. 31, 2013, 100% of Children's Medical Services' area offices will have gone through a comprehensive management review to ensure continuous improvement efforts related to the processes and functions of the Children's Medical Services Network.

OBJECTIVE HI4.3.6 By Jan. 31, 2014, DOH's Children's Medical Services will implement a new care coordination system to ensure more efficient provision and monitoring of care coordination services for children in the Children's Medical Services Network.

OBJECTIVE HI4.3.7 By July 1, 2013, every CHD will have sent at least one team to DOH Practice Management Institute training to achieve a higher level of clinical and operational efficiency.


OBJECTIVE HI4.3.8 By Dec. 31, 2015, 100% of CHD strategic plans will align with community health improvement plans. ²⁰

OBJECTIVE HI4.3.9 By Dec. 31, 2013, DOH's performance management data system will be operational. ²⁰

COORDINATING AGENCY DOH

PARTNERS AND STAKEHOLDERS CHDs

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Appendix A: Public Health System Assessment Process Summary and Key Findings

Process Summary

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In 2011, the Florida DOH led a coordinated, statewide effort to assess the capacities of state and local public health systems. The goals of the assessment were several-fold: to create stronger systems through collaboration; to identify strengths, challenges and system-wide solutions; to foster quality improvement by using national benchmarks; to more fully inform community health improvement planning efforts; to prepare agencies for national voluntary public health agency accreditation; and, ultimately, to positively impact health outcomes of Floridians. State and local instruments from the National Public Health Performance Standards Program (NPHPSP) were used to measure the state's capacity to deliver the ten Essential Public Health Services (EPHS). This document focuses on the results of the state public health system assessment.

Background The NPHPSP seeks to ensure that strong, effective public health systems are in place to deliver EPHS. Developed as a collaborative effort of seven national public health organizations led by the Centers for Disease Control and Prevention (CDC), the NPHPSP provides instruments to assess state, local and governance capacities. There are four key concepts that frame the national standards: their design around the ten EPHS, a focus on public health systems, a structure that describes optimal standards of performance, and applicability to quality improvement processes. A public health system is defined as "all public, private and voluntary entities that contribute to public health activities within a given area." Depicted as a network of entities, this construct recognizes the contributions and roles of partners in the health and well-being of communities and the state.

The EPHS include the following:

EPHS 1: Monitor Health Status to Identify Health Problems

EPHS 2: Diagnose and Investigate Health Problems and Health Hazards

EPHS 3: Inform, Educate and Empower People about Health Issues

EPHS 4: Mobilize Partnerships to Identify and Solve Health Problems

EPHS 5: Develop Policies and Plans that Support Individual and Statewide Health Efforts

EPHS 6: Enforce Laws and Regulations that Protect Health and Ensure Safety

EPHS 7: Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable

EPHS 8: Assure a Competent Public and Personal Health Care Workforce

EPHS 9: Evaluate Effectiveness, Accessibility and Quality of Personal and Population-based Health Services

EPHS 10: Research for New Insights and Innovative Solutions to Health Problems

Assessment Method On October 25, 26 and 27, 2011, diverse groups of public health professionals representing a wide spectrum of areas of expertise gathered for three half-day (8:30 am–12 noon) retreats to assess the performance and capacity of Florida’s public health system. A total of 53 representatives from the Florida DOH, county health departments and external partner agencies participated in the process. A core team of participants were present for the assessment of all ten EPHS. Each day began with an overview of the NPHPSP instruments and assessment process. The workgroups were guided through the NPHPSP state instrument questions and discussion by a skilled facilitator, supported by a recorder who took notes of discussion points and proceedings. Three EPHS were assessed each day as follows.

Belinda Johnson-Cornett, Administrator, Osceola County Health Department

Barbara Locke, Administrator, Levy County Health Department

Daniel Parker, MSP, Division of Environmental Health, Florida DOH

Annette Phelps, ARNP, MSN, Director, Division of Family Health Services, Florida DOH

Jennifer Prather, Dept. of Children and Families

Celeste Putnam, Researcher, Center for Prevention and Early Intervention, Florida State University

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Kristin Roberts, Marketing Specialist, Office of Communications, Florida DOH

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Kayla Shelton, Epidemiologist, Office of Injury Prevention, Florida DOH

Phyllis Sloyer, RN, PhD, FAHM, FAAP, Division Director, Children’s Medical Services, Florida DOH

October 25

EPHS 6: Enforce laws and regulations that protect health and ensure safety

EPHS 8: Assure a competent public and personal health care workforce

EPHS 9: Evaluate effectiveness, accessibility and quality of personal and population-based health services

October 26

EPHS 3: Inform, educate and empower people about health issues

EPHS 4: Mobilize partnerships to identify and solve health problems

EPHS 7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

October 27

EPHS 1: Monitor health status to identify health problems

EPHS 2: Diagnose and investigate health problems and health hazards

EPHS 5: Develop policies and plans that support individual and statewide health efforts

October 28

On October 28, 2011, the core assessment team met to assess EPHS 10 (research for new insights and innovative solutions to health problems), aided by previously gathered input on EPHS 10 from public health system partners with relevant subject matter expertise.

Each workgroup used the same process to arrive at consensus responses. The facilitator read aloud the essential service description, activities and model standard for each indicator. Discussion time followed during which participants shared how their division or organization contributed to meeting the standard and Florida’s overall performance in the area under consideration.

Assessment stem questions were then read aloud by the facilitator who guided participants in a voting process. Using color-coded voting cards, responses were cast and tabulated using the scale below:

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

SIGNIFICANT ACTIVITY: Greater than 50% but no more than 75% 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

MINIMAL ACTIVITY: Greater than zero but no more than 25% of the activity described within the question is met

NO ACTIVITY: 0% or absolutely no activity

In instances when consensus was not apparent in the voting, the facilitator opened up the floor for further discussion and repeat voting. Each workgroup responded to the stem questions for their assigned essential services. Responses to sub-questions were determined by the core assessment team based on discussion notes and their participation in the sessions. Sub-questions were answered immediately following the discussion sessions. All responses were entered into a CDC-maintained database; reports of results were available within minutes of submission.

Key Findings

Assessment results point to areas of relative strength and challenges for the state public health system. The following groupings were used to indicate how well the model standard is being met: "Optimal Activity" (greater than 75%), "Significant Activity" (51–75%), "Moderate Activity" (26–50%), "Minimal Activity" (1–25%) or "No Activity" (0%).

Results by EPHS Florida's state public health system scored highest for capacity and performance in the following EPHS:

EPHS 2: Diagnose and investigate health problems and health hazards (84%, optimal activity)

EPHS 1: Monitor health status to identify community health problems (82%, optimal activity)

EPHS 5: Develop policies and plans that support individual and statewide health efforts (63%, significant activity)

Lowest scores were recorded in the following areas:

EPHS 8: Assure a competent public health and personal health care workforce (39%, moderate activity)

EPHS 10: Research for new insights and innovative solutions to health problems (45%, moderate activity)

EPHS 7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable (46%, moderate activity)

No EPHS received performance scores in the "no activity" (0%) category. However, stem question 7.1.3 on state public health system responsibility for monitoring and coordinating personal health care delivery in the state received a "no activity" or 0% rating.

Challenges and Opportunities The following challenges and opportunities emerged from the review of the state public health system assessment and the aggregated local public system assessments. These attributes, assets and areas for improvement can be considered: 1) when determining priorities, goals and strategies for the state health improvement plan; 2) for developing performance indicators for use in the performance management system; 3) in selecting priorities in the state strategic plan; 4) in preparing the state health department for national voluntary agency accreditation; and 5) by statewide programs in programmatic planning and quality improvement efforts.

Challenges Several major system wide challenges emerged from the assessment data and discussions by assessment participants.

ASSURING A COMPETENT WORKFORCE [ESSENTIAL PUBLIC HEALTH SERVICE 8 (EPHS 8)]:

Lowest performance score (39%, moderate activity) among the ten EPHS. Noted weaknesses include:

- Lack of resources for training, continuing education, recruitment and retention.
- Lack of succession planning, career ladders, and advancement and leadership opportunities.

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Appendix A: Public Health System Assessment Process Summary and Key Findings

- Inefficient, ineffective leveraging of partnerships among agencies and institutions of higher learning to enhance and improve current workforce capacity and support education of future public health professionals.
- Low capacity of local public health systems to assess workforce composition, size, skills, gaps and recruitment and retention activities.
- Lack of leadership development resources and opportunities in aggregate of local public health systems.

LINKING PEOPLE TO NEEDED HEALTH SERVICES (EPHS 7): Tied for second lowest performance score (45%, moderate activity). Related findings include:

- Needed services include dental, mental health, substance abuse, primary care; also noted were lack of medical homes for many and attention to needs of those transitioning from youth services into adult services.
- Challenges in meeting disparate needs of populations due to geography, age, language, race, ethnicity, income, and co-morbidities.
- Varying capacities in linking people to services and assuring service provision was evident in a wide range of scores across some model standards, pointing to pockets of high and low capacity in geographic distribution and by program and health topic area.
- In the aggregate, local public health systems perform in the assurance role at higher capacity (65%, significant activity); however, many local systems view this as unacceptably low performance as the assurance function should be at optimal levels.

RESEARCH FOR NEW INSIGHTS AND INNOVATIVE SOLUTIONS TO HEALTH PROBLEMS (EPHS 10): Tied for second lowest performance score (45%, moderate activity). Other findings include:

- A public health research agenda is not established in a collaborative process, nor are research goals written and shared across the system.
- Research is not a priority for many county health departments and community-based service provider organizations.
- In the aggregate, local public health systems rated capacity to initiate or participate in research as the second lowest capacity of their entire assessment (49%, moderate activity).

PUBLIC HEALTH CAPACITY AND RESOURCES ACROSS ALL TEN EPHS: In the aggregate rated as lowest area of capacity among the model standards (46%, moderate activity) Model standards represent major components, activities or practice areas. Each essential service contains the following model standards: 1) planning and implementation; 2) state-local relationships; 3) performance management and quality improvement; and 4) public health capacity and resources. Related findings include:

- Lack commitment of sufficient resources including financial, human, leadership, technology.
- System fragmentation exists.
- Insufficient workforce (numbers of and expertise of) to serve state's population.
- Local public health systems overall report reduced financial and human resources.

PERFORMANCE MANAGEMENT AND QUALITY IMPROVEMENT (MODEL STANDARD): Garnered the lowest capacity ratings of the entire assessment in two EPHS. Those EPHS and findings are:

Educating, empowering and informing about health issues (EPHS 3) (25%, minimal activity).

- Limited or no review of effectiveness of health communications, health education and promotion interventions.
- Minimal system wide assurance of accurate and current content of health communications, health education and promotion interventions.

Appendix A: Public Health System Assessment Process Summary and Key Findings

- Minimal activity to assess system wide effectiveness of efforts to reach targeted populations with culturally and linguistically appropriate health communications and resource materials.

- Limited activity to manage overall system performance in informing, educating and empowering people about health issues.

Mobilizing partnerships to solve health issues (EPHS 4) (25%, minimal activity).

- Limited or no system-wide review of partnership development activities.

- Minimal activity to determine effectiveness of partnership efforts.

- Limited or no system-wide review of participation and commitment of policy leaders and system partners in mobilization efforts.

- In the aggregate, local systems rated capacity to build, facilitate and sustain coalitions, partnerships and strategic alliances as the second lowest of ten EPHS (59%, significant activity).

Opportunities The state public health system is not without opportunities that could be seized upon to move closer to enhanced system performance and ultimately, improved health outcomes of Floridians. Potential opportunities include:

- Emerging technologies in health care.

- Advocacy potential for upcoming 2012 legislative session.

- Capitalizing on strong system performance on EPHS 1 and 2 (monitoring health status and diagnose and investigate health problems) and high capacity across EPHS related to emergency preparedness.

- Active involvement in budget reduction negotiations and agency efficiency discussions.

Appendix B: Health Status Assessment Process Summary and Key Findings

Process Summary

The Florida Department of Health led a coordinated, statewide effort to assess the health status of Floridians. The goal of the assessment was to identify the major causes of mortality and morbidity in the state as well as behaviors and health care access issues that exacerbate the identified conditions. This document presents the key findings of the Health Status Assessment.

Background Florida is a large and diverse state with nearly 19 million residents and approximately 80 million visitors each year. In 2010, 22% of the population identified as Hispanic, and adults ages 65 and older accounted for a larger proportion (17.7%) of Florida's population than in any other state. Life expectancy in Florida surpassed that of the US in 2000, and the gap continues to widen over time. In fact, Floridians' life expectancy is longer now than at any other point in history; a person born in Florida in 2010 can expect to live 79.8 years.^E As life expectancy extends, Florida's elderly population continues to grow.

Florida's public health system successes include reductions in:

- Cardiovascular disease and cancer deaths
- Tobacco use
- Teen pregnancy rates
- Cases of vaccine-preventable diseases in young children
- Foodborne and communicable diseases

Nevertheless, the public health system continues to be challenged by the growth and diversity of Florida's population, the complexity of current public health problems and Floridian's lack of access to quality medical and preventive health services.

Assessment Method The Health Status Assessment Workgroup included staff from the Office of Health Statistics and Assessment, the state epidemiologist, and the lead epidemiologists in communicable and chronic diseases, environmental health and maternal and child health. The workgroup identified leading causes of mortality and morbidity and health-related behaviors using existing birth, death, surveillance, hospitalization and survey data. Staff from the Office of Health Statistics and Assessment then interviewed key informants in the partner agencies to broaden the scope of issues being considered and to gather data related to each issue. They compiled all leading causes of mortality and morbidity and the health-related behaviors underlying them and held a facilitated consensus process through which the state epidemiologists selected issues that would be advanced to this summary and the SHIP Steering Committee. Criteria used for selection included health issues that affect a large percentage of the population, show evidence of disparity, or have been identified by the Centers for Disease Control and Prevention (CDC) as Winnable Battles (known effective strategies for improving outcomes within five years).

