

CHA REPORT

SHELBY COUNTY, TN

COMMUNITY HEALTH ASSESSMENT



2012-2014



Facilitated by:
Shelby County Health Department

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Introduction



SHELBY COUNTY STRIVES FOR A HEALTHIER PLACE TO LIVE

Place matters. Health outcomes and quality of life are *not* solely contingent on genetics; how *and* where we live, work, play, learn, and worship also influence our quality of life and health outcomes. Therefore, understanding the social and environmental factors in addition to the health status of Shelby County is critical to the efforts of improving community health. Painting a clearer picture of our community illustrates current, existing health issues and, as a result, informs the development of plans to align partnerships to address those issues. Assessment and planning are essential tools that we use to ensure that Shelby County continues to become one of the *healthiest places to live in the nation*.

In 2011, the Shelby County Health Department (SCHD) spear-headed an effort to create a community health profile for Shelby County, TN, to mobilize community partnerships, and to identify, prioritize, and plan to address key health issues within the community. With the help of its community partners, SCHD conducted a Community Health Assessment in 2012-2013 using a community-driven tool called Mobilizing Action through Planning and Partnerships (MAPP). The intent of the assessment was to share its contents to the community and organizations.

This document compiles the four assessments conducted for Shelby County's Community Health Assessment. The CHA provides an *in depth* depiction of health status in Shelby County. The document highlights the following:

- status of health outcomes and health behaviors
- status of social and physical environments
- resident views on community health and needs
- state of the Local Public Health System
- barriers and opportunities to community health

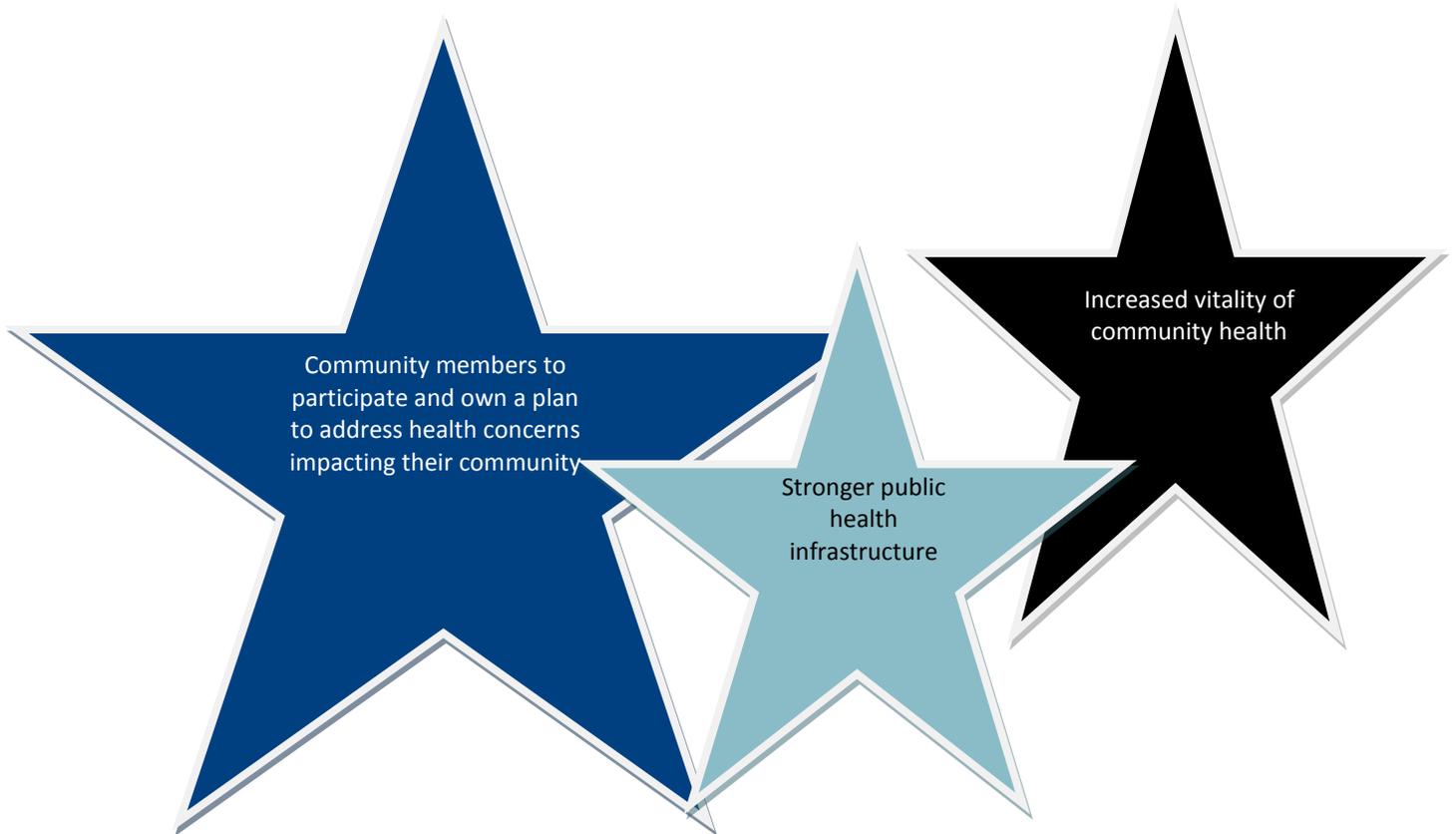
What is the MAPP Process?

The MAPP Process helps Shelby County strive to become one of the healthiest places to live in the nation. Developed by the National Association of County and City Health Officials and the Centers for Disease Control and Prevention, the acronym MAPP stands for *Mobilizing Action through Planning and Partnerships*. This strategic framework is designed to help communities *improve health and quality of life* through a community-wide and community-driven strategic planning process. Through MAPP, Shelby County seeks to achieve optimal health by 1) *identifying and using their resources wisely*, 2) taking into account the residents' *unique circumstances and needs*, and 3) *forming effective partnerships for strategic action*. MAPP focuses on strengthening the entire local public health system by bringing together *diverse interests* to *collaboratively* determine the most *effective* way to conduct community health activities. This cultivation and development of a strong community consensus around the needs of the local public health system serves as a springboard towards future collective action and collective impact.

MAPP is divided into *six phases*: I) Organizing; II) Visioning; III) Conducting assessments; IV) Identifying priorities; V) Developing goals and strategies; and VI) Taking Action. *Two deliverables* are produced from this 6 phase process: the Community Health Assessment and the Community Health Improvement Plan. This document focuses on the **Community Health Assessment**. For more information on the Community Health Improvement Plan, see the CHA/CHIP Report at www.shelbycountyttn.gov/health.

What is a Community Health Assessment?

Community Health Assessments are conducted during Phase III of the MAPP process. One of the essential Public Health Services is to monitor the health status of the residents and environment of a community. Conducting a community health assessment is a collective activity and essential tool that we use to ensure that Shelby County continues to become one of the *healthiest places to live in the nation*. A community health assessment (CHA) creates an opportunity for:

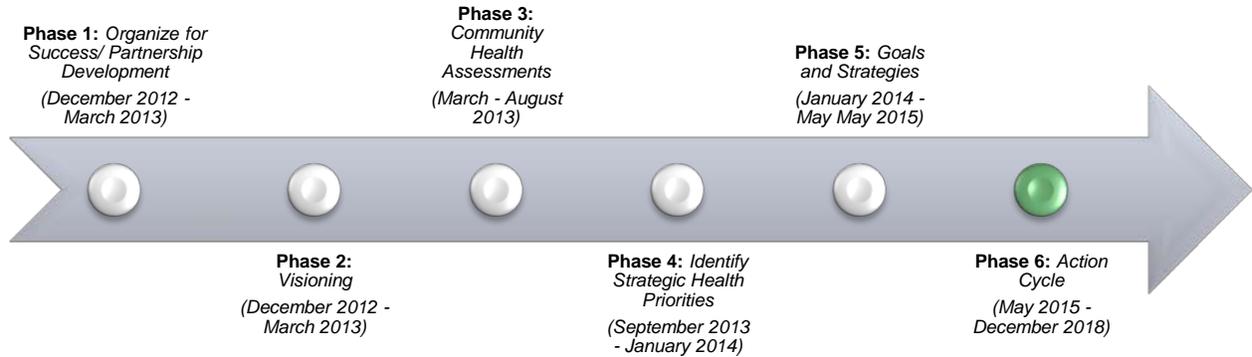


A CHA answers the following questions:

- What are the health problems in a community?
- Why do health issues exist in a community?
- What factors create or determine the health problems?
- What resources are available to address the health problems?
- What are the health needs of the community from a population-based perspective?

The MAPP Process in Shelby County

To move towards being a healthy place to live, Shelby County began its six phase process in 2012.



Phase I and Phase II: December 2012-March 2013

The MAPP Steering Committee and MAPP Community Partnership were established during phase I and II to plan and implement the MAPP process. The committee included academic institutions, government, social and health agencies, social and health agencies, community associations, hospital systems, and public school systems. Information was shared with the general public via email and a Community Commons portal. The first significant piece of work completed by the MAPP Steering Committee and Community Partnership was the creation of a vision and value statements for the MAPP Process.

Shelby County MAPP Vision

A Shelby County that provides and assures opportunities for every resident to develop and participate in activities and services that enhance their health, well-being, and quality of life.

Shelby County MAPP Value Statements

- ❖ **Assurance:** Through policy and environmental level support, every resident is assured the proper support to engage in healthy lifestyle and behaviors.
- ❖ **Collaboration:** Every resident, business, organization or association throughout Shelby County is important and will work together to achieve our vision of a healthy community.
- ❖ **Inclusivity:** Every resident, every organization, and every institution is involved and respected for its voice and perspective toward achieving our vision of a healthy community.
- ❖ **Ownership:** Every resident has a stake in achieving our vision of a healthy community.
- ❖ **Health Equity:** Every resident has access to quality, culturally appropriate health care and opportunities to engage in activities that contribute to healthy living and lifestyle.
- ❖ **Efficient & Effective Healthcare:** Every resident has access to both efficient and effective healthcare that considers the effects of care services as well as the costs.
- ❖ **Healthy Environment:** Every resident has the opportunity to live, work, and play in environments with a positive infrastructure and free from harmful pollutants.
- ❖ **Knowledge:** Every resident has an opportunity to equip themselves with knowledge that will positively impact their healthy lifestyle choices and overall health.
- ❖ **Wellness:** Every resident embraces all components of a healthy community -prevention, early detection/intervention, healthy lifestyle, and culturally appropriate care services for the mind, body, emotion, and spirit.
- ❖ **Safety:** Every resident has the opportunity to live, work, and play in a safe community.

Phase III: March-August 2013

During Phase III (May - September 2013), the Community Health Assessment comprised of four MAPP assessments was conducted:



Over 2,500 concerned citizens and organizations (such as academia, faith-based organizations, government, social and health agencies, public school systems, etc.) provided input into these four assessments by:

- Participating in a focus group,
- Completing on-line and written surveys, and
- Participating in group sessions.

Phase IV – VI: September 2013-Ongoing

The data from MAPP assessments was used to identify the strategic health priorities in Phase IV. In January 2015, community partners began convening within each strategic health priority to develop the *Community Health Improvement Plan* in Phase V. The work ahead for Shelby County lies with putting the *Community Health Improvement Plan* into action. With commitment from local government and the community-at-large to address these health priorities, Shelby County *will* become one of the healthiest places in the nation.

COMMUNITY HEALTH ASSESSMENT STRUCTURE

Becoming one of the healthiest places to live in the nation begins by assessing the current state of health in our community. The following sections provide detail of Shelby County's health as described through the four MAPP assessments. Together, these assessments inform the selection of strategic health priorities and the Community Health Improvement Plan. Below is a snapshot of what to expect in each of the four assessments.

Community Health Status

- overall landscape of health within Shelby County
- results compiled from existing National, State, and Local data sources
- includes metrics on Demographics and Social Environment, Health Care (Assess & Quality), Health Outcomes, Health Behaviors, and Physical Environment.

Community Themes & Strengths

- wants, needs, and desires of residents around their community's health
- self-reported data collected by survey
- includes metrics on Quality of Life Statements, Health Outcomes, Child Health Information, Personal Behaviors, Community Related Behaviors, Physical Environment, Health Care, Emergency Preparedness, and Demographics

Local Public Health System

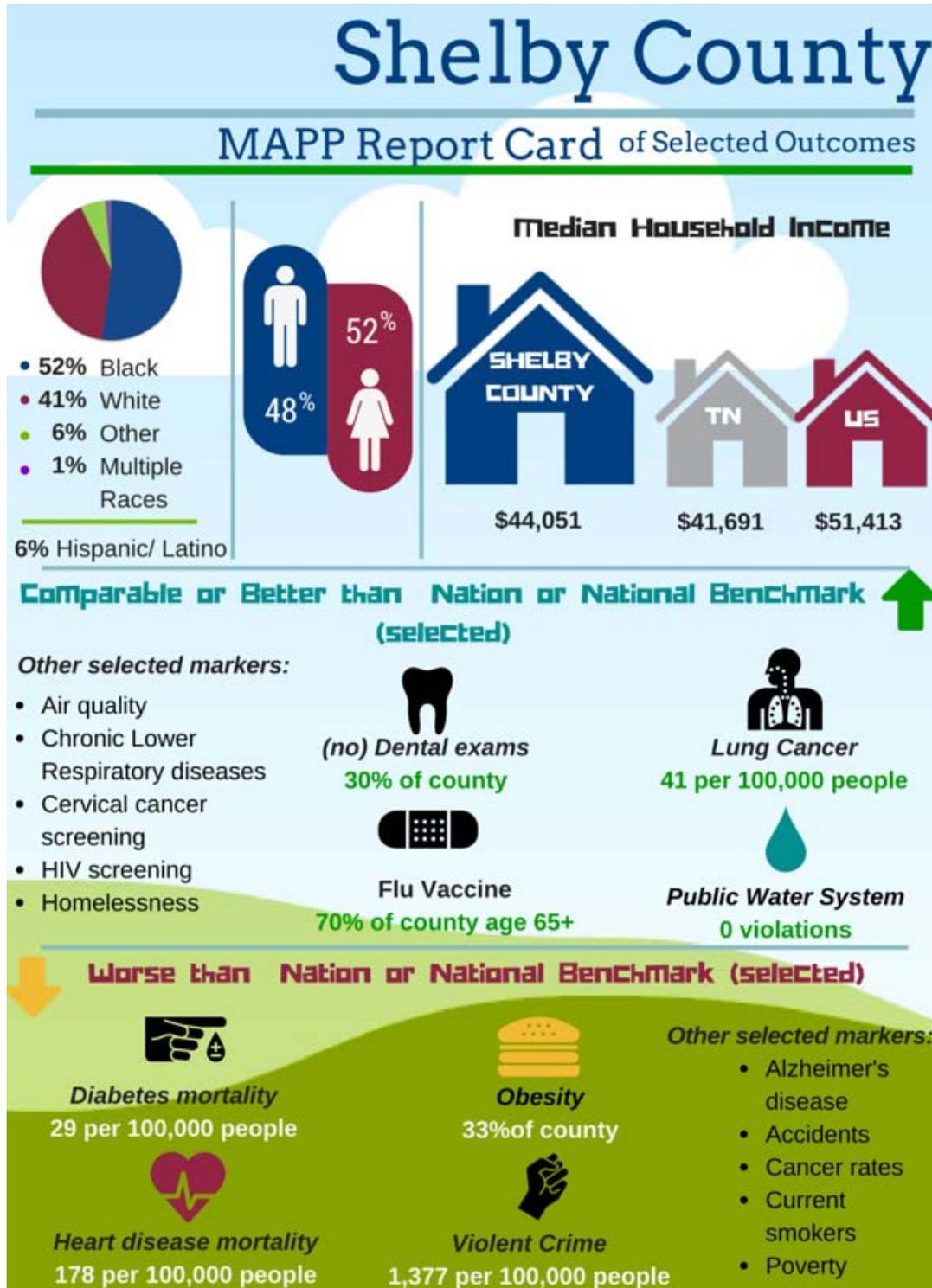
- components, activities, competencies, and capacities of our local public health system and description of how the 10 Essential Public Health Services are provided in the community
- data collected by group discussion and utilizing a tool developed by NPHPS
- provides score cards based on the 10 Essential Public Health Services

Forces of Change

- trends, factors, and/or events that influence health and quality of life in Shelby County
- data collected by group discussion and qualitative worksheet

HIGHLIGHTS

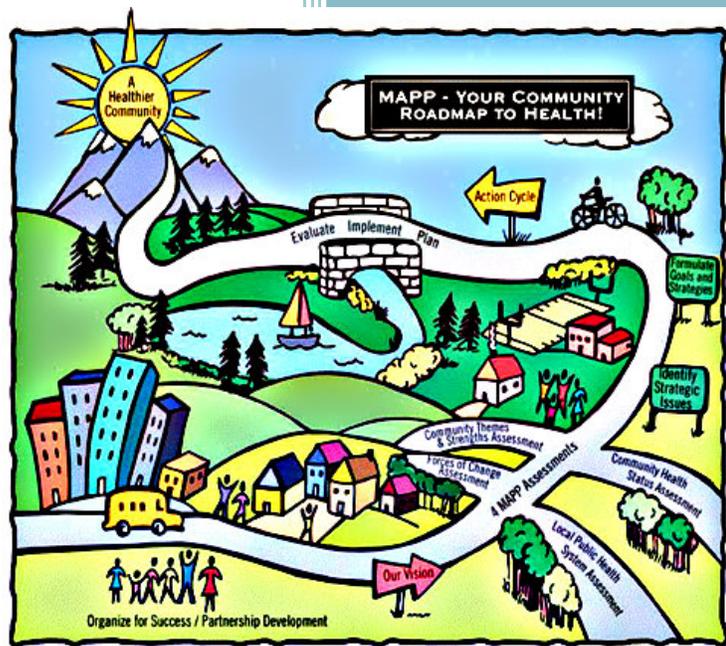
The info graphic below highlights some of the findings of the Community Health Assessment, including some strengths and weakness in health outcomes found in Shelby County. More information on these health outcomes and other factors can be found throughout the remainder of this document.



Community Health Assessment SUMMARY



Community Health Status Assessment Report Summary



METHODS

Using the Centers for Disease Control and Prevention’s (CDC) Community Health Assessment for Population Health Improvement¹ as a guide, members of the CHSA Working Group selected data that aligned with the Core Indicators. The CDC’s guide provides a framework of metrics that have been determined to be key indicators in community health, see **Table I** for more information.

Table I Health Metrics for Community Health Assessments

Community Health Assessment for Population Health Improvement Most Frequently Recommended Health Metrics ²					
Health Outcome Metrics		Health Determinant and Correlate Metrics			
Mortality	Morbidity	Health Care (Access & Quality)	Health Behaviors	Demographics & Social Environment	Physical Environment
Leading causes of death	Obesity	Health insurance coverage	Tobacco use/ smoking	Age	Air quality
Infant mortality	Low birth- weight	Provide rates	Physical activity	Sex	Water quality
Injury-related mortality	Hospital utilization	Asthma-related hospitalization	Nutrition	Race/ Ethnicity	Housing
Motor vehicle mortality	Cancer rates		Unsafe sex	Income	
Suicide	Motor vehicle injury		Alcohol use	Poverty level	
Homicide	Overall health status		Seatbelt use	Educational attainment	
	STDs		Immunization and screenings	Employment status	
	HIV/AIDS			Foreign born	
	Tuberculosis			Homelessness	
				Language spoken at home	
				Marital status	
				Domestic violence and child abuse	
				Violence and crime	
				Social capital/ social support	

¹ Centers for Disease Control and Prevention. (2013). Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants. Retrieved from: <http://chna22.org/wp-content/uploads/2013/06/Community-Health-Assessment-for-Population-Health-Improveme.pdf>

² Centers for Disease Control and Prevention. (2013). Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants. Retrieved from: <http://chna22.org/wp-content/uploads/2013/06/Community-Health-Assessment-for-Population-Health-Improveme.pdf>

This report will follow the guidelines of the health metrics suggestions put forth by the CDC. In some instances additional data points are included. In future drafts of this report, sub-county data will be provided to allow for examination of zip code level data and distribution of certain indicators. Maps will be provided as appendices. Data sources are provided in their respective tables.

DEMOGRAPHICS & SOCIAL ENVIRONMENT

The CHSA reports several indicators on demographics and the social environment of Shelby County. Demographic and social environment indicators include the following:

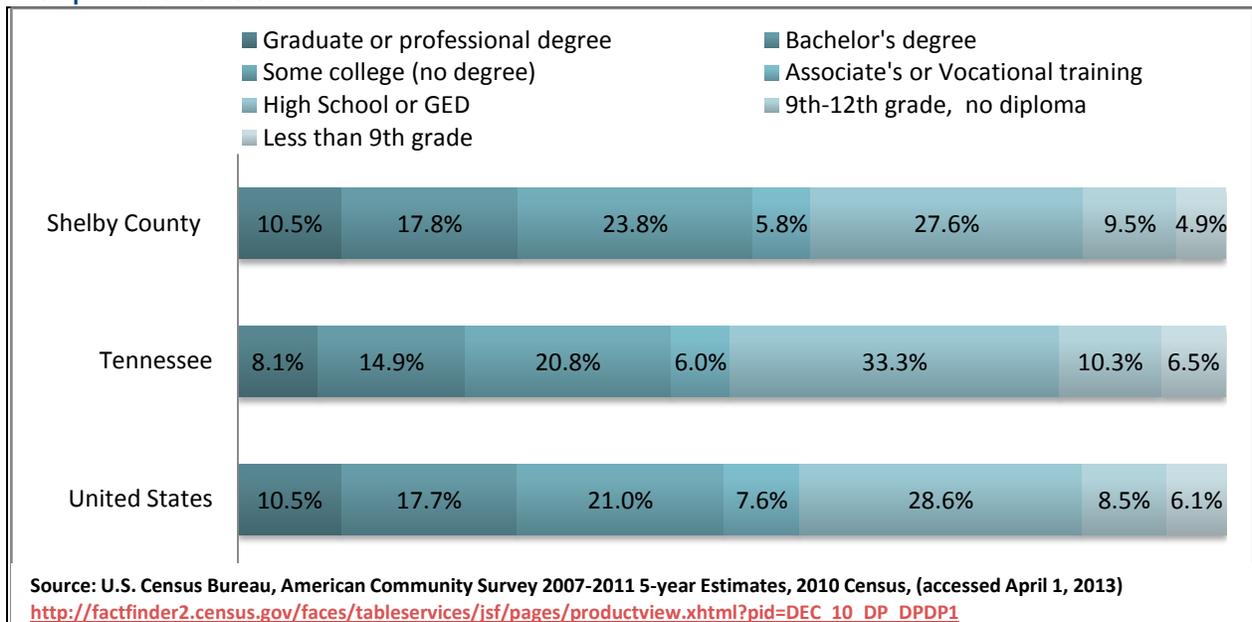
As of the 2009 Population Data from the Tennessee Department of Health, 930,689 residents live in Shelby County. In Shelby County, 47.7% of the residents are male and 52.3% are female.³ In the context of race and

- age,
- race/ethnicity,
- socioeconomic measures,
- educational attainment,
- employment status,
- foreign born status,
- homelessness,
- language,
- marital status,
- domestic violence and child abuse,
- violence and crime, and
- social capital/social support.

ethnicity, a higher proportion of Black or African American residents live in Shelby County (52.1% Black, 40.6% White, 0.2% American Indian and Alaskan Native, 2.3% Asian, 5.6% Hispanic or Latino, and 3.3% Other Race).⁴

A few tables and graphs **highlighting** other demographic and social environment indicators are provided below. The full CHA will provide the demographic and social environment section in its entirety.

Graph I Education level



³ Tennessee Department of Health, 2009 Population Data, (accessed April 1, 2013) Retrieved from: <http://hit.state.tn.us/pop.aspx>

⁴ U.S. Census Bureau, 2010 Census, (accessed April 1, 2013) Retrieved from: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_DP_DPDP1

Table 2 Socioeconomic measures

Socioeconomic Measure	Shelby County ¹	Tennessee ¹	United States
Core Indicators			
Percent below Poverty Level (100% FPL[*])			
Children	30.3%	24.0%	19.9%
Families	16.7%	13.7%	-
Total	20.1%	16.8%	14.3%
Median Household Income			
	\$44,051	\$41,691	\$51,413
Percent receiving SNAP^{**} benefits in last 12 months²			
	27.7%	20.5%	14.5%
Employment- Percent Unemployed⁴			
	9.8%	8.4%	7.7%
Special Populations			
Population with less than HS diploma	14.4%	16.8%	14.6%
Population receiving Medicaid	24.4%	18.5%	19.9%
Veteran population	9.1%	10.5%	-
Population speaking English less than “very well”	4.1%	2.9%	8.7%
Population without health insurance	16.3%	14.1%	15.2%
Homelessness rate (per 10,000)	15	14.7	20.3
Population ages 65 and older	10.2%	13.3%	12.9%
Foreign born	6%	4.5%	12.8%
Source:			
² US Census Bureau, Small Area Income & Poverty Estimates: 2010 . Source geography: County.			
³ The State of Homelessness in America, 2012 http://b.3cdn.net/naeh/a18b62e5f015e9a9b8_pdm6iy33d.pdf http://b.3cdn.net/naeh/025f630bc6a9728920_y6m6ii6hp.pdf			
⁴ US Department of Labor, Bureau of Labor Statistics: 2013-July . Source geography: County.			
Definitions:			
[*] Federal Poverty Level			
^{**} Supplemental Nutrition Assistance Program			

Other indicators to note within this section are child abuse, domestic violence, violent crime, and social support. Shelby County’s substantiated child abuse neglect rate (5.3 per 1,000 children) is lower than TN (6 per 1,000 children) and US (9 per 1,000 children).⁵ However, Shelby County’s domestic violence rate (2,949 per 100,000) is

⁵ Kid Count Data Center, (2010) Retrieved from:
<http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=TN&ind=2986&dtm=13282>



higher than the state (1,323 per 100,000).⁶ Shelby County's violent crime rate (1,377 per 100,000) is also higher than TN (667 per 100,000) and higher than the national benchmark (66 per 100,000).⁷ In regards to social support, 19.7% of respondents reported inadequate social support which slightly higher than TN (18.9%) but slightly lower than US (20.9%).⁸

Table 3 Domestic Violence and Child Abuse

	Shelby County	Tennessee	United States
Substantiated child abuse neglect rate (per 1,000 children)¹	5.3	6	9
Domestic violence rate (per 100,000)²	2,949	1,323	-

Source:

¹Kid Count Data Center, 2010

<http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=TN&ind=2986&dtm=13282>

²Urban Child Institute, <http://www.urbanchildinstitute.org/articles/research-to-policy/overviews/domestic-violence-hurts-children-even-when-they-are-not-direct>

Table 4 2004-2010 Violence and crime rates

	Shelby County	Tennessee	National Benchmark
Violent crime rate (per 100,000)	1,377	667	66
Homicide rate (per 100,000)	17	8	-

Source:

2013 County Health Rankings,

<http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank>

⁶ Urban Child Institute (2010) Retrieved from: <http://www.urbanchildinstitute.org/articles/research-to-policy/overviews/domestic-violence-hurts-children-even-when-they-are-not-direct>

⁷ 2013 County Health Rankings, <http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank>

⁸ Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2005-11. Accessed using the [Health Indicators Warehouse](#).. Source geography: County.

HEALTH OUTCOME METRICS

In regards to health outcome metrics, the CHSA includes both mortality and morbidity data within Shelby County. *Mortality* metrics report the state of *death*, whereas *morbidity* metrics report the state of *illness*.

Mortality

The CHSA features several types of mortality data:

- leading causes of death,
- infant mortality,
- injury-related mortality,
- motor vehicle mortality,
- suicide, and
- homicide.

Leading Causes of Death

According to CDC's National Vital Statistics System (2006-2010), the leading causes of death in Shelby County, Tennessee were the following: 1) cancer (all), 2) heart disease, 3) stroke, 4) unintentional injury, 5) chronic lower respiratory diseases, 6) Alzheimer's disease, 7) diabetes mellitus, 8) influenza and pneumonia, 9) homicide, 10) nephritis, nephritic syndrome, and nephrosis (kidney).⁹

The table below provides more information on the leading causes of death in Shelby County, Tennessee from 2006-2010. The age- adjusted rates are compared against the rates for the State of Tennessee as well as the Healthy People 2020 (HP) target rate if available. The rates below are per 100,000 persons.

Table 5 2006-2010 Leading Causes of Death per 100,000

Cause of Death	Shelby County ¹	Tennessee ¹	US ¹	HP 2020 Target ²
Cancer (all)	210.2	199.1	176.6	<=160.6
Heart disease	177.6	175.5	134.6	<=100.8
Cerebrovascular diseases (stroke)	59.4	52.4	41.7	<=33.8
Accidents (unintentional injury)	45.1	52.7	39.1	<=36.0
Chronic lower respiratory diseases	41.2	51.7	42.4	-
Alzheimer's Disease	38.8	36.2	25.9	-
Diabetes Mellitus	28.9	26.4	23.1	-
Influenza and Pneumonia	19.5	21.9	17.8	-
Assault (homicide)	16.8	7.6	5.8	<=5.5
Nephritis, Nephrotic Syndrome and Nephrosis	16.4	13.8	-	-

Source:

¹ [Centers for Disease Control and Prevention, National Vital Statistics System: 2006-10](#). Accessed using [CDC WONDER](#)

² <http://www.healthypeople.gov/2020/default.aspx>

⁹ [Centers for Disease Control and Prevention, National Vital Statistics System: 2006-10](#). Accessed using [CDC WONDER](#)

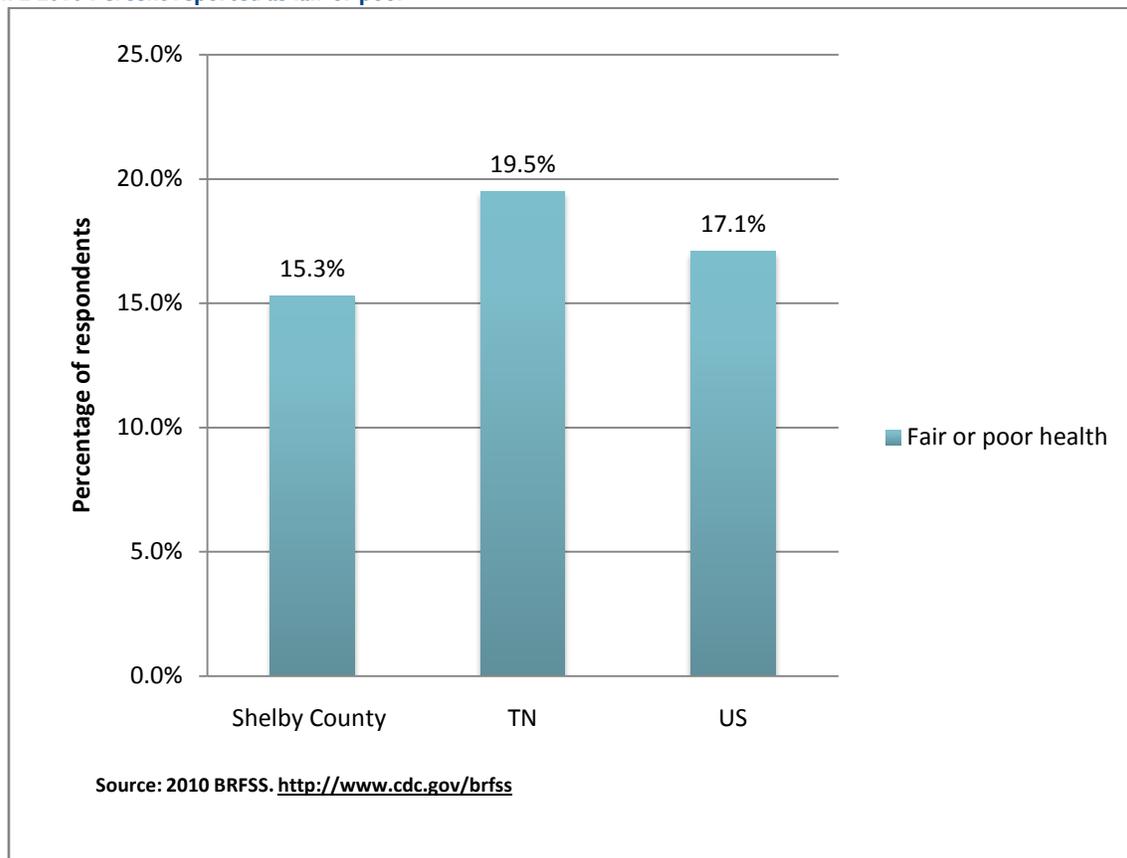
Additional Mortality Metrics

The CHSA also provides mortality data on infants, injury-related, motor vehicle, suicide, and homicide. Both infant mortality and injury-related mortality are higher in Shelby County (12.6 per 1,000 live births and 45.1 per 100,000, respectively) than TN, US and the Healthy People 2020 Target. According to the National Vital Statistics System of 2006-2010, Shelby County has lower motor vehicle mortality and suicide rates than the state. Although Shelby County's motor vehicle mortality (15.3 per 100,000) is lower the state's rate (19.1 per 100,000), motor vehicle deaths in Shelby County are slightly higher than the national rate (13.0 per 100,000). However, Shelby County's suicide rate (10.6 per 100,000) is slightly lower than the national rate (11.6 per 100,000).^{10, 11}

Morbidity

Morbidity indicators are as follows: overall health status, obesity, low birth-weight, diabetes, hospital utilization, cancer rates, sexually transmitted infections (STIs), HIV/ AIDS, and tuberculosis. According to the 2010 BRFSS, 15.3% of Shelby County respondents reported fair or poor health.¹²

Graph 2 2010 Percent reported as fair or poor



¹⁰ Death Certificate Data (Tennessee Resident Data) Tennessee Department of Health

¹¹ <http://www.healthypeople.gov/2020/default.aspx>

¹² 2010 BRFSS. <http://www.cdc.gov/brfss>

Although residents reported lower percentages of fair or poor health than the state and nation, the morbidity statistics provide a different picture of the health status in Shelby County. The following conditions have a **higher** percentage, rate, or prevalence in **Shelby County** than Tennessee and US:

- **Obesity** (33.4% Obese in Shelby County; 31.1% in TN; 27.6% in US) ¹³
- **Percent of total births that are low-weight** (11.1% in Shelby County; 9.3% in TN; 8.1% in US) ¹⁴
- **Diagnosed with diabetes** (13.0% in Shelby County; 11.3% in TN; 8.7% in US) ¹⁵
- **Diabetes with pre-diabetes or borderline diabetes** (6.6% in Shelby County; 5.2% in TN; 1.2% in US) ¹⁶
- **Cancer** ¹⁷
 - **Breast** (126 per 100,000 in Shelby County; 118.7 per 100,000 in TN; 119.7 per 100,000 in US)
 - **Cervical** (10.5 per 100,000 in Shelby County; 8.7 per 100,000 in TN; 7.7 per 100,000 in US)
 - **Colon and rectum** (50.6 per 100,000 in Shelby County; 46 per 100,000 in TN; 43.9 per 100,000 in US)
 - **Prostate** (180.8 per 100,000 in Shelby County; 144.3 per 100,000 in TN; 143.7 per 100,000 in US)

Shelby County also has higher rates in Sexually Transmitted Infections, HIV/AIDS, and Tuberculosis than Tennessee and US.