PARTICIPANTS

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Key Findings

The key health status issues identified by the Health Status Assessment Workgroup were:

- 1. CHRONIC DISEASES**
- 2. TOBACCO**
- 3. OVERWEIGHT, OBESITY AND PHYSICAL INACTIVITY**
- 4. UNINTENTIONAL INJURY AND PRESCRIPTION DRUG ABUSE**
- 5. INFANT MORTALITY AND PREMATUREITY**
- 6. UNINTENDED AND TEEN PREGNANCY**
- 7. BREASTFEEDING**
- 8. CHILD ABUSE, NEGLECT AND OTHER ADVERSE CHILDHOOD EVENTS**
- 9. DEPRESSION AND BEHAVIORAL HEALTH**
- 10. HIV AND AIDS**
- 11. INFLUENZA**
- 12. ACCESS TO CARE**
- 13. EMERGING HEALTH ISSUES**

Health status issues are not mutually exclusive. For example, injury and chronic disease outcomes are associated with access to care while infant mortality and prematurity are associated with unintended and teen pregnancy. A short discussion of each health status issue follows.

Throughout the discussion, Florida's national ranking is provided on a scale of one to 51 (which includes 50 states and Washington, DC). A ranking of one is considered best, while a ranking of 51 is considered worst. Age-adjusted rates per 100,000 population are also referenced in this discussion. An age-adjusted rate is a measure that allows one population to be compared to another without concern for the age structure of that population. This is very important when comparing Florida to the US, since Florida has a larger proportion of the elderly.

1 Chronic Diseases

Several chronic diseases were considered priorities by the state epidemiologists: high blood pressure; heart disease and stroke; cervical, colorectal and breast cancers (cancers for which screening is readily available leading to early diagnosis); diabetes and asthma.

High Blood Pressure (Hypertension)

According to the 2010 BRFSS, 34.3% of Floridians have been diagnosed with hypertension. Prevalence differs across subpopulations: black adults at 41.7%, white adults at 35.4% and Hispanic adults at 24.8%, and those over age 65 at 61.7%.^C

Heart Disease

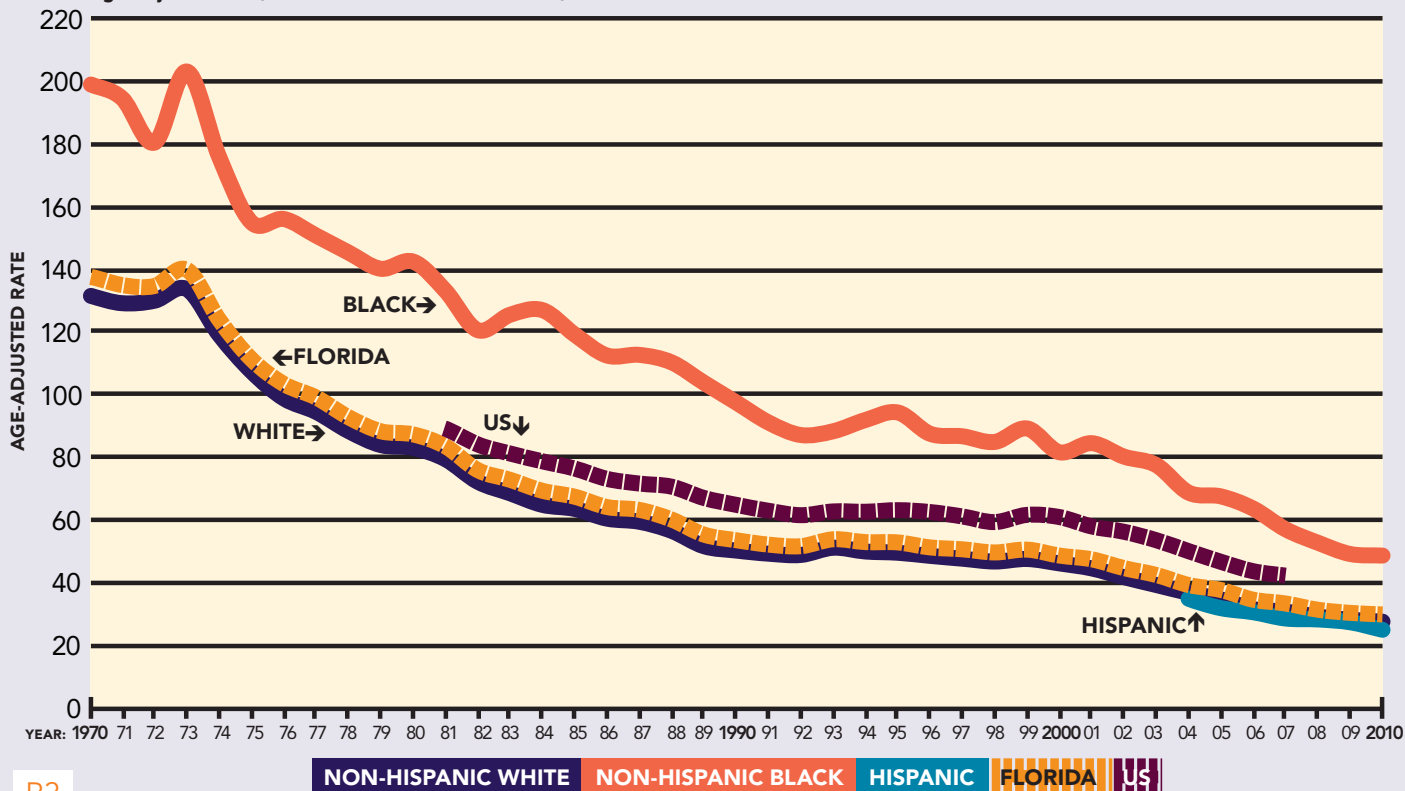
Heart disease was the leading cause of death in Florida in 2010.^F Among heart disease deaths, heart attack represents a significant proportion of those deaths at about 19% since 2007.^E While over the last 40 years deaths from heart attack have declined in Florida from 189 per 100,000 persons in 1970 to 27.7 per 100,000 persons in 2010 (age-adjusted rates), blacks and Hispanics are still 1.3 times more likely than whites to have died from a heart attack.

Stroke

In 2007, Florida ranked fourth best in the nation for stroke age-adjusted death rates.^D Despite the fact that the age-adjusted death rate for stroke has declined over the past 40 years, Florida's rate for blacks continues to be about twice the rate of whites and Hispanics.^E Blacks are almost twice as likely to die from stroke as whites and almost twice as likely to be hospitalized.^{E,P}

STROKE MORTALITY RATE BY RACE/ETHNICITY

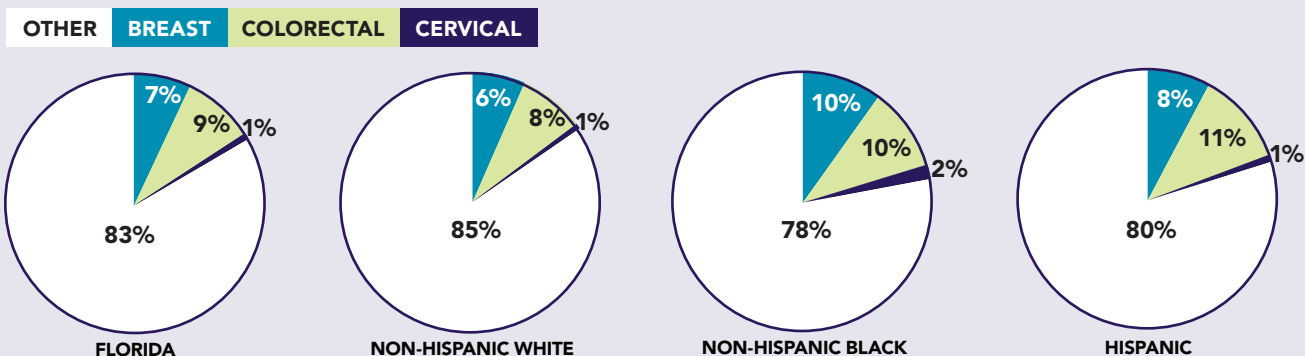
Age-Adjusted Rate, Florida & US 1970–2010: Source, Florida Bureau of Vital Statistics & NVSS



Appendix B: Health Status Assessment Process Summary and Key Findings

CANCER DEATHS, PERCENT BY RACE, ETHNICITY AND TYPE OF CANCER, 2010

Source, Florida Bureau of Vital Statistics



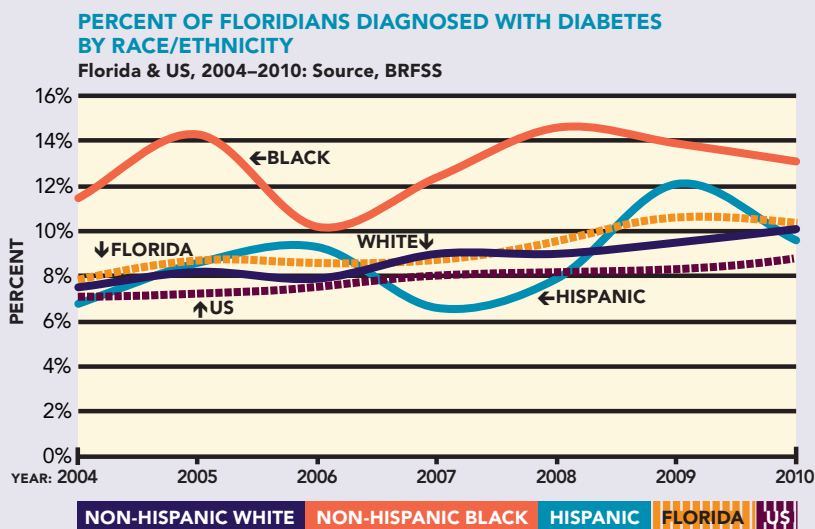
Cancer (Malignant Neoplasm)

Cancer was the second leading cause of death in Florida in 2010, accounting for 28.4% of all deaths.^E While the age-adjusted death rate from cancer has steadily decreased since 1990 from 208.0 to 159.2 per 100,000 population in 2010, it was still the leading cause of death for individuals aged 45–84, accounting for 35.6% of the total deaths in this age group.

Together, cervical, colorectal and breast cancers account for 16.6% of all of Florida’s cancer deaths. Because regular screenings have been shown to be an effective means of reducing the associated mortality, cervical, colorectal and breast cancers were identified as key health status issues. The distribution of all three of these types of cancers is greater among non-Hispanic blacks than whites. The age-adjusted death rate for cervical cancer for blacks is 1.7 times that of whites. Although Hispanics and blacks have nearly equal proportions of deaths from colorectal cancers, the black age-adjusted death rate for colorectal cancer is 1.4 times that of whites. In 2007, Florida ranked 13th among the states in breast cancer deaths, 22nd in cervical cancer deaths and 12th in colorectal cancer deaths.^B

Diabetes

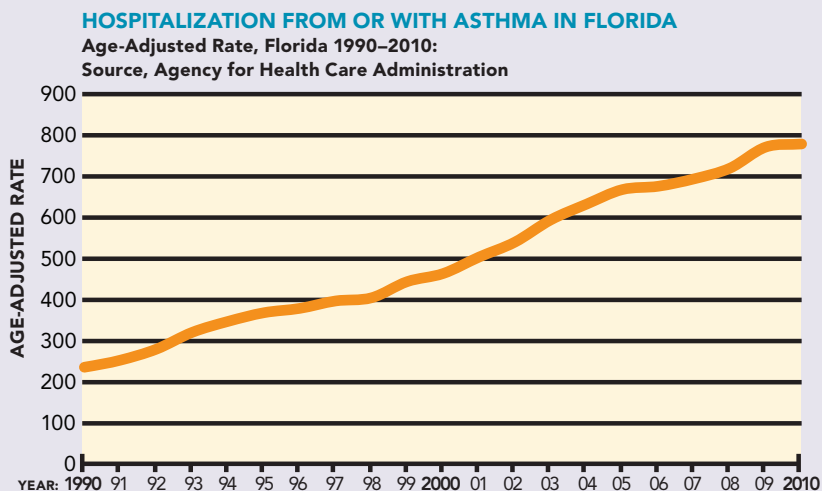
Diabetes prevalence is at an all time high. Diabetes mellitus was the sixth leading cause of death in Florida in 2010 with a rate of 26.6 per 100,000 population,^E and in 2007, Florida ranked 15th nationally in death rates from diabetes.^D In 2010, compared with whites, blacks had higher rates of diabetes deaths (39.0 versus 17.1 age-adjusted death rate per 100,000 population),^E hospitalizations (4,264.2 versus 1,867.8 age-adjusted hospitalization rate per 100,000 population),^P and amputation due to diabetes (68 versus 19.6 per 100,000 population).^P Each year since 2004, the percent of Floridians diagnosed with diabetes has continued to exceed the US average for black, white and Hispanic populations.^C This is a winnable battle, with established clinical management guidelines.