- Sexually Transmitted Infections ^{18, 19}
 - **Chlamydia** (1,048.2 per 100,000 in Shelby County; 490.1 per 100,000 in TN; 452.1 per 100,000 in US)
 - **Gonorrhea** (361.7 per 100,000 in Shelby County; 120.8 per 100,000 in TN; 102.8 per 100,000 in US)
 - **Syphilis** (11.8 per 100,000 in Shelby County; 4.4 per 100,000 in TN; 4.5 per 100,000 in US)
- **HIV/AIDS** (848.5 per 100,000 in Shelby County; 300.5 per 100,000 in TN; 340.4 per 100,000 in US) ²⁰
- **Tuberculosis** (6.1 per 100,000 in Shelby County; 2.5 per 100,000 in TN; 3.2 per 100,000 in US) ²¹

However, in regards to lung cancer, the State Cancer Profiles of 2006-2010 reveals that Shelby County (64.8 per 100,000) fares better than Tennessee (79.1 per 100,000) and US (64.9 per 100,000).

¹³ 2012 BRFSS. <http://www.cdc.gov/brfss>

¹⁴ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas: 2010.

¹⁵ 2012 BRFSS. <http://www.cdc.gov/brfss>

¹⁶ 2012 BRFSS. <http://www.cdc.gov/brfss>

¹⁷ State Cancer Profiles: 2006-10. Source geography: County.2 <http://www.healthypeople.gov/2020/default.aspx>

¹⁸ Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2011.

¹⁹ Shelby County Health Department, HIV Disease and STD Annual Surveillance Summary 2011

²⁰ Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2010.

²¹ State of Tennessee, Department of Health, Communicable and Environmental Disease Services: Tuberculosis Elimination Program. http://health.state.tn.us/ceds/tb/PDFs/2012_Regional_TB_Cases_and_Rates_by_County.pdf

OTHER HEALTH DETERMINANT AND CORRELATE METRICS

In addition to demographics and the social environment, other health determinants that affect health outcomes are access to and quality of health care, health behaviors, and the physical environment. This section of the CHSA focuses on those particular health determinant metrics.

Healthcare (Access & Quality)

In regards to access and quality metrics, the CHSA provides data on health insurance coverage, medical provider ratios, and asthma-related hospitalizations. The percentage of uninsured is higher in Shelby County (16.3%) than Tennessee (14.1%) and US (15.2%). Asthma-related hospitalizations are higher in Shelby County (301 per 100,000) than TN (168 per 100,000).²² The ratio of the Shelby County population to medical providers is lower than Tennessee but higher than the national benchmark.

Table 6 2011-2012 Ratio of population to provider

	Shelby County	Tennessee	National Benchmark
Primary care physicians (PCP)	1,274 to 1	1,409 to 1	1,067 to 1
Dentists	1,707 to 1	2,186 to 1	1,516 to 1
Mental health providers	2,299 to 1	3,470 to 1	-

Source:
2013 County Health Rankings,
<http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank>

Health Behaviors

Tobacco use, physical inactivity, inadequate nutrition, unsafe sex, heavy consumption of alcohol use, and low rates of immunizations and screenings are all behaviors that can lead to poor health outcomes. In Shelby County, 37.7% of respondents were former or current smokers compared to 45.7% in Tennessee and 42.9% in US.²³ Although tobacco use is lower in Shelby County than US, physical inactivity is higher in Shelby County (29.3%) and Tennessee (30.7%) than US (23.4%). Inadequate fruit/vegetable consumption is relatively high nationally at 75.8%, in Tennessee at 74.6%, and locally in Shelby County at 73.3%.²⁴ In regards to alcohol consumption, heavy consumption of alcohol is also higher in Shelby County (11.7%) than Tennessee (8.5%) but lower than US (15%).²⁵ In addition, Shelby County has high rates of teen pregnancies (62 per 1,000 females ages 15-19) and sexually transmitted infections (1,076 per 100,000) compared to the state and national benchmarks.²⁶

Shelby County does not meet or exceed state or national rates for the following screenings and immunizations:

- **Breast cancer screening** (62.1% in Shelby County; 63.3% in TN; 65.3% in US)

²² 2013 County Health Rankings,

<http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank>

²³ Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2005-11. Accessed using the [Health Indicators Warehouse](#)..

²⁴ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas: 2010. Source geography: County.

²⁵ Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2005-11. Accessed using the [Health Indicators Warehouse](#)..

²⁶ 2013 County Health Rankings,

<http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank>

- **Colorectal screening** (55.1% in Shelby County; 54% in TN; 57.4% in US)
- **Diabetic screening** (84% in Shelby County; 86% in TN; 60.1% in US)
- **Annual Pneumonia vaccine (Age 65+)** (58.1% in Shelby County; 66.2% in TN; 66.3% in US)²⁷
- **On time immunizations for 24 month year olds** (67.9% in Shelby County; 74.9% in TN)²⁸

In addition, Shelby County has a higher percentage of respondents with no or late prenatal care (38.6%) than TN (29.6%) and US (17.2%).

However, according to BRFSS 2006-2010, Shelby County has either better rates than or close rates to TN and/or US for the following screenings, immunizations, and services:

- **Cervical cancer screening (Pap Test)** (83% in Shelby County; 81.4% in TN; 80.4% in US)
- **Adults never screened for HIV** (46.7% in Shelby County; 58.5% in TN; 60.1% in US)
- **Adults with no dental exam** (30.1% in Shelby County; 33.9% in TN; 30.1% in US)
- **No primary care doctor** (15.7% in Shelby County; 16.5% in TN; 19.3% in US)
- **Flu vaccine (Age 65+)** (69.5% in Shelby County; 69.9% in TN; 60.1% in US)²⁹

Physical Environment

Air and water quality, the food environment, as well as access to food and physical activity also influence health outcomes. Most of Shelby County fares better than US in air and water quality. In 2008, there were 0% of days above ozone standards and 0.28% of days above particular matter standards. Shelby County has an average daily density of fine particulate matter in micrograms per cubic meter (PM2.5) of 13.0; however, it is higher than the national benchmark of 8.8 PM2.5. In 2013, 0% of the population received water from a public water system with at least one health-based violation.^{30, 31}

Although Shelby County has good air and water quality, food access is an issue. Approximately 31% of the population has low food access which is higher than TN (27.4%) and US (23.6%).³²

In regards to access to physical activity, 44% of residents live with ½ mile of a park which is higher than TN (17%) and US (39%). However, the recreation and fitness facility rate is only 7.2 per 100,000—lower than the national rate of 9.5 per 100,000. Another element to physical activity access is use of public transportation. According to the American Community Survey, very few residents use public transportation in Shelby County (1.7%) which is lower than US (4.9%) but higher than TN (<1%).³³

²⁷ Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2006-10. Additional data analysis by CARES.. Source geography: County.

²⁸ State of Tennessee, 2011 Immunization Survey, <http://health.state.tn.us/ceds/PDFs/ImmunizationSurvey2011.pdf>

²⁹ Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2006-10. Additional data analysis by CARES.. Source geography: County.

³⁰ Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network: 2008. Additional data analysis by CARES.. Source geography: Tract.

³¹ 2013 County Health Rankings, <http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank>

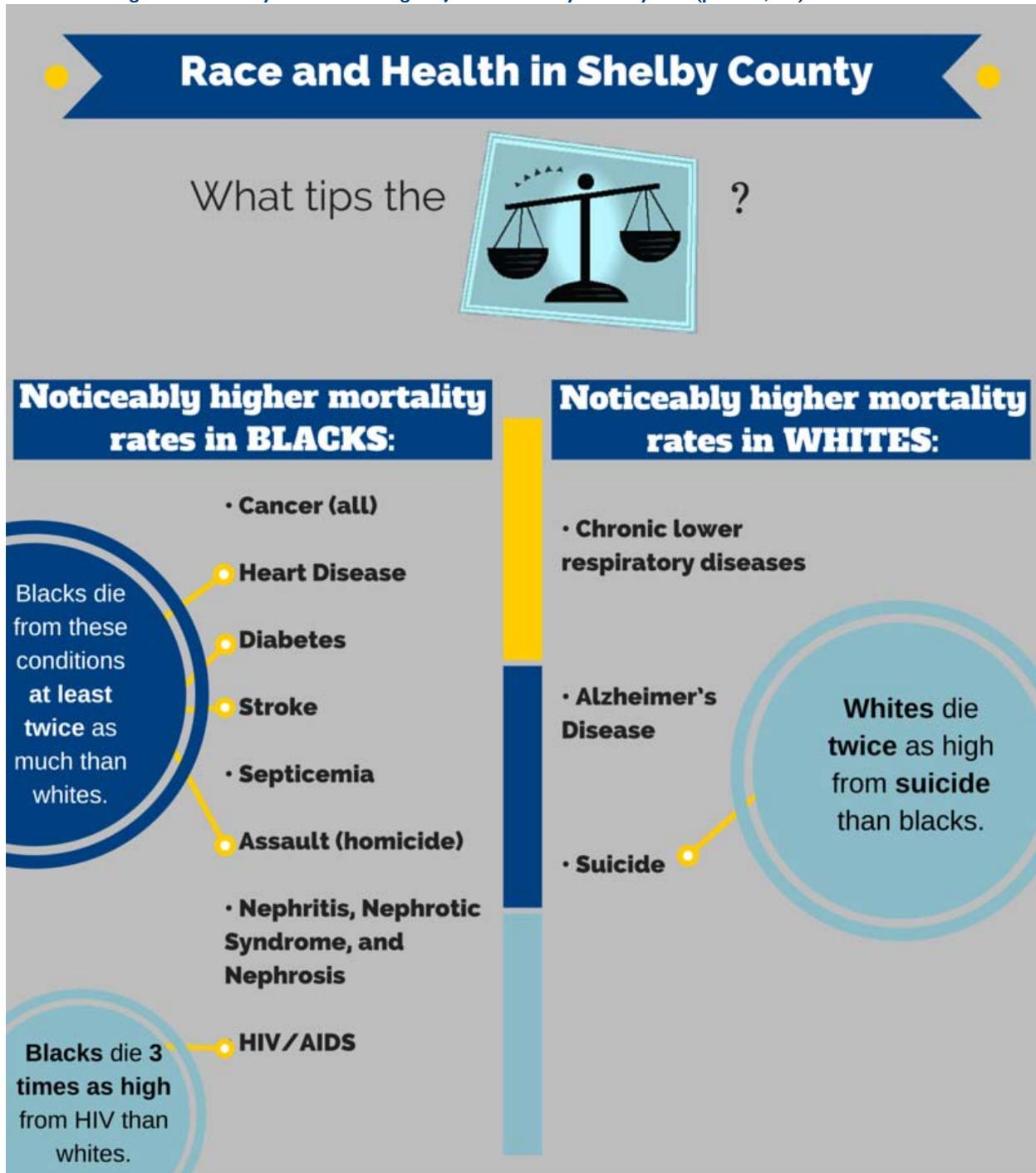
³² US Department of Agriculture, Economic Research Service, Food Access Research Atlas: 2010. Source geography: Tract.

³³ US Census Bureau, American Community Survey: 2007-11. Source geography: County.

ADDENDUM I: RACE AND HEALTH OUTCOMES

Addendum I examines health outcomes by race. The quantitative data shows there are noticeable racial differences in regards to health outcomes. The figure summarizes disproportionate deaths by race.

Addendum I Figure 1. Summary of 2007-2009 Age adjusted mortality rated by race (per 100,000)³⁴



³⁴ Death Certificate Data (Tennessee Resident Data) Tennessee Department of Health

ADDENDUM 2: COMPARISON SUMMARY

Addendum 2 summarizes the CHSA report into comparison tables. The tables below provide “at a glance” summaries of how Shelby County compares to Tennessee, United States, and existing benchmarks or Healthy People 2020 goals on community health indicators within the CHSA.

Addendum 2 Table 1. Summary of Shelby County Metrics Compared to State

	Comparable or Better than TN 	Worse than TN 
Demographics and Social Environment	<ul style="list-style-type: none"> Population with less than HS diploma Substantiated child abuse neglect rate (per 1,000 children) 	<ul style="list-style-type: none"> Poverty Level: Children Poverty Level: Families Total Poverty Level Employment- Percent Unemployed⁴ Population without health insurance Homelessness rate Domestic violence rate Violent crime rate Homicide rate Inadequate social support
Mortality	<ul style="list-style-type: none"> Accidents (unintentional injury) Chronic lower respiratory diseases Influenza and Pneumonia Injury-related mortality Motor vehicle mortality Suicide 	<ul style="list-style-type: none"> Cancer (all) Heart disease Cerebrovascular diseases (stroke) Alzheimer’s Disease Diabetes Mellitus Assault (homicide) Nephritis, Nephrotic Syndrome and Nephrosis Infant mortality (All causes) Homicide
Morbidity	<ul style="list-style-type: none"> Preventable hospital stays Lung cancer rate Overall health status (Fair or poor health) 	<ul style="list-style-type: none"> Obese (BMI 30.0 and above) Overweight (BMI 25.0-29.9) Low birth-weight Diagnosed with diabetes Diagnosed w/ pre-diabetes or borderline diabetes Breast cancer rate Cervical cancer rate Colon and rectum cancer rate Prostate cancer rate Chlamydia Gonorrhea Syphilis (primary and secondary) HIV

	Comparable or Better than TN 	Worse than TN 
		<ul style="list-style-type: none"> ▪ Tuberculosis
Health Care Access and Quality	<ul style="list-style-type: none"> • Primary care physicians (PCP) • Dentists • Mental health providers 	<ul style="list-style-type: none"> ▪ Uninsured population ▪ Asthma- related Inpatient hospitalization rate (1 to 17 year olds)
Health Behaviors, Immunizations, and Screenings	<ul style="list-style-type: none"> • Tobacco use (current smokers) • Tobacco use (former and current smokers) • Tobacco use (quit attempt in past 12 months) • No leisure time physical activity • Inadequate fruit/vegetable consumption • Cervical cancer screening (Pap Test) • Colorectal screening (colonoscopy) • HIV screening (adults never screened) • Dental care (no dental exam) • Primary care (no regular doctor) 	<ul style="list-style-type: none"> ▪ Teen birth rate ▪ Sexually transmitted infections ▪ Heavily consuming alcohol ▪ Breast cancer screening (mammogram) ▪ Diabetic screening (Medicare enrollees) ▪ No or late prenatal care ▪ Annual Pneumonia vaccine (Age 65+) ▪ Flu vaccine (Age 65+) ▪ 24 month year olds w/on time immunizations
Physical Environment	<ul style="list-style-type: none"> • Ozone- Percent of days exceeding standards • Daily fine particulate matter • Population receiving water from public water system with at least one health-based violation • SNAP Food store rate • Within ½ mile of a park • Recreation and fitness facility rate • Use of public transportation 	<ul style="list-style-type: none"> ▪ Particulate matter – Percent of days exceeding standards ▪ Fast food restaurant rate ▪ Grocery store rate ▪ Liquor store rate ▪ WIC Food store rate ▪ Population with low food access ▪ Low income population with low food access

Addendum 2 Table 2. Summary Shelby County Metrics Compared to Nation

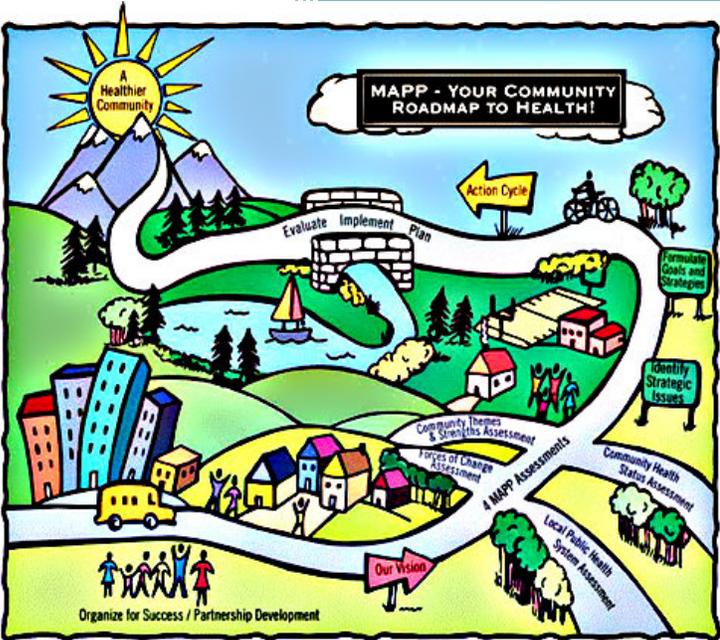
	Comparable or Better than US 	Worse than US 
Demographics and Social Environment	<ul style="list-style-type: none"> • Population with less than HS diploma • Homelessness rate • Substantiated child abuse neglect rate (per 1,000 children) • Inadequate social support 	<ul style="list-style-type: none"> ▪ Poverty Level: Children ▪ Total Poverty Level ▪ Employment- Percent Unemployed⁴ ▪ Population without health insurance
Mortality	<ul style="list-style-type: none"> • Chronic lower respiratory diseases • Suicide 	<ul style="list-style-type: none"> ▪ Cancer (all) ▪ Heart disease ▪ Cerebrovascular diseases (stroke) ▪ Accidents (unintentional injury) ▪ Alzheimer’s Disease ▪ Diabetes Mellitus ▪ Influenza and Pneumonia ▪ Assault (homicide) ▪ Infant mortality (All causes) ▪ Injury-related mortality ▪ Motor vehicle mortality ▪ Homicide
Morbidity	<ul style="list-style-type: none"> • Overweight (BMI 25.0-29.9) • Lung cancer rate • Overall health status (Fair or poor health) 	<ul style="list-style-type: none"> ▪ Obese (BMI 30.0 and above) ▪ Low birth-weight ▪ Diagnosed with diabetes ▪ Diagnosed w/ pre-diabetes or borderline diabetes ▪ Breast cancer rate ▪ Cervical cancer rate ▪ Colon and rectum cancer rate ▪ Prostate cancer rate ▪ Chlamydia ▪ Gonorrhea ▪ Syphilis (primary and secondary) ▪ HIV ▪ Tuberculosis
Health Care Access and Quality		<ul style="list-style-type: none"> ▪ Uninsured population
Health Behaviors, Immunizations, and Screenings	<ul style="list-style-type: none"> • Tobacco use (former and current smokers) • Tobacco use (quit attempt in past 12 months) • Inadequate fruit/vegetable consumption • Heavily consuming alcohol • Cervical cancer screening (Pap Test) 	<ul style="list-style-type: none"> ▪ Tobacco use (current smokers) ▪ No leisure time physical activity ▪ Breast cancer screening (mammogram) ▪ Colorectal screening (colonoscopy) ▪ No or late prenatal care ▪ Annual Pneumonia vaccine (Age 65+)

	Comparable or Better than US 	Worse than US 
	<ul style="list-style-type: none"> • HIV screening (adults never screened) • Dental care (no dental exam) • Primary care (no regular doctor) • Flu vaccine (Age 65+) 	
Physical Environment	<ul style="list-style-type: none"> • Ozone- Percent of days exceeding standards • Particulate matter – Percent of days exceeding standards • Grocery store rate • SNAP Food store rate • Within ½ mile of a park 	<ul style="list-style-type: none"> ▪ Fast food restaurant rate ▪ Liquor store rate ▪ WIC Food store rate ▪ Population with low food access ▪ Low income population with low food access ▪ Recreation and fitness facility rate ▪ Use of public transportation

Addendum 2 Table 3. Summary of Shelby County Metrics Compared to Existing National Benchmarks or Healthy People 2020 Goals

	Comparable or Better than National Benchmarks or Healthy People 2020 Goals 	Worse than National Benchmarks or Healthy People 2020 Goals 
Demographics and Social Environment		<ul style="list-style-type: none"> Violent crime rate
Mortality		<ul style="list-style-type: none"> Cancer (all) Heart disease Cerebrovascular diseases (stroke) Accidents (unintentional injury) Assault (homicide) Infant mortality (All causes) Injury-related mortality Suicide Homicide
Morbidity		<ul style="list-style-type: none"> Preventable hospital stays Cervical cancer rate Colon and rectum cancer rate
Health Care Access and Quality		<ul style="list-style-type: none"> Primary care physicians (PCP) Dentists
Health Behaviors, Immunizations, and Screenings		<ul style="list-style-type: none"> Teen birth rate Sexually transmitted infections Diabetic screening (Medicare enrollees)
Physical Environment	<ul style="list-style-type: none"> Population receiving water from public water system with at least one health-based violation 	<ul style="list-style-type: none"> Daily fine particulate matter

Community Themes & Strengths Assessment Report Summary



METHODS

The CTSA Working Group decided that a survey combined with focus groups would be the best approach to gather data for this assessment. The working group was able to use a Community Health Opinion Survey developed by the Centers for Disease Control and Prevention (CDC) and helped determine how the instrument worked at the local level. Due to the length of the original survey, the CTSA Working Group decided to use a two-pronged approach in administering the survey: 1) full length online version and 2) a shorter in-person version.

The survey was developed by the CDC using the Community Health Assessment for Population Health Improvement¹ as a guide and is sectioned into nine content areas:

1. Quality of Life Statements
2. Health Outcomes
3. Child Health Information
4. Personal Behaviors
5. Community Related Behaviors
6. Physical Environment
7. Health Care
8. Emergency Preparedness
9. Demographics

The shorter, in-person survey contained the following sections only:

1. Quality of Life Statements
2. Health Outcomes
3. Community Related Behaviors
4. Demographics

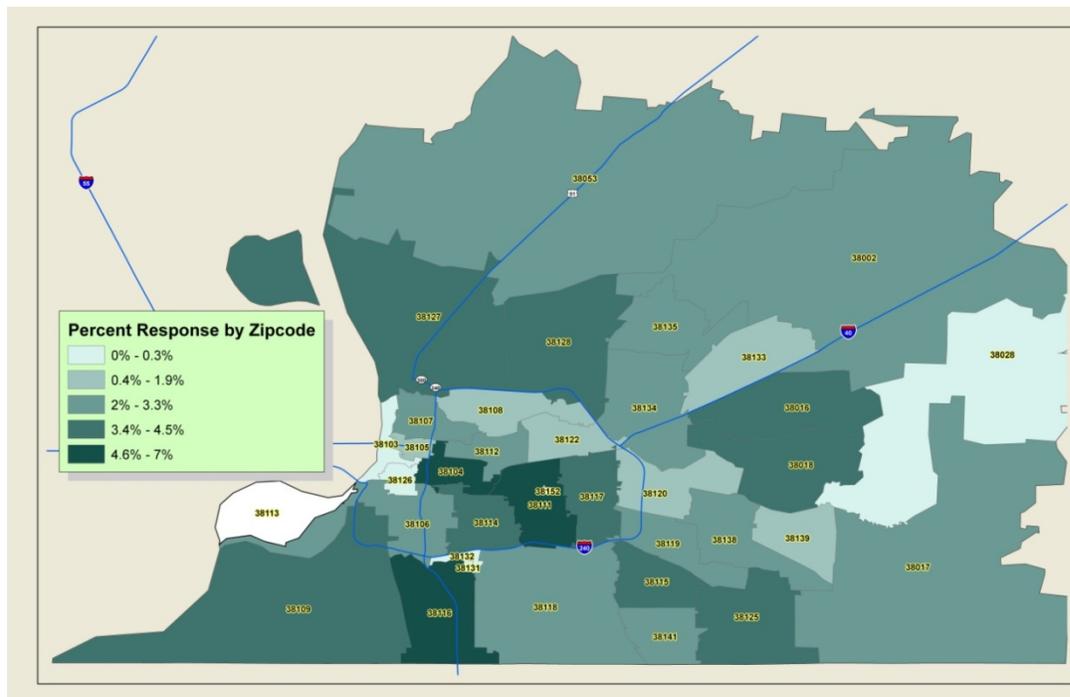
¹ Centers for Disease Control and Prevention. (2013). Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants. Retrieved from: <http://chna22.org/wp-content/uploads/2013/06/Community-Health-Assessment-for-Population-Health-Improvement.pdf>

SURVEY SAMPLE

The sample for this survey was a *convenience sample*. It was determined by the CTSA Working Group that, given available resources (staff, time, money), the best approach would be to rely on partner networks to disseminate the online and in-person survey. The survey was open from June through September 2013, resulting in 1,536 responses (911 online; 625 in-person).

Respondents' Zip code

All respondents were asked to provide their zip code. Overall, responder location distribution covered most parts of the county. Notable exceptions included 38126, 38103, and 38028. Zip codes with highest percentages of responders included 38104, 38116, and 38111.



Demographics

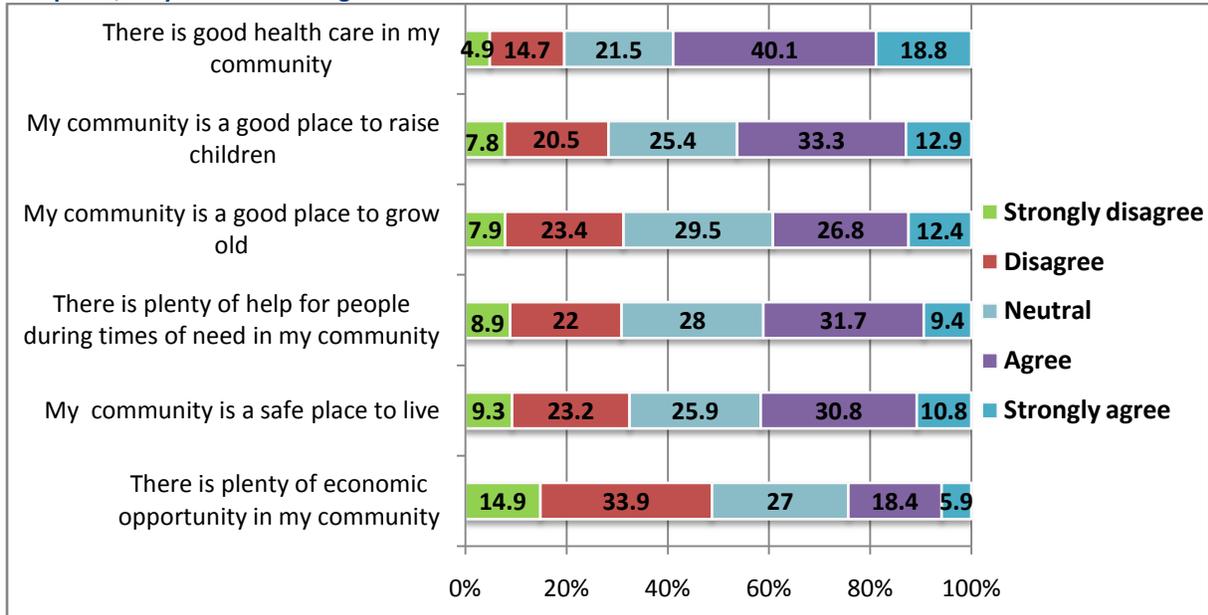
Basic demographic questions were asked of all survey respondents. According to The American Community Survey 2010, survey respondent makeup closely matched the demographic profile of Shelby County in age, income, race, and marital status. Some discrepancies existed in the following:

- **Race/Ethnicity-** Both the Asian and Pacific Islander community and individuals with Hispanic or Latino origin were slightly underrepresented in the CTSA survey.
 - Asian/Pacific Islander respondents: 0.7%; compared to 2.4% of Shelby County
 - Respondents with Hispanic/Latino(a) origin: 2.9%; in Shelby County: 5.6%
- **Education-** The CTSA survey overrepresented the population that was college educated and above in Shelby County. In particular, those with a high school diploma only or lower were underrepresented in the CTSA survey.
 - 21.6% of respondents had a bachelor's degree and 29.1% had a graduate or professional degree (compared to 17.8% and 10.5% of Shelby County)
 - 8% of respondents did not graduate from high school (compared to 14.4% of Shelby County)
- **Sex-**The number of female vs. male respondents was relatively high in comparison to sex statistics for Shelby County.
 - Male respondents: 23.3%; compared to 47.7% of Shelby County
 - Female respondents: 74.2%, compared to 52.3% of Shelby County

QUALITY OF LIFE STATEMENTS

This section gathered information regarding perception of the general well-being of the community. This data provides background to both strengths and challenges for Shelby County.

Graph 3 Quality of Life Percentage Breakdown



PERSONAL BEHAVIORS

The following section queried respondents about their own personal habits and health activities. This section was presented in the online survey only.

- Physical Activity: 74.5% of respondents reported that they engaged in physical activity for at least 30 minutes.
 - Most common places for activity: neighborhood, home, gym/rec center, public parks/trails
 - Common reasons for not engaging in physical activity: being too tired, not having enough time, not liking to exercise
- Access to Fresh Foods: 83.3% reported easy access to fresh foods; 16.7% reported not easy access
 - 60.9% of respondents bought fresh food from full service grocery stores
- Secondhand smoke exposure: 55% of respondents reported second hand smoke exposure
- Access to Mental Health Care: 13% reported a need for mental health care without receiving services
 - Most common reasons for not receiving care: couldn't afford cost, other reasons (thought I could handle the problem without treatment, don't have time, no transportation, etc), concern for effect on employment

COMMUNITY RELATED BEHAVIORS AND ISSUES

The following section asked respondents to rank their concern level (major concern, concern, minor concern, not a concern) for each of a list of community related behaviors and issues.

Behaviors Results

Highest concern: Unsafe sex, Poor nutrition, Illegal drug use

Lowest concern: Binge drinking, Lack of seatbelt use, Low immunization rates

Issues Results

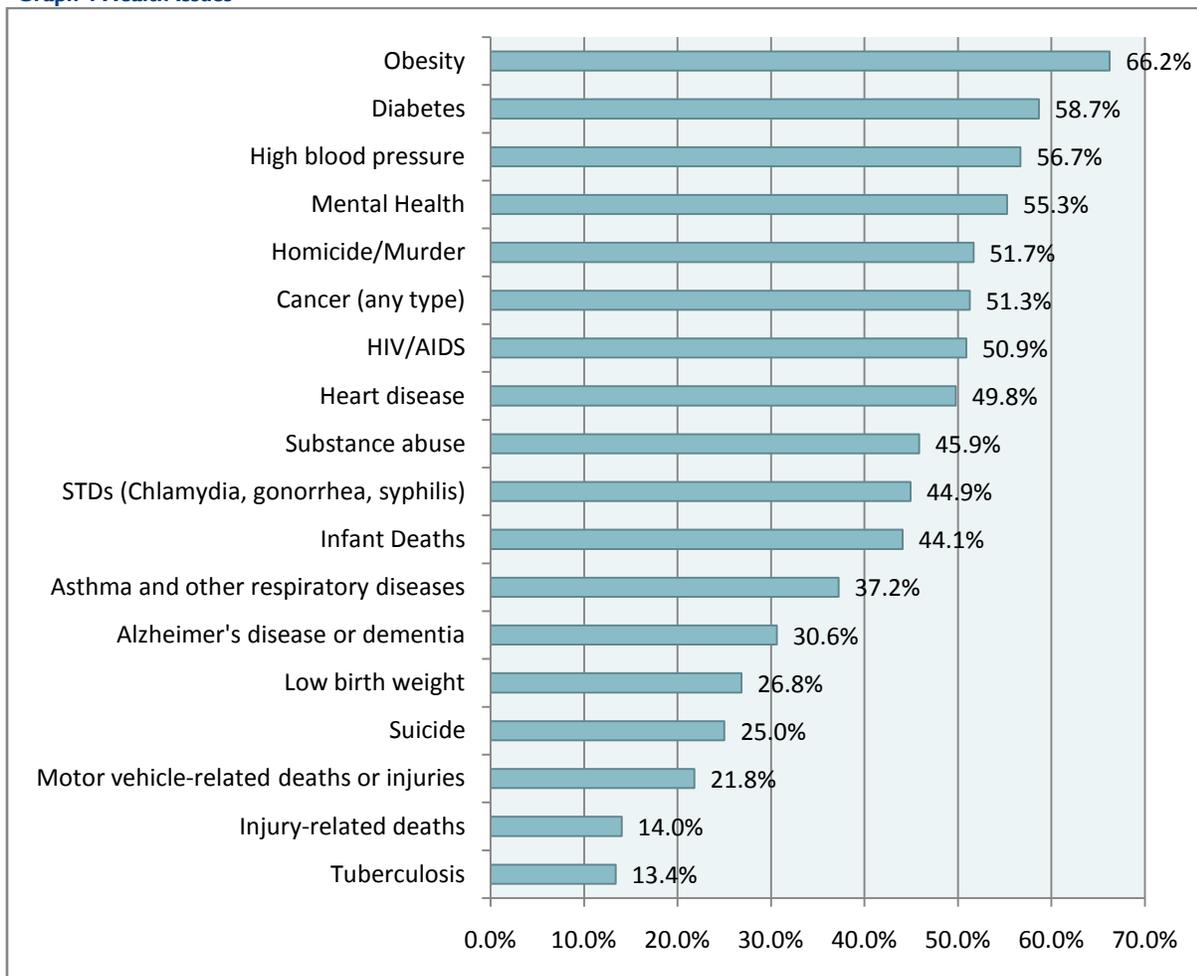
Highest Concern: Crime, Violence, Poverty, Domestic Violence

Lowest Concern: Community Support and Neighborliness

HEALTH OUTCOMES

The following section asked respondents to select issues that required the most attention from a list of 18 health issues. Respondents were able to select as many of those health issues as needed.

Graph 4 Health Issues



EMERGENCY PREPAREDNESS

Questions in this section queried respondents about emergency preparedness related behaviors.

- Smoke Detectors: 55.7% had smoke detectors only; 33.8% also had a carbon monoxide detector
- Emergency supply kit: 55.9% did not have a kit
 - About 46% of respondents with a kit believed it would last more than a week
- Most frequent communication methods during emergency: television (31.7%), radio (20.3%), and text messaging (18.9%)

PHYSICAL ENVIRONMENT

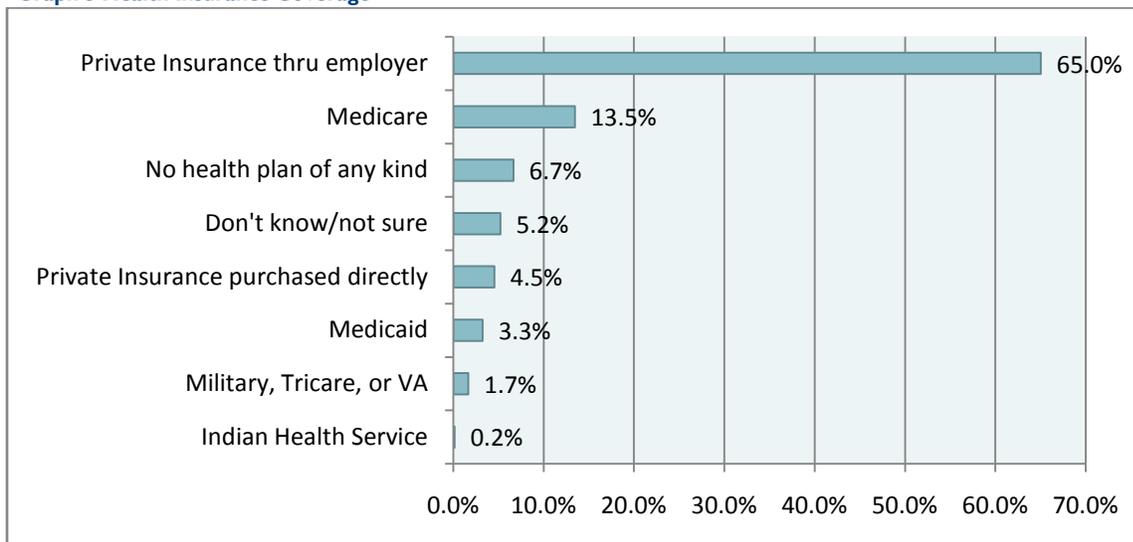
This section asked respondents about the physical environment and health of their neighborhood.

- Public Transportation: 17.2% use public transportation
 - Bus was the most frequently identified type of public transit used at 49%.
- Walking and Biking: Close to 50% of responders stated that they either walked or biked either inside or outside of their neighborhood during a typical week.
 - Of the responders, a majority indicated they walked only; around 5% biked only
 - Reasons for not biking/walking: Safety concerns, no bicycle, too much traffic
 - Adequate sidewalks: 27% said no; Adequately lighted sidewalks: about 41% said no
 - Bike lanes in neighborhood: just over 56% said no
- Food Availability: 94.8% stated there was both a grocery and a drug store within a 15 minute drive
 - 69.1% had access to a full service grocery only; 1.7% had access to convenience store only
 - 61.5% indicated their convenience store did not have quality fruits and vegetables

HEALTH CARE

The following section asked respondents about topics related to health care, including insurance coverage and access to care.

Graph 5 Health Insurance Coverage



Problems Accessing Health Care: Almost 17% said yes

- Most common service access issues: General practitioner (20.9%), Dentist (19.5%), Eye care (11.3%)
- Reasons for not receiving care: Insurance did not cover, Have no insurance, Share of the cost was too high

Local Public Health System Assessment Report Summary



METHODS

To conduct this assessment, the LPHSA working group used the Local Public Health Assessment Instrument developed by NPHPS. This tool assesses the performance and capacity of the collective and interactive system as a whole by using the 10 Essential Public Health Services as the framework for assessing the local system¹. The assessment was divided by Essential Service area to ensure participation and appropriate expertise at the table. Over the course of 5 separate meetings, approximately 65 individuals from various organizations took part in this assessment. On August 29, 2013, these participants were invited for follow-up discussion concerning preliminary results of the assessment, identification of priorities, and proposing next steps.

The LPHSA's goal is to assess the entire local public health system not one entity, organization, or agency. Figure 1 below provides a commonly used graphic to demonstrate the interconnectedness and diversity of the local public health system. To assess the local public health system as a whole, the Centers for Disease Control and Prevention (CDC) worked to develop the National Public Health Performance Standards (NPHPS)², which provides a framework to identify areas for system improvement, strengthening partnerships, and ensuring a strong system is in place for addressing public health issues.

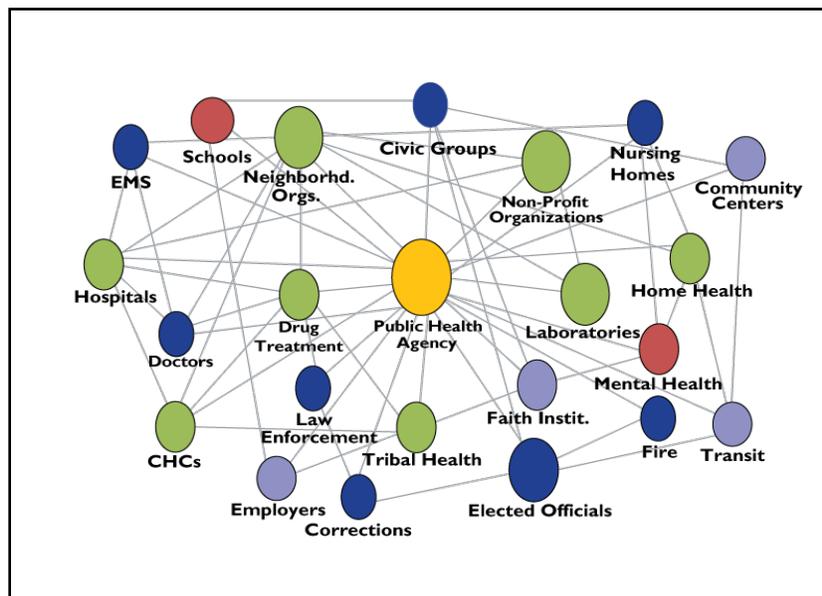


Figure 1: Local Public Health System

¹ Centers for Disease Control and Prevention. (2014) The public health system and the 10 essential public health services. Retrieved from: <http://www.cdc.gov/nphsp/essentialservices.html>

²Centers for Disease Control and Prevention. (2015) National public health performance standards. Retrieved from: <http://www.cdc.gov/nphsp/>

SUMMARY OF RESULTS

The summary below provides a brief synopsis of the Local Public Health System Assessment (LPHSA) results and discussion. The scores represent the average level of perceived activity occurring for each of the Essential Services.

Scoring Card	Activity Level
Optimal	76-100%
Significant	51-75%
Moderate	26-50%
Minimal	1-25%
No Activity	0%

Table 1: Scoring key

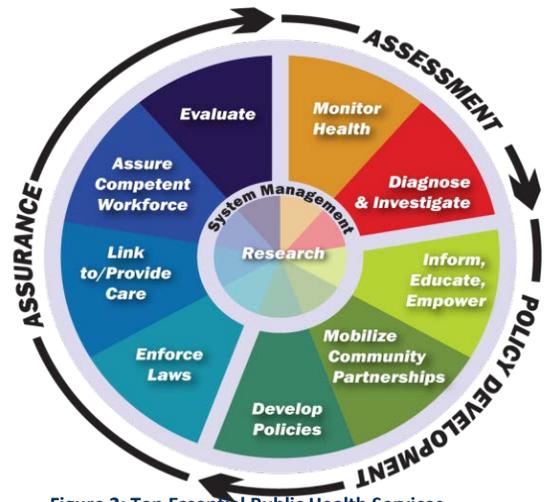
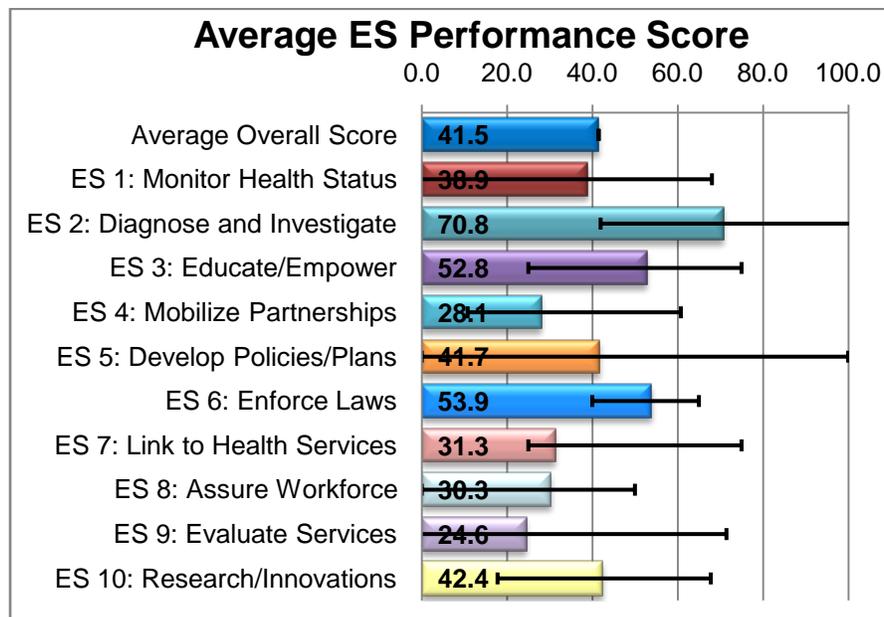


Figure 2: Ten Essential Public Health Services



Graph 1: Summary of Average ES Performance Scores (black bars indicate range)

Table 2: Overall Scores for LPHSA

Essential Public Health Services	Score
1. Monitor health status to identify community health problems.	38.9
2. Diagnose and investigate health problems and health hazards in the community.	70.8
3. Inform, educate, and empower people about health issues.	52.8
4. Mobilize community partnerships to identify and solve health problems.	28.1
5. Develop policies and plans that support individual and community health efforts.	41.7
6. Enforce laws and regulations that protect health and ensure safety.	53.9
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.	31.3
8. Assure a competent public health and personal health care workforce.	38.3
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.	24.6
10. Research for new insights and innovative solutions to health problems	42.4
Overall score	41.5

DISCUSSION SUMMARY

Participants of this assessment convened to discuss the resulting scores in August 2013. As a result of this discussion, strengths and areas of challenge were identified and several priorities were selected as foci for improving the delivery of the Essential Services in Shelby County.

Strongest areas:

- ES#2: Diagnose and investigate health problems and health hazards in the community
- ES#6: Enforce laws and regulations that protect health and ensure safety
- ES# 3: Inform, educate, and empower people about health issues

Areas of challenge:

- ES# 9: Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- ES# 4: Mobilize community partnerships to identify and solve health problems
- ES# 7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable

DISCUSSED PRIORITIES:

1. Acknowledge impact of social determinants throughout delivery of all essential services.
2. Establish collective accountability across the local public health system via a Board of Health, Regional Health Council, or similar entity.
 - Helps to guide, oversee, and facilitate communication among stakeholders engaged in community health related activities
 - Establishes a recognized entity that emphasizes accountability among public health system partners
3. Increase willingness and ability to share data among partners in the local public health system.
 - Helps to increase activity around system-wide evaluation of delivery of personal and population-based health services
 - Helps to understand the gaps in personal health care delivery and how to leverage existing resources to address found gaps
 - Helps to increase activity around system-wide evaluation of delivery of personal and population-based health services
4. Continue engagement and community outreach
 - Increases community knowledge and builds on desire for transparency and civic involvement

Forces of Change Assessment Report Summary



METHODS

The Forces of Change Assessment Work Group met throughout April and June 2013 to formulate the logistics of conducting the FOCA. The finalized approach involved a three hour brainstorming session held in lieu of the MAPP partnership meeting in July 2013. Prior to the session, participants were provided with a Forces of Change worksheet to stimulate thoughts about forces that are impacting community health in Shelby County.

Brainstorm session participants were divided into small groups to discuss forces and identify the threats and opportunities posed by these forces. At the conclusion of the session, the notes gathered from each small group were compiled into a single “Forces of Change Worksheet” and shared among all MAPP partners for edits, comments, and general feedback. At the end of this comment period, the FOCA identified twenty forces that could impact community health in Shelby County.

IDENTIFIED FORCES OF CHANGE

In the Forces of Change Assessment, MAPP partners were asked “*What is occurring or might occur that affects health of Shelby County?*” and, “*What specific threats or opportunities are generated by these forces?*” The following table provides some of the major forces identified by the MAPP partnership.

These forces are categorized as trends, events, and factors, defined as:

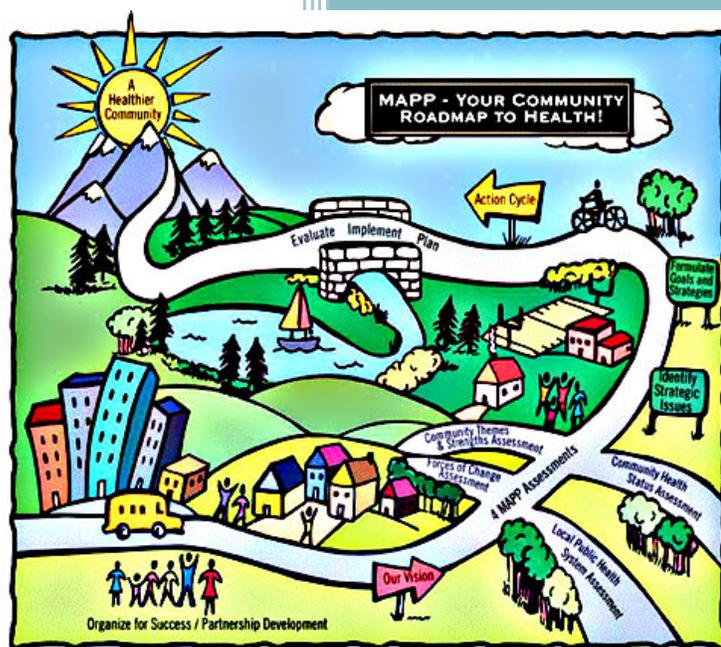
- Trends are patterns over time
- Events are one-time occurrences
- Factors are discreet elements

In compiling this list, we understand that forces will dissipate and rise, as will the threats and opportunities which each present. Therefore, this assessment should be viewed as a snapshot of forces of change versus a definitive list.

Table 1: Identified Forces of Change

Trends	Events	Factors
Changing demographics	School district merger	Racial & economic divisions in Shelby County
Decreases in local, state, and federal funding	Affordable Care Act	Elected officials and politics
Growing inequalities (health and wealth)	Local flooding	Public health language: Individual-minded vs. Community-minded
Urban planning initiatives	Extreme heat	High poverty rates
Culture and lifestyle	Obesity declared a disease	Geographic location (Tri-State area)
Crime and violence		Technology
Health disparities		Tax policy
Lack of mental health care		
Changes in local food system		

Results



IDENTIFYING PRIORITIES

As a result of the four MAPP assessments conducted from May 2013 to September 2013, 17 disease, behavior, and system related issues were identified as *potential priority areas* for the Shelby County.

Disease/Health Outcome Related	Behavior Related	System Related
<ul style="list-style-type: none">•Diabetes•Heart disease•Hypertension•Sexually transmitted diseases•Mental health illnesses	<ul style="list-style-type: none">•Tobacco use & secondhand smoke•Physical inactivity•Violence as a public health issue•Obesity	<ul style="list-style-type: none">•Increase collaboration, communication, and coordination across local public health system•Increase healthy food access•Health disparities•Social determinants of health•Focus on community assets•Foster partnerships with primary care providers

Following the identification of the priorities listed above, community members were invited to provide input regarding their opinions for the ultimate, most pressing and significant health priorities amongst the original seventeen identified areas.

As a result of the MAPP process, the community health assessment (CHA) results, and community feedback, Shelby County selected the following as *the most significant priorities* for community health improvement efforts in Shelby County:

- Diabetes**
- Health Disparities & Social Determinants of Health**
- Increasing Collaboration, Communication, & Coordination across the Local Public Health System**
- Mental Health**
- Obesity & Related Chronic Diseases**
- Violence as a Public Health Issue**

FINAL STRATEGIC HEALTH PRIORITIES

In order to avoid duplication of efforts, two strategic health priorities were later combined: Diabetes and Obesity & Related Chronic Diseases. The SHP was renamed “Healthy Lifestyles.” The finalized strategic health priorities are displayed on the graphic below.

STRATEGIC HEALTH PRIORITIES

»»» → **GOALS** ← «««

CROSS-CUTTING PRIORITIES

Health Disparities & Social Determinants of Health

Collaboration, Communication, & Coordination across the Local Public Health System

MENTAL HEALTH

To enhance mental health, wellbeing, and quality of life by addressing depression in Shelby County

HEALTHY LIFESTYLES

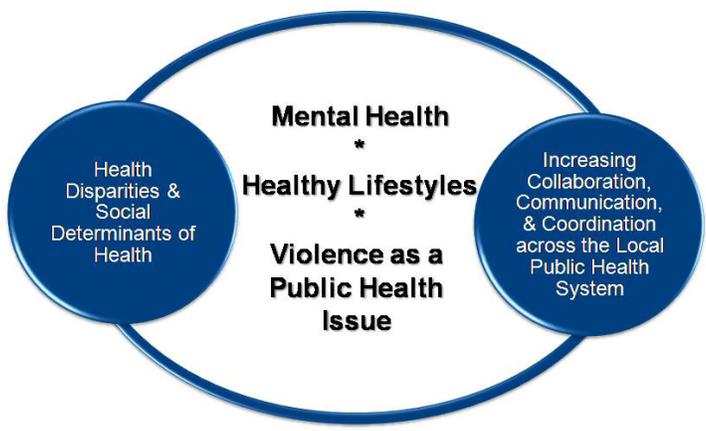
To establish healthy lifestyles and community wellness as a norm in Shelby County

VIOLENCE AS A PUBLIC HEALTH ISSUE

To prevent youth violence, limit exposure to violence, and enhance youth safety in Shelby County

Cross Cutting Priorities

All five of the strategic health priorities represent some of the most pressing issues and barriers in Shelby County’s mission to be the healthiest place to live. However, two of the five priorities were system-related and cross-cutting issues. Because of the significance and magnitude of the two cross-cutting priorities, addressing health disparities & social determinants of health and increasing collaboration, communication, & coordination were integrated within the main three priorities. This relationship is depicted in the image below.



Moving Forward: Shelby County CHIP

For more information about the current status of community health planning in Shelby County, TN, read more in the Shelby County Community Health Improvement Plan. Want to know what you can do to help make Shelby County a healthier place to live? Contact the Shelby County Health Department community health planners:

Amy Collier | 901-222-9618 | amy.collier@shelbycountyttn.gov

Angela Moore | 901-222-9620 | angela.p.moore@shelbycountyttn.gov

Thank you to all the community partners and assessment working group members who participated and contributed to the Community Health Assessment and the Community Health Improvement Plan!



Appendix I: Definitions



DEFINITIONS

CHA - Community Health Assessment- describes the health status of the population, identifies areas for health improvement, determines factors that contribute to health issues, and identifies assets and resources that can be mobilized to address population health improvement. (National Association of County and City Health Officials)

CHIP – Community Health Improvement Plan which is based on the CHA, a plan that describes the health status of a community and how it plans to work to improve the health of the population

Chronic Disease - A chronic disease is one lasting 3 months or more, by the definition of the U.S. National Center for Health Statistics. Chronic diseases generally cannot be prevented by vaccines or cured by medication, nor do they just disappear. (MedicineNet)

Community Health Status Assessment - analysis of data to identify trends, health problems, environmental health hazards, and social and economic conditions that adversely affect the public's health.(National Association of County and City Health Officials)

CoP – Communities of Practice - a group of people with a shared interest or concern who regularly interact to improve their knowledge and skills and to achieve individual and group goals

CTSA - Community Themes and Strengths Assessment - provides a deep understanding of the issues that residents feel are important. (National Association of County and City Officials)

FOC - Forces of Change Assessment - focuses on identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. (National Association of County and City Health Officials)

Health Disparities - a type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. (Centers for Disease Control and Prevention)

Health Equity - When all people have "the opportunity to 'attain their full health potential' and no one is "disadvantaged from achieving this potential because of their social position or other socially determined circumstance." (Center for Disease Control and Prevention)

DEFINITIONS

Healthy Lifestyles – a lifestyle that helps to keep and improve one's health and well-being, including adequate sleep, sufficient hydration, daily physical activity, good nutrition, etc.

LPHSA - Local Public Health System Assessment – focuses on all of the organizations and entities that contribute to the public's health system... (National Association of County and City Health Officials)

MAPP - Mobilizing for Action through Planning and Partnerships - a six-phase, community-driven strategic planning process for improving community health. (Centers for Disease Control and Prevention)

Mental Health—a person's condition regarding his/her psychological and emotional well-being.

Mobilizing – bringing together and connecting the community to identify and solve health problems

Cross-cutting Priorities – priorities that influence every part of improving the public's health such as health equity, infrastructure, capacity, etc.

Public Health – seeks to benefit the health of the largest number of people; population health

Public Health System— both public-sector agencies and private-sector organizations whose actions have significant consequences for the public's health. (U.S. Department of Health and Human Services)

Social Determinants of Health - factors that contribute to a person's current state of health - biological, socioeconomic, psychosocial, behavioral, or social

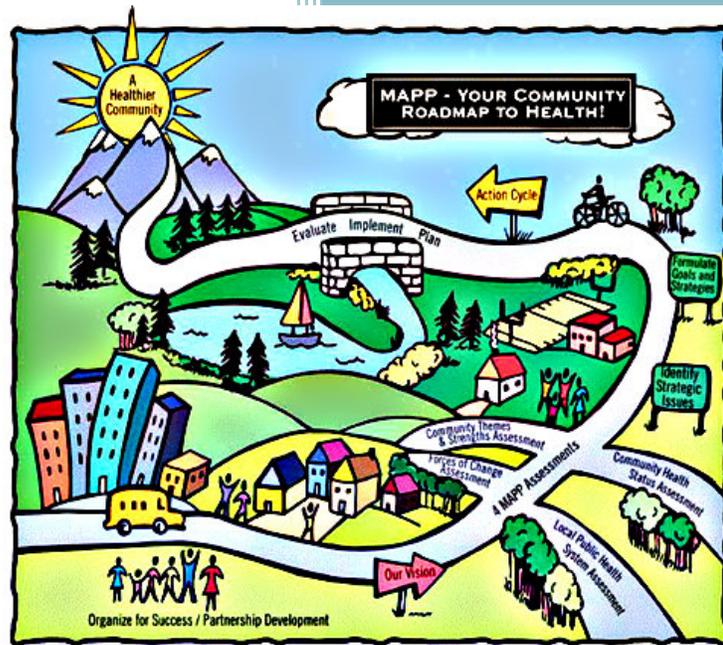
Strategic Health Priorities - identified by exploring the convergence of the results of the four MAPP Assessments and determining how those issues affect the achievement of the shared vision. (National Association for County and City Health Officials)

Violence as a Public Health Issue – addressing violence with the public health approach of: 1) Defining and Monitoring the Problem; 2) Identifying Risk and Protective Factors; 3) Developing and Testing Prevention Strategies; and, 4) Assuring Widespread Adoption.

Appendix II: Community Health Assessment FULL REPORT



Community Health Status Assessment Report



INTRODUCTION

A primary outcome of the Community Health Status Assessment (CHSA) is to understand the overall landscape of health within Shelby County. The data resulting from the CHSA will be combined with other assessment data to guide the MAPP team in developing strategic issues and formulating goals and strategies aimed at impacting community health in Shelby County.

Methods

Using the Center for Disease Control and Prevention's (CDC) Community Health Assessment for Population Health Improvement¹ as a guide, members of the CHSA Working Group inputted in data that aligned with the Core Indicators as outlined in the monograph. The CDC's guide provides a framework of metrics that have been determined to be key indicators in community health, see Table I below for more information.

This report will follow the guidelines of the health metrics suggestions put forth by the CDC. In some instances additional data points are included. In future drafts of this report, sub-county data will be provided to allow for examination of zip code level data and distribution of certain indicators. Maps will be provided as appendices. Data sources are provided in their respective tables.

¹ <http://chna22.org/wp-content/uploads/2013/06/Community-Health-Assessment-for-Population-Health-Improvement.pdf>

Table I Health Metrics for Community Health Assessments

Community Health Assessment for Population Health Improvement Most Frequently Recommended Health Metrics ¹					
Health Outcome Metrics		Health Determinant and Correlate Metrics			
Mortality	Morbidity	Health Care (Access & Quality)	Health Behaviors	Demographics & Social Environment	Physical Environment
Leading causes of death	Obesity	Health insurance coverage	Tobacco use/ smoking	Age	Air quality
Infant mortality	Low birth- weight	Provide rates	Physical activity	Sex	Water quality
Injury-related mortality	Hospital utilization	Asthma-related hospitalization	Nutrition	Race/ Ethnicity	Housing
Motor vehicle mortality	Cancer rates		Unsafe sex	Income	
Suicide	Motor vehicle injury		Alcohol use	Poverty level	
Homicide	Overall health status		Seatbelt use	Educational attainment	
	STDs		Immunization and screenings	Employment status	
	HIV/AIDS			Foreign born	
	Tuberculosis			Homelessness	
				Language spoken at home	
				Marital status	
				Domestic violence and child abuse	
				Violence and crime	
				Social capital/ social support	

¹ Centers for Disease Control and Prevention. (2013). Community Health Assessment for Population Health Improvement: Resource of Most Frequently Recommended Health Outcomes and Determinants. Retrieved from: <http://chna22.org/wp-content/uploads/2013/06/Community-Health-Assessment-for-Population-Health-Improveme.pdf>

HEALTH OUTCOME METRICS

Mortality

LEADING CAUSES OF DEATH

The table below provides the leading causes of death in Shelby County, Tennessee from 2006-2010. The age-adjusted rates are compared against the rates for the State of Tennessee as well as the Healthy People 2020 (HP) target rate if available. The rates below are per 100,000 persons.

Table 2 2006-2010 Leading Causes of Death per 100,000

Cause of Death	Shelby County ¹	Tennessee ¹	US ¹	HP 2020 Target ²
Cancer (all)	210.2	199.1	176.6	<=160.6
Heart disease	177.6	175.5	134.6	<=100.8
Cerebrovascular diseases (stroke)	59.4	52.4	41.7	<=33.8
Accidents (unintentional injury)	45.1	52.7	39.1	<=36.0
Chronic lower respiratory diseases	41.2	51.7	42.4	-
Alzheimer's Disease	38.8	36.2	25.9	-
Diabetes Mellitus	28.9	26.4	23.1	-
Influenza and Pneumonia	19.5	21.9	17.8	-
Assault (homicide)	16.8	7.6	5.8	<=5.5
Nephritis, Nephrotic Syndrome and Nephrosis	16.4	13.8	-	-

Source:

¹ [Centers for Disease Control and Prevention, National Vital Statistics System: 2006-10](#). Accessed using [CDC WONDER](#)

² <http://www.healthypeople.gov/2020/default.aspx>

INFANT MORTALITY

The table below provides data comparing infant mortality rates per 1,000 live births between Shelby County and Tennessee.