Appendix B: Health Status Assessment Process Summary and Key Findings

Asthma

Asthma is a chronic respiratory disease, which causes wheezing, breathlessness, chest tightness, and coughing, and can greatly limit an individual's quality of life and level of productivity. According to the CDC's 2008 estimates, about 10.2% of adults in Florida have ever had asthma, and 6.6% of adults currently live with asthma. That number is increasing each year, mirroring national statistics. The number of people diagnosed with asthma grew from 7.3% in 2001 to 8.4% in 2010, when 25.7 million persons had asthma.^Q Florida statistics show a steady increase in hospitalizations due to asthma, from just over 200 per 100,000 population in 1990 to over 700 per 100,000 in 2010.^P

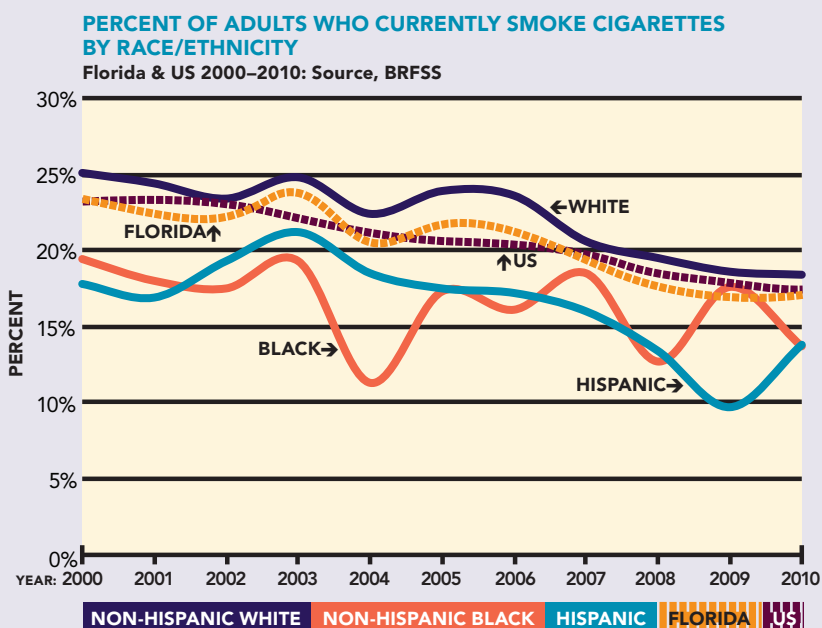


It's important to highlight disparities and the need to target effected populations with interventions and care. For the period 2007–2009, asthma visit rates (per 100 persons with asthma) in primary care settings for black persons were similar to those for white persons, but rates for asthma emergency department visits, hospitalizations, and deaths were higher. The black rate of asthma hospitalizations in 2010, at 1,205.2 per 100,000 persons was 1.9 times that of the white rate at 644.7 per 100,000 population.^P

2 Tobacco

In the US, more deaths are caused each year by tobacco use than all deaths from HIV, illegal drug use, alcohol use, motor vehicle injuries, suicides and murders combined.

Smoking increases the risk of coronary heart disease and stroke by a factor of two to four and of dying from chronic obstructive lung diseases by a factor of 12.^S In 2010, Florida ranked 24th nationally in percentage of smokers.^C Tobacco use in Florida has declined over time, but greater progress is still possible through cessation, reducing second-hand smoke exposure and youth tobacco prevention activities.



3 Overweight, Obesity and Physical Inactivity

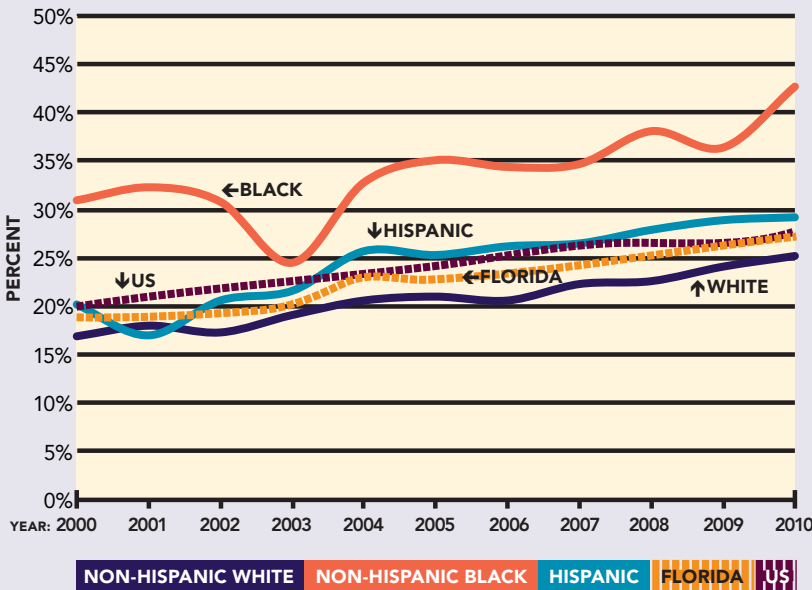
Over the past decade, obesity has become recognized as a national health threat and a major public health challenge. Obese adults are at increased risk for serious health conditions including coronary heart disease, hypertension, stroke, type 2 diabetes, and certain types of cancer. Adult obesity is also associated with reduced quality of life, social stigmatization, and discrimination.^T The 2012 Institute of Medicine report *American's Obesity Crises* cites \$190.2 billion as the estimated annual cost of obesity-related illness with 21% of annual medical spending on obesity-related illness, and 27% of the increases in U.S. medical costs associated with obesity-related diseases.^T Consequently, the US Surgeon General has called for strong public

health action to prevent and decrease overweight and obesity. In 2010, Florida ranked 45th nationally in its proportion of population that was overweight and 24th in the proportion who were obese.^C In 2010, 25.2% of Florida's white population, 42.7% of its black population, and 29.2% of its Hispanic population were obese.^C

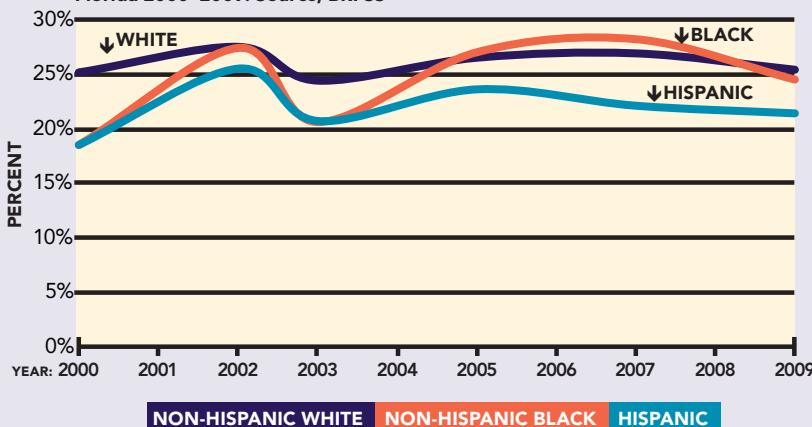
Regular physical activity not only helps people to avoid being overweight, but reduces the risk for other adverse health conditions such as coronary heart disease, stroke, high blood pressure, high cholesterol or triglycerides, type 2 diabetes and more.^U Florida ranks 34th among states in physical activity, with the black and Hispanic population less likely to engage in regular, moderate physical activity than whites.^C

Eating a healthy diet is another recommended strategy for maintaining healthy weight. Yet, in 2009, only one-quarter of adult Floridians met the dietary goal of five fruits and vegetables daily. Since 2000, Hispanics have had the lowest rate of adequate fruit and vegetable consumption.^C

PERCENT OF ADULTS WHO ARE OBESE BY RACE/ETHNICITY
Florida & US 2000–2010: Source, BRFSS



PERCENT OF ADULTS WHO CONSUME 5 OR MORE FRUITS AND VEGETABLES DAILY
Florida 2000–2009: Source, BRFSS



4 Unintentional Injury

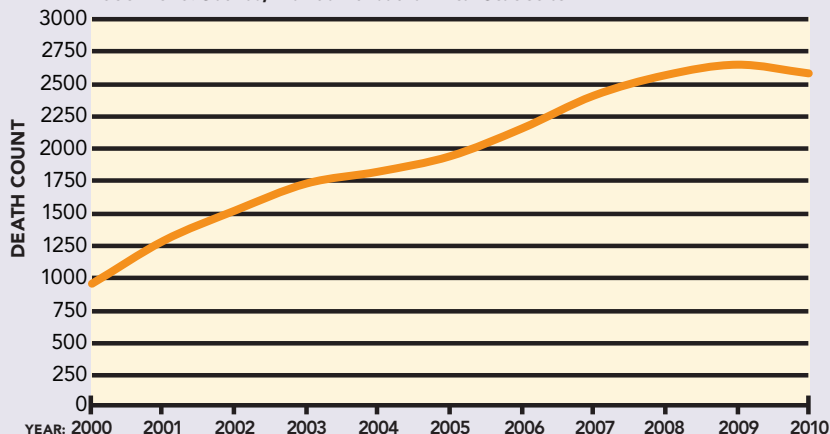
In 2007, Florida ranked 32nd among all states in unintentional injury-related deaths,^F and in 2010, within Florida, unintentional injuries were the 4th leading cause of death among all age groups and the leading cause among those younger than 45 years old.^E Florida's epidemiologists identified the following unintentional injuries as significant health issues: prescription drug abuse and motor vehicle injuries including bicycle and pedestrian injuries, falls among the elderly population and drowning among children.

Prescription Drug Abuse

Florida has experienced a substantial rise in unintentional poisoning deaths over the past two decades—the overwhelming majority of which can be attributed to the abuse of prescription and illegal drugs. The number of unintentional poisonings, officially classified as “deaths from poisoning and noxious substance exposure”, rose from 954 deaths in 2000 to 2,582 in 2010. Consequently, unintentional poisonings have now surpassed motor vehicle accidents as the leading cause of unintentional injury death among Floridians.^E

DEATHS FROM POISONING AND NOXIOUS SUBSTANCE EXPOSURE IN FLORIDA

2000–2010: Source, Florida Bureau of Vital Statistics



Motor-Vehicle Crash Fatalities

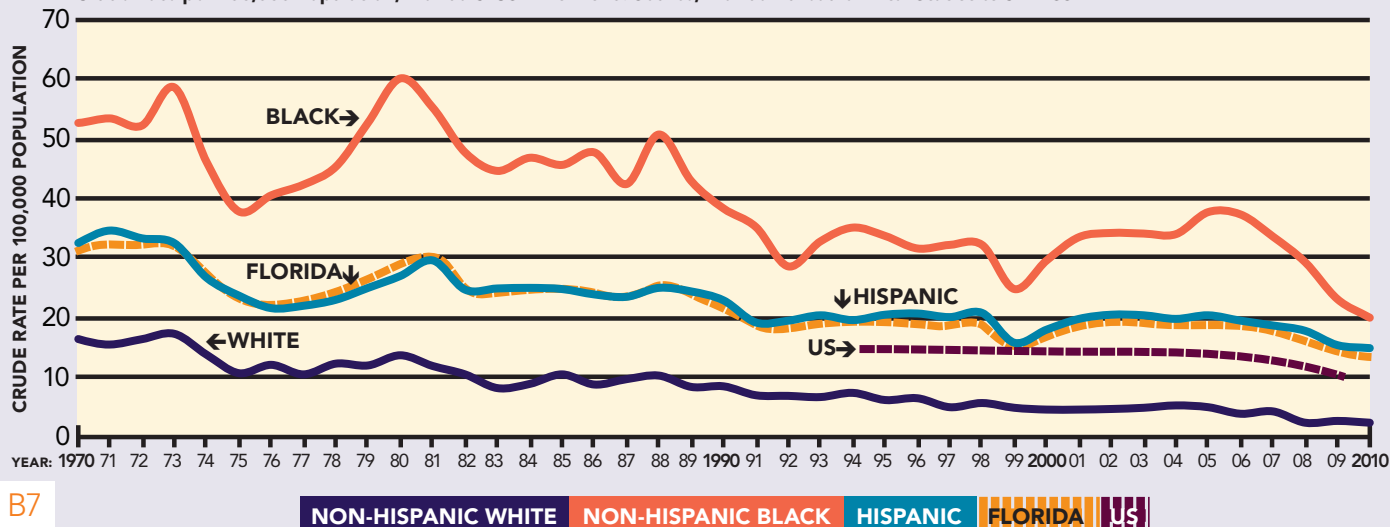
In Florida, fatalities from motor vehicle crashes have dropped each year—from 3,491 in 2005 to 2,449 in 2010.^E The State Mileage Death Rate (the number of deaths per 100 million miles traveled) decreased to 1.25 deaths per 100 million vehicle miles traveled in 2010—the lowest since the rate has been calculated.^V Although motor-vehicle crash fatalities are generally declining in Florida, the rate among those age 16–24 (20.0

per 100,000 population) is substantially higher than the overall rate in both Florida (13 per 100,000 population) and in the US (11.0 per 100,000 population).^F In 2007, Florida ranked 35th nationally in the rate of motor vehicle accident deaths.^F

In addition to motor vehicle deaths, bicycle and pedestrian safety was a concern. In 2010, the

MOTOR VEHICLE CRASH FATALITIES BY SELECTED AGE GROUPS

Crude Rate per 100,000 Population, Florida & US 1970–2010: Source, Florida Bureau of Vital Statistics & NVSS



Appendix B: Health Status Assessment Process Summary and Key Findings

Department of Highway Safety and Motor Vehicles reported 76 bicyclists killed, 4,600 bicyclists injured and 4,925 bicycle crashes as well as 499 pedestrians killed, 7,290 pedestrians injured and 7,894 pedestrians involved in crashes in Florida.^V

Falls

Among the elderly, injuries from falls are a major cause of disability and death. Florida's 2008–10 death rate due to unintentional falls among those ages 65 and over, at 51.6 per 100,000, was significantly greater than the total state rate of 7.1 per 100,000.^E The large proportion of older adults in

Florida makes this issue a growing concern.