Table 3 2007-2009 Infant mortality rates per 1,000 live births

Per 1,000 live births	Shelby County ¹	Tennessee ¹	United States ¹	HP 2020 Target ²
Infant mortality (All causes)	12.6	8.1	6.7	<= 6.0

Source:

¹ Death Certificate Data (Tennessee Resident Data) Tennessee Department of Health

² <http://www.healthypeople.gov/2020/default.aspx>

INJURY-RELATED MORTALITY

Table 4 2006-2010 Injury-related mortality per 100,000

	Shelby County ¹	Tennessee ¹	United States ¹	HP 2020 Target ²
Injury-related mortality	45.1	52.1	39.1	<=36.0

Source:

¹ Centers for Disease Control and Prevention, National Vital Statistics System: 2006-10. Accessed using [CDC WONDER](#)

² <http://www.healthypeople.gov/2020/default.aspx>

MOTOR VEHICLE MORTALITY

Table 5 2006-2010 Motor vehicle mortality per 100,000

	Shelby County ¹	Tennessee ¹	United States ¹	HP 2020 Target ²
Motor vehicle mortality	15.3	19.1	13.1	-

Source:

¹ Centers for Disease Control and Prevention, National Vital Statistics System: 2006-10. Accessed using [CDC WONDER](#)

² <http://www.healthypeople.gov/2020/default.aspx>

SUICIDE

Table 6 2006-2010 Suicide per 100,000

	Shelby County ¹	Tennessee ¹	United States ¹	HP 2020 Target ²
Suicide	10.6	14.4	11.6	<=10.2

Source:

¹ [Centers for Disease Control and Prevention, National Vital Statistics System: 2006-10](#). Accessed using [CDC WONDER](#)

² <http://www.healthypeople.gov/2020/default.aspx>

HOMICIDE

Table 7 2006-2010 Homicide per 100,000

	Shelby County ¹	Tennessee ¹	United States ¹	HP 2020 Target ²
Homicide	16.8	7.6	5.8	<=5.5

Source:

¹ [Centers for Disease Control and Prevention, National Vital Statistics System: 2006-10](#). Accessed using [CDC WONDER](#)

² <http://www.healthypeople.gov/2020/default.aspx>

Morbidity

OBESITY

Table 8 2012 Population Overweight/Obese

	Shelby County	Tennessee	United States
% Obese (BMI 30.0 and above)	33.4%	31.1%	27.6%
% Overweight (BMI 25.0-29.9)	34.9%	34.2%	35.8%
Data Source: 2012 CDC, BRFSS Data: http://apps.nccd.cdc.gov/brfss/			

LOW BIRTH-WEIGHT

Table 9 2003-2009 Percent of total births that are low-weight (under 5.5 pounds)

	Shelby County	Tennessee	United States
Low birth-weight	11.1%	9.3%	8.1%
Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas: 2010.			

DIABETES

Table 10 2010 Diabetes prevalence

	Shelby County	Tennessee	United States
Diagnosed with diabetes	13.0%	11.3%	8.7%
Diagnosed w/ pre-diabetes or borderline diabetes	6.6%	5.2%	1.2%
Data Source: 2012 CDC, BRFSS Data: http://apps.nccd.cdc.gov/brfss/			

Table 11 2010 Preventable hospital stays per 1,000 Medicare enrollees

	Shelby County ¹	Tennessee ¹	National Benchmark
Preventable hospital stays	62	83	47
Data Source: County Health Rankings & Roadmaps. http://www.countyhealthrankings.org/app/tennessee/2013/measure/factors/5/data/sort-0			

CANCER RATES

Table 12 2006-2010 Cancer rates per 100,000

Cancer site	Shelby County ¹	Tennessee ¹	United States	HP 2020 Target ²
Breast	126	118.7	119.7	-
Cervical	10.5	8.7	7.7	<=7.1
Colon and rectum	50.6	46	43.9	<=38.6
Lung	64.8	79.1	64.9	-
Prostate	180.8	144.3	143.7	-
Source: ¹ State Cancer Profiles: 2006-10. Source geography: County. ² http://www.healthypeople.gov/2020/default.aspx				

OVERALL HEALTH STATUS

Table 13 2010 Percent reported as fair or poor

	Shelby County	Tennessee	United States
Fair or poor health	15.3%	19.5%	17.1%
Source: 2010 BRFSS. http://www.cdc.gov/brfss/			

Table 14 2011 STD rates per 100,000

STI	Shelby County ¹	Tennessee ¹	United States
Chlamydia	1,048.2	490.1	452.1
Gonorrhea	361.7	120.8	102.8
Syphilis (primary and secondary)²	11.8	4.4	4.5

Source:
¹ [Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2011.](#)
² Shelby County Health Department, HIV Disease and STD Annual Surveillance Summary 2011

HIV/AIDS

Table 15 2010 HIV rates per 100,000

	Shelby County	Tennessee	United States
HIV	848.5	300.5	340.4

Source:
[Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2010.](#)
 Source geography: County.

TUBERCULOSIS

Table 16 2012 Tuberculosis rates per 100,000

	Shelby County	Tennessee	United States
Tuberculosis	6.1	2.5	3.2

Source:
 State of Tennessee, Department of Health, Communicable and Environmental Disease Services: Tuberculosis Elimination Program. http://health.state.tn.us/ceds/tb/PDFs/2012_Regional_TB_Cases_and_Rates_by_County.pdf

HEALTH DETERMINANT AND CORRELATE METRICS

Healthcare (Access & Quality)

HEALTH INSURANCE COVERAGE

Table 17 2009-2011 | Percent without health insurance

	Shelby County	Tennessee	United States
Uninsured population	16.3%	14.1%	15.2%
Source: US Census Bureau, American Community Survey: 2009-11 . Source geography: PUMA.			

PROVIDER RATES

Table 18 2011-2012 Ratio of population to provider

	Shelby County	Tennessee	National Benchmark
Primary care physicians (PCP)	1,274 to 1	1,409 to 1	1,067 to 1
Dentists	1,707 to 1	2,186 to 1	1,516 to 1
Mental health providers	2,299 to 1	3,470 to 1	-
Source: 2013 County Health Rankings, http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank			

Table 19 1997-2007 Asthma hospitalization rates per 100,000

	Shelby County	Tennessee
Inpatient hospitalization rate (1 to 17 year olds)	301	168

Source:

Tennessee Department of Health, http://health.state.tn.us/statistics/PdfFiles/Childhood_Asthma_Report_07.pdf

Health Behaviors

TOBACCO USE/SMOKING

Table 20 2005-2011 Tobacco use/smoking

	Shelby County	Tennessee	United States
Tobacco use (current smokers)	19%	22.9%	18.5%
Tobacco use (former and current smokers)	37.7%	45.7%	42.9%
Tobacco use (quit attempt in past 12 months)	66.7%	58.8%	58.4%

Source:

[Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2005-11](#). Accessed using the [Health Indicators Warehouse](#)..

PHYSICAL ACTIVITY

Table 21 2010 No leisure time physical activity

	Shelby County	Tennessee	United States
No leisure time physical activity	29.3%	30.7%	23.4%

Source:

[Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Diabetes Atlas: 2010](#). Source geography: County.

Table 22 2005-2009 Inadequate fruit/vegetable consumption

	Shelby County	Tennessee	United States
Inadequate fruit/vegetable consumption	73.3%	74.6%	75.8%

Source:

[Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2005-11](#). Accessed using the [Health Indicators Warehouse](#)..[Atlas: 2010](#). Source geography: County.

UNSAFE SEX

Table 23 Unsafe sex indicators

	Shelby County	Tennessee	National Benchmark
Teen birth rate	62	50	21
Sexually transmitted infections	1,076	446	92
Source: 2013 County Health Rankings, http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank			

ALCOHOL USE

Table 24 2005-2011 Population heavily consuming alcohol

	Shelby County	Tennessee	United States
Heavily consuming alcohol	11.7%	8.5%	15%

Source:

[Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2005-11](#). Accessed using the [Health Indicators Warehouse](#)..

IMMUNIZATION RATES

Table 25 Screening and immunization rates

	Shelby County	Tennessee	United States
Breast cancer screening (mammogram)	62.1%	63.3%	65.3%
Cervical cancer screening (Pap Test)	83%	81.4%	80.4%
Colorectal screening (colonoscopy)	55.1%	54%	57.4%
HIV screening (adults never screened)	46.7%	58.5%	60.1%
Diabetic screening (Medicare enrollees)	84%	86%	90% (benchmark)
<i>Access to preventative care services</i>			
No or late prenatal care	38.6%	29.6%	17.2%
Dental care (no dental exam)	30.1%	33.9%	30.1%
Primary care (no regular doctor)	15.7%	16.5%	19.3%
<i>Vaccinations/Immunizations</i>			
Annual Pneumonia vaccine (Age 65+)	58.1%	66.2%	66.3%
Flu vaccine (Age 65+)	69.5%	69.9%	60.1%
24 month year olds w/on time immunizations¹	67.9%	74.9%	-

Source:

Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2006-10. Additional data analysis by CARES.. Source geography: County.

¹ State of Tennessee, 2011 Immunization Survey, <http://health.state.tn.us/ceds/PDFs/ImmunizationSurvey2011.pdf>

DEMOGRAPHICS & SOCIAL ENVIRONMENT

AGE

Table 26 Age and sex profile

Age and Sex Profile									
Age Group	Shelby County ¹						Tennessee ¹		
	Number			Percentage			Percentage		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
<1	7,503	7,209	14,712	0.8	0.8	1.6	0.7	0.6	1.3
1-14	99,788	96,377	196,165	10.7	10.4	21.1	9.3	8.9	18.2
15-24	66,053	66,010	132,063	7.1	7.1	14.2	7	6.7	13.7
25-44	120,602	128,721	249,323	13	13.8	26.8	13.6	13.5	27.1
45-64	114,667	130,474	245,141	12.3	14	26.3	12.9	13.7	26.6
65-74	21,699	28,819	50,518	2.3	3.1	5.4	3.3	3.9	7.2
75 & older	13,954	28,813	42,767	1.5	3.1	4.6	2.1	3.8	5.9
Total	444,266	486,423	930,689	47.7	52.3	100	48.9	51.1	100

Sources:

¹Tennessee Department of Health, 2009 Population Data, (accessed April 1, 2013) <http://hit.state.tn.us/pop.aspx>

Note:

Total population estimates differ from Census population. TN DOH was used for Age and Sex Profile because it provided age categories suggested by the Community Health Status Indicators Worksheet.

Table 27 Race/Ethnicity

Population	Shelby County		Tennessee
	Number	Percentage	Percentage
White	376,277	40.6	77.6
Black or African American	483,381	52.1	16.7
American Indian and Alaskan Native	2,279	0.2	0.3
Asian	21,391	2.3	1.4
Asian Indian	6,290	0.7	0.4
Chinese	4,190	0.5	0.2
Filipino	2,002	0.2	0.1
Japanese	577	0.1	0.2
Korean	1,669	0.2	0.2
Vietnamese	3,678	0.4	0.2
Other Asian	2,985	0.3	0.3
Hispanic or Latino	52,092	5.6	4.6
Mexican	37,125	4.0	2.9
Puerto Rican	1,981	0.2	0.3
Cuban	937	0.1	0.1
Other Hispanic/Latino	12,049	1.3	1.2
Native Hawaiian or other Pacific Islander	441	0.0	0.1
Native Hawaiian	110	0.0	0.0
Guamanian or Chamorro	204	0.0	0.0
Samoan	48	0.0	0.0
Other Pacific Islander	79	0.0	0.0
Some Other Race	30,580	3.3	2.2

Source:
U.S. Census Bureau, 2010 Census, (accessed April 1, 2013)
http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_DP_DPDP1
Note: Individuals can select more than one race/ethnicity, so total population subgroups will not equal total population.

Table 28 Socioeconomic measures

Socioeconomic Measure	Shelby County ¹	Tennessee ¹	United States
Core Indicators			
Percent below Poverty Level (100% FPL*)			
Children	30.3%	24.0%	19.9%
Families	16.7%	13.7%	-
Total	20.1%	16.8%	14.3%
Median Household Income			
	\$44,051	\$41,691	\$51,413
Percent receiving SNAP** benefits in last 12 months²			
	27.7%	20.5%	14.5%
Employment- Percent Unemployed⁴			
	9.8%	8.4%	7.7%
Special Populations			
Population with less than HS diploma	14.4%	16.8%	14.6%
Population receiving Medicaid	24.4%	18.5%	19.9%
Veteran population	9.1%	10.5%	-
Population speaking English less than “very well”	4.1%	2.9%	8.7%
Population without health insurance	16.3%	14.1%	15.2%
Homelessness rate (per 10,000)	15	14.7	20.3
Population ages 65 and older	10.2%	13.3%	12.9%
Foreign born	6%	4.5%	12.8%
Source:			
² US Census Bureau, Small Area Income & Poverty Estimates: 2010 . Source geography: County.			
³ The State of Homelessness in America, 2012 http://b.3cdn.net/naeh/a18b62e5f015e9a9b8_pdm6iy33d.pdf http://b.3cdn.net/naeh/025f630bc6a9728920_y6m6ii6hp.pdf			
⁴ US Department of Labor, Bureau of Labor Statistics: 2013-July . Source geography: County.			
Definitions:			
*Federal Poverty Level			
**Supplemental Nutrition Assistance Program			

Table 29 Education level

	Shelby County	Tennessee	United States
Graduate or professional degree	10.5%	8.1%	10.5%
Bachelor's degree	17.8%	14.9%	17.7%
Some college (no degree)	23.8%	20.8%	21.0%
Associate's or Vocational training	5.8%	6.0%	7.6%
High School or GED	27.6%	33.3%	28.6%
9th-12th grade, no diploma	9.5%	10.3%	8.5%
Less than 9th grade	4.9%	6.5%	6.1%

Source:

U.S. Census Bureau, American Community Survey 2007-2011 5-year Estimates, 2010 Census, (accessed April 1, 2013)

http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_10_DP_DPDP1

EMPLOYMENT STATUS

Table 30 Unemployment status

	Shelby County	Tennessee	United States
Unemployed	9.8%	8.5%	7.7%

Source:

[US Department of Labor, Bureau of Labor Statistics: 2013-July](#). Source geography: County.

FOREIGN BORN

Table 31 Foreign born population

	Shelby County	Tennessee	United States
Foreign born	6%	4.5%	12.8%

Source:

[US Census Bureau, American Community Survey: 2007-11](#). Source geography: County.

Table 32 Homelessness rate

	Shelby County	Tennessee	United States
Homelessness rate (per 10,000)	15	14.7	20.3
Source: The State of Homelessness in America, 2012 http://b.3cdn.net/naeh/a18b62e5f015e9a9b8_pdm6iy33d.pdf http://b.3cdn.net/naeh/025f630bc6a9728920_y6m6ii6hp.pdf			

LANGUAGE INDICATORS

Table 33 Language indicators

	Shelby County	Tennessee	United States
Limited English proficiency (Age 5+)	4.1%	2.8%	8.7%
Linguistically isolated homes	2.7%	1.8%	5%
Source: US Census Bureau, American Community Survey: 2007-11. Source geography: Tract.			

MARITAL STATUS

Table 34 Marital status

	Shelby County	Tennessee	United States
Married	40.4%	51.0%	49.7%
Divorced	11.6%	12.4%	10.5%
Never married/single	38.4%	27.6%	31.4%
Separated	3.7%	2.3%	2.1%
Unmarried partner	1.9%	2.0%	2.2%
Widowed	6.3%	6.6%	6.1%
Source: US Census Bureau, American Community Survey: 2007-11.			

DOMESTIC VIOLENCE AND CHILD ABUSE

Table 35 Domestic Violence and Child Abuse

	Shelby County	Tennessee	US
Substantiated child abuse neglect rate (per 1,000 children)¹	5.3	6	9
Domestic violence rate (per 100,000)²	2,949	1,323	-

Source:

¹Kid Count Data Center, 2010

<http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=TN&ind=2986&dtm=13282>

²Urban Child Institute, <http://www.urbanchildinstitute.org/articles/research-to-policy/overviews/domestic-violence-hurts-children-even-when-they-are-not-direct>

VIOLENCE AND CRIME

Table 36 2004-2010 Violence and crime rates

	Shelby County	Tennessee	National Benchmark
Violent crime rate (per 100,000)	1,377	667	66
Homicide rate (per 100,000)	17	8	-

Source:

2013 County Health Rankings,

<http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank>

Table 37 2005-2011 Reporting inadequate social support

	Shelby County	Tennessee	United States
Inadequate social support	19.7%	18.9%	20.9%

Source:

Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System: 2005-11. Accessed using the [Health Indicators Warehouse](#). Source geography: County.

PHYSICAL ENVIRONMENT

AIR QUALITY

Table 38 Air quality indicators

	Shelby County	Tennessee	United States
Ozone- Percent of days exceeding standards	0%	0.08%	0.47%
Particulate matter – Percent of days exceeding standards	0.28%	0.24%	1.2%
Daily fine particulate matter²	13.0	13.9	8.8 (National Benchmark)

Source:

Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network: 2008. Additional data analysis by [CARES](#). Source geography: Tract.

²2013 County Health Rankings,

<http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank>

Table 39 Drinking water safety

	Shelby County	Tennessee	National Benchmark
Population receiving water from public water system with at least one health-based violation	0%	15%	0%

Source

2013 County Health Rankings,

<http://www.countyhealthrankings.org/app/tennessee/2013/shelby/county/outcomes/overall/snapshot/by-rank>

FOOD ENVIRONMENT

Table 40 Retail establishment rate per 100,000 people

	Shelby County	Tennessee	United States
Fast food restaurant rate¹	73.1	68.9	70
Grocery store rate¹	20.1	18.1	20.8
Liquor store rate¹	11.7	8.7	10.3
SNAP Food store rate²	111.1	103.4	78.4
WIC Food store rate³	11.5	15.4	15.6

Source:

¹US Census Bureau, [County Business Patterns: 2011](#). Additional data analysis by [CARES](#). Source geography: County

²US Department of Agriculture, Food and Nutrition Service, [SNAP Retailer Locator: 2013](#). Additional data analysis by [CARES](#).

Source geography: Tract.

³US Department of Agriculture, Economic Research Service, [Food Environment Atlas: 2011](#). Source geography: County.

Table 41 Population with low food access

	Shelby County	Tennessee	United States
Population with low food access	31.2%	27.4%	23.6%
Low income population with low food access	9.6%	8.7%	6.3%

Source:

[US Department of Agriculture, Economic Research Service, Food Access Research Atlas: 2010](#). Source geography: Tract.

PHYSICAL ACTIVITY ENVIRONMENT

Table 42 Physical activity access

	Shelby County	Tennessee	US
Within ½ mile of a park¹	44%	17%	39%
Recreation and fitness facility rate per 100,000²	7.2	7.1	9.5
% using public transportation	1.7%	0%	4.9%

¹ [Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network: 2010](#). Source geography: County.

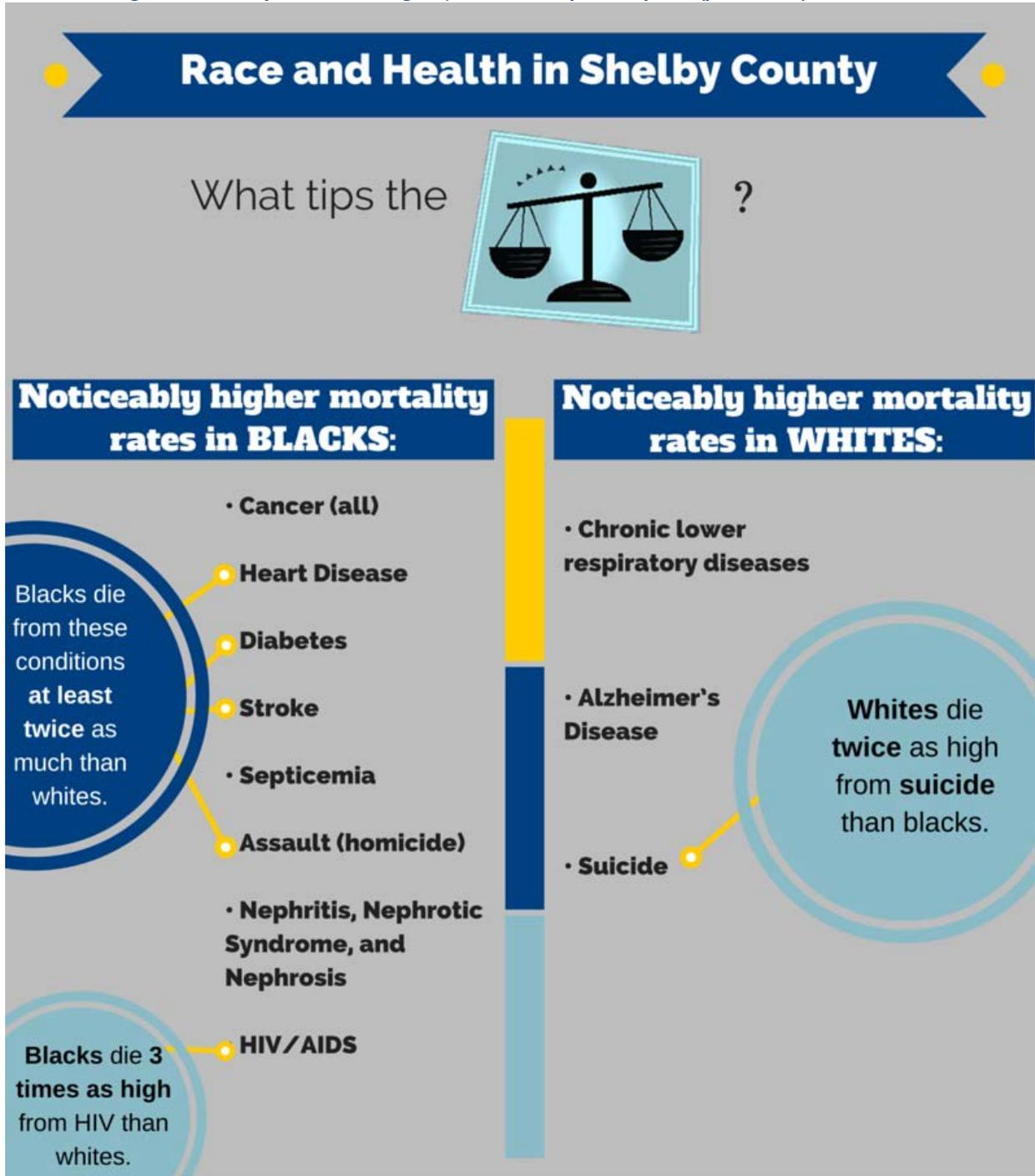
² [US Census Bureau, County Business Patterns: 2011](#). Additional data analysis by [CARES](#). Source geography: County.

³ [US Census Bureau, American Community Survey: 2007-11](#). Source geography: County.

ADDENDUM I: RACE AND HEALTH OUTCOMES

Addendum I examines health outcomes by race. The quantitative data shows there are noticeable racial differences in regards to health outcomes. The figure summarizes disproportionate deaths by race.

Addendum I Figure I. Summary of 2007-2009 Age adjusted mortality rated by race (per 100,000)²



² Death Certificate Data (Tennessee Resident Data) Tennessee Department of Health

Table I 2007-2009 Age Adjusted Mortality Rates by Race (per 100,000)

Cause of Death by Race in Shelby County	Shelby County White	Shelby County Black	Shelby County All
Heart disease	199	277	231
Cancer (all)	176	252	207
Cerebrovascular diseases (stroke)	42	81	58
Accidents (unintentional injury)	43	43	44
Chronic lower respiratory diseases	48	30	42
Alzheimer's Disease	40	36	39
Diabetes Mellitus	17	48	29
Influenza and Pneumonia	19	19	19
Suicide	14	6	10
Septicemia	11	21	15
Assault (homicide)	18	29	18
Nephritis, Nephrotic Syndrome and Nephrosis	16	26	16
HIV/AIDS	13	25	13
Data Source: Death Certificate Data (Tennessee Resident Data) Tennessee Department of Health			

Table 2 Disease rates in Shelby County by Race (per 100,000)

Disease Incidence/Prevalence by Race	Shelby County White	Shelby County Black	Shelby County All	Tennessee All
Cancer Annual Incidence Rates (2006-2010)¹				
Breast Cancer	125	123	126	118
Cervical Cancer	7	13	10	9
Colon and Rectum Cancer	43	59	50	46
Lung Cancer	58	73	65	79
Prostate Cancer	164	203	181	144
Cancer Annual Mortality Rates (2007-2009)²				
Breast Cancer	19	42	28	23
Cervical Cancer	2	7	4	3
Colon and Rectum Cancer	18	29	22	19
Lung Cancer	51	63	56	65
Prostate Cancer	25	64	38	25
Data Source: ¹ State Cancer Profiles: 2006-10 . Source geography: County. ² Death Certificate Data (Tennessee Resident Data) Tennessee Department of Health				

Table 3 Sexually Transmitted Infections by Race (per 100,000)

Sexually Transmitted Infections ¹	Shelby County White	Shelby County Black	Shelby County All	Tennessee All
Chlamydia Incidence	172	1,840	1,048	490
Gonorrhea	29	668	362	121
Syphilis (Primary & Secondary)	2	21	12	4.4 ²
HIV Incidence	8	63	37	-
Living w/ HIV or AIDS	260	1,149	716	301 ³

Data Source:
¹ [Shelby County HIV/AIDS and STD Annual Surveillance Statistics, 2011.](#)
² Centers for Disease Control and Prevention, [Sexually Transmitted Diseases Surveillance 2011.](#)
³ Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention: 2010.

ADDENDUM 2: COMPARISON SUMMARY

Addendum 2 summarizes the CHSA report into comparison tables. The tables below provide “at a glance” summaries of how Shelby County compares to Tennessee, United States, and existing benchmarks or Healthy People 2020 goals on community health indicators within the CHSA.

Addendum 2 Table 1. Summary of Shelby County Metrics Compared to State

	Comparable or Better than TN 	Worse than TN 
Demographics and Social Environment	<ul style="list-style-type: none"> Population with less than HS diploma Substantiated child abuse neglect rate (per 1,000 children) 	<ul style="list-style-type: none"> Poverty Level: Children Poverty Level: Families Total Poverty Level Employment- Percent Unemployed⁴ Population without health insurance Homelessness rate Domestic violence rate Violent crime rate Homicide rate Inadequate social support
Mortality	<ul style="list-style-type: none"> Accidents (unintentional injury) Chronic lower respiratory diseases Influenza and Pneumonia Injury-related mortality Motor vehicle mortality Suicide 	<ul style="list-style-type: none"> Cancer (all) Heart disease Cerebrovascular diseases (stroke) Alzheimer’s Disease Diabetes Mellitus Assault (homicide) Nephritis, Nephrotic Syndrome and Nephrosis Infant mortality (All causes) Homicide
Morbidity	<ul style="list-style-type: none"> Preventable hospital stays Lung cancer rate Overall health status (Fair or poor health) 	<ul style="list-style-type: none"> Obese (BMI 30.0 and above) Overweight (BMI 25.0-29.9) Low birth-weight Diagnosed with diabetes Diagnosed w/ pre-diabetes or borderline diabetes Breast cancer rate Cervical cancer rate Colon and rectum cancer rate Prostate cancer rate Chlamydia Gonorrhea Syphilis (primary and secondary) HIV Tuberculosis
Health Care Access and Quality	<ul style="list-style-type: none"> Primary care physicians (PCP) Dentists Mental health providers 	<ul style="list-style-type: none"> Uninsured population Asthma- related Inpatient hospitalization rate (1 to 17 year olds)

	Comparable or Better than TN 	Worse than TN 
Health Behaviors, Immunizations, and Screenings	<ul style="list-style-type: none"> ● Tobacco use (current smokers) ● Tobacco use (former and current smokers) ● Tobacco use (quit attempt in past 12 months) ● No leisure time physical activity ● Inadequate fruit/vegetable consumption ● Cervical cancer screening (Pap Test) ● Colorectal screening (colonoscopy) ● HIV screening (adults never screened) ● Dental care (no dental exam) ● Primary care (no regular doctor) 	<ul style="list-style-type: none"> ■ Teen birth rate ■ Sexually transmitted infections ■ Heavily consuming alcohol ■ Breast cancer screening (mammogram) ■ Diabetic screening (Medicare enrollees) ■ No or late prenatal care ■ Annual Pneumonia vaccine (Age 65+) ■ Flu vaccine (Age 65+) ■ 24 month year olds w/on time immunizations
Physical Environment	<ul style="list-style-type: none"> ● Ozone- Percent of days exceeding standards ● Daily fine particulate matter ● Population receiving water from public water system with at least one health-based violation ● SNAP Food store rate ● Within ½ mile of a park ● Recreation and fitness facility rate ● Use of public transportation 	<ul style="list-style-type: none"> ■ Particulate matter – Percent of days exceeding standards ■ Fast food restaurant rate ■ Grocery store rate ■ Liquor store rate ■ WIC Food store rate ■ Population with low food access ■ Low income population with low food access

Addendum 2 Table 2. Summary Shelby County Metrics Compared to Nation

	Comparable or Better than US 	Worse than US 
Demographics and Social Environment	<ul style="list-style-type: none"> ● Population with less than HS diploma ● Homelessness rate ● Substantiated child abuse neglect rate (per 1,000 children) ● Inadequate social support 	<ul style="list-style-type: none"> ■ Poverty Level: Children ■ Total Poverty Level ■ Employment- Percent Unemployed⁴ ■ Population without health insurance
Mortality	<ul style="list-style-type: none"> ● Chronic lower respiratory diseases ● Suicide 	<ul style="list-style-type: none"> ■ Cancer (all) ■ Heart disease ■ Cerebrovascular diseases (stroke) ■ Accidents (unintentional injury) ■ Alzheimer’s Disease ■ Diabetes Mellitus ■ Influenza and Pneumonia ■ Assault (homicide) ■ Infant mortality (All causes) ■ Injury-related mortality ■ Motor vehicle mortality ■ Homicide
Morbidity	<ul style="list-style-type: none"> ● Overweight (BMI 25.0-29.9) ● Lung cancer rate ● Overall health status (Fair or poor health) 	<ul style="list-style-type: none"> ■ Obese (BMI 30.0 and above) ■ Low birth-weight ■ Diagnosed with diabetes ■ Diagnosed w/ pre-diabetes or borderline diabetes ■ Breast cancer rate ■ Cervical cancer rate ■ Colon and rectum cancer rate ■ Prostate cancer rate ■ Chlamydia ■ Gonorrhea ■ Syphilis (primary and secondary) ■ HIV ■ Tuberculosis
Health Care Access and Quality		<ul style="list-style-type: none"> ■ Uninsured population
Health Behaviors, Immunizations, and Screenings	<ul style="list-style-type: none"> ● Tobacco use (former and current smokers) ● Tobacco use (quit attempt in past 12 months) ● Inadequate fruit/vegetable consumption ● Heavily consuming alcohol ● Cervical cancer screening (Pap Test) ● HIV screening (adults never screened) ● Dental care (no dental exam) ● Primary care (no regular doctor) 	<ul style="list-style-type: none"> ■ Tobacco use (current smokers) ■ No leisure time physical activity ■ Breast cancer screening (mammogram) ■ Colorectal screening (colonoscopy) ■ No or late prenatal care ■ Annual Pneumonia vaccine (Age 65+)

	Comparable or Better than US 	Worse than US 
	<ul style="list-style-type: none"> • Flu vaccine (Age 65+) 	
Physical Environment	<ul style="list-style-type: none"> • Ozone- Percent of days exceeding standards • Particulate matter – Percent of days exceeding standards • Grocery store rate • SNAP Food store rate • Within ½ mile of a park 	<ul style="list-style-type: none"> ▪ Fast food restaurant rate ▪ Liquor store rate ▪ WIC Food store rate ▪ Population with low food access ▪ Low income population with low food access ▪ Recreation and fitness facility rate ▪ Use of public transportation

Addendum 2 Table 3. Summary of Shelby County Metrics Compared to Existing National Benchmarks or Healthy People 2020 Goals

	Comparable or Better than National Benchmarks or Healthy People 2020 Goals 	Worse than National Benchmarks or Healthy People 2020 Goals 
Demographics and Social Environment		<ul style="list-style-type: none"> ▪ Violent crime rate
Mortality		<ul style="list-style-type: none"> ▪ Cancer (all) ▪ Heart disease ▪ Cerebrovascular diseases (stroke) ▪ Accidents (unintentional injury) ▪ Assault (homicide) ▪ Infant mortality (All causes) ▪ Injury-related mortality ▪ Suicide ▪ Homicide
Morbidity		<ul style="list-style-type: none"> ▪ Preventable hospital stays ▪ Cervical cancer rate ▪ Colon and rectum cancer rate
Health Care Access and Quality		<ul style="list-style-type: none"> ▪ Primary care physicians (PCP) ▪ Dentists
Health Behaviors, Immunizations, and Screenings		<ul style="list-style-type: none"> ▪ Teen birth rate ▪ Sexually transmitted infections ▪ Diabetic screening (Medicare enrollees)
Physical Environment	<ul style="list-style-type: none"> • Population receiving water from public water system with at least one health-based violation 	<ul style="list-style-type: none"> ▪ Daily fine particulate matter

Community Themes and Strengths Report



INTRODUCTION

The Community Themes and Strengths Assessment (CTSA) serves to gather data from Shelby County citizens that will provide a deeper understanding of the wants, needs, and desires concerning community health.

METHODOLOGY

The CTSA Working Group decided that a survey approach combined with focus groups would be best to gather the data for this assessment. The CTSA was presented with an opportunity to utilize a tested Community Health Opinion Survey developed by the Centers for Disease Control and Prevention (CDC) in order to determine how the instrument worked at the local community level. Due to the length of the original survey, the CTSA Working Group decided to use a two-pronged approach in administering the survey: 1) full length online version and 2) a shorter in-person version.

The survey was developed by the CDC using the Community Health Assessment for Population Health Improvement¹ as a guide and is sectioned into 9 content areas:

1. Quality of Life Statements
2. Health Outcomes
3. Child Health Information
4. Personal Behaviors
5. Community Related Behaviors
6. Physical Environment
7. Health Care
8. Emergency Preparedness
9. Demographics

The shorter, in-person survey contained the following sections only:

1. Quality of Life Statements
2. Health Outcomes
3. Community Related Behaviors
4. Demographics

In the report below, the sections are marked with an asterisk "*" to indicate that the items within that specific section were asked on the online survey only.

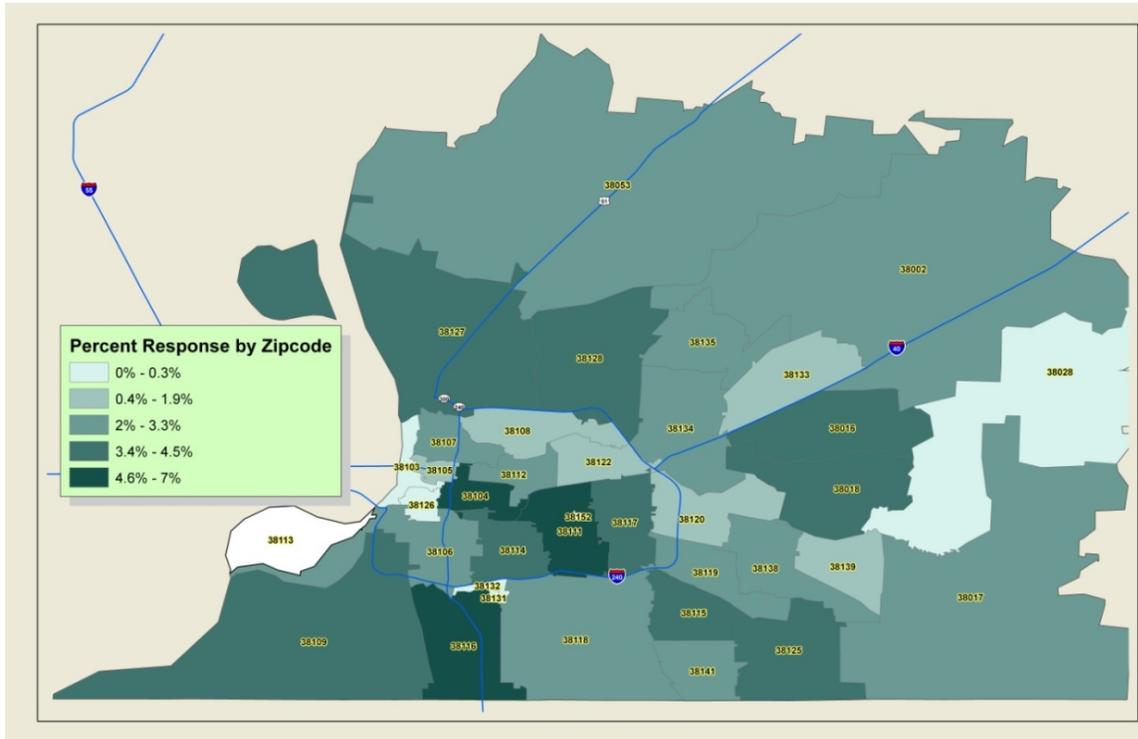
SURVEY SAMPLE

The sample for this survey was a *convenience sample*. It was determined by the CTSA Working Group that, given available resources (staff, time, money), the best approach would be to rely on partner networks to disseminate the online and in-person survey. The survey was open from June through September 2013, resulting in 1,536 responses (911 online; 625 in-person).

¹ <http://chna22.org/wp-content/uploads/2013/06/Community-Health-Assessment-for-Population-Health-Improvement.pdf>

RESPONDENTS' ZIP CODE

All respondents were asked to provide their zip code. Overall, responder location distribution covered most parts of the county. Notable exceptions included 38126, 38103, and 38028. Zip codes with highest percentages of responders included 38104, 38116, and 38111.



PART I: DEMOGRAPHICS

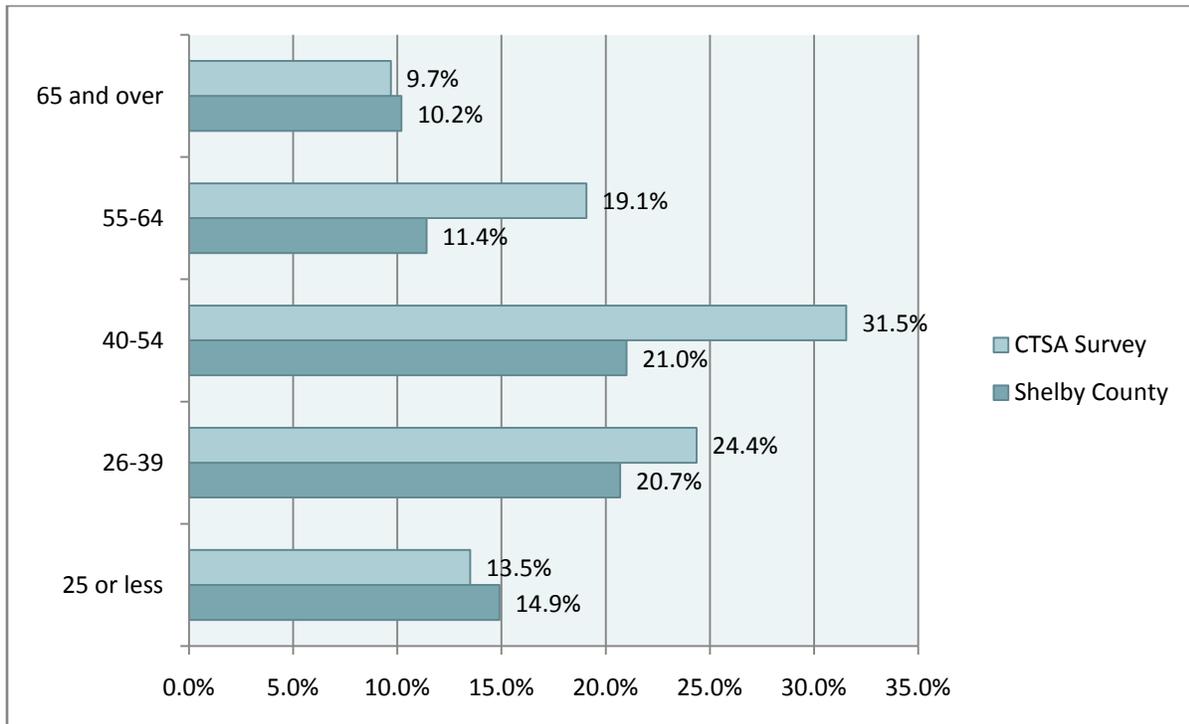
INTRODUCTION

Basic demographic questions were asked of all survey respondents. Some sections were asked in the online survey only (indicated by an asterisk “*”). In the appropriate sections, survey respondents are compared against overall 2010 Shelby County census counts of demographic profiles.

AGE

Age categories captured in the Community Themes and Strengths (CTSA) survey were relatively close to actual age distributions for Shelby County. The largest difference was in the 40 to 54 age group where the CTSA survey overrepresented this group by about 10 percentage points.

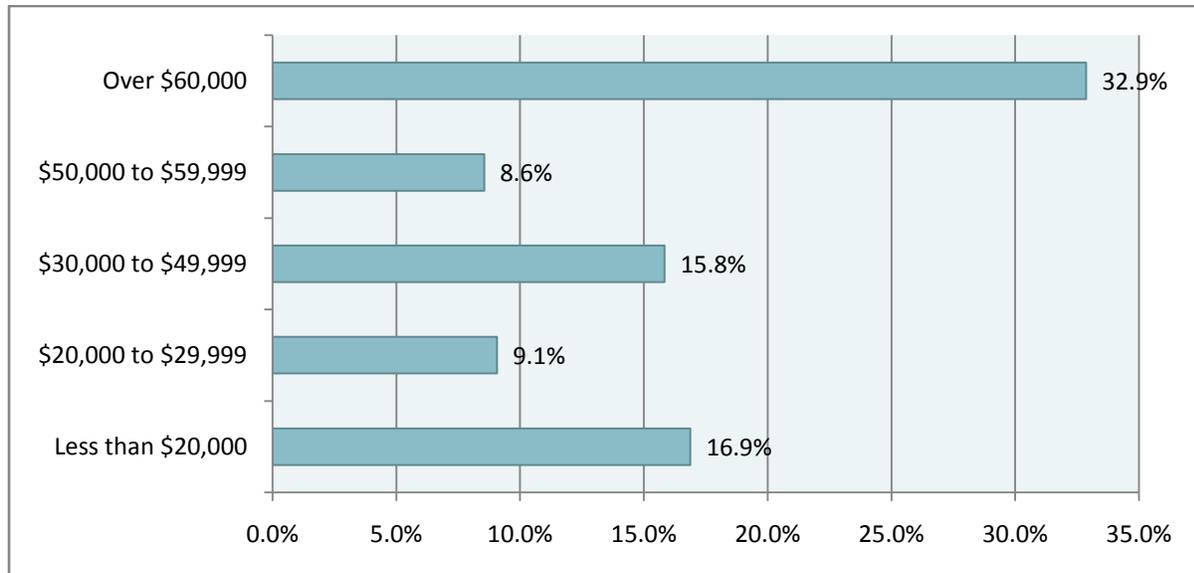
Figure 1. Age Groupings



INCOME

The American Community Survey does not collect household income in the same categories collected in the CTSA survey so direct comparisons are not possible. However, based on ACS breakdowns, the CTSA survey captured roughly similar income categories found distributed in Shelby County.

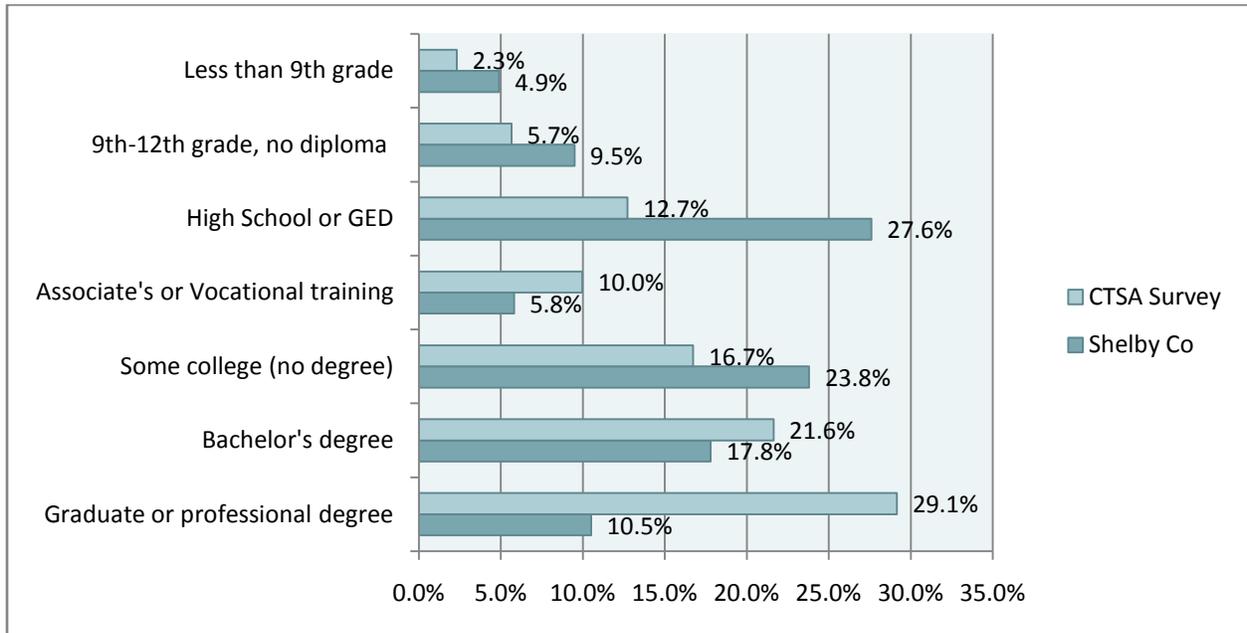
Figure 2. Household income



EDUCATION LEVEL

The CTSA survey overrepresented the population that was college educated and above in Shelby County. In particular, those with a high school diploma only or lower were underrepresented in the CTSA survey.

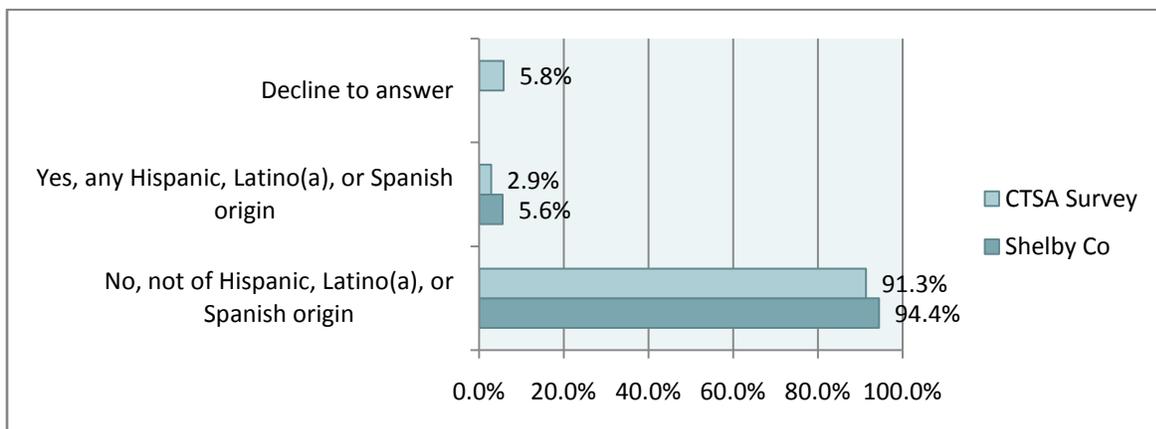
Figure 3. Education level



RACE/ETHNICITY

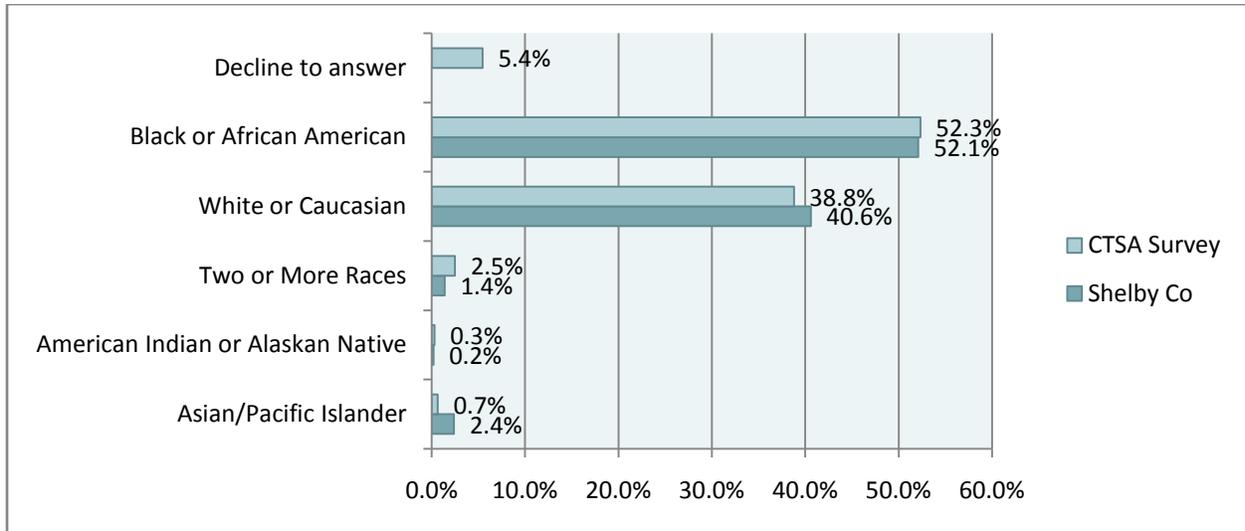
The CTSA underrepresented individuals with Hispanic or Latino(a) origin, but gained some respondents through work in translating the survey into Spanish.

Figure 4. Hispanic/Latino(a) origin



The overall racial breakdown from the CTSA survey compared closely to that of Shelby County residents. The Asian and Pacific Islander community was slightly underrepresented in the CTSA survey.

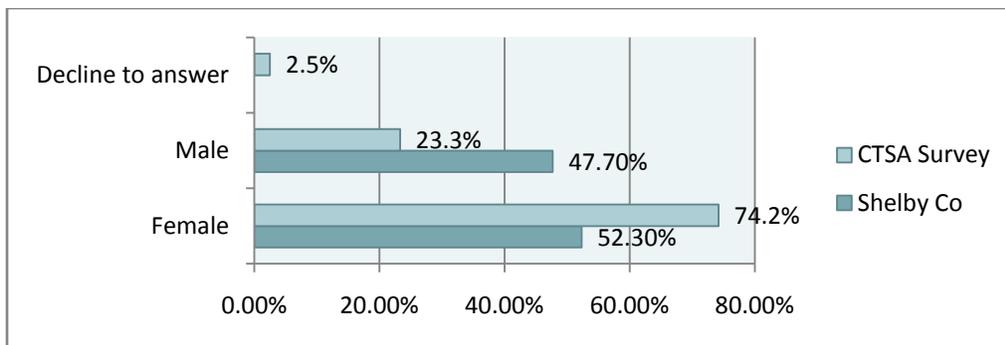
Figure 5. Race



SEX

Only 23% of survey respondents were male. In future assessments, more targeted efforts could be undertaken to ensure higher participation from males in Shelby County.

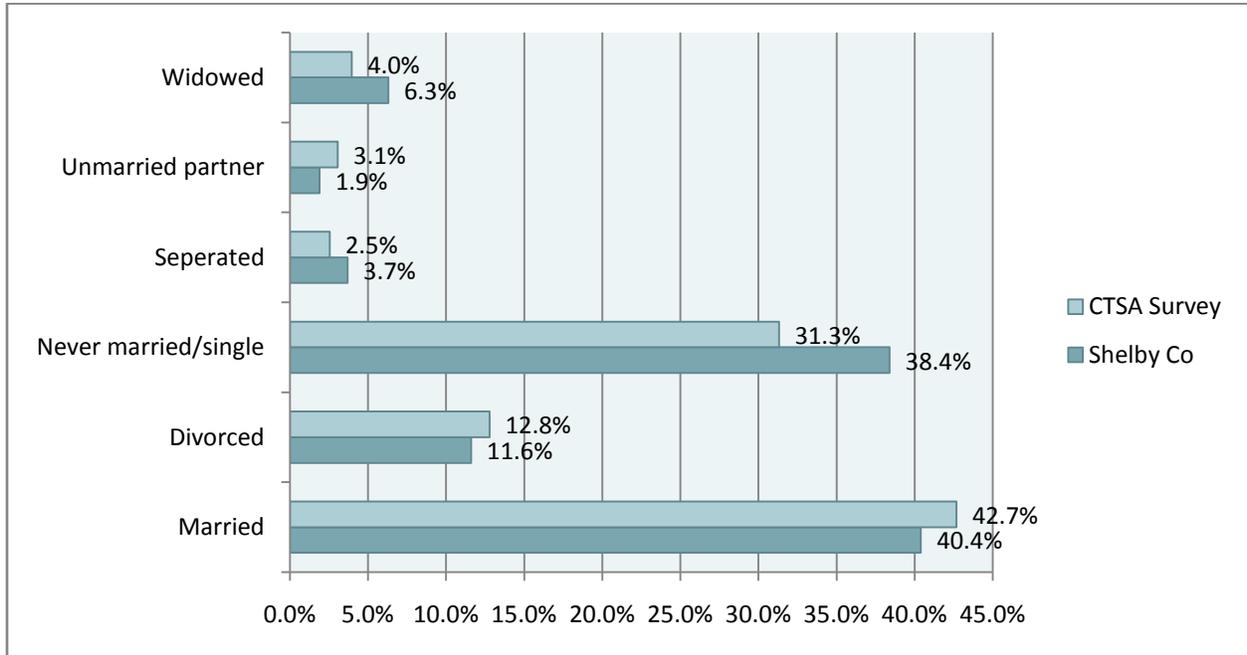
Figure 6. Sex



MARITAL STATUS

The breakdown of marital status among CTSA responses closely matches the breakdown found in Shelby County.

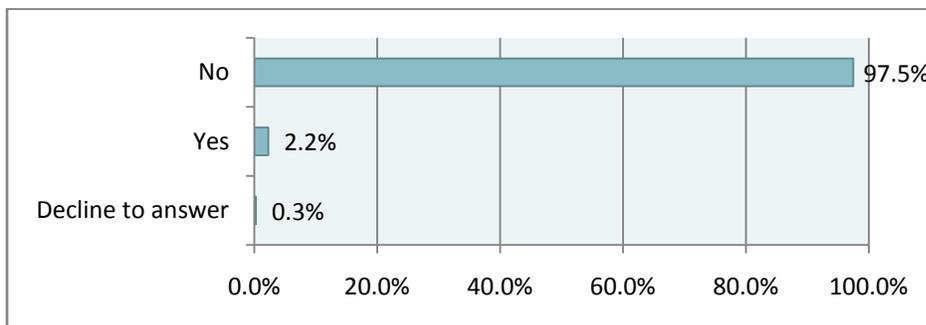
Figure 7. Marital Status



*LIVING WITH A PHYSICAL, MENTAL OR EMOTIONAL DISABILITY

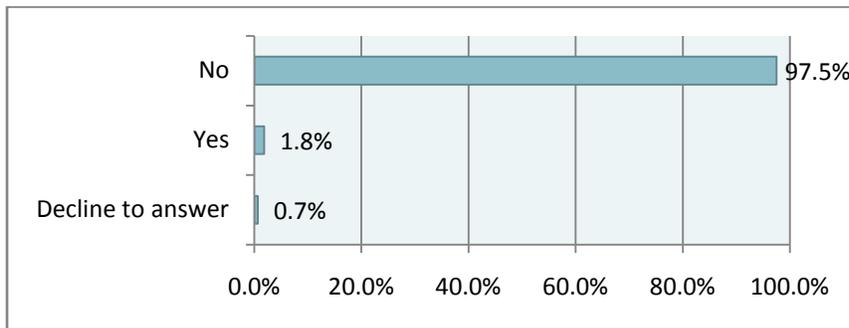
Participants in the online survey were asked a series of questions about living with a physical, mental or emotional disability. Around 2% of respondents indicated they were deaf or had serious difficulty hearing.

Figure 8. Deaf or serious difficulty hearing



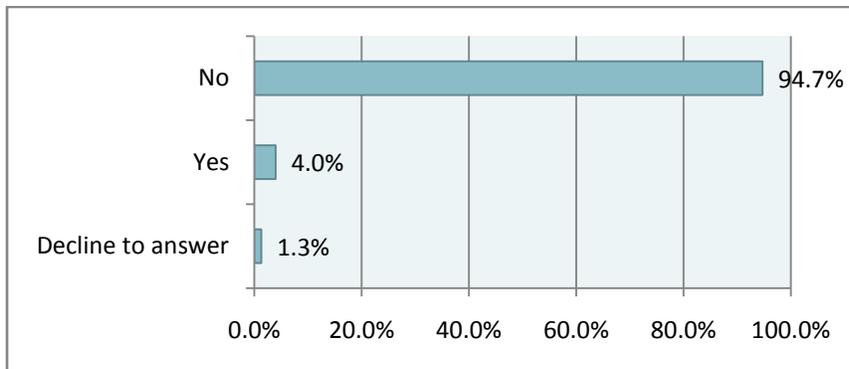
Close to 2% of respondents stated they were blind or had serious difficulty seeing even with glasses.

Figure 9. Blind or serious difficulty seeing



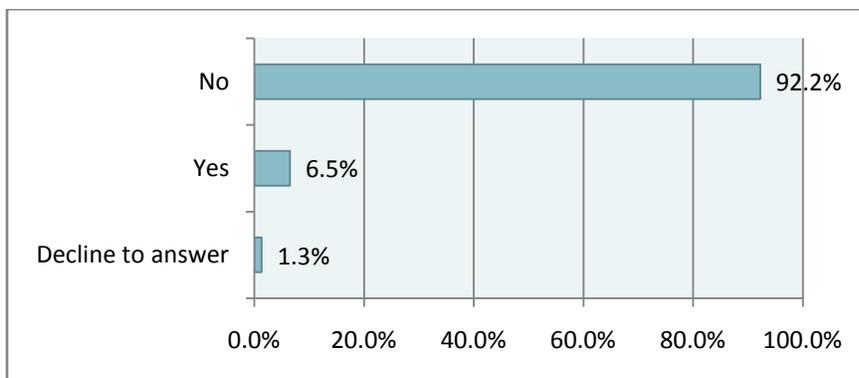
Four percent of respondents indicated they had serious difficulty concentrating, remembering, or making decisions due to a physical, mental, or emotional condition.

Figure 10. Difficulty concentrating, remembering, or making decisions



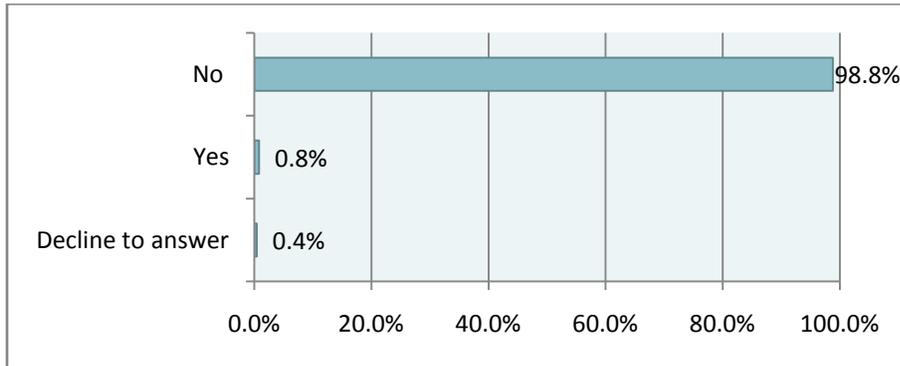
Almost 7% of responders indicated they had difficulty walking or climbing the stairs.

Figure 11. Difficulty walking or climbing stairs



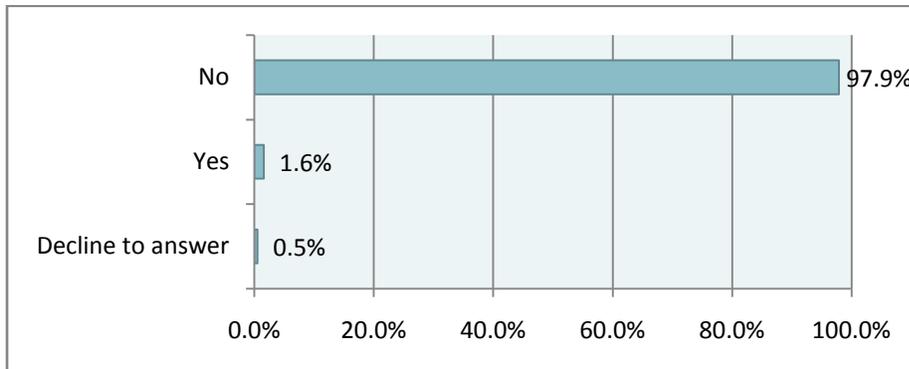
Less than 1% of respondents indicated that they had difficulty bathing or dressing.

Figure 12. Difficulty dressing or bathing



About 1.5% of respondents indicated they had difficulty doing errands alone (e.g. visiting a doctor’s office or shopping) due to a physical, mental, or emotional condition.

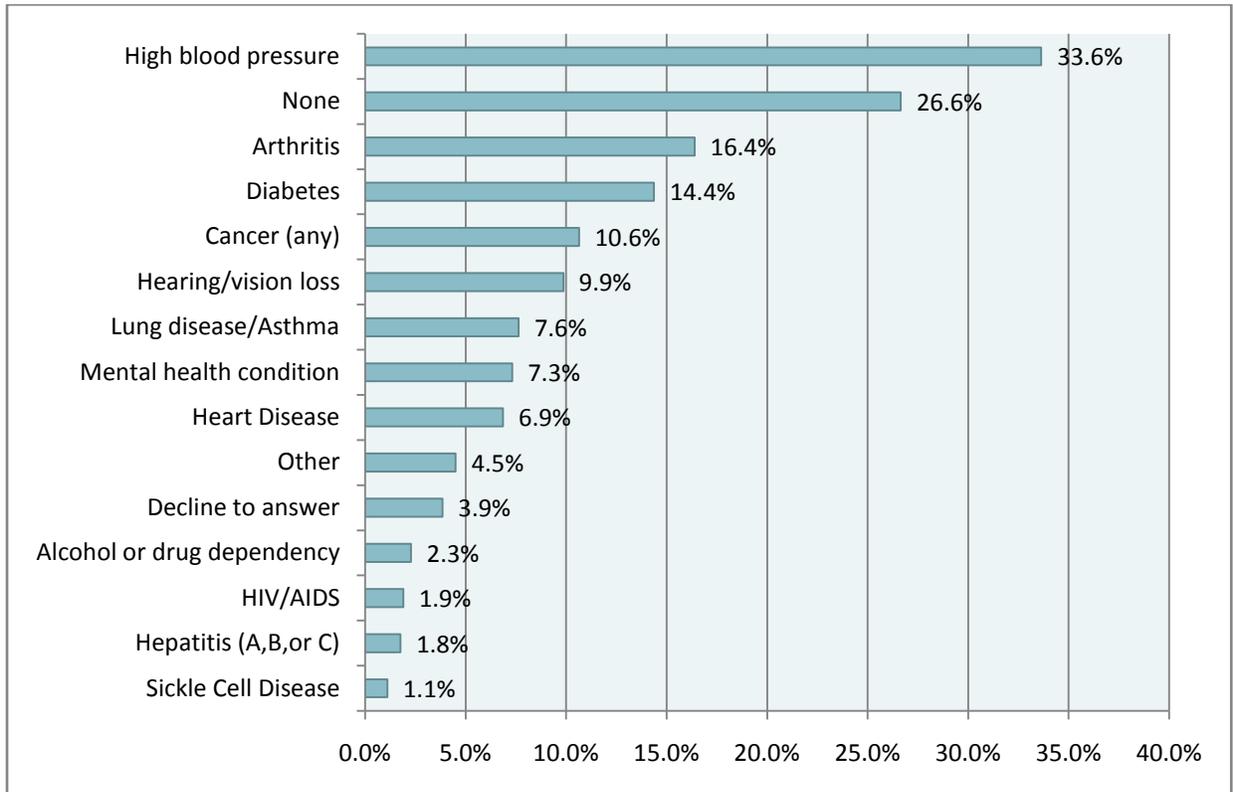
Figure 13. Difficulty doing errands



HEALTH OUTCOMES

All survey respondents were asked if they or anyone in their households had been told by a medical professional that they had specific conditions. The most commonly selected health outcomes included high blood pressure, arthritis, diabetes, and cancer. Close to 27% of respondents indicated that no one in their household had been told he or she had any of these conditions.