Childhood Drowning

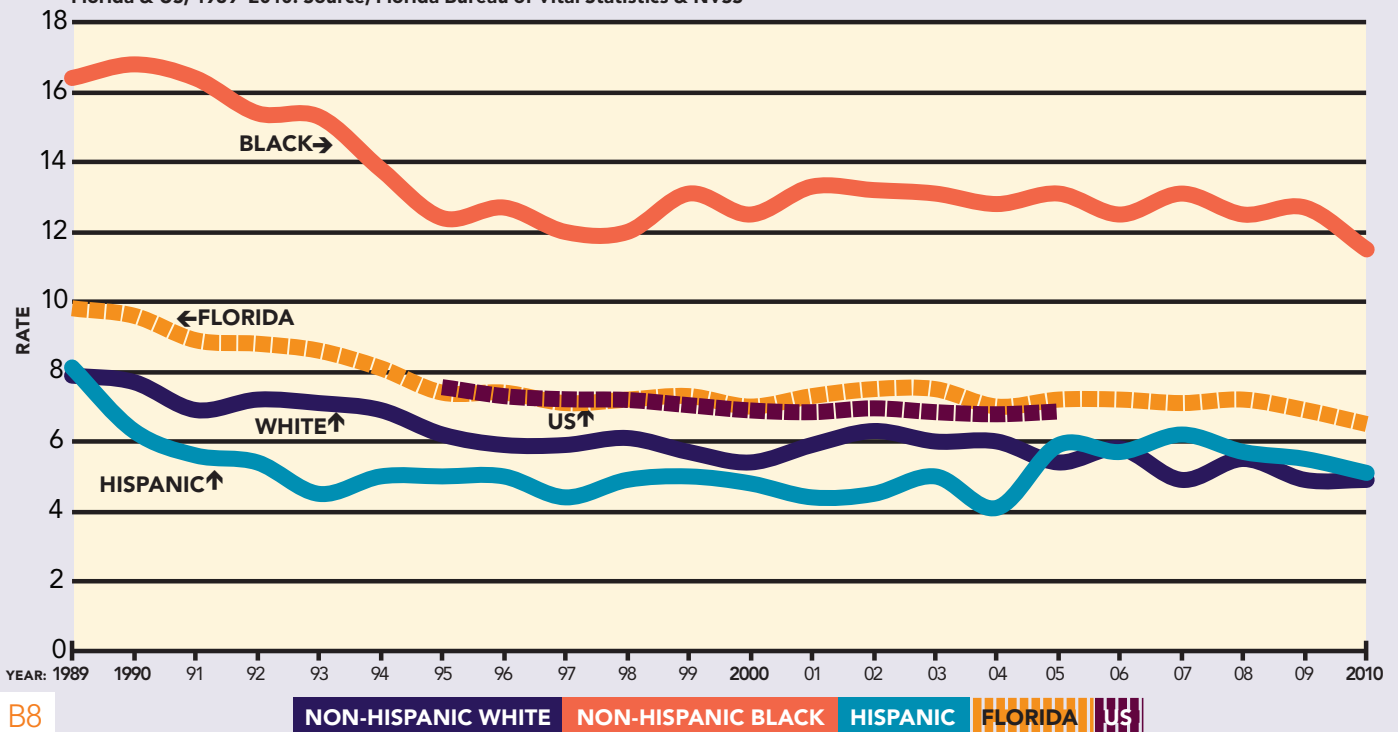
The overall age-adjusted death rate from drowning in Florida decreased from 2.5 per 100,000 in 1991 to 1.9 per 100,000 in 2010. Those aged 0–4 consistently have the highest rates of drowning (9.3 in 1989–91 to 6.0 in 2008–2010). This age group accounted for the largest proportion of drowning deaths in the state in 2010 at 18.45%.^E

5 Infant Mortality and Prematurity

Infant mortality is often used as a measure of overall population health. In 2009, Florida's infant mortality rate ranked 29th among the states,^D and in 2010, black babies born in Florida were 2.5 times as likely to experience an infant death as white babies.^E Preterm birth is a major contributor to infant mortality. In 2009, Florida was ranked 42nd nationally in its rate of preterm birth,^D with black mothers experiencing preterm birth 1.5 times more often than white mothers.^E

INFANT MORTALITY RATE BY RACE/ETHNICITY PER 1,000 LIVE BIRTHS

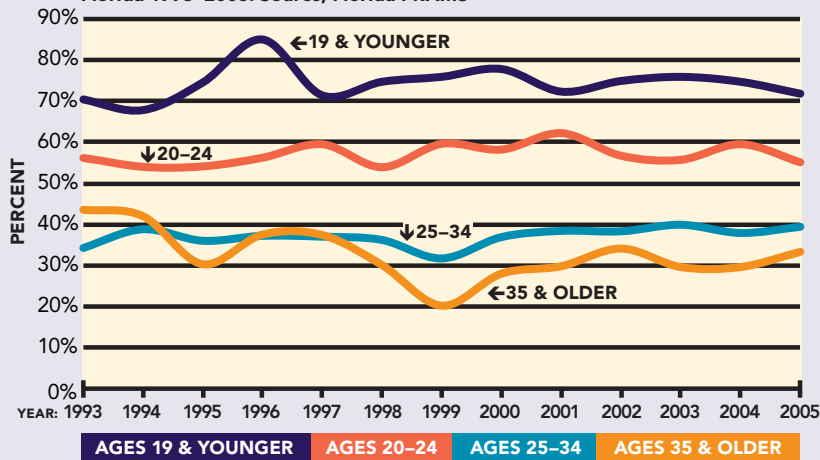
Florida & US, 1989–2010: Source, Florida Bureau of Vital Statistics & NVSS



6 Unintended and Teen Pregnancy

PERCENT OF UNINTENDED PREGNANCIES BY AGE OF MOTHER

Florida 1993–2005: Source, Florida PRAMS

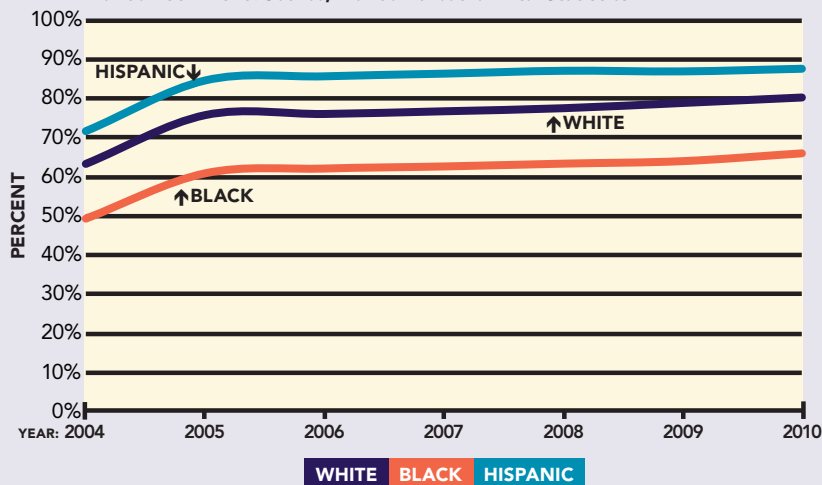


A 2011 study reported that 49% of pregnancies in the US were unintended in 2006 and among women 19 years and younger, four out of five pregnancies were unintended.^w Unintended pregnancy is associated with an increased risk of morbidity and mortality for women and with adverse outcomes for infants related to late-onset prenatal care.^w Women of all ages may have unintended pregnancies, but some groups, such as teens, are at higher risk.^w Florida ranks 20th in unintended pregnancy^h and 29th in teen pregnancy.^l In 2009, the percentage of teenage mothers who had another birth within their teenage years was 18.9%, ranking Florida 41st in the US.^l

7 Breastfeeding

PERCENT OF BIRTHS BY BREASTFEEDING INITIATION AND RACE/ETHNICITY

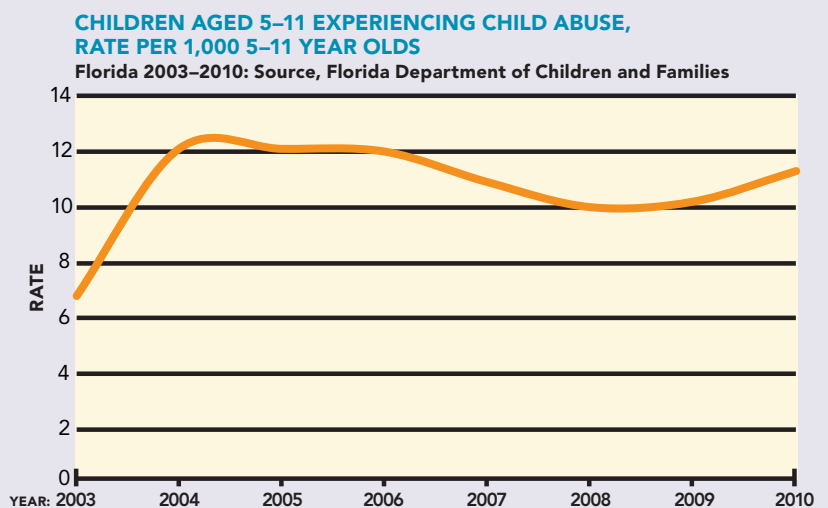
Florida 2004–2010: Source, Florida Bureau of Vital Statistics



Breastfeeding is one of the best ways to start life. Breastfeeding provides nutrients and antibodies, is easier for babies to digest, and is associated with reduced risks of respiratory infections, asthma, obesity, type 2 diabetes and sudden infant death syndrome.¹ In Florida, in 2010, 69.6% of black mothers initiated breastfeeding their infants before being discharged from the hospital as compared to 83% of white mothers and 87.6% of Hispanic mothers.^f Mothers born in the US were less likely to initiate breastfeeding compared with foreign-born mothers.

8 Child Abuse, Neglect and other Adverse Childhood Events

Nationally, in 2010, child protective organizations received over 3.3 million reports of alleged maltreatment of approximately 5.9 million children. Victims in the age group of birth to 1 year had the highest rate of victimization at 20.6 per 1,000 children. The overall rate of child fatalities was 2.07 deaths per 100,000 children. More than 30 percent (32.6%) of child fatalities were attributed exclusively to neglect, and more than 40 percent (40.8%) of child fatalities were caused by multiple maltreatment types.^Y Child abuse and neglect can result in death, disability, poor school performance, teen pregnancy, and mental and emotional disorders. Child abuse is a risk factor for violent behavior in adolescents and adult criminality. In adulthood, victims of childhood abuse and neglect are more likely to experience drug use, hypertension, depression and a shortened lifespan.^Z Primary, secondary and tertiary prevention programs can improve opportunities for children to be raised in healthy, safe, stable and nurturing family environments, yet Florida's rate of child abuse to those ages 5–11 has increased from 6.8 per 1,000 children in 2003 to 11.3 in 2010.



9 Depression and Behavioral Health

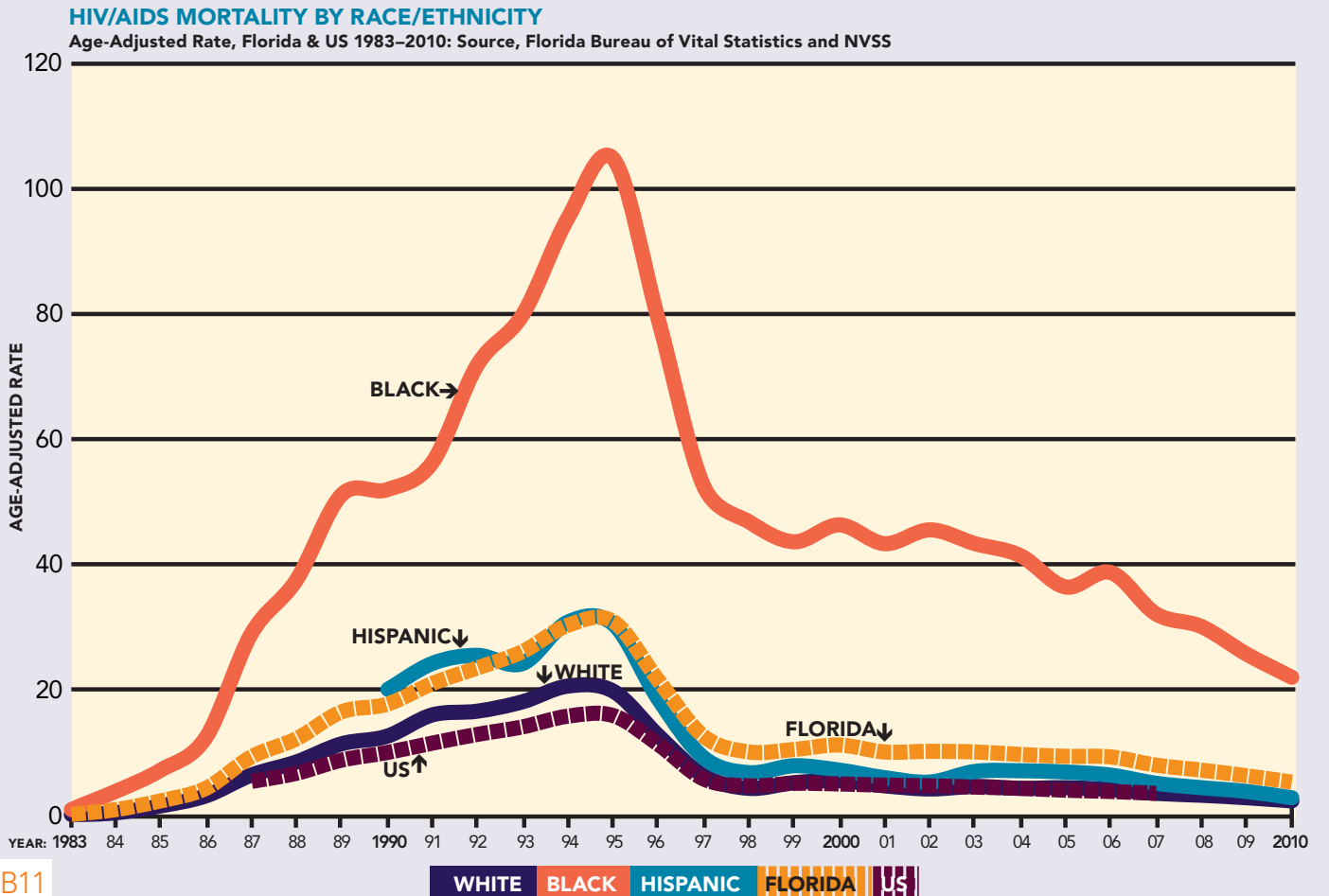
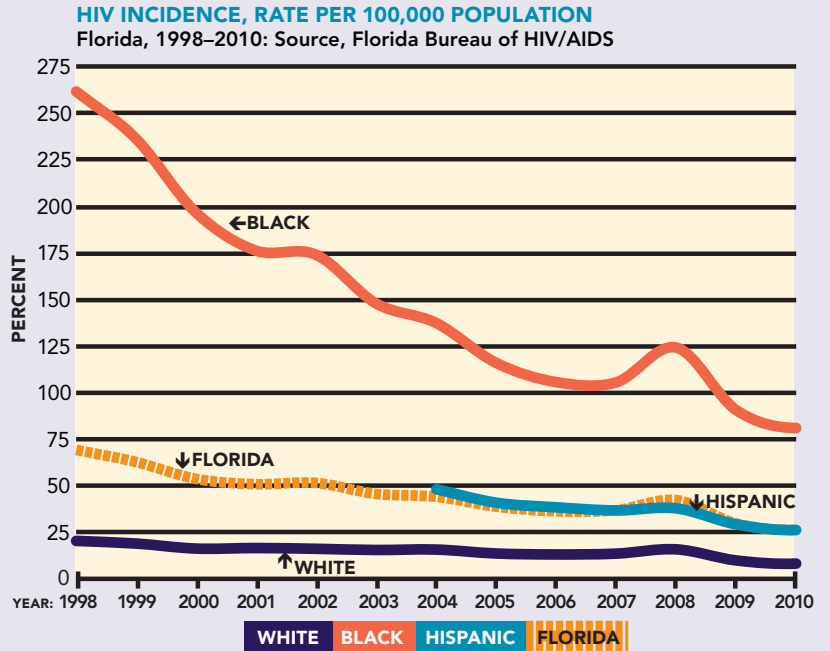
An estimated 12 million American adults are living with major depression.^X Depression can interfere with normal functioning and frequently causes problems with work, social and family adjustment and can be costly and debilitating to sufferers. It can adversely affect the course and outcome of common chronic conditions, such as arthritis, asthma, cardiovascular disease, cancer, diabetes, and obesity. Depression also can result in increased work absenteeism, short-term disability, and reduced productivity.^X As a marker for depression, Florida's rate of attempted suicide (102.9 per 100,000) exceeded the national rate of 87.9 in 2009.^F Suicide was the ninth leading cause of death for Floridians in 2010.^E