Figure 14. Health outcomes



PART 2: QUALITY OF LIFE STATEMENTS

INTRODUCTION

This section gathered information regarding perception of the general well-being of the community. This data provides background to both strengths and challenges for Shelby County. The scoring table was as follows:

Level of Agreement	Score
Strongly agree	1
Agree	2
Neutral	3
Disagree	4
Strongly disagree	5

RESULTS

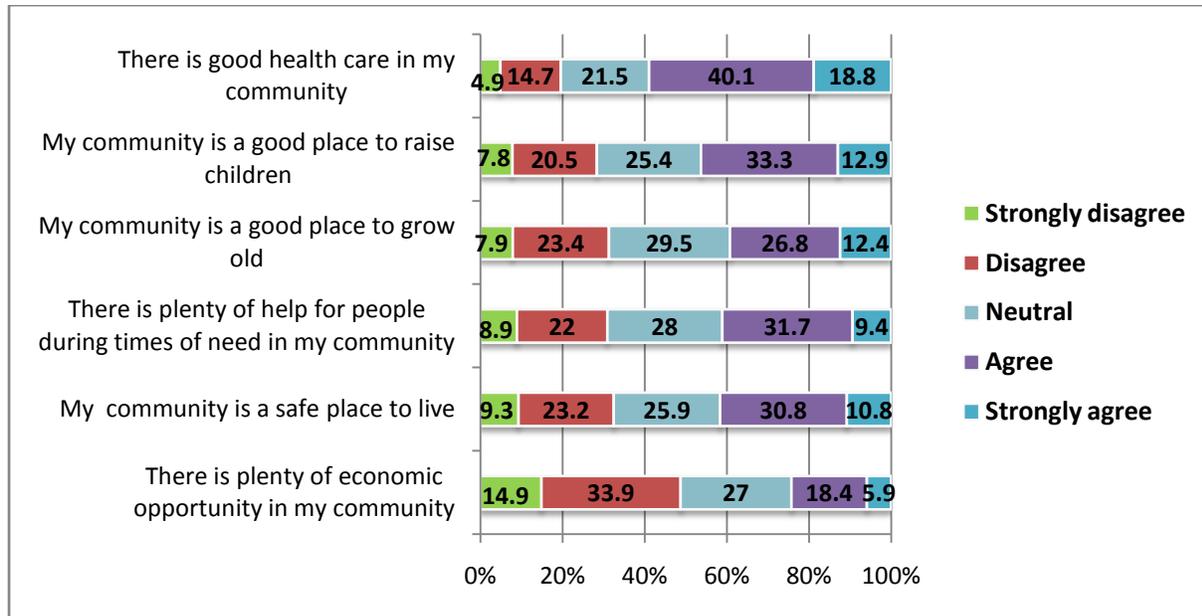
According to the above scoring system, the total score possible for each statement ranged from 1 to 5 points. Lower scores indicated a higher level of agreement; higher scores indicated a lower level of agreement. Overall, level of agreement for each statement ranged from “Agree” to “Neutral”. “There is good health care in my community” garnered the highest level of agreement from respondents, while “there is plenty of economic opportunity in my community” registered the lowest level of agreement overall.

Figure 16. Quality of Life Average Scores



Figure 2 provides a more detailed breakdown of the level of agreement with the Quality of Life Statements. The exact percentage is labeled within the figure below.

Figure 17. Quality of Life Percentage Breakdown



DISCUSSION

Part I of the Community Themes and Strengths Assessment (CTSA) Survey points to areas of strengths and challenges, overall, in terms of perceived Quality of Life in Shelby County. As for strengths, close to 60% of responders strongly agreed or agreed that their community has “good health care”. Forty-six percent agreed or strongly agreed that their community was a “good place to raise children”.

The Quality of Life scale also presented challenge areas for Shelby County communities. Close to half of all responders disagreed or strongly disagreed that there was “plenty of economic opportunity” in their community. Roughly one third of all responders disagreed or strongly disagreed that their community is a “safe place to live” and that there is “plenty of help for people during times of need”.

Both safety and economic opportunity represent important social determinants of health for a community. For example, concerns about neighborhood safety may impact a parent’s decision of whether or not to let his or her child play outside and engage in physical activity – a positive behavior for health. An individual concerned about job opportunities and financial stability could increase his or her level of stress and anxiety, leading to poor health outcomes.

The above data provides an opportunity to capitalize on the existence of good health care in Shelby County and a relatively high perception about the community as a place to raise children to impact community health. Further exploration of this data based on demographic characteristics and geographic location will come later.

PART 3: HEALTH OUTCOMES

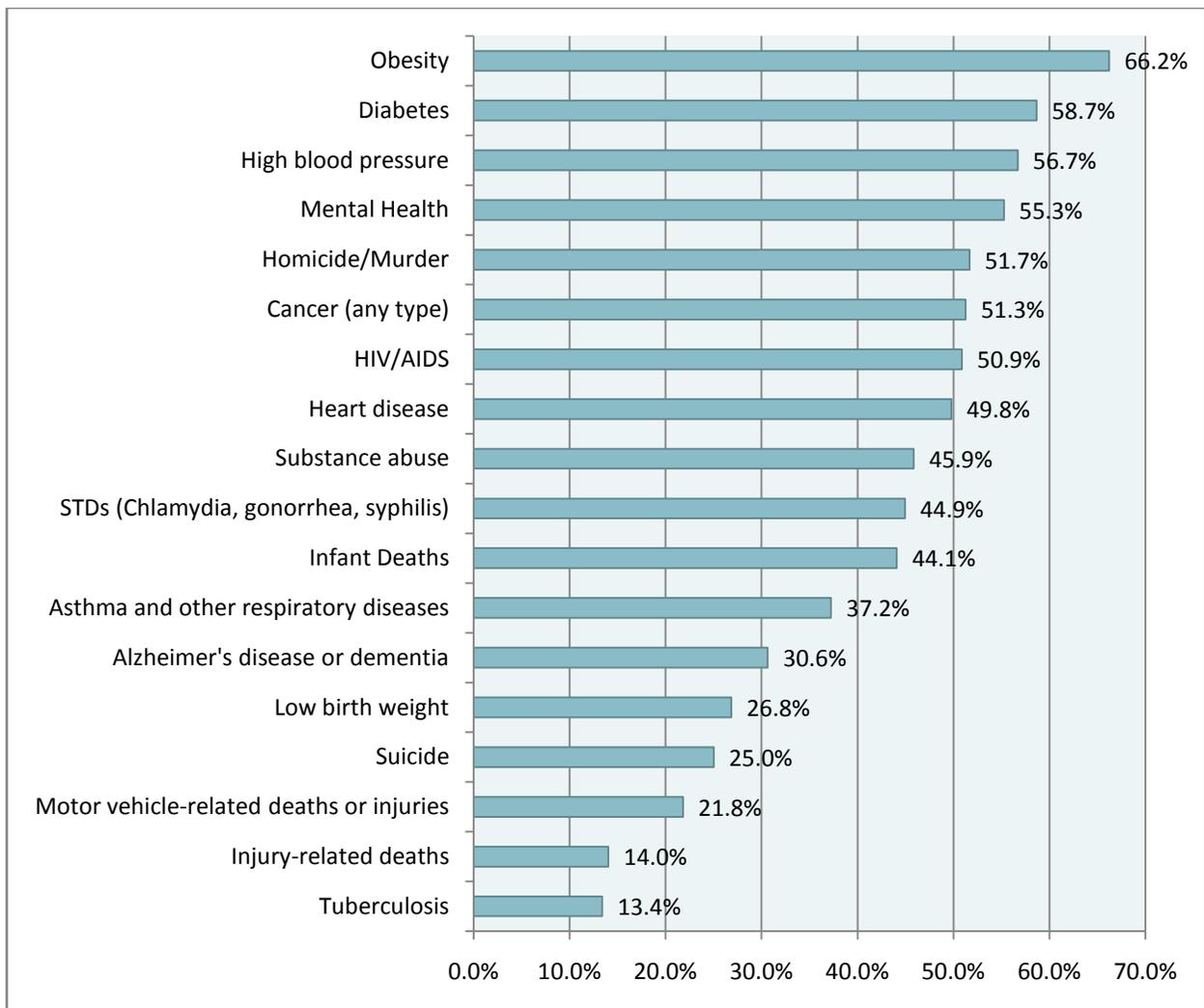
INTRODUCTION

The following section asked respondents to select issues that required the most attention from a list of 18 health issues. Respondents were able to select as many of those health issues as needed.

RESULTS

Sixty-six percent of responders identified “Obesity” as a health issue requiring the most attention in their community. Diabetes (59%), High blood pressure (57%), Mental Health (55%), and Homicide (52%) rounded out the top five most commonly chosen health issues among all responders.

Figure 18. Health Issues



*PART 4: CHILD HEALTH INFORMATION

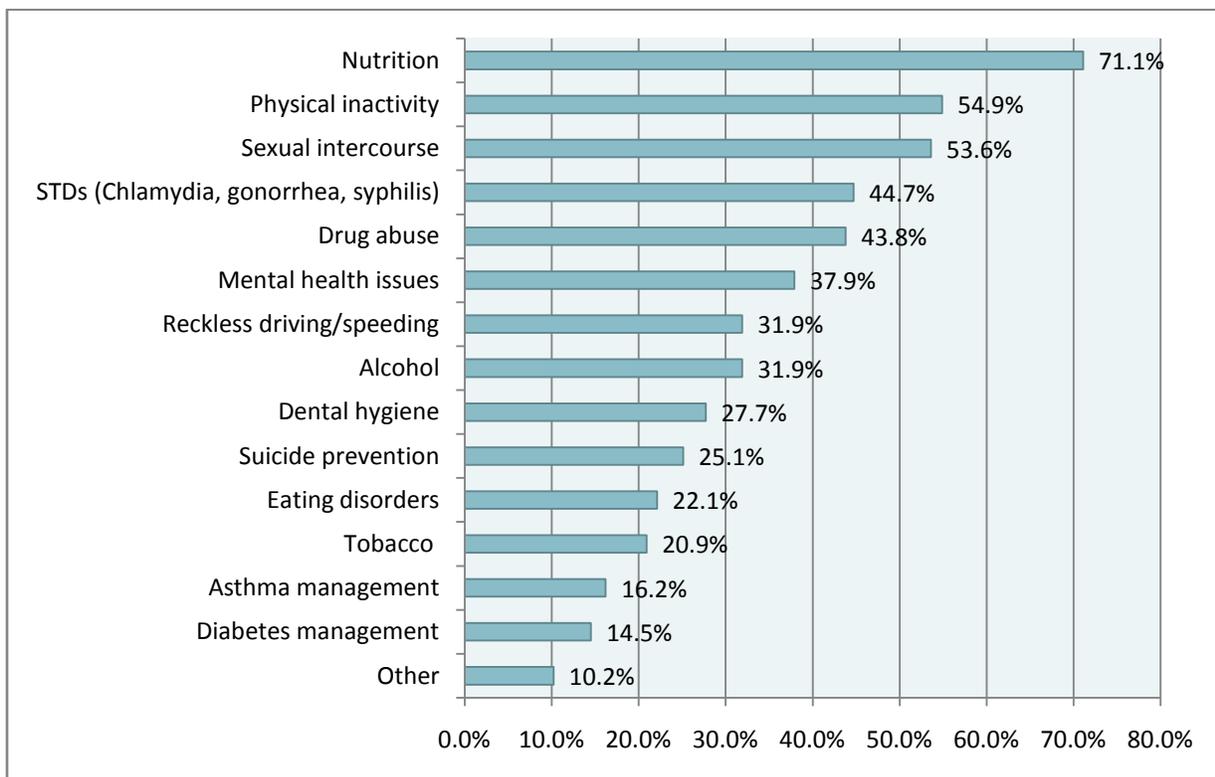
INTRODUCTION

The following section applied to those responders who identified themselves as caretakers for at least one child between the ages of 9 and 19 years old. Of the online survey responders, 28% identified themselves as caretaker of a child.

RESULTS

Those who identified themselves as a caretaker of a 9 to 19 year old child were asked to select among 14 health issues they felt their child needed more information about. By a large margin, Nutrition (71%) was the most frequently chosen health topic caregivers felt their children needed to know more information about. Physical inactivity (55%), sexual intercourse (54%), STDs (45%), and drug abuse (44%) rounded out the top five most frequently chosen health topics.

Figure 19. Child Health Topics



*PART 5: PERSONAL BEHAVIORS

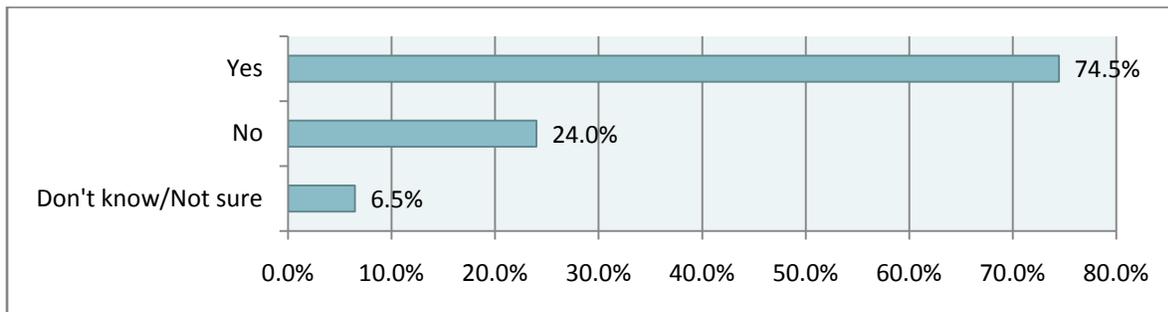
INTRODUCTION

The following section queried respondents about their own personal habits and health activities. This section was presented in the online survey only.

PHYSICAL ACTIVITY

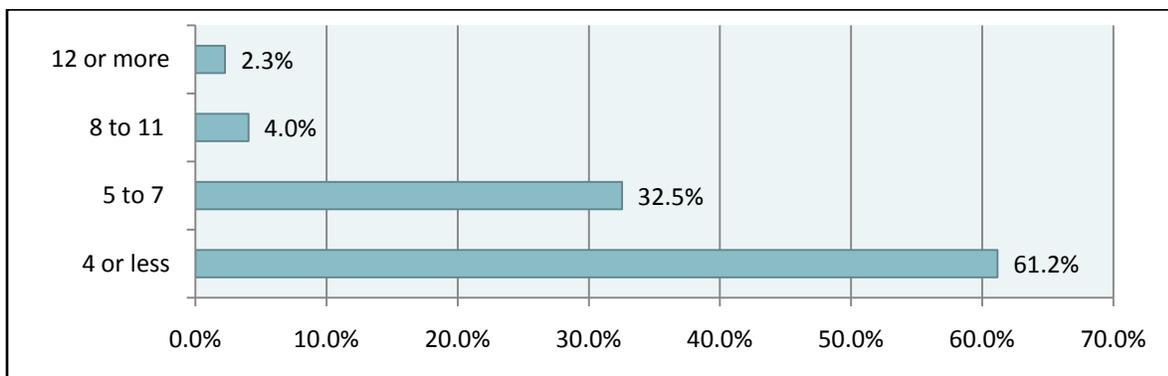
Participants were asked whether they engaged in physical activity or exercise outside of their normal job that lasts at least 30 minutes. Close to 75% of online survey responders engaged in some form of physical activity outside of their normal job, just fewer than 25% did not, and 6.5% were unsure.

Figure 20. Engage in Physical Activity



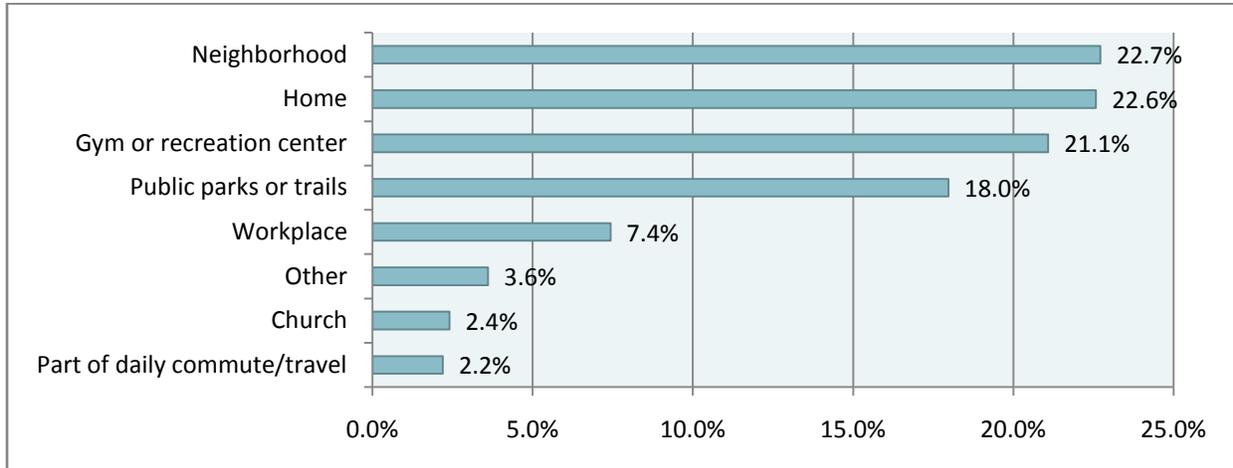
Specific follow-up questions were presented to those who did and did not engage in physical activity for at least 30 minutes during a normal week. For those that did engage in physical activity, respondents were asked to estimate how many times during a normal week they engage in at least 30 minutes of physical activity outside of work. Of those that participated in activity outside of work, over half did not meet the CDC Guidelines of at least 150 minutes of physical activity during a week.

Figure 21. Time engaged in physical activity during a normal week



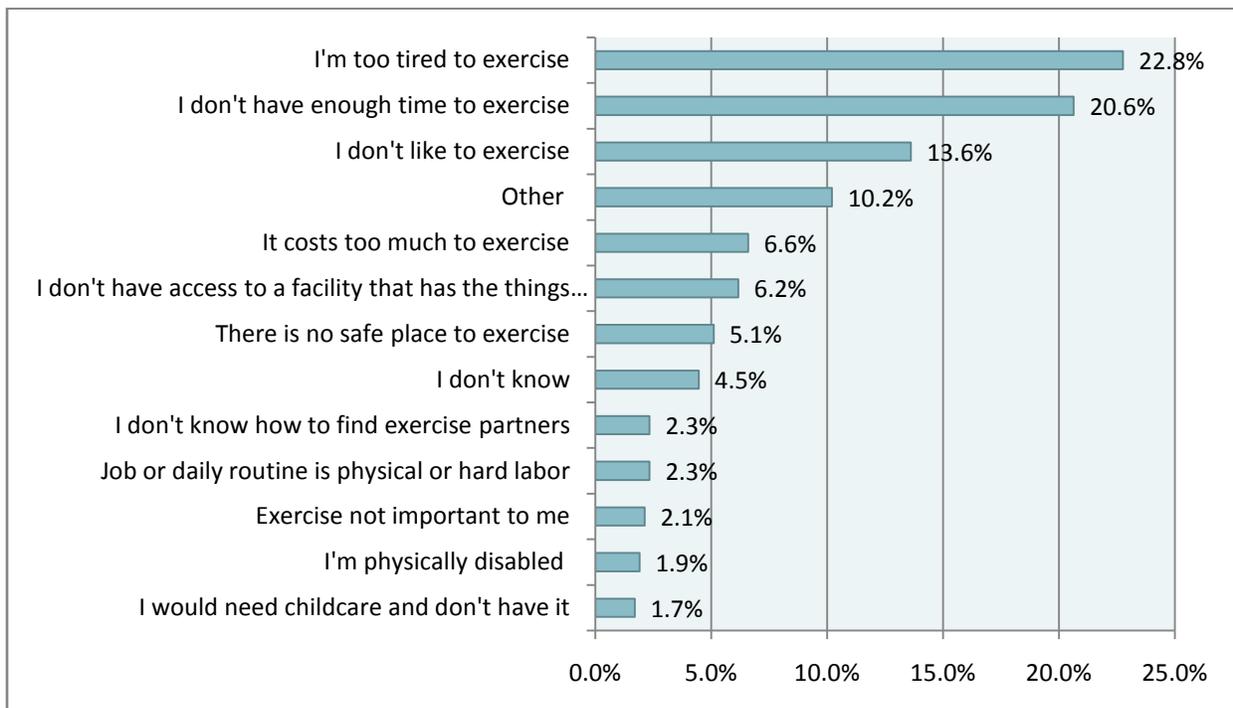
Participants who engaged in physical activity were then asked to identify where they typically participated in physical activity. The most common areas chosen were neighborhood, home, gym/recreation center, and public parks/trails.

Figure 22. Location of engagement in physical activity/exercise



Those individuals indicating they did not engage in physical activity for 30 minutes outside of work at least once a week were asked to indicate top reasons they did not participate in physical activity. The top reasons identified were being too tired to exercise, not having enough time, and not liking to exercise.

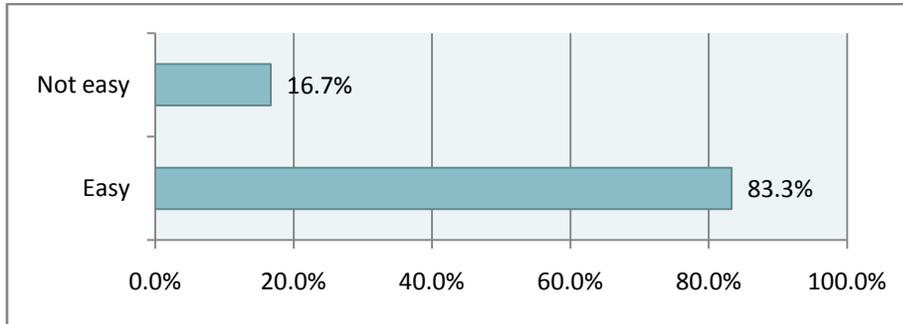
Figure 23. Reasons not engaged in physical activity



ACCESS TO FRESH FOODS

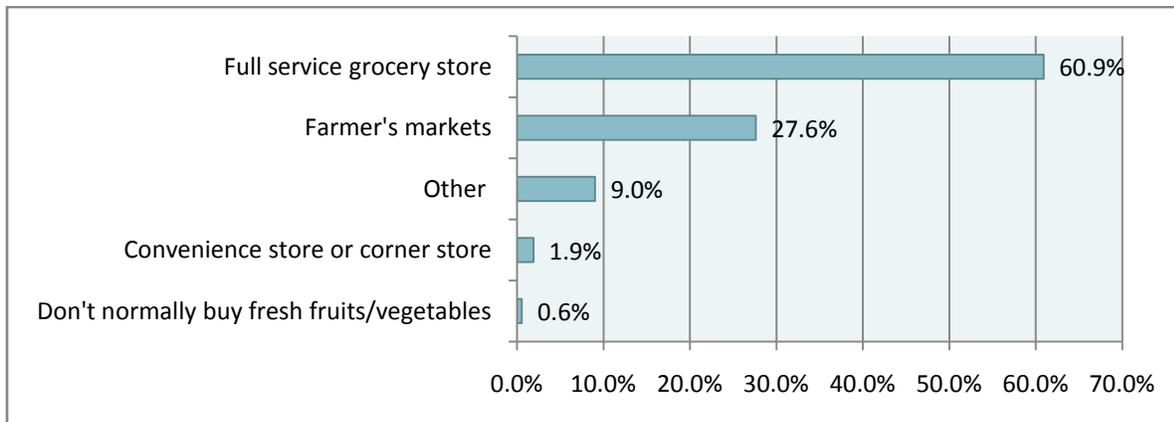
In the following subsection of Personal Behaviors, respondents were asked about access to and personal consumption of fresh foods. Overall, 83% of online survey respondents indicated that access to affordable fresh fruits and vegetables in the area where they live was “easy.”

Figure 24. Access to fresh foods



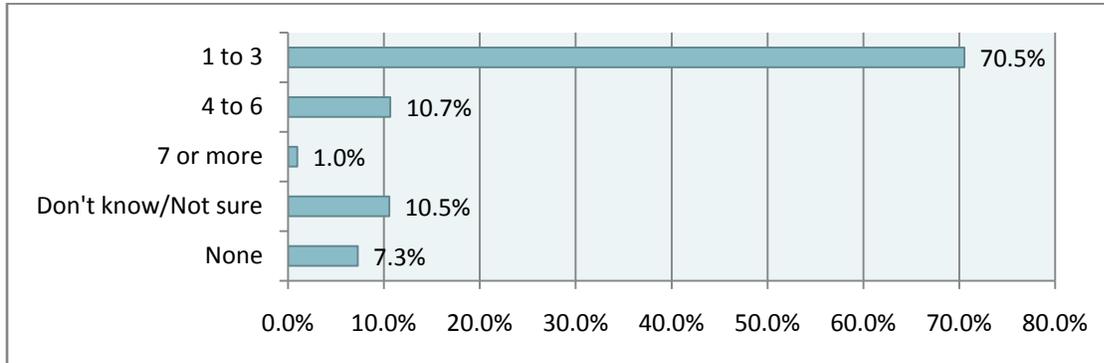
Respondents were also asked to identify where they usually purchase fresh fruits and vegetables. A majority of respondents, 61%, purchased food at a full service grocery store (e.g. Kroger). Only 2% of respondents identified convenience or corner stores as a location for fresh fruits and vegetables. Responses in the “other” category included Easy Way, personal or community garden, and Community Support Agriculture (CSA).

Figure 25. Purchase location for fresh foods



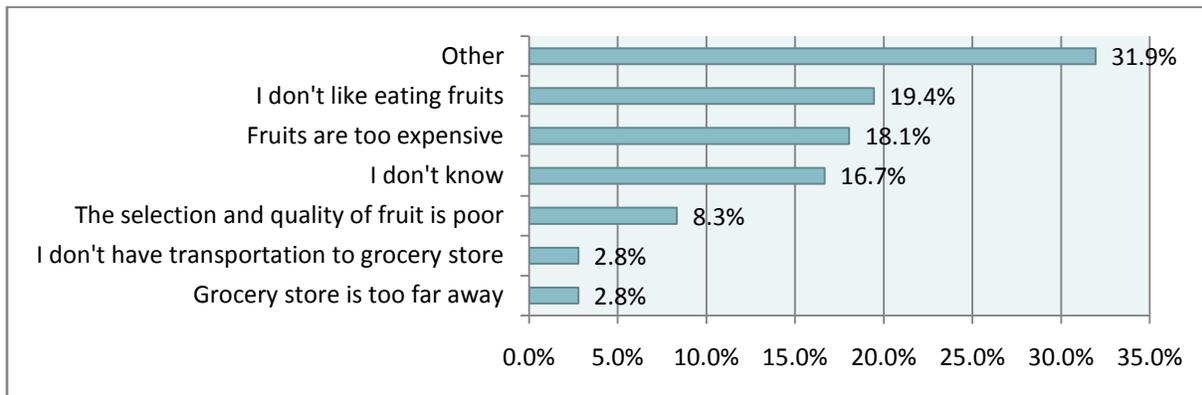
In the subsequent subsections, respondents were asked to provide information on the amount of fresh fruits and vegetables they consumed during a normal day. Seventy percent of respondents reported eating at least one cup of fruit in a typical day.

Figure 26. Cups of fruit in a day



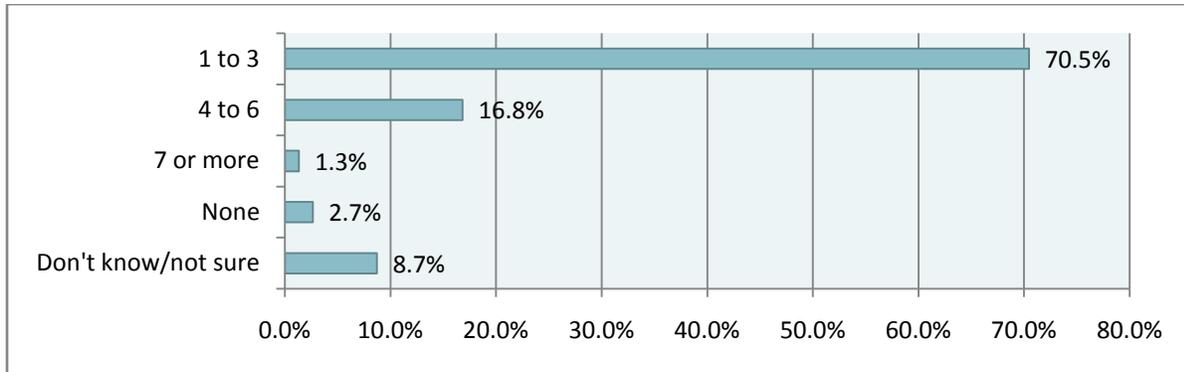
Those respondents indicating they did not eat any fruit in a typical day were asked to select reasons for not eating fruits. Aside from “Other,” the most commonly chosen reasons included not liking fruits, fruits being too expensive, and unsure. Common other responses included eating fruit (but not daily), fruits not available at work, and dietary restrictions.

Figure 27. Reasons not eating fruit



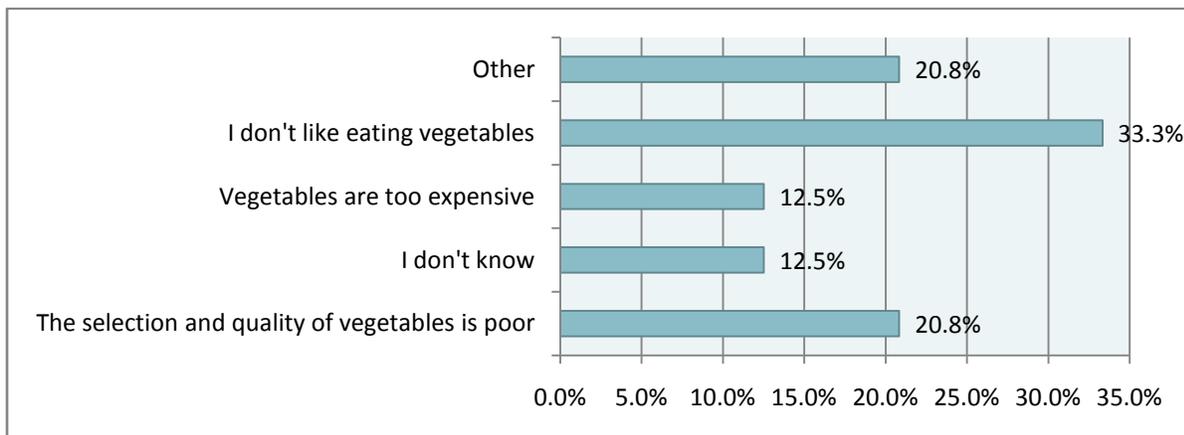
Respondents were questioned similarly about their consumption of vegetables on a typical day. Similar to fruit, 70% of respondents reported eating 1 to 3 cups of fruit a day.

Figure 28. Cups of vegetables in a day



Those respondents indicating they did not eat any vegetables in a typical day were asked to provide some reasons why. Of those providing reasons for why they do not eat vegetables, the top choice was “I don’t like eating vegetables”.