HIV and AIDS

HIV disease includes all people with evidence of HIV infection, regardless of immune status or symptoms. AIDS cases are a subset of those with HIV disease. Since the AIDS epidemic began in 1981, over 1.7 million Americans have been infected with HIV and over 600,000 have died of AIDS-related causes. An estimated 21% of people living with HIV are undiagnosed, and every 9.5 minutes, a new case is found.^{LM}

In Florida, the rate of new HIV disease cases has decreased from a peak of 69.5 per 100,000 residents in 1998 to 26.5 per 100,000 residents in 2010. The overall decreases in HIV disease and AIDS diagnoses have been observed across all racial and ethnic groups, however, blacks are still 9.6 times more likely than whites to be diagnosed with HIV.^K

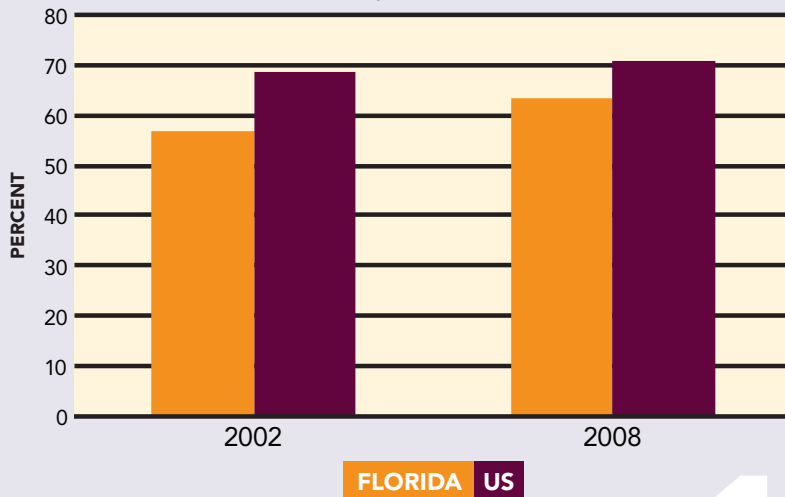
In 2010, the age-adjusted HIV/AIDS death rate for blacks was 22.2 per 100,000 population as compared to 3.0 per 100,000 for Hispanics and 2.5 per 100,000 for whites.^E In 2009, Florida ranked 49th in its age-adjusted death rate for HIV and AIDS^D, 51st in HIV cases^K and 49th in AIDS cases.^K



11 Influenza

PERCENT OF ADULTS AGE 65 AND OLDER WHO RECEIVED A FLU SHOT IN THE PAST YEAR

Florida & US 2002 & 2008: Source, BRFSS

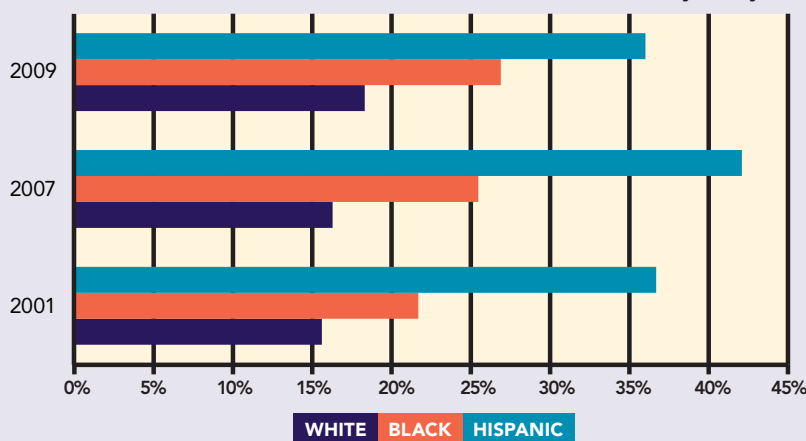


Influenza affects approximately five to 20% of US residents annually, resulting in loss of work, productivity and school attendance. The effects of influenza are more extreme among the young and the older populations.⁴ Compared to other states, Floridians are less likely to be vaccinated for influenza. In particular, the overall prevalence of flu immunization among Floridians ages 65 years and older has been slightly lower than the national prevalence for the past decade.^c

12 Access to Care

PERCENT OF FLORIDIANS UNDER 65 WITHOUT HEALTH INSURANCE BY RACE/ETHNICITY

2001, 2007 & 2009: Source, US Census Bureau, American Community Survey



Access to care includes availability of health insurance, providers and health care facilities. Health insurance helps people engage in preventative care and seek treatment before their illness becomes chronic. Based on three-year estimates (2008–2010), Florida ranked 49th in the country for the percentage of its population who were uninsured.⁸ According to the US Census, 21% of Florida’s population does not have health insurance.⁶ Of these, 25% are currently employed but still lack health insurance, primarily because many work part time and are ineligible for employer benefits. The numbers of children and adults without health insurance are increasing, and blacks and Hispanics are more likely to be uninsured than whites. While 19.1% of the white population has no health insurance, 25.7% of blacks and 34.3% of Hispanics are uninsured. In Florida, those ages 25–34 constitute the highest percentage of people without insurance coverage (37%), followed by those ages 35–44 (31%). Almost 13% of children (ages 0–17) are uninsured. In 2007, 15.1% of adults in Florida reported they could not see a doctor at least once in the past year due to cost, which rose to 17.3% in 2010.^c

Appendix B: Health Status Assessment Process Summary and Key Findings

Dental Care and Oral Health

Dental care and oral health are related to serious medical conditions such as heart disease, premature birth and low birth weight, and infections of the blood and bones.² Access to dental care is as important as health insurance. In 2010, only 66% of the general population had visited a dentist within the past year.^c In 2007, 19.2% of adult Floridians could not see a dentist because of cost.^c Over one-third of dentists are over age 55, and the number graduating is not enough to replace the number retiring.

Health Care Providers

A shortage of as many as 150,000 doctors is predicted for the US in the next 15 years, according to the Association of American Medical Colleges. Too few providers will limit access to health care and create longer wait times for appointments. Additionally, financial rewards for specialty care

physicians far outweigh those of primary care physicians; yet, it is primary care physicians who are most needed for serving the general needs of a population.

Given current graduation and training rates, health care providers will continue to be in great demand in Florida. Currently, Florida has 1,329 health care shortage areas for primary care, 1,146 shortage areas for dental care and 276 shortage areas for mental health. These areas, defined by the US Department of Health and Human Services, are designated based on specific criteria about the geography, population and facilities in an area.³

Health facilities also contribute to the ability to care for a population. Since 2008, very little change has occurred in the number of hospital beds, specialty beds, nursing home beds, adult psychiatric beds, or substance abuse beds per 100,000 residents despite growing needs.^p

13 Emerging Issues

Florida must also be prepared to deal with the continual threat of natural disasters, health emergencies, health misinformation, tropical diseases and epidemics. The state epidemiologists identified the following emerging issues which Florida will have to monitor carefully over the next decade:

- Our tropical climate provides an environment hospitable to many organisms that could not prosper in colder climates, and the continued threat of new or more virulent strains of infectious diseases such as malaria, dengue fever, cholera, tuberculosis and hepatitis B, related to the influx of migrants, immigrants and refugees is of concern.
- Decline or non-acceptance of proven childhood immunizations and prevention strategies due to public misperceptions (for example, basic series and HPV immunizations, water fluoridation) continues to be a challenge.
- Florida has many older homes with lead-based paint as well as an immigrant population with lead poisoning or who are at risk due to occupational hazards (battery recycling, etc.). This is a winnable battle.

Appendix B: Health Status Assessment Process Summary and Key Findings

Florida Health Status Assessment SELECTED INDICATORS	Year	Healthy People 2020 Goals	State Rank *	US Rate	Florida Rate	White	Black	Hispanic
<p>STATE RANKINGS: 1=most favorable; 51=least favorable among 50 states and Washington, D.C</p> <p>‡ Ranking is among the 25 Prenatal Risk Assessment and Monitoring System (PRAMS) participating states</p>								
CHRONIC DISEASES								
Hypertension Prevalence ^C	2009	26.9%	42	28.7%	32.1%	33.6%	38.2%	25.2%
Heart Disease Age-Adjusted Death Rate ^{SE}	2008		10	186.5	154.6	156.3	196.0	155.2
Stroke Age-Adjusted Death Rate ^{DE}	2007	33.8	4	42.2	30.3	30.7	57.0	28.5
Cervical Cancer Age-Adjusted Death Rate ^{ABE}	2007	2.2	22	2.4	2.5	2.2	3.7	2.1
Colorectal Cancer Age-Adjusted Death Rate ^{ABE}	2007	14.5	12	16.7	14.2	14.4	18.6	13.6
Breast Cancer Age-Adjusted Death Rate ^{ABE}	2007	20.6	13	22.8	20.8	19.0	27.5	13.5
Diabetes Age-Adjusted Death Rate ^{DE}	2007		15	22.5	19.1	18.1	43.5	20.6
People Who Have Been Told by a Doctor They Have Diabetes ^C	2010		43	8.7%	10.4%	10.1%	13.1%	9.6%
Asthma Hospitalizations (per 100,000) ^N	2009			672.8	769.7			
TOBACCO								
Adults Who Currently Smoke ^C	2010	12%	24	17.3%	17.1%	18.4%	13.7%	13.8%
OVERWEIGHT, OBESITY AND PHYSICAL INACTIVITY								
Adults Who are Overweight (BMI >25) ^C	2010		45	36.2%	37.8%	37.9%	36.3%	37.3%
Adults Who are Obese (BMI >=30) ^C	2010	30.6%	24	27.6%	27.2%	25.2%	42.7%	29.2%
Adults Who Engaged in Any Physical Activity During the Past Month ^C	2009		34	76.2%	75.3%	78.2%	71.6%	68.3%
Adults Who Eat Five Servings of Fruits and Vegetables per Day ^C	2009		20	23.4%	24.4%	25.4%	24.5%	21.4%
UNINTENTIONAL INJURY								
Unintentional Injury Age-Adjusted Death Rate ^{EF}	2007	36	32	40	42.6	48.3	33.2	34.3
Motor Vehicle Accident Age-Adjusted Death Rate ^{E5}	2007	12.4	35	14.4	13.6	18.3	14.7	17.8
Fall Death Rate, Ages 65+ ^{DE}	2007	45.3		45.3	44.7	46.9	19.4	25.9
Drowning Death Rate, ages 0-4 ^{FE}	2009			2.32	6.2	5.7	5.8	4.4
INFANT MORTALITY AND PREMATURITY								
Infant Mortality Rate (per 1,000 live births) ^{ED}	2009	6	29	6.7	6.9	4.9	13.2	5.5
Preterm Birth (less than 37 weeks gestation) ^{E9}	2009		42	12.2	13.5	12.5	18.6	13.7
UNINTENDED AND TEEN PREGNANCY								
Unintended Pregnancies ^H	2008	44%		49%	47.4%	45.5%	65.5%	41.8%
Birthrate to Teens Ages 15-19 ^{EI}	2008		29	42	37.4	34.7	61.3	48.7
Repeat Births to Teens Ages 15-19 ^{EI}	2009		41	18.9%	18.9%	28.3%	38.5%	30.6%
BREASTFEEDING								
Mothers Who Initiate Breastfeeding ^E	2010				80%	83%	69.6%	87.6%
DEPRESSION AND BEHAVIORAL HEALTH								
Attempted Suicide (per 100,000) ^F	2009			87.9	102.9			
Adolescent Suicide Attempts, 9-12th Grade ^J	2009		8	6.30%	6.50%	5.20%	7.30%	7.90%
HIV AND AIDS								
HIV and AIDS Age-Adjusted Death Rate (per 100,000) ^D	2009	3.3	49	3	6.5	3	25.9	4
HIV Incidence (per 100,000) ^{KLM}	2009		51	17.4	29.8			
AIDS Incidence (per 100,000) ^M	2009	13	49	11.2	23.7			
INFLUENZA								
Pneumonia and Influenza Age-Adjusted Death Rate ^{De}	2007		1	16.2	8.5	8.1	11.5	7.0
Adults 65 and Over Who Received a Flu Shot in the Past Year ^C	2010	90.0%	38	67.5%	65.6%	70.0%	41.6%	44.1%
ACCESS TO CARE								
Adults Without Health Insurance ^B	2010	0%	49	17.8%	21.5%	17.1%	26.7%	32.8%
Adults Who Visited a Dentist within the Past Year ^C	2010		39	69.7%	66.4%	69.5%	56.9%	62.0%
Total Physicians (per 10,000) ^O	2008		26	25.7	24.2			
Total Dentists (per 10,000) ^O	2007		30	6.0	5.3			
Total Hospital Beds (per 1,000 population) ⁷	2010		22	2.6	2.8			

Data is provided for the latest year for which a US and Florida comparison are available.

STATE RANKINGS: *State Rankings were calculated internally using data from the data sources noted for the indicator

DATA SOURCES: SEE NEXT PAGE



Appendix B: Health Status Assessment Process Summary and Key Findings

DATA SOURCES:

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Appendix C: Forces of Change Assessment Process Summary and Key Findings

Process Summary

PARTICIPANTS

The State Health Improvement Plan (SHIP) Advisory Committee members participated in the Forces of Change Assessment. Participants included:

Andrew Behrman, M.B.A., President and CEO, Florida Association of Community Health Centers

Robert Brooks, MD, MA, MBA, MPH, Associate Vice President for Health Care Leadership, USF Health

Jeffrey Gregg, Chief of Health Facility Regulation, Agency for Health Care Administration

Dawn Emerick, President, Florida Association of Health Planning Agencies, Inc.

Earl Fox, Executive Director, MD, MPH, Florida Public Health Institute

Penny Detscher, Office of Healthy Schools, Florida Dept. of Education

Mollie Palmer, Deputy Chief of Staff, Dept. of Environmental Protection

Pete Digre, Deputy Secretary, Dept. of Children and Families

H. Frank Farmer, Jr., MD, PhD, FACP, State Surgeon General, Florida DOH

Richard C. Solze, Jr., M.A., Chief of Staff, Florida DOH

Steven L. Harris, M.D., M.Sc., Deputy Secretary for Health and Director, Office of Minority Health

Kimberly A. Berfield, Deputy Secretary, Florida DOH

Bonita Sorensen, M.D., Director, Volusia County Health Department

The Florida DOH led a coordinated, statewide effort to conduct a Forces of Change Assessment in 2011. This assessment addresses the issues of what is occurring or might occur that affects the health of our state or the state public health system and what specific threats or opportunities are generated by these occurrences. The forces identified serve as the foundation for identifying strategic issues. This document presents the results of the Forces of Change Assessment.

Background A Forces of Change Assessment is one of four comprehensive assessments recommended by the National Association of County and City Health Officials (NACCHO) as communities or states develop a health improvement plan.

Participants engage in brainstorming sessions aimed at identifying trends, factors, and events that influence the health and quality of life of the community and the effectiveness of the local public health system.

Assessment Method The Advisory Committee convened and participated in a facilitated session on October 17, 2011 to discuss and identify the forces that affect the public health system as part of the State Health Improvement (SHIP) planning process. The group was asked to focus on issues such as factors that impact the environment in which the public health system operates; trends; legislation; funding shifts; federal, state and local legislation; technological advances; changes in organization of health care services; shifts in economic and employment forces; changing family structures; gender roles, and more. A summary of the Forces of Change Assessment is provided in the tables that follow and details are included in the Forces of Change Discussion section.

Key Findings

Opportunities for Synergy and Partnership in the Planning Process

The SHIP is an opportunity to educate leaders and policy makers to create synergy and cross-cutting solutions to shared problems. Non-profit and community hospitals should be included in the planning process because they are required to conduct their own needs assessment in order to maintain their IRS tax-exempt status. Local health committees are also trying to integrate other types of assessments (e.g., environmental) with the Mobilizing for Action through Planning and Partnerships (MAPP) process to create a more holistic approach. Environmental assessments and Protocol for Assessing Community Excellence in Environmental Health (PACE EH) projects present additional opportunities to make improvements in the environmental impact on health. Integrating PACE EH with MAPP-based health improvement planning is an opportunity for a more holistic approach and will bring more partners to the table.

Economic and Demographic Forces of Change Florida is facing a series of economic and demographic challenges to our current health care system. This includes an aging and increasingly obese population, an increasing number of people without health insurance, the

Appendix C: Forces of Change Assessment Process Summary and Key Findings

diminished capacity of health care safety net providers, difficulties associated with controlling health care costs, major pending changes to Florida's Medicaid service delivery system, and a growing shortage of health care providers.

Florida currently has one of the oldest resident populations in the nation. Older persons have increased health care needs. At the same time Florida is seeing the prevalence of obesity increase in all age groups along with the adverse health consequences obesity entails.

Workers are losing health insurance as more businesses are finding health insurance coverage too expensive to provide to their employees. Florida has one of lowest rates of health insurance coverage in the nation. The high rate of uninsured persons places great stress on our health care system, particularly the safety net system. Economic downturns impact health care providers as well. During economic downturns providers typically experience reduced support from local, state, and federal sources while seeing more patients and proportionally more uninsured patients. This results in the perverse situation where demand on the system increases at the same time capacity decreases.

The conversion of Florida Medicaid to essentially a completely managed care service delivery system in 2014 presents both opportunities and risks. Opportunities include the potential for better access to, and coordination of, health care services to Medicaid recipients along with a higher degree of cost control. Risks include the extent to which Medicaid managed care plans can attract and retain quality health care providers and by extension the ability of Medicaid recipients to access needed services.

Hospitals serve as an important component of the health care safety net. The loss of hospital capacity, particularly those that serve the indigent, greatly impacts Florida's health care safety net. Many hospitals in Florida are struggling to remain solvent. Hospital occupancy is dropping as insurance companies move more care to an outpatient basis. Decreasing inpatient occupancy often leads to corresponding decreases in emergency department staffing and capacity. Although inappropriate, emergency rooms still comprise an important component of Florida's primary care safety net.

The nature of health care and the presence of third-party payers tends to inhibit the application of market competition, in part because the cost of services is frequently not the driving consideration. Market solutions to health care system problems can be challenging to develop and implement. The practice of "creaming" by provider organizations—working to obtain and maintain a panel of relatively healthy patients while minimizing the number of sicker and more costly patients—is a phenomenon that must be addressed to maintain an equitable and effective system. Fraud and the overutilization of services are also significant factors in our health care system. Current mechanisms for addressing fraud and encouraging the efficient use of resources appear inadequate.

The distribution of health care practitioners, particularly among nurses and dentists, is very uneven across the state and results in much diminished access to needed care. Florida's population is aging and having greater needs while at the same time our health care provider workforce is aging and retiring. There is great unmet need in Florida in the area of dental services to adults. Insurance coverage for dental care is often very limited and Medicaid only covers emergency services and dentures for adults.

Summary: Economic and Demographic Forces of Change

CHALLENGES

- An aging population
- An increasingly obese population
- Increasing numbers of uninsured persons
- Diminishing health care safety net capacity on the part of Federally Qualified Health Centers, county health departments, and hospitals
- Difficulty implementing cost controls in the health care area
- Transitioning to a completely managed care Medicaid system

OPPORTUNITIES

- Interest in workplace wellness and behavioral change strategies are growing
- The economy is improving, which should improve the health care fiscal picture
- Managed care systems, implemented well and funded adequately, offer the opportunity for better coordinated care and improved access to specialists
- Managed care systems, implemented well and funded adequately, are well-positioned to support true patient centered medical homes
- Providers and insurers are showing more interest in controlling health care costs and trying innovative programs
- The implementation of Medicaid risk-based capitation rates will lessen the impact of manipulated patient selection
- Managed care tends to better control practitioner-related fraud and abuse and discourage the provision of unnecessary services

Appendix C: Forces of Change Assessment Process Summary and Key Findings

Access to Care Forces of Change Access to care, particularly on behalf of low-income persons, is becoming increasingly problematic. As addressed in the Economic and Demographic Forces of change section, many safety net providers are experiencing reductions in their infrastructure which results in corresponding reductions to appointment slots, service offerings, hours of operation, etc. The closing of hospital emergency rooms sometimes denies persons access to the only outpatient medical care they are able to obtain.

Dental health, especially for low income children, is greatly underutilized. A high proportion of low income children in Florida are covered by Medicaid. However, private provider participation in the Medicaid Dental Program is minimal. Safety net providers could find their participation in the Medicaid Dental Program challenged by the move to managed care depending on the reimbursement rates available. Dental care for adults is particularly problematic. Private dental insurance, if available, often provides very limited coverage whereas Medicaid only covers dentures and emergency services for adults. A recent analysis of emergency room patient data shows large costs associated with dental problems—approximately \$73 million. Medical studies also show that poor dental health can have a significant negative impact on a person’s overall health including poor birth outcomes, cardiovascular disease and more.

Substance and prescription drug abuse among adults has increased the number of children in foster care. Both the parents and the children need health and dental care. Only 60% of children in foster care are current with the Early Periodic Screening, Diagnosis and Treatment (EPSDT) schedule. Primary care medical homes need to be found for foster children and their parents. There is also a need to address Children’s Medical Services clients who are transitioning out of the Children’s Medical Services system into an adult care system.

Summary: Access to Care Forces of Change

CHALLENGES

- The capacity of traditional safety net providers is decreasing
- Lack of true medical homes for many low income persons, persons in DCF care, and persons aging out of the CMS system
- Poor access to dental care on the part of the low-income population, particularly the Medicaid population
- More health care shortage areas are emerging geographically
- Increasing prevalence of adult substance abuse impacts families, children and foster care needs
- Greater need for behavioral health services
- Educating persons to use a primary care medical home when available rather than emergency rooms for primary care and an understanding the importance of preventive as well as acute care

OPPORTUNITIES

- Diminishing resources have led to an increased emphasis on partnering among providers
- Telemedicine offers the opportunity to significantly expand access to care, particularly in rural areas
- Managed care can be a vehicle to improve access to care, if implemented and managed properly
- There is increased recognition of the importance of good dental health on overall health
- The expanded scope of practice for Registered Dental Hygienists offers an opportunity to increase the provision of preventive dental care, the most cost-effective form of dental care
- Increased willingness to revisit and modify regulatory requirements to streamline activities and reduce cost
- Many Low Income Pool hospital alternative projects exist in Florida and can be evaluated for best practices

Appendix C: Forces of Change Assessment Process Summary and Key Findings

Health Care Practitioner Workforce Forces of Change Florida is experiencing worrisome trends in the health care workforce. Florida's health care practitioner workforce is becoming increasingly older and retiring at a higher rate. Florida's medical schools have relatively few residency slots from which replacement providers are often obtained. The health care practitioners Florida does have tend to be located in the more desirable urban and suburban areas and much less so in rural areas. As such, not only is the overall availability of health care providers becoming of more concern but so is the distribution of providers.

Summary: Health Care Practitioner Workforce Forces of Change

CHALLENGES

- Florida's health care provider workforce is aging
- Florida has significant shortages of health care providers in rural areas
- Florida has relatively few medical school residency slots
- Florida has a substantial number of rural counties and medically underserved areas

OPPORTUNITIES

- Florida is an attractive market and Florida can compete nationally for health care providers
- DOH's Medical Quality Assurance unit has strong provider assessment capability
- DOH has physician, dental and nursing assessments already completed
- DOH has a strong workforce development office and houses Florida's HRSA funded Primary Care Office
- There is interest at the policy level in increasing the number of medical school residency slots
- Support exists for Primary Care programs in the state (ie. Florida State University)

Policy and Practice Model Forces of Change Debates related to the Affordable Care Act, health care coverage, federal deficit reduction, state funding shortfalls, the solvency of Medicare, and the future configuration of Medicaid have focused much attention on health care access and financing issues. This attention creates fertile ground for policy discussion, policy change, and experimentation with innovative models of preventive and acute health care programs. These include new partnerships among health care providers, non-traditional health insurance options, opportunities related to the use of health care extenders, the establishment of patient centered medical homes and accountable care organizations and shifting health care financing from service-based to performance/health care outcome-based. The SHIP presents an opportunity to initiate discussion and change on these and other issues.

Regarding partnerships, Florida's Public Health Preparedness effort is an excellent model of public-private cooperation. Funding made available post-9/11 facilitated conversations beyond just emergencies that enhanced the integration of services and systems among state, federal, local and private entities. Well organized public-private partnerships benefit from the strengths and competencies of both systems. The Primary Care Access Network (P-CAN) in Orange County Florida is an example of effective cooperation among state, county, and private interests to expand health care access and implement a more effective and cost-efficient health care system.

The escalating costs of health insurance and growing numbers of uninsured have led to renewed interest in new methods of providing health care coverage. Both policymakers and health insurance companies are open to innovative options including health savings accounts, cafeteria style health insurance policies, modified risk pools, modified rates based on health behavior, etc. These could be discussed and initially pursued on a pilot basis.

Model school-based student wellness and worksite wellness programs are emerging. Districts with system-wide school wellness programs have a great impact where a school district is a major employer. Recognition of healthy school districts arose from an assessment created by health and education partners and based on CDC's coordinated school health model that builds infrastructure around core areas including staff wellness, health education, physical education, nutrition services, healthy school environment, family and community involvement, health services, counseling, psychology, and social services. Florida now has 18 recognized districts.

Consideration should be given to the more aggressive use of physician extenders and laypersons such as Community Health Workers to expand access to basic and preventive health care services. The enhancement

Appendix C: Forces of Change Assessment Process Summary and Key Findings

of preventive efforts is universally recognized as desirable; however, financially supporting these efforts have been problematic. Physician extenders and qualified laypersons could lessen this barrier.

Burdensome regulations create a disincentive for collaborative efforts and effecting change. There is a need to thoroughly review regulations in relation to their intent, application, and impact on the health care system. Regulations that inhibit progress and yield little benefit should be revised or discarded.