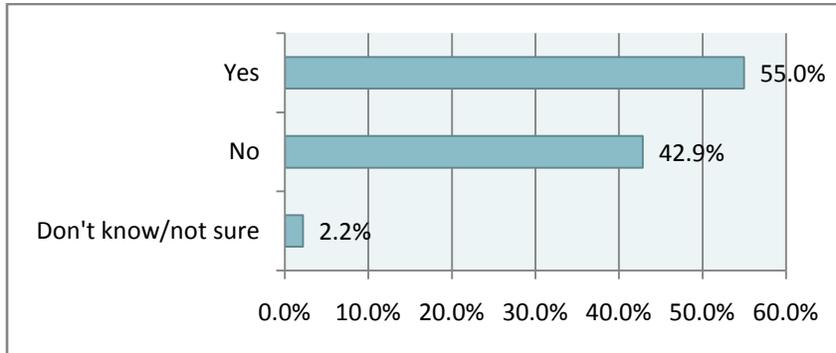
Figure 29. Reasons for not eating vegetables



SECONDHAND SMOKE EXPOSURE

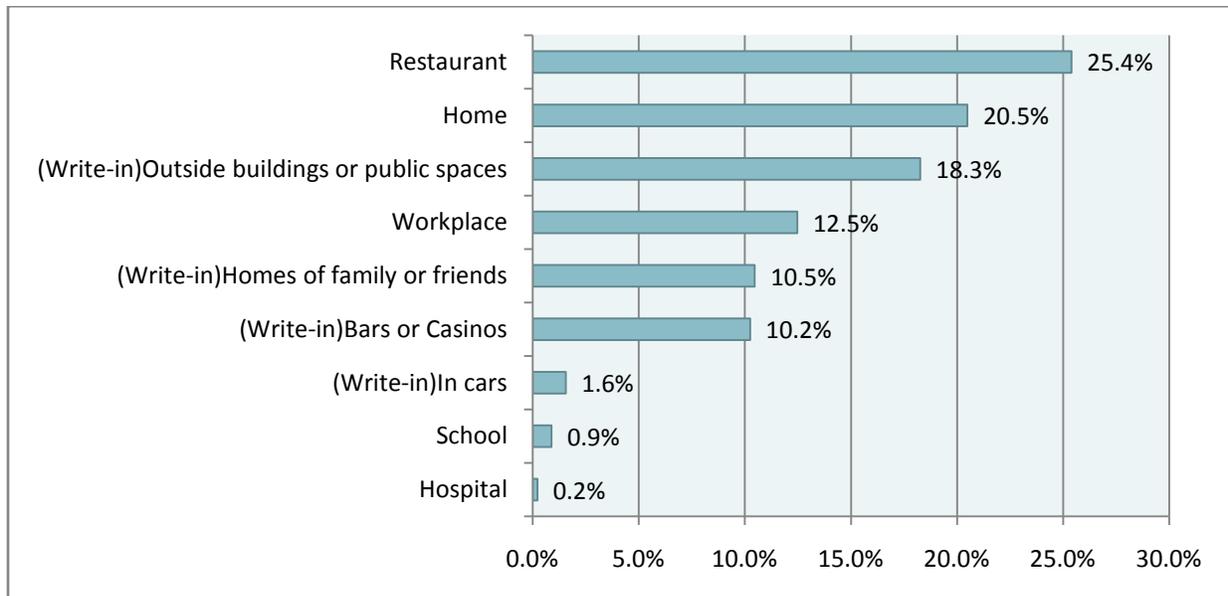
This subsection of Personal Behaviors investigates exposure to secondhand smoke. Respondents were asked if they had been exposed to secondhand smoke at anytime in the past year. Over half of online survey responders reported being exposed to secondhand smoke.

Figure 30. Exposed to secondhand smoke within past year



Those respondents indicating they were exposed to secondhand smoke were then asked to pick a location where they thought they were exposed to secondhand smoke most often. “Other” was the most frequently selected choice at 40.5%. Write-in responses for “Other” are indicated with “(Write-in)” next to location in the chart below. Restaurants, homes, and outside buildings were leading places respondents were exposed to secondhand smoke.

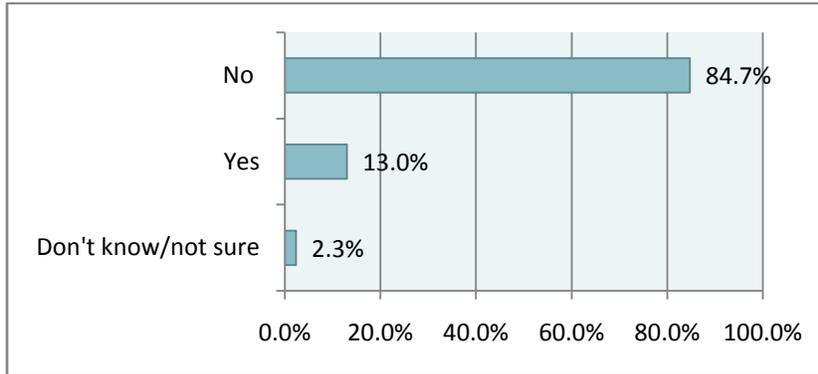
Figure 31. Location of exposure to secondhand smoke



ACCESS TO MENTAL HEALTH CARE

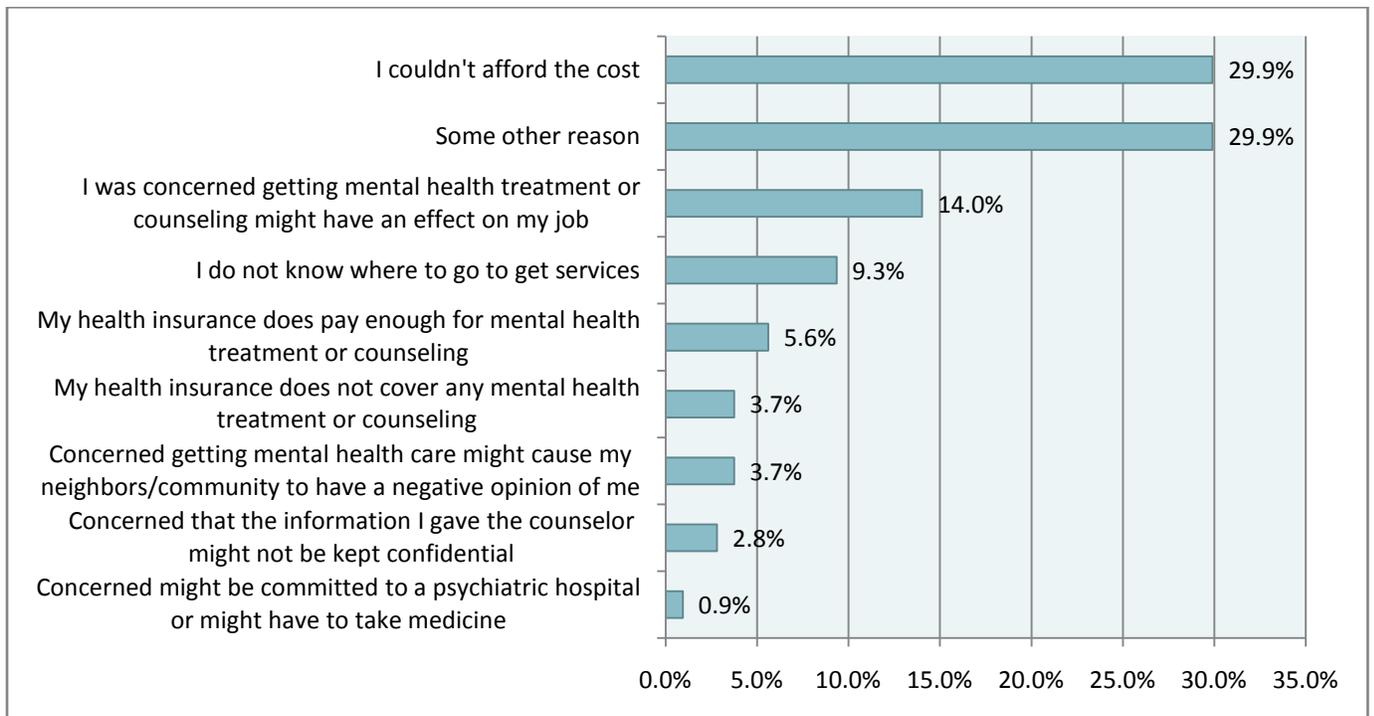
Online survey respondents were asked about their access to mental health treatment or counseling during the past 12 months. Thirteen percent of responders indicated there was a time in the last 12 months when they needed mental health treatment or counseling and did not receive it.

Figure 32. Need mental health care but did not receive



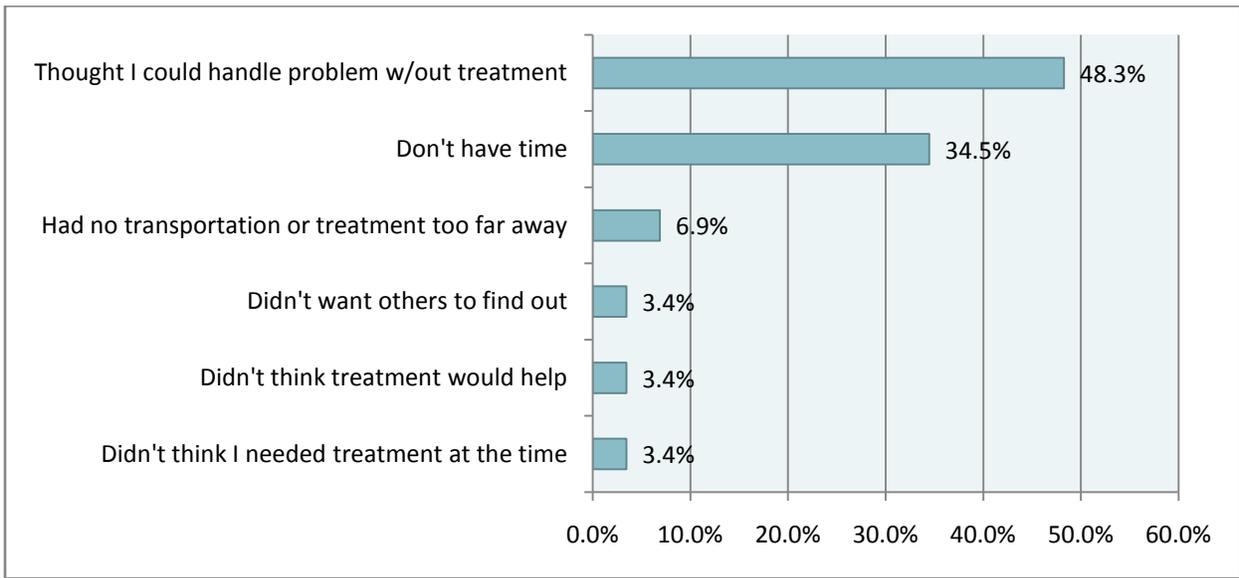
The 13% of responders indicating they did not receive needed mental health treatment or counseling were asked to select reasons for not receiving mental health care.

Figure 33. Reasons for not receiving mental health care



The 30% of respondents selecting “some other reason” were asked a second set of questions about reasons for not receiving mental health care.

Figure 34. Other reasons for not receiving mental health care



PART 6: COMMUNITY RELATED BEHAVIORS

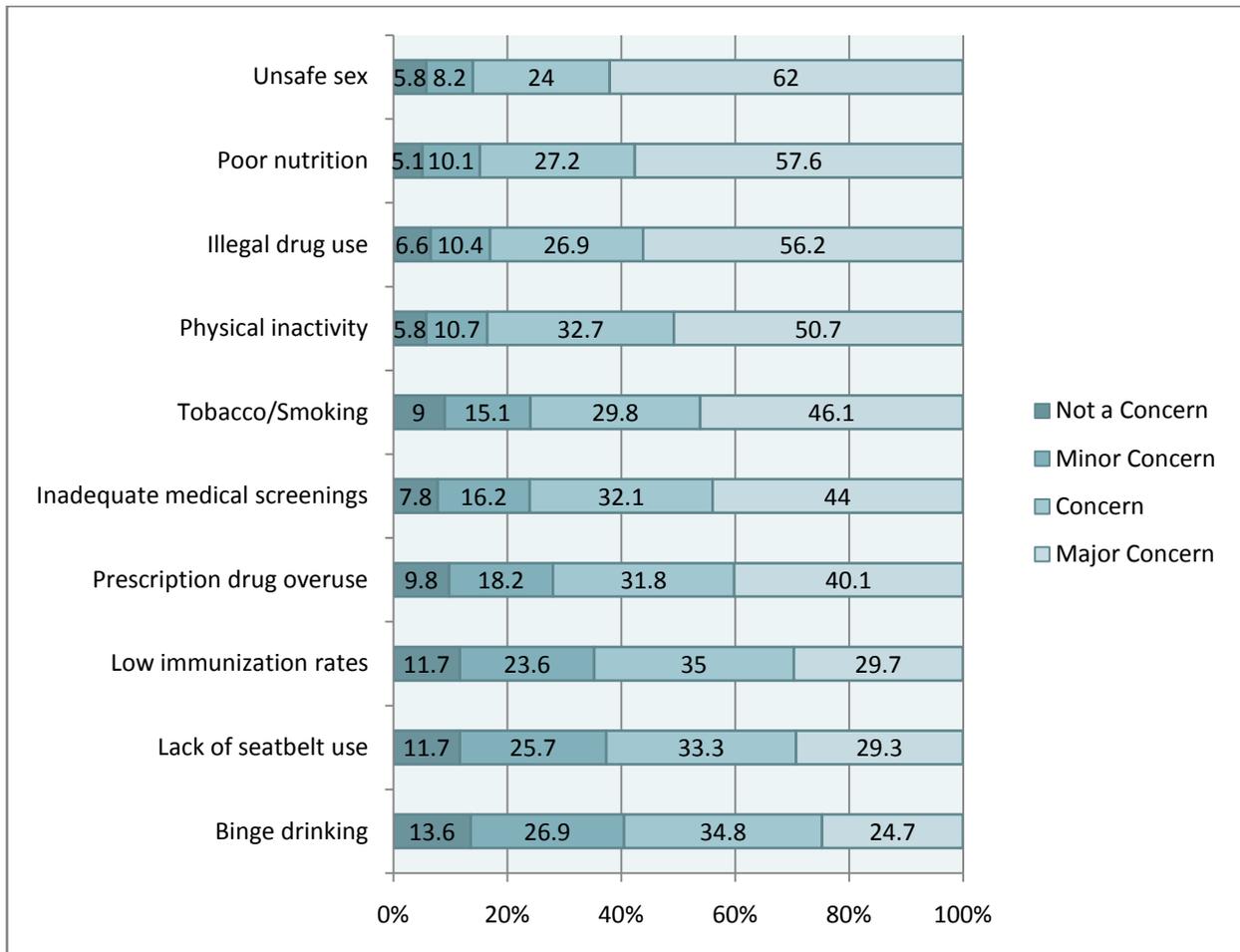
INTRODUCTION

The following section asked respondents to rank their concern level (major concern, concern, minor concern, not a concern) for each of a list of community related behaviors and issues.

RESULTS

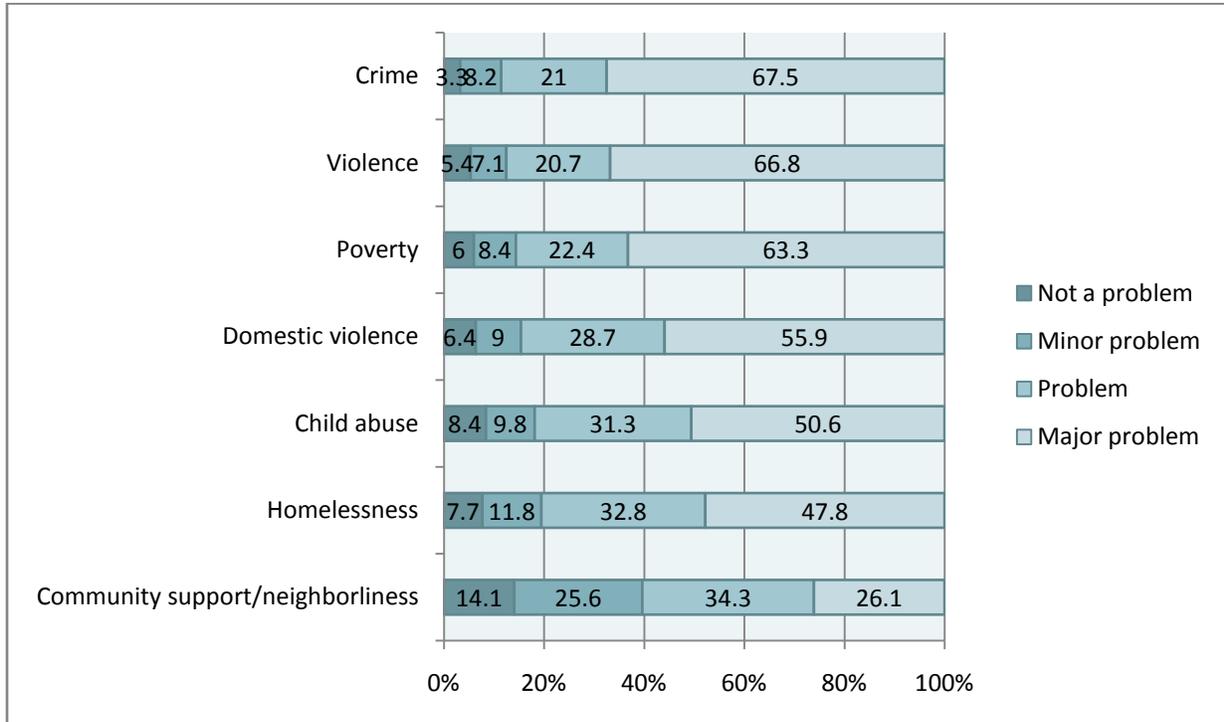
Respondents were first asked to identify how much of a concern they had about specific community related issues. Those issues receiving the most concern included unsafe sex, poor nutrition, illegal drug use, and physical inactivity. Those issues more frequently scoring “not a concern” included binge drinking, lack of seatbelt use, and low immunization rates.

Figure 35. Community related behaviors



Respondents were then asked to rate how much of a problem they saw specific community related issues. Those issues being viewed as a *major problem* included crime, violence, poverty, and domestic violence. The community related issue most frequently viewed as *not a problem* was community support and neighborliness.

Figure 36. Community related issues



*PART 7: PHYSICAL ENVIRONMENT

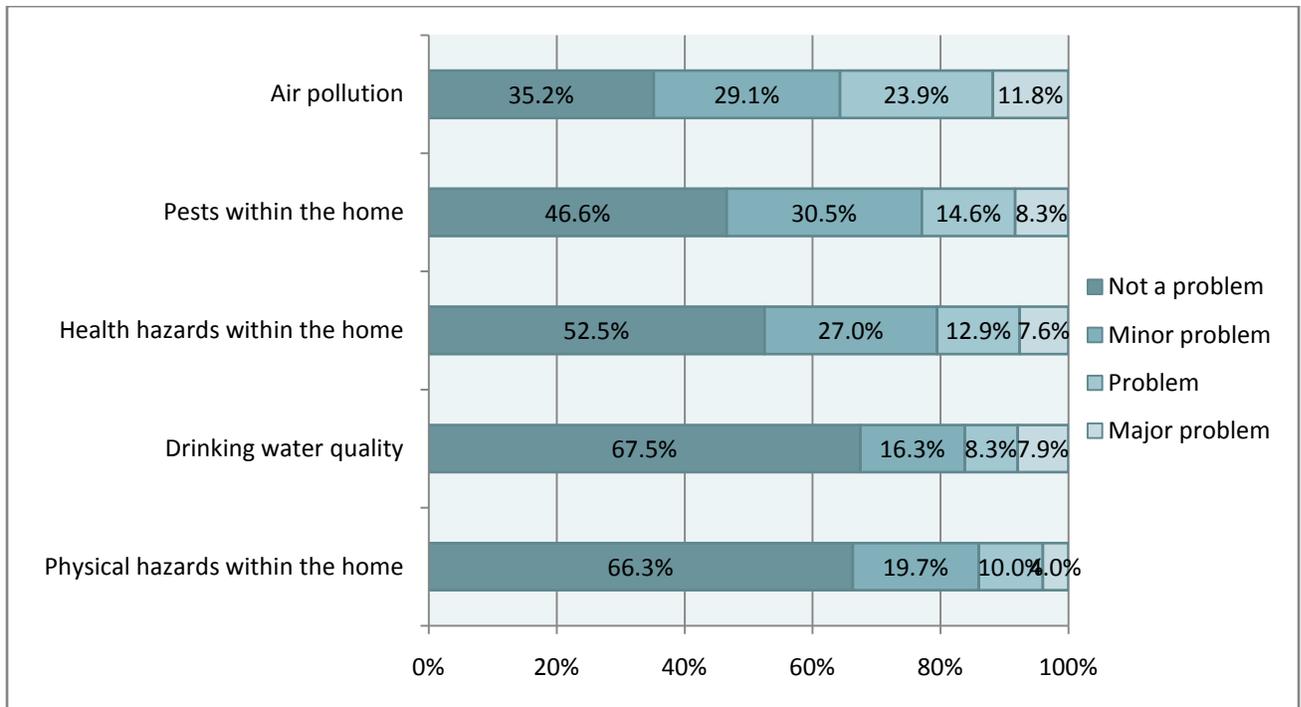
INTRODUCTION

In part six of the online survey, respondents were asked about the physical environment and health of their neighborhood.

HEALTH IN HOME

Participants were asked to rate how much of a problem certain issues were within their home. Air pollution was most frequently ranked as a major problem compared to the other outcomes; physical hazards in the home and drinking water quality were most often ranked as not a problem.

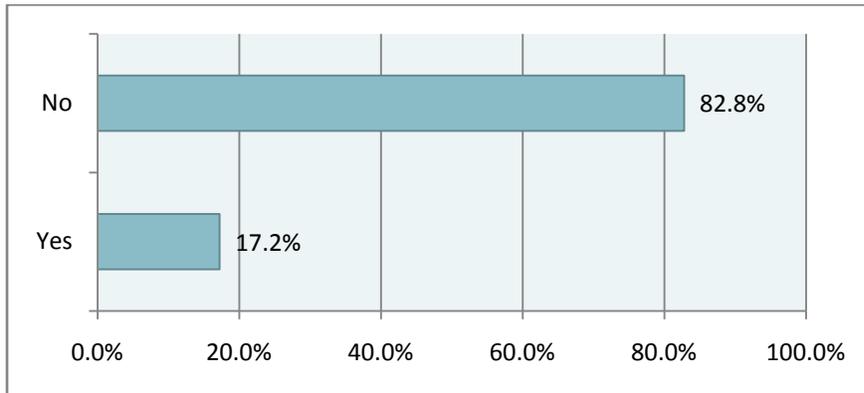
Figure 37. Physical environment problems



PUBLIC TRANSPORTATION

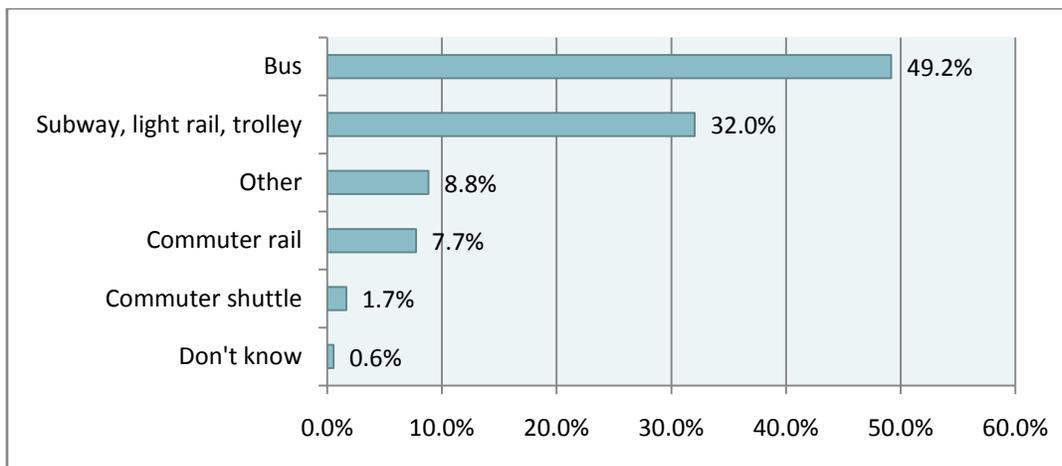
The subsection below asked a series of questions around public transportation use. Of the online survey responders, 17% identified that they or someone in their household ever used public transportation.

Figure 38. Public transportation use



Those participants that had ever used public transportation were asked a follow-up question about the types of public transportation used. Bus was the most frequently identified type of public transit used at 49%.

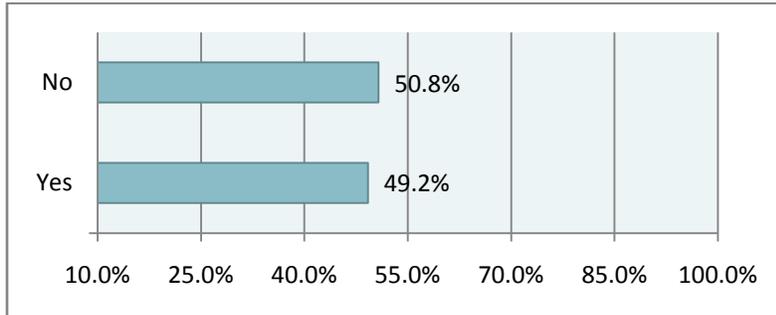
Figure 39. Types of public transit used



WALKING AND BIKING

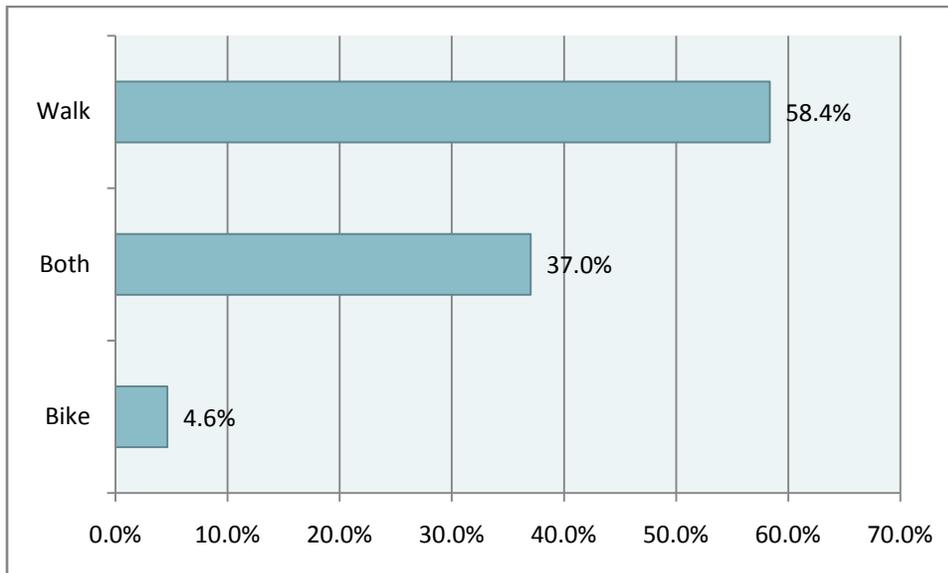
In the next subsection, online survey responders were asked a series of questions about biking and walking in their neighborhood. Close to 50% of responders stated that they either walked or biked either inside or outside of their neighborhood during a typical week.

Figure 40. Walk or bike in a typical week



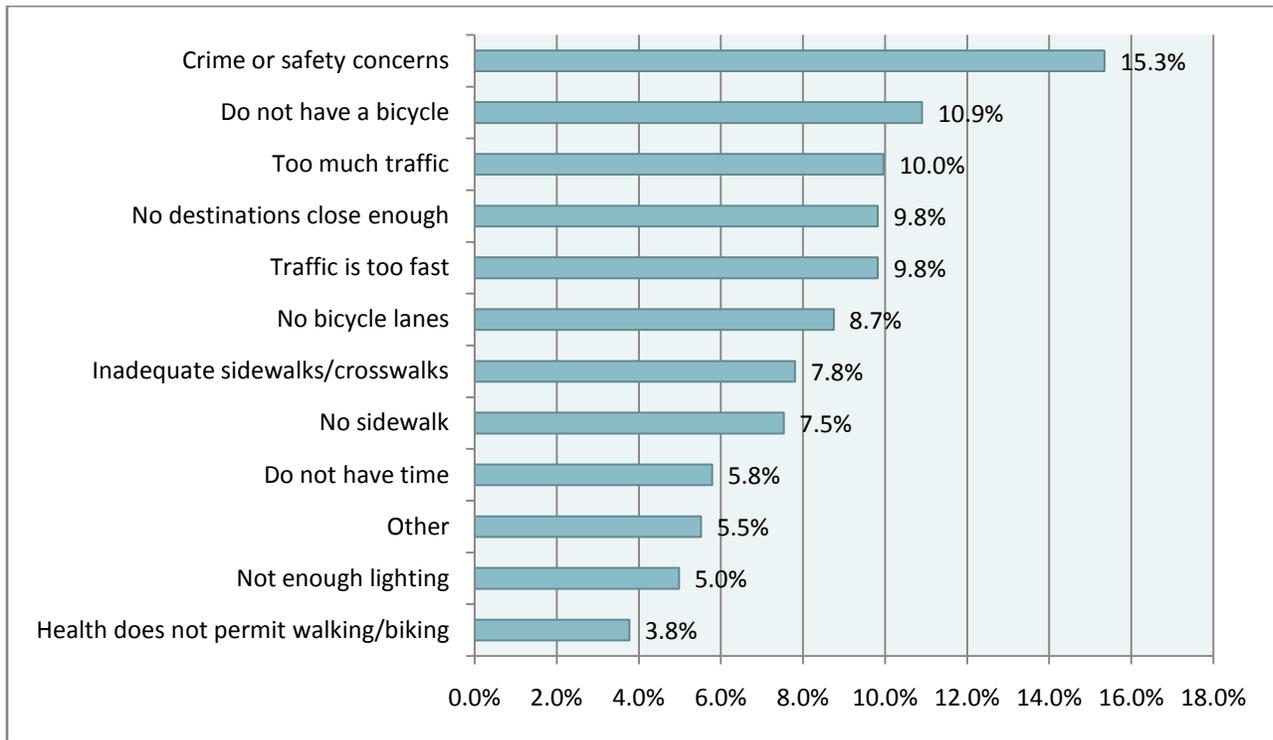
Those close to 50% of responders indicating they walked or bike in a typical week were asked whether they walked or biked or did both in a typical week. Of the responders, a majority, 58% indicated they walked only; around 5% biked only and 37% did both.

Figure 41. Walk, bike, or both in typical week



The 50% of responders stating they did not engage in either biking or walking in their neighborhood were asked a follow-up question to state the reasons that prohibit them from engaging in walking or biking during a typical week. The top 3 commonly selected reasons were: crime or safety concerns, not having a bicycle, and too much traffic.

Figure 42. Reasons not biking or walking



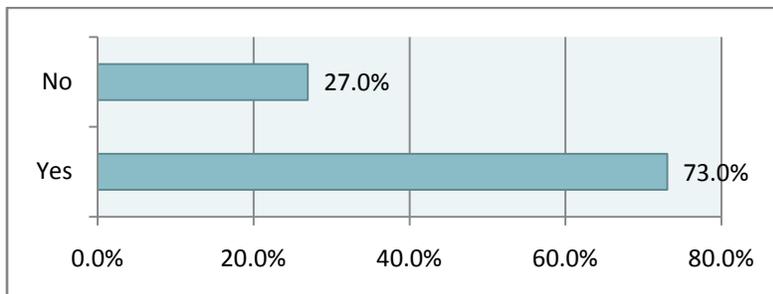
PHYSICAL ENVIRONMENT OF NEIGHBORHOOD

The next subsection asked responders to think about the area in their neighborhood and the availability of adequate sidewalks, bike lanes, grocery stores, and presence of vandalized or abandoned buildings.

BIKELANES AND SIDEWALKS

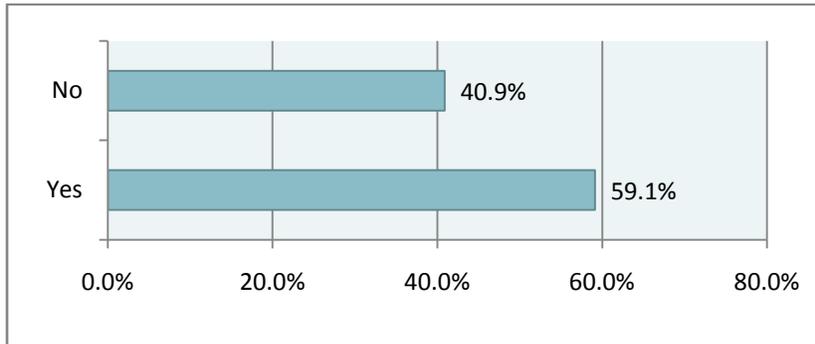
The first set of these questions asked about the availability of adequate sidewalks in the neighborhood. Twenty-seven percent of responders indicated their neighborhood does not contain sidewalks that are wide enough for two adults to walk side by side.