Summary: Policy and Practice Model Forces of Change

CHALLENGES

- Categorical funding, reporting, and administrative systems that reinforce isolation
- History of competition rather than cooperation among providers
- Misunderstanding of privacy and confidentiality laws that inhibit coordination
- Overly burdensome regulations
- Continued reductions in required physical education in schools
- Minimal participation in school based physical education when available
- An increasingly sedentary lifestyle
- Current lack of strong health care cost and utilization controls

OPPORTUNITIES

- Willingness of policymakers and providers to consider new ideas
- Willingness to support pilot and demonstration projects
- Recognition of patient centered medical home concept
- Recognition of the efficacy of preventive health services
- Use of the SHIP to educate the public and policy makers about what is important in public health
- Many good model practices exist that can be expanded.
Examples:
 - Public Health Preparedness
 - Healthy School Districts
 - Youth surveys (collaboration on questions and sharing results)
 - Use of lay health care facilitators
- Propose changes in regulations to improve service delivery
- Increase coordination of local health planning.
Examples
 - Non-profit, community hospitals (have an IRS requirement for an assessment)
 - Local health committees' assessments that integrate with the MAPP process
 - Integrate environmental assessments with other community health improvement assessments

Appendix D: Community Themes and Strengths Assessment Process Summary and Key Findings

PARTICIPANTS

Assessing themes and strengths of the public health system included reviewing statewide Behavioral Risk Factor Survey (BRSS) data, county health department strategic plans, local public health plans as well as getting input from the State Health Improvement Plan Steering Committee Members and Office of Health Assessment and Statistics' Review Team.

Process Summary

Community Themes and Strengths Assessment results present perspectives from a cross-section of the public health system that includes Florida citizens and residents, state and community public health partners, and local county health departments. Specifically, this assessment seeks to answer the following questions:

What is important to our state?

How is quality of life perceived in our state?

What assets do we have that can be used to improve Florida's health?

Background The Community Themes and Strengths Assessment is one of four assessments that serves as the framework for the State Health Improvement Plan (SHIP). This document summarizes findings from several facets of the statewide public health system.

Assessment Method The Community Themes and Strengths Assessment Team identified the priorities, resources and quality of life issues by analyzing data from the Community Health Improvement Survey, county health department strategic plans and the Behavioral Risk Factor Surveillance Survey data.

COMMUNITY HEALTH IMPROVEMENT SURVEY Since 2003, county health departments have responded to an annual survey on community health improvement activities. The survey ascertains the unique capacities, current and planned community health improvement activities, and training, technical assistance and resource needs. The Assessment Team reviewed survey results from 2003 through 2011, looking at trends in how county health departments answered the questions "What themes are being addressed by community-identified strategic issues?" and "What topics are being addressed by community-identified goals and objectives?" Because Florida's county health departments use the community-driven strategic planning tool, Mobilizing for Action through Planning and Partnerships, the answers to these questions reflected the concerns of a wide spectrum of residents of each county.

COUNTY HEALTH DEPARTMENT STRATEGIC PLANS The Assessment Team reviewed and analyzed county health department strategic plans to ascertain local health priorities, existing infrastructure and resource allocation. This analysis provided another source of data that confirmed findings from the community health improvement survey by showing that at the local level, access to health care and chronic diseases are leading priorities.

BEHAVIORAL RISK FACTOR SURVEILLANCE SURVEY BRFSS is a survey of randomly selected respondents ages 18 and older throughout the state about their health behaviors and preventive health practices related to the leading causes of morbidity and mortality. Additionally, the BRFSS queries participants about their perceived quality of life and the correlates that impact health and well-being. These data provide insight into how residents of our state perceive their quality of life. The Assessment Team reviewed 2007 and 2010 data from key survey questions: "percent of adults with good to excellent overall health;" "percentage of adults who are limited in any way in any activities;" "percentage of adults who use special equipment because of a health problem;"

“percentage of adults who are ‘very satisfied’ or ‘satisfied’ with their lives;” “percentage of adults who always or usually receive the social and emotional support they need;” “percentage of adults with good physical health;” “percentage of adults with good mental health.”

ASSETS AND COMMUNITY RESOURCES The Florida DOH maintains its own snapshot that describes the priorities around which the agency and county health departments have chosen to organize their resources and efforts in support of the agency’s mission and vision. County health departments, in particular, function as the primary mechanisms of direct public health services. This document incorporates several areas of importance: health components, service populations, resources and organizing principles.

Key Findings

Access to Care and Health Behaviors The recurring themes in local community health assessment and health improvement planning processes in Florida are access to health care and health behaviors.

- Nearly all 67 county-level community health assessment and health improvement planning processes identified access to health care as a strategic health priority area.
- Diabetes, obesity and overweight, tobacco use and teen pregnancy were specified as health issues affecting communities and in need of intervention.
- Dental issues emerged in 2010 as a priority community health improvement topic for more than half of the communities.
- Concern over the public health infrastructure and policies and laws has continued to grow in significance over the past several years.

Quality of Life As people are living longer, quality of life becomes increasingly important to Floridians. Quality of life refers to perceived physical and mental health that impacts overall health status.

- A large majority of Floridians report a good quality of life that includes both mental and physical health.
- About nine out of every ten adult Floridians report being satisfied with their lives.
- Four out of every five adult Floridians report that they usually receive the social and emotional support they need.
- A minority of adult Floridians report physical and emotional limitations.
- Nearly a quarter of adult Floridians are limited in some way in their activities.
- One out of every ten adult Floridians uses special equipment because of a health problem.

Assets and Community Resources Through identifying resources, community partners can analyze whether there are unrecognized assets or opportunities from which they can draw to enhance quality of life and to improve health outcomes.

- Locally, a network of partnerships exist between health care providers and ancillary care groups that augment the health care needs of the population in each county.
- DOH administers public health through 67 county health departments. They are the primary service providers in the areas of infectious disease control and prevention, family health services and environmental health services. Statewide functions such as the laboratories, Vital Statistics, a state pharmacy, and disaster preparedness and emergency operations assure efficient and coordinated approaches to monitoring diseases and responding to emerging needs at a population level.

Appendix D: Community Themes and Strengths Assessment Process Summary and Key Findings

- DOH provides specialized assistance to pregnant women, infants and children with special health care needs through its Children's Medical Services (CMS) Program. The statewide network of 22 local CMS clinics as well as private physicians' offices, regional medical centers and medical specialty care service centers includes a range of providers not usually available through individual health plans. CMS also coordinates care with community agencies such as schools and social service agencies.
- DOH's Health Care Practitioner and Access program improves access to health care and ensures practitioners meet licensing and practice requirements according to accepted standards of care. This program coordinates the placement of health care professionals in underserved areas through Area Health Education Centers, rural health networks and local health planning councils.
- Florida's public health statutes have been recently reviewed and are keeping pace with scientific developments and current constitutional, legal and ethical changes.

Appendix E: Key Health Disparity Objectives and Measures*

Health Protection

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

Chronic Disease Prevention

■ By Dec. 31, 2015, decrease the percentage of adults who are overweight from 37.8% to 35.9%.

■ By Dec. 31, 2015, decrease the percentage of adults who are obese from 27.2% to 25.8%.

■ By Dec. 31, 2014, reduce current smoking rates among Florida adults by 15%, from 17.1% to 14.5%.

■ By Dec. 31, 2015, reduce current cigarette use among Florida's youth, ages 11–17, by 10 percent from 8.3% to 7.5%.

Access to Care

■ By Dec. 31, 2012, and every four years thereafter, DOH will assure all underserved areas in Florida maintain a Health Professional Shortage Area (HPSA) designation.

■ By Dec. 31, 2012, and annually thereafter, the maximum number (30) of J-1 visa slots for health professionals in medically underserved areas in Florida will be filled.

■ By Dec. 31, 2012, and annually thereafter, all National Health Services Corps site and provider applications will be processed by federal deadlines.

■ By Dec. 31, 2015, the percentage of mid-level providers in primary care practice settings will increase by 10%.

■ By Dec. 31, 2015, increase the percentage of persons who report having any kind of health care coverage, including health insurance, prepaid plans such as HMOs or government plans such as Medicare from 83% to 87%.

■ By Dec. 31, 2015, the percentage of persons who report they were unable to see a doctor during the past 12 months due to cost will decrease from 17.3% to 16.4%.

■ By Dec. 31, 2015, reduce the infant mortality rate from 6.9 to 6.6 per 1,000 live births.

■ By Dec. 31, 2015, reduce the non-white infant mortality rate from 10.8 to 10.7 per 1,000 live births.

■ By Sept. 30, 2015, DOH and the Dept. of Children and Families will identify or include objectives in agency strategic plans that address providing culturally and linguistically appropriate services.

■ By June 30, 2013, DOH will facilitate development a self-assessment of Culturally and Linguistically Appropriate Services (CLAS) that can be used across many provider settings.

■ By June 30, 2014, DOH and other social services agencies will distribute and implement use of a CLAS self-assessment tool.

*Key health disparity objectives align to the measures in the *Health and Human Service Action Plan to Reduce Disparities* and will be tracked according to race, ethnicity and income where these data are available.

Appendix F: Alignment with National and State Goals, Objectives and Measures

Health Protection	Alignment
Strategy HP1.1: Immunization	Recommended by the Centers for Disease Control and Prevention's Community Guide
OBJECTIVE HP1.1.1	DOH Long Range Program Plan Objective 1B
OBJECTIVE HP1.1.2	Healthy People 2020 IID-12.7; National Prevention Strategy; HHS Action Plan to Reduce Disparities Goal III, Measure 2
OBJECTIVE HP1.1.3	DOH Long Range Program Plan Objective 1B
OBJECTIVE HP1.1.4	Healthy People 2020 IID-1.4
OBJECTIVE HP1.1.5	Healthy People 2020 IID-1.2
Strategy HP1.2: Sexually transmitted diseases (STDs), tuberculosis (TB) and other infectious diseases	
OBJECTIVE HP1.2.1	Healthy People 2020 STD-1-STD-7; DOH Long Range Program Plan Objective 1C
OBJECTIVE HP1.2.3	Healthy People 2020 IID-29
OBJECTIVE HP1.2.4	Healthy People 2020 IID-30
OBJECTIVE HP1.2.6	Healthy People 2020 IID-30
OBJECTIVE HP1.2.7	DOH Long Range Program Plan Objective 5C
Strategy HP1.3: HIV/AIDS	CDC Winnable Battle: HIV in the US; Recommended by the Centers for Disease Control and Prevention's Community Guide
OBJECTIVE HP1.3.1	DOH Long Range Program Plan Objective 5C; Healthy People 2020 HIV-4; DOH Long Range Program Plan Objective 1A
OBJECTIVE HP1.3.2	Healthy People 2020 HIV-13; National Prevention Strategy
OBJECTIVE HP1.3.3	Healthy People 2020 HIV-10
OBJECTIVE HP1.3.4	Healthy People 2020 HIV-2
Strategy HP2.2: Environmental threats	
OBJECTIVE HP2.2.3	Healthy People 2020 EH-8.2
Strategy HP2.3: Compliance with public health standards	
OBJECTIVE HP2.3.1	Healthy People 2020 EH-4; Dept of Environmental Protection Long Range Program Plan Objective 1B
Strategy HP3.1: Prepare for all hazards	
OBJECTIVE HP3.1.1	CDC Public Health Preparedness Measure



Appendix F: Alignment with National and State Goals, Objectives and Measures

Strategy HP3.2: Manage all hazards	
OBJECTIVE HP3.2.1	PAHPA Benchmark Measure
Strategy HP3.3: Surge capacity for all hazards	
OBJECTIVE HP3.3.1	DOH Long Range Program Plan
Strategy HP3.4: Health consequences of any event	
OBJECTIVE HP3.4.1	CDC Public Health Preparedness Performance Measure
Strategy HP3.5: Chemical, biological, radiological, nuclear and explosive (CBRNE) threats	
OBJECTIVE HP3.5.1	CDC Public Health Preparedness Performance Measure
OBJECTIVE HP3.5.2	CDC Public Health Preparedness Performance Measure
Strategy HP3.6: Information	
OBJECTIVE HP3.6.1	CDC Public Health Preparedness Performance Measure
OBJECTIVE HP3.6.2	CDC Public Health Preparedness Performance Measure
Strategy HP4.1: Injury prevention	
OBJECTIVE HP4.1.2	Healthy People 2020 IVP-25
OBJECTIVE HP4.1.3	CDC Winnable Battle: Motor Vehicle Injuries; National Prevention Strategy; DOH Long Range Program Plan Objective 8C
Strategy HP4.3: Injury response	
OBJECTIVE HP4.3.1	DOH Long Range Program Plan Objective 8D
Chronic Disease Prevention	Aligned National, State Goals, Objectives and Measures
Goal CD1: Healthy Weight	Healthy People 2020 NWS-8 objective; CDC Winnable Battle: Nutrition, Physical Activity, and Obesity
Strategy CD1.1: Clinical practices	Healthy People 2020 NWS-5 objective
Strategy CD1.2: Evidence-based clinical guidelines	Healthy People 2020 NWS-6 objective; US Preventive Services Task Force Recommendations (USPSTF)
OBJECTIVE CD1.2.1	Healthy People 2020 NWS-5
OBJECTIVE CD1.2.2	Healthy People 2020 NWS-6
Strategy CD1.3: Healthful food	Healthy People 2020 NWS objectives; Public Health Law and Policy (www.phlpnet.org); CDC Winnable Battle: Nutrition, Physical Activity, and Obesity
OBJECTIVE CD1.3.1	Healthy People 2020 NWS-3
OBJECTIVE CD1.3.2	Healthy People 2020 NWS-3
OBJECTIVE CD1.3.3	Healthy People 2020 NWS-4
OBJECTIVE CD1.3.4	Healthy People 2020 NWS-13
OBJECTIVE CD1.3.5	Healthy People 2020 NWS-13
OBJECTIVE CD1.3.6	Healthy People 2020 NWS-14, NWS-15



Appendix F: Alignment with National and State Goals, Objectives and Measures

Strategy CD2.1: Healthy behaviors	
OBJECTIVE CD2.1.1	Healthy People 2020 NWS-8 and TU-4
OBJECTIVE CD2.1.2	Healthy People 2020 NWS-8
OBJECTIVE CD2.1.3	Healthy People 2020 NWS-5
Strategy CD2.2: Employee wellness programs	Recommended by the Centers for Disease Control and Prevention's Community Guide
OBJECTIVE CD2.2.1	Healthy People 2020 NWS-7
OBJECTIVE CD2.2.2	Healthy People 2020 NWS-7
Strategy CD2.3: Alliance for a Healthier Generation's Healthy Schools Program and/or USDA's HealthierUS School Challenge	
OBJECTIVE CD2.3.4	Healthy People 2020 NWS 10.3
Goal CD3: Chronic disease	Healthy People 2020 D-1
Strategy CD3.1: Chronic disease self-management education	
OBJECTIVE CD3.1.1	Healthy People 2020 D-14
OBJECTIVE CD3.1.2	Healthy People 2020 AOCBC-8
OBJECTIVE CD3.1.3	Healthy People 2020, RD 7.3
Strategy CD3.2: Chronic diseases such as asthma, cancer, heart disease and diabetes	
OBJECTIVE CD3.2.1	Healthy People 2020, C-3
OBJECTIVE CD3.2.2	Healthy People 2020, C-4
OBJECTIVE CD3.2.3	Healthy People 2020, C-5
OBJECTIVE CD3.2.4	Healthy People 2020, HDS-6
OBJECTIVE CD3.2.5	Healthy People 2020, D15
OBJECTIVE CD3.2.6	Healthy People 2020, D15
Strategy CD3.3: Chronic diseases management	
OBJECTIVE CD3.3.1	Healthy People 2020, RD-7.1
OBJECTIVE CD3.3.4	Healthy People D-5
Goal CD4: Tobacco use and secondhand smoke exposure	CDC Winnable Battle: Nutrition, Physical Activity, and Obesity



Appendix F: Alignment with National and State Goals, Objectives and Measures

Strategy CD4.1: Youth and young adults initiation	
OBJECTIVE CD4.1.1	Healthy People 2020 TU-3
Strategy CD4.2: Quitting	Healthy People 2020 TU-4, TU-5, and TU-7; USPSTF recommendations; Recommended by the Centers for Disease Control and Prevention's Community Guide
OBJECTIVE CD4.2.1	Key Health Disparity Objective; Healthy People 2020 TU-1
OBJECTIVE CD4.2.2	Healthy People 2020 TU-1.2
OBJECTIVE CD4.2.3	Key Health Disparity Objective; Healthy People 2020 TU 2.2
OBJECTIVE CD4.2.4	Healthy People 2020 TU-2.3 and TU-2.4
Strategy CD4.3: Exposure to secondhand tobacco smoke	Healthy People 2020 TU-11; Recommended by the Centers for Disease Control and Prevention's Community Guide
OBJECTIVE CD4.3.1	Healthy People 2020 TU-14
OBJECTIVE CD4.3.2	Healthy People 2020 TU-11.2
Community Redevelopment and Partnerships	Aligned National, State, Goals, Objectives and Measures
Goal CR1: Planning and assessment processes	Public Health Law and Policy (www.phlpnet.org)
Strategy CR1.1: Public health component in community planning processes	Public Health Law and Policy (www.phlpnet.org)
OBJECTIVE CR1.1.1	FL Statutes 408.033 11-(d), F.S., Local and State Health Planning and 186.507 10, F.S. Strategic Regional Policy Plans
OBJECTIVE CR1.1.4	Florida Statutes Section 260.014
Strategy CR1.2: The built environment and healthy behaviors	Public Health Law and Policy (www.phlpnet.org)
OBJECTIVE CR1.2.1	Public Health Law and Policy (www.phlpnet.org)
OBJECTIVE CR1.2.2	Public Health Law and Policy (www.phlpnet.org)
OBJECTIVE CR1.2.3	Public Health Law and Policy (www.phlpnet.org)
OBJECTIVE CR1.2.4	Public Health Law and Policy (www.phlpnet.org)
Strategy CR2.1: Community policing, substandard housing and aging-in-place	Public Health Law and Policy (www.phlpnet.org)
OBJECTIVE CR2.1.1	FL Dept. of Transportation Long Range Program Plan, Goal 2, Objective 2b
OBJECTIVE CR2.1.3	CDC Healthy Places program
OBJECTIVE CR2.1.4	The FL Dept. of Health Healthy Homes Consortium mission
OBJECTIVE CR2.1.5	FL Dept. of Health Healthy Homes Consortium mission
OBJECTIVE CR2.1.6	FL Dept. of Elder Affairs Elder Housing Unit mission; FL Dept. of Elder Affairs Long Range Program Plan Goals 1–3



Appendix F: Alignment with National and State Goals, Objectives and Measures

Strategy CR2.2: Physical activity	CDC Winnable Battle: Nutrition, Physical Activity, and Obesity—Recommended by the Centers for Disease Control and Prevention’s Community Guide
OBJECTIVE CR2.2.1	Healthy People 2020, NWS-8, NWS-9, NWS-10, NWS-11, PA-15
OBJECTIVE CR2.2.2	Healthy People 2020, NWS-10, NWS-11
OBJECTIVE CR2.2.3	Healthy People 2020, NWS-8, NWS-9, NWS-10, NWS-11
OBJECTIVE CR2.2.4	Healthy People 202, NWS-8, NWS-9, NWS-10, and NWS-11
Goal CR3: Culturally and linguistically competent care	Healthy People 2020: ECBP-11
Access to Care	Aligned National, State Goals, Objectives and Measures
Strategy AC1.1: Florida’s health care access resources and needs	
OBJECTIVE AC1.1.1	Public Health Accreditation Board (PHAB) community health assessment prerequisite and standard 1.1.2
OBJECTIVE AC1.1.3	PHAB community health assessment prerequisite and standard 1.1.2
OBJECTIVE AC2.1.2	HHS Action Plan to Reduce Disparities, goal II, measure 1
OBJECTIVE AC2.1.3	HHS Action Plan to Reduce Disparities, goal II, measure 1
OBJECTIVE AC2.1.4	HHS Action Plan to Reduce Disparities, goal II, measure 1
DEVELOPMENTAL OBJECTIVE AC2.1.5	HHS Action to Plan to Reduce Disparities, goal II, measure 2
LONG-RANGE OBJECTIVE AC2.1.8	Healthy People 2020 AHS-4, AHS-4.1, AHS-4.2, AHS-4.3, AHS-4.4
Strategy AC2.2: Health care service barriers	
OBJECTIVE AC2.2.1	HHS Action to Plan to Reduce Disparities, goal I, measure 1; Healthy People 2020 AHS-1
OBJECTIVE AC2.2.2	HHS Action Plan to Reduce Disparities, goal 1, measure 3
LONG-RANGE OBJECTIVE AC2.2.4	Healthy People 2020 MHMD-5
Strategy AC3.1: Substance abuse and mental health services with delivery of primary care	Recommended by the Centers for Disease Control and Prevention’s Community Guide
OBJECTIVE AC3.1.1	Healthy People 2020 MHMD-5
Strategy AC4.1: Florida’s state oral health improvement plan (SOHIP)	
OBJECTIVE AC4.1.1	CDC Oral Health Strategic Plan, Goal 6
OBJECTIVE AC4.1.2	CDC Oral Health Strategic Plan, Goal 6; Healthy People 2020 OH-16
OBJECTIVE AC4.1.3	CDC Oral Health Strategic Plan, Goal 6; Healthy People 2020 OH-16
OBJECTIVE AC4.1.4	CDC Oral Health Strategic Plan, Goal 6; Healthy People 2020 OH-16
OBJECTIVE AC4.1.5	CDC Oral Health Strategic Plan, Goal 6



Appendix F: Alignment with National and State Goals, Objectives and Measures

Strategy AC4.2: Oral health care system and other health care providers	
OBJECTIVE AC4.2.1	CDC Oral Health Strategic Plan, Goal 1; Healthy People 2020 OH-7; Healthy People 2020 OH-7;Healthy People 2020 AHS-6; National Prevention Strategy
OBJECTIVE AC4.2.2	CDC Oral Health Strategic Plan, Goal 1; Healthy People 2020 OH-4
OBJECTIVE AC4.2.3	CDC Oral Health Strategic Plan, Goal 1
OBJECTIVE AC4.2.4	Healthy People 2020 OH-8; DOH Long Range Program Plan Objective 4E
Strategy AC4.3: Geographic distribution of practitioners and types of practice	
LONG-RANGE, DEVELOPMENTAL OBJECTIVE AC4.3.2	Healthy People 2020 OH-12
LONG-RANGE DEVELOPMENTAL OBJECTIVE AC4.3.3	Healthy People 2020 OH-11
Strategy AC4.4: Oral health care delivery practice models	Recommended by the Centers for Disease Control and Prevention's Community Guide
OBJECTIVE AC4.4.3	CDC Oral Health Strategic Plan, Goal 6; Healthy People 2020 OH-13
OBJECTIVE AC4.4.4	Healthy People 2020 HC/HIT-10
OBJECTIVE AC4.4.5	CDC Oral Health Strategic Plan, Goal 6; Healthy People 2020 OH-13
Strategy AC5.1: Being healthy prior to pregnancy	
OBJECTIVE AC5.1.1	Healthy People 2020 MICH-16; Healthy People 2020 FP-7; National Prevention Strategy; DOH Long Range Program Plan Objective 4B
OBJECTIVE AC5.1.2	Healthy People 2020 MICH-5
Strategy AC5.2: Medicaid Family Planning Waiver services	
OBJECTIVE AC5.2.1	Healthy People 2020 FP-5
OBJECTIVE AC5.2.2	Healthy People 2020 FP-1
Strategy AC5.3: Abstinence and teen sexual activity	Recommended by the Centers for Disease Control and Prevention's Community Guide
OBJECTIVE AC5.3.1	Healthy People 2020 FP-8, FP-10; CDC Winnable Battle: Teen Pregnancy
OBJECTIVE AC5.3.2	Healthy People 2020 FP-8, FP-9, FP-10, FP-11, FP-12, FP-13; National Prevention Strategy; CDC Winnable Battle: Teen Pregnancy; DOH Long Range Program Plan Objective 4C
Strategy AC5.4: Safe sleep	
OBJECTIVE AC5.4.1	Healthy People 2020 MICH-20
OBJECTIVE AC5.4.3	Healthy People 2020 MICH-1; National Prevention Strategy; HHS Action Plan to Reduce Disparities, goal III, measure 1; DOH Long Range Program Plan Objective 4A
OBJECTIVE AC5.4.4	Healthy People 2020 MICH-1; National Prevention Strategy; HHS Action Plan to Reduce Disparities, goal III, measure 1; DOH Long Range Program Plan Objective 4B
OBJECTIVE AC5.4.5	Healthy People 2020 MICH-21
Strategy AC6.1:Healthcare services for children in foster care	
OBJECTIVE AC6.1.1	Healthy People 2020 AHS-5; DOH Long Range Program Plan Objectives 2A, 2B, 2C



Appendix F: Alignment with National and State Goals, Objectives and Measures

Strategy AC6.2: Adult primary care providers	
OBJECTIVE AC6.2.1	DOH Long Range Program Plan Objective 2A
Strategy AC6.3: Health care transition education	
OBJECTIVE AC6.3.1	Healthy People 2020 AHS-5; DOH Long Range Program Plan Objectives 2A, 2B, 2C
Strategy AC6.4: Safe environments for people living in public developmental disabilities centers	
OBJECTIVE AC6.4.1	Agency for Persons with Disabilities Long Range Program Plan Objective 3.1.1
Strategy AC6.5: Provider network capacity to serve persons age 60 and older, their families and caregivers	
OBJECTIVE AC6.5.1	Healthy People 2020 OA-8; Dept of Elder Affairs Long Range Program Plan Objective 1.2
OBJECTIVE AC6.5.2	Healthy People 2020 Objective OA-9; Dept of Elder Affairs Long-Range Program Plan Objective 1.3
Strategy AC7.1: Culturally and linguistically appropriate services	
OBJECTIVE AC7.1.1	Healthy People 2020 HC/HIT-2; HHS Action Plan to Reduce Disparities, goal 1, measure 5; National Prevention Strategy
OBJECTIVE AC7.1.2	Healthy People 2020 HC/HIT-2; HHS Action Plan to Reduce Disparities, goal 1, measure 5; National Prevention Strategy
OBJECTIVE AC7.1.3	Healthy People 2020 HC/HIT-2; HHS Action Plan to Reduce Disparities, goal 1, measure 5; National Prevention Strategy
Health Finance and Infrastructure	Aligned National, State Goals, Objectives and Measures
Strategy HI1.1: Providers and electronic health record systems	42 CFR Parts 412, 413, 422 et al.; Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule
Strategy HI1.2: Adoption of certified electronic health record software	Healthy People 2020 HC/HIT-10
OBJECTIVE HI1.2.1	Healthy People 2020 HC/HIT-10
OBJECTIVE HI1.2.4	Healthy People 2020 HC/HIT-11
Strategy HI1.3: Using information technology for reportable diseases and conditions of public health significance	42 CFR Parts 412, 413, 422 et al.; Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule
Strategy HI3.2: Core competencies for public health professionals	Healthy People 2020 PHI-3



Appendix F: Alignment with National and State Goals, Objectives and Measures

Strategy HI4.1: Health improvement planning at state and local levels	Healthy People 2020 PHI 15
OBJECTIVE HI4.1.1	Healthy People 2020 PHI 15.3; Public Health Accreditation Board (PHAB) community health improvement plan prerequisite and standard 5.2.2 L
OBJECTIVE HI4.1.2	Healthy People 2020 PHI 15.4; PHAB community health improvement plan prerequisite and standard 5.2.2 L
Strategy HI4.2: Monitoring the SHIP	PHAB community health improvement plan prerequisite and standard 5.2.2 S
OBJECTIVE HI4.2.1	PHAB community health improvement plan prerequisite and standard 5.2.2 S
OBJECTIVE HI4.3.3	PHAB prerequisites and standards 1.1.2 L, 5.2.2 L and 5.3.2
OBJECTIVE HI4.3.4	Healthy People 2020 PHI-17
OBJECTIVE HI4.3.8	Healthy People 2020 PHI-15.4
OBJECTIVE HI4.3.9	Healthy People 2020 PHI-16