Figure 43. Adequate sidewalks in neighborhood



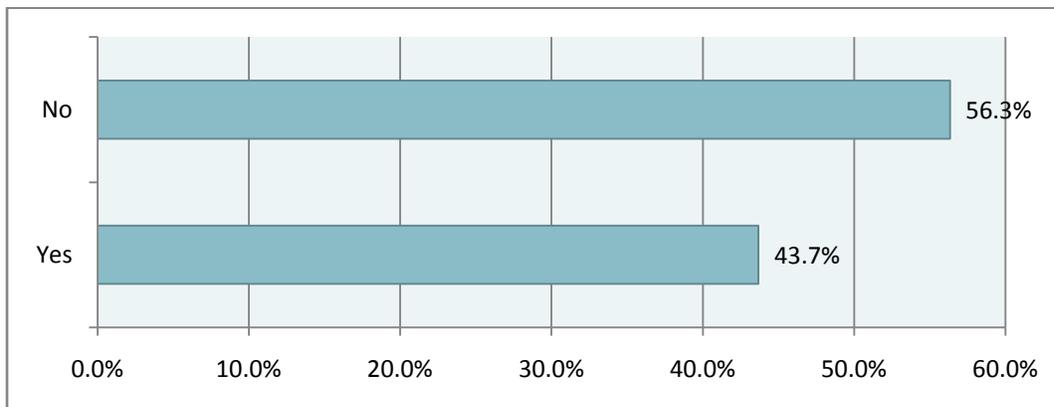
Respondents were then asked about the level of adequate lighting for sidewalks if they were present in the neighborhood. Approximately 41% of responders indicated that sidewalks in their neighborhood did not have adequate lighting.

Figure 44. Sidewalks adequately lighted



Respondents were then asked a similar question about the availability of bike lanes in their neighborhood. A majority of respondents, 56%, indicated that there were no bike lanes in their neighborhood.

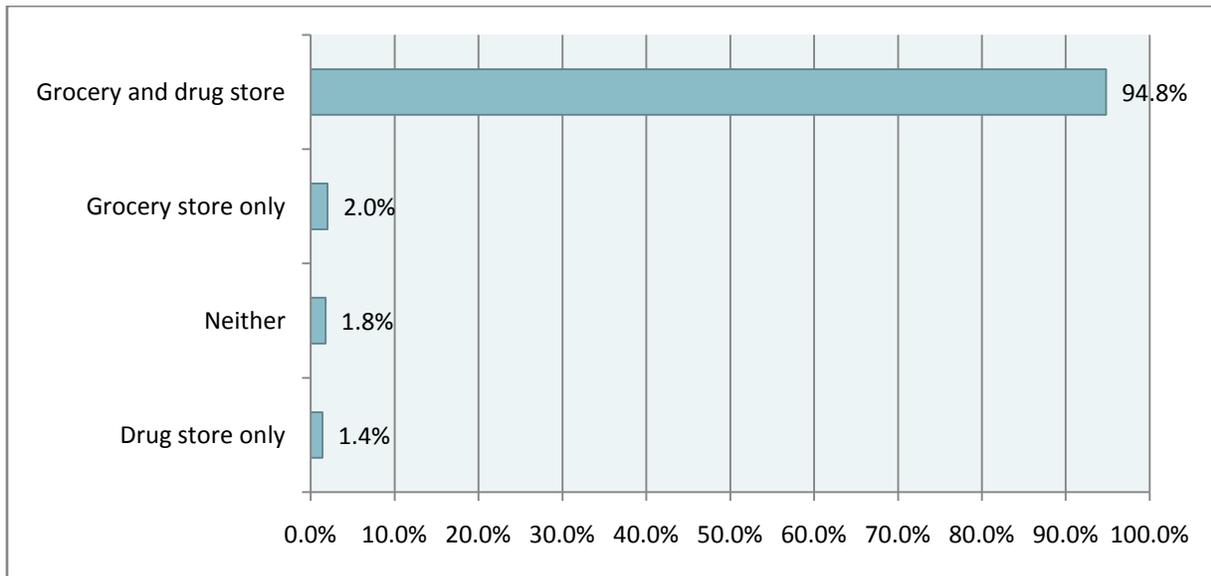
Figure 45. Bike lanes in neighborhood



FOOD AVAILABILITY

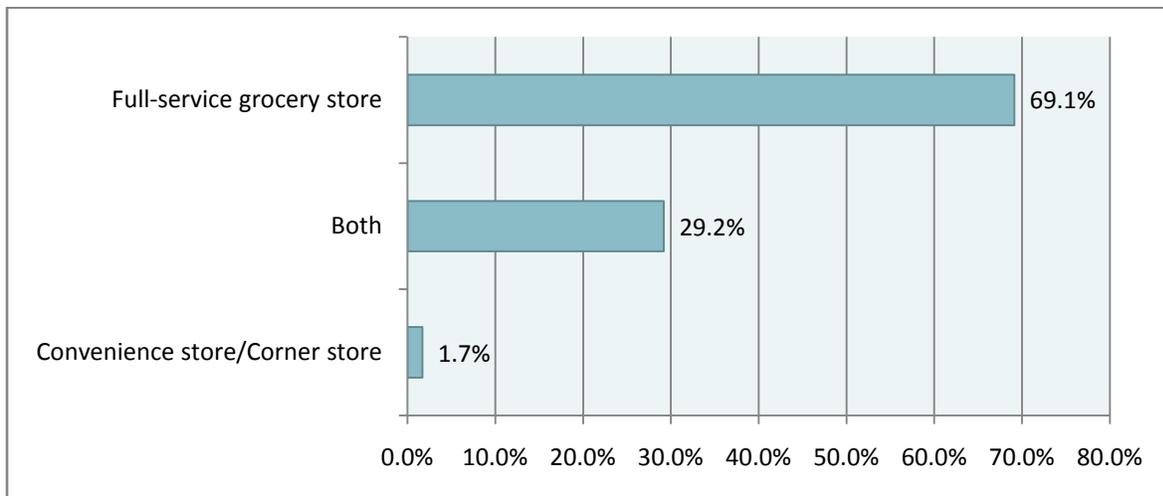
The next series of questions centered on the availability of grocery and drug stores within a 15 minute drive of respondents' neighborhoods. A vast majority of respondents indicated that there were both a grocery and drug store within a 15 minute drive of their neighborhood. Close to 2% of respondents stated that neither a drug store nor grocery store was within a 15 minute drive.

Figure 46. Available grocery and/or drug store in neighborhood



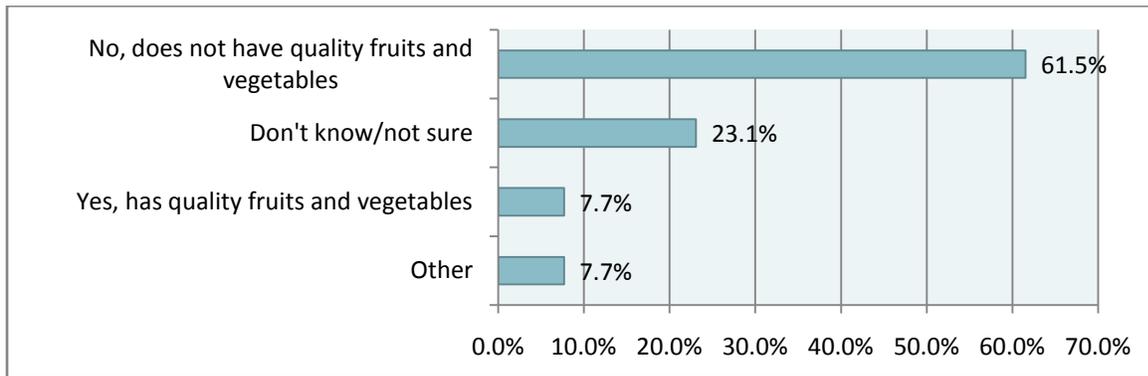
Respondents who indicated a nearby grocery store was available were asked a series of questions specific to the grocery store. The first question queried whether the nearby grocery store was a full-service grocery store (e.g. Kroger), a convenience store/corner store, or both. A majority of respondents had a full-service grocery store nearby.

Figure 47. Type of nearby grocery store



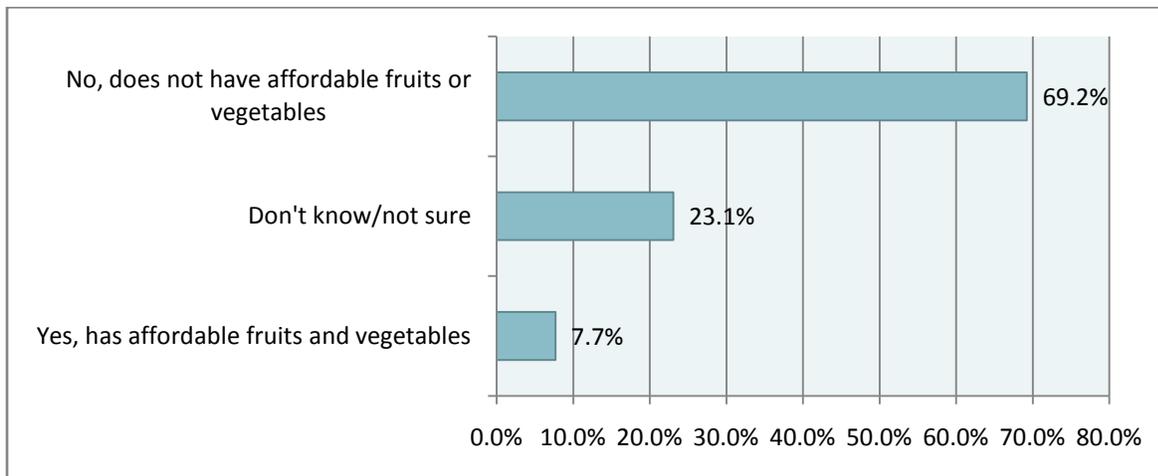
Respondents who indicated having a convenience or corner store nearby were asked questions about the quality of fresh foods available at these non-full-service grocery stores. Over 60% of respondents indicated that the nearby convenience/corner store in their neighborhood did not have quality fruits or vegetables.

Figure 48. Quality of fresh food at convenience store



A similar follow-up question about nearby convenience/corner store asked respondents about the affordability of fresh foods at the store. Close to 70% of respondents with a nearby convenience/corner store indicated the store did not have affordable fresh fruits or vegetables.

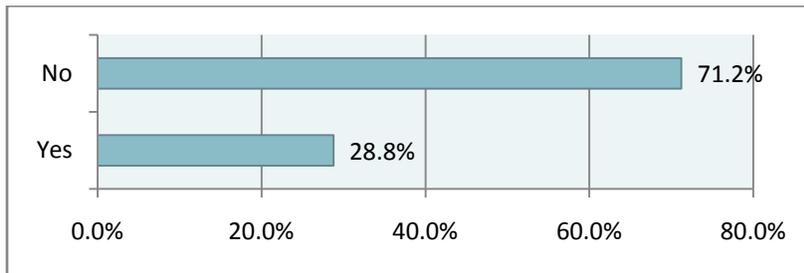
Figure 49. Affordable fresh foods at convenience store



BLIGHT AND LITTER IN NEIGHBORHOOD

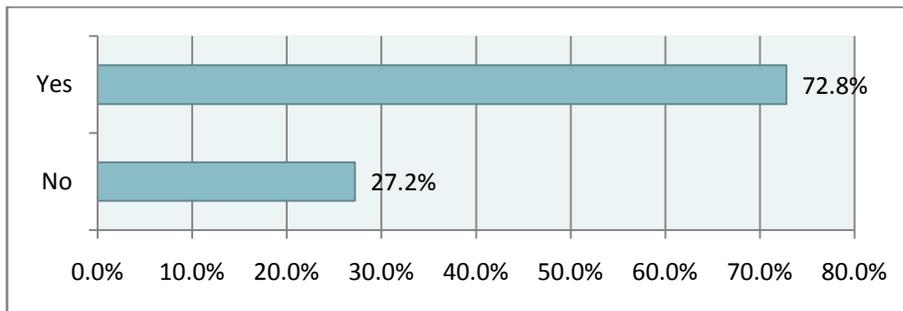
The next question asked respondents about the presence of abandoned or vandalized buildings in their neighborhood. Close to 30% of online survey responders indicated that there were either vandalized or abandoned buildings in their neighborhood.

Figure 50. Vandalized or abandoned buildings present



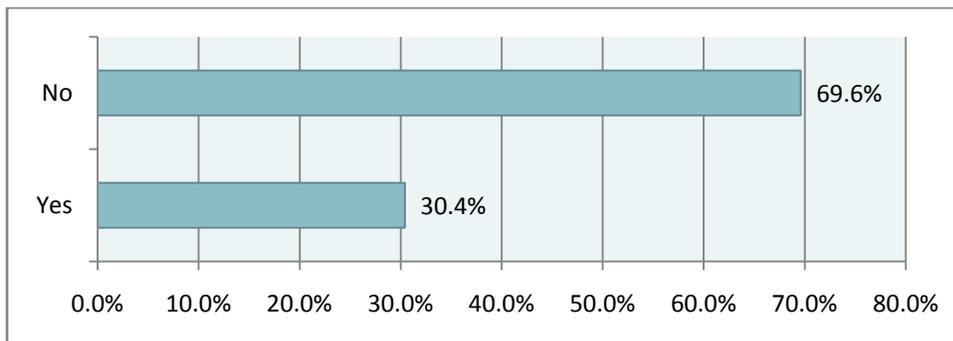
Those indicating the presence of an abandoned/vandalized building were asked a follow-up question about the number of these types of buildings. Of those indicated the presence of abandoned or vandalized building in their neighborhood, over 70% indicated that more than one of these types of buildings was present.

Figure 51. More than one vandalized/abandoned building



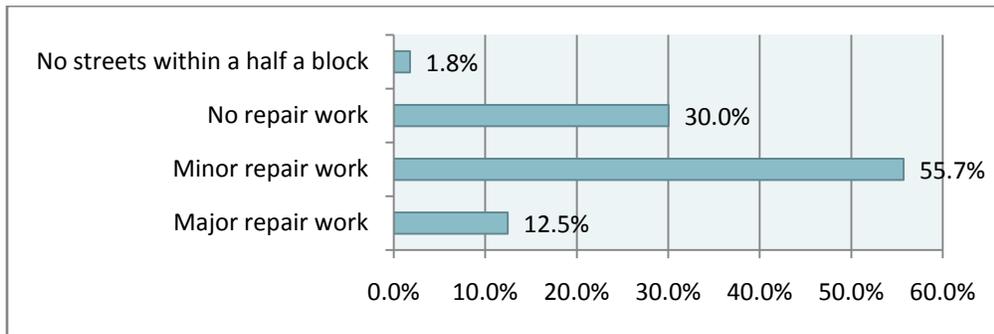
Respondents were asked about the cleanliness of their neighborhood as well, specifically if trash, litter, or junk was in the streets within a half block of where they lived. Thirty percent of responders indicated the presence of litter in the streets within a half block of their homes.

Figure 52. Trash, litter, junk in streets within neighborhood



Respondents were also asked about the conditions of the streets within a half a block of their homes. Over 50% of responders indicated streets within a half a block needed at least minor repair work.

Figure 53. Conditions of streets within half block of home



*PART 8: HEALTH CARE

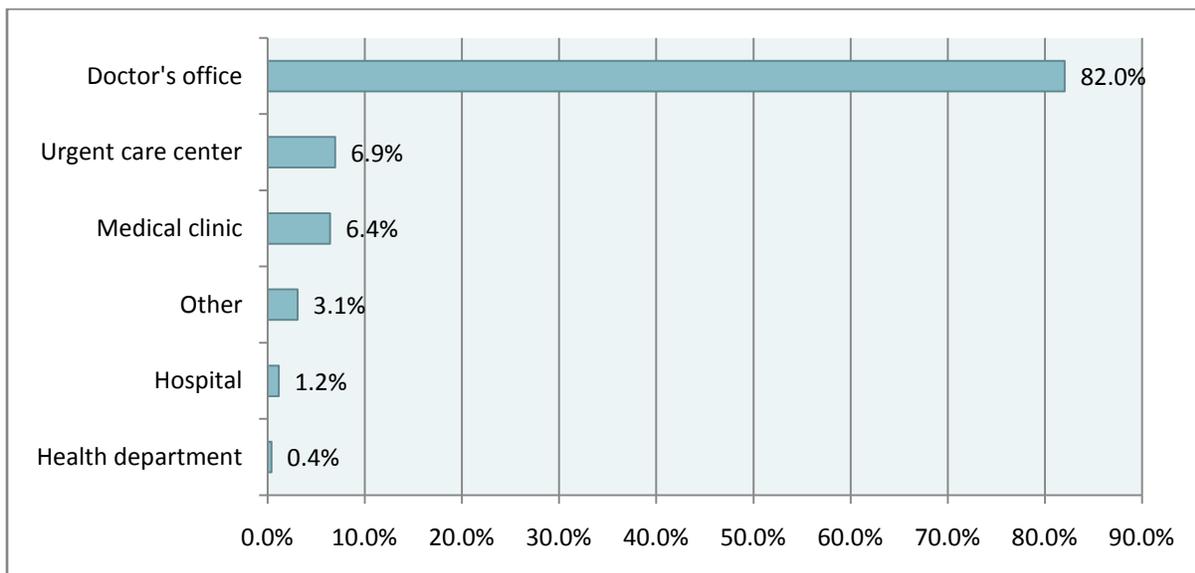
INTRODUCTION

The following section queries respondents on topics related to access to health care, insurance coverage, specialist care, barriers to care, and flu vaccination.

ACCESS TO HEALTH CARE

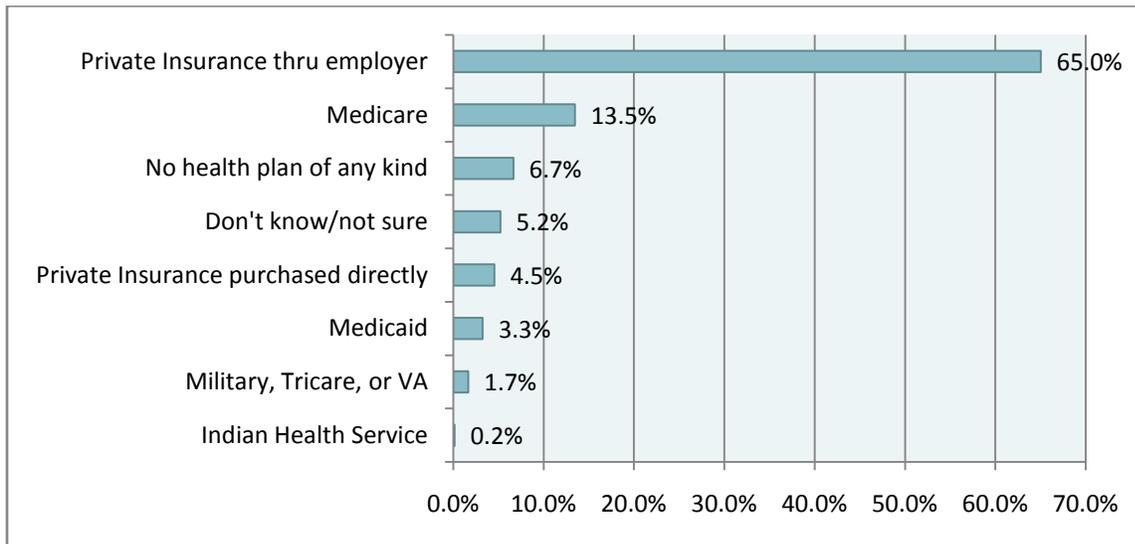
The following subsection asks where respondents access health care the most, type of health insurance (if any) coverage, and barriers to care. A majority of responders indicated they received medical care most often from a doctor's office when they are sick.

Figure 54. Location of receiving care most often when sick



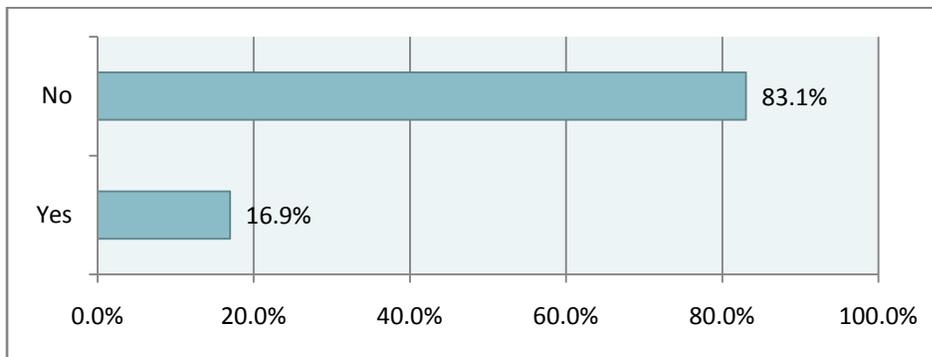
The following question was the only question in this section asked of both online and in-person survey responders. A majority of respondents, 65%, had health insurance coverage through their employer. Almost 7% indicated they did not have health insurance of any kind.

Figure 55. Health Insurance coverage



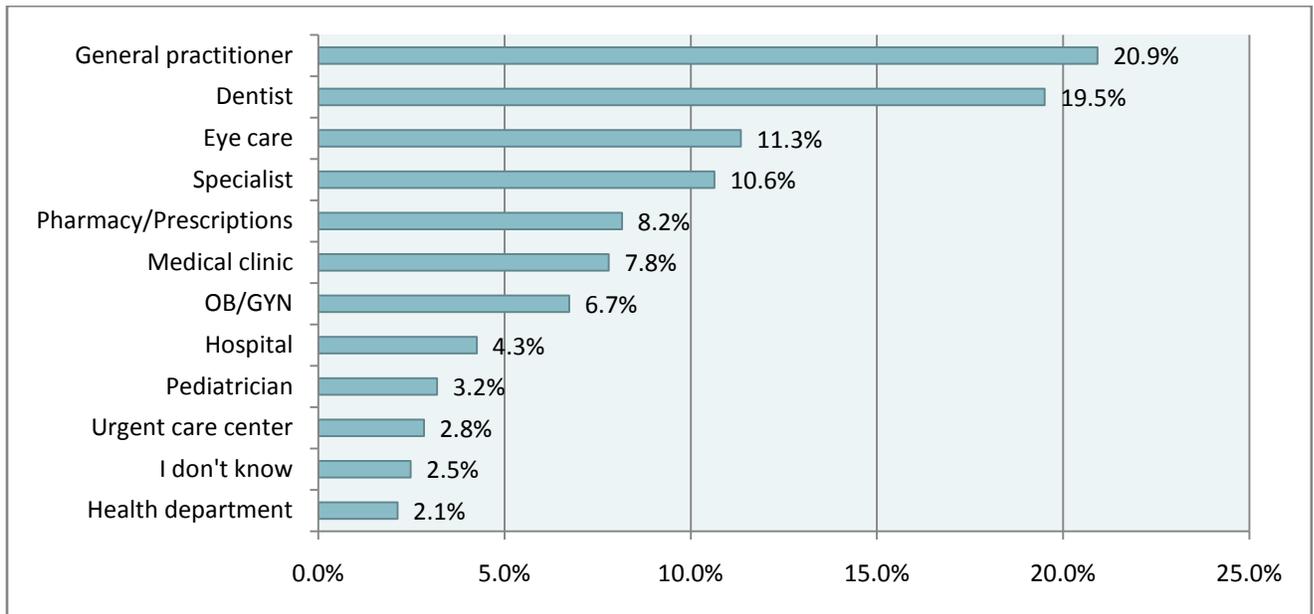
Respondents were asked about problems accessing health care in the previous 12 months. Nearly 17% of respondents indicated they had a problem getting health care they needed personally or for a family member from any type of health care provider, dentist, pharmacy, or other facility.

Figure 56. Problem getting any type of health care in last 12 months



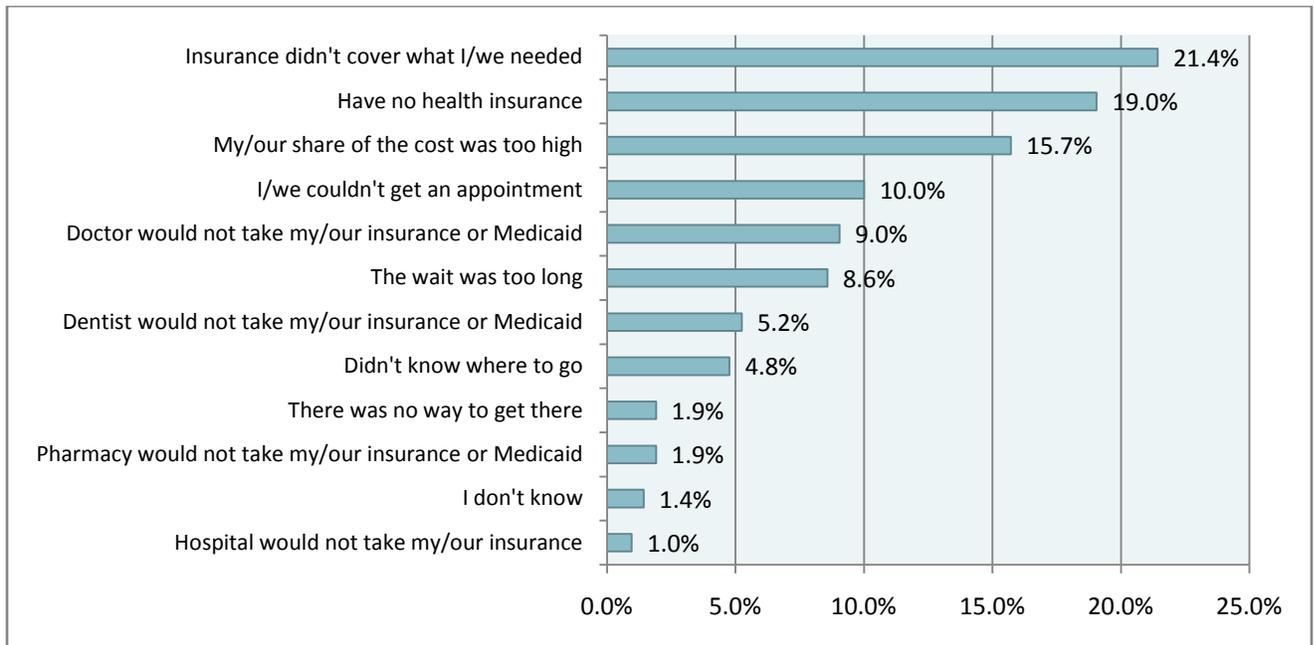
As a follow-up to the above question, respondents indicating having problems getting health care in the past 12 months were asked to specify what type of care they had trouble getting. The top types of care participants indicated they had a problem receiving included general practitioner, dental, and eye care.

Figure 57. Type of care had a problem getting



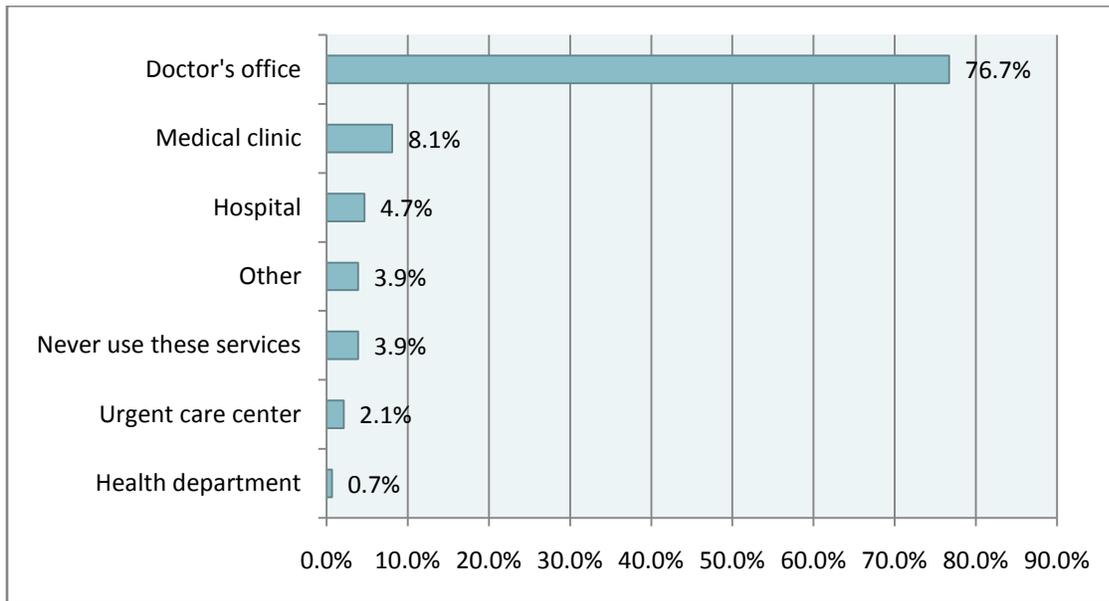
Respondents who indicated they had a problem receiving care were then asked what problems prevented them from receiving the necessary health care they needed. The top 3 problems included insurance not covering needed care, having no health insurance, or the share of the cost was too high.

Figure 58. Reason did not receive needed care



The following question asked respondents where they typically go to get preventative services (annual checkups, mammography, colonoscopy, prostate screening). Respondents overwhelmingly indicated they received preventative health services from a doctor's office.

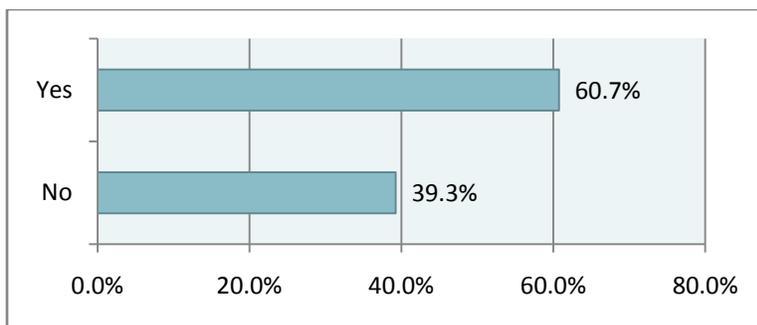
Figure 59. Location of preventative services



FLU VACCINATION

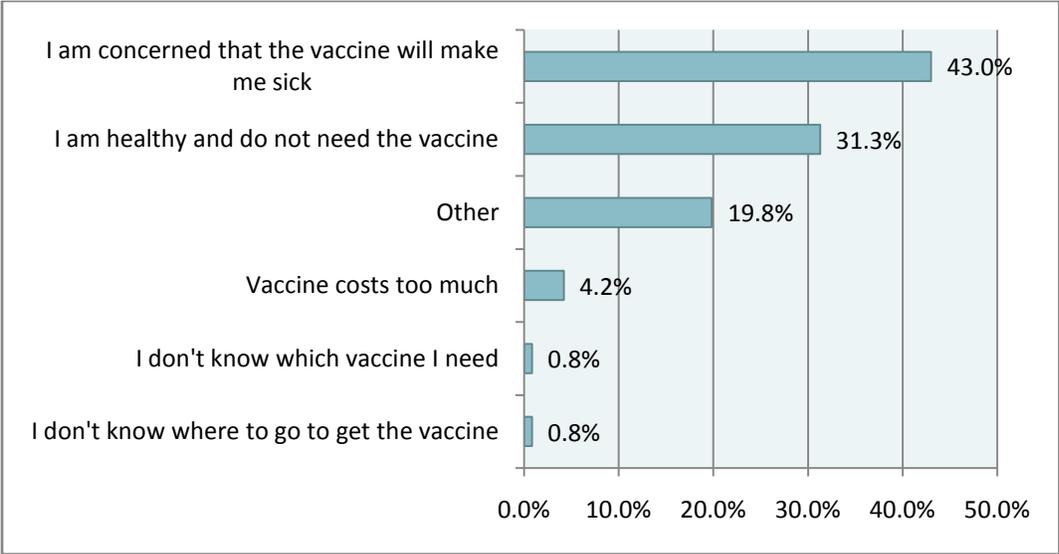
The following questions relate to respondents' activities around regular flu vaccination. A majority of online respondents indicated they received the flu vaccination annually.

Figure 60. Receive flu vaccinations annually



Those respondents who stated they did not receive a flu vaccine annually were asked to provide a reason why. The most commonly selected reason for not receiving an annual flu shot was the concern that the vaccine would make them sick.

Figure 6 I. Reasons for not getting flu vaccine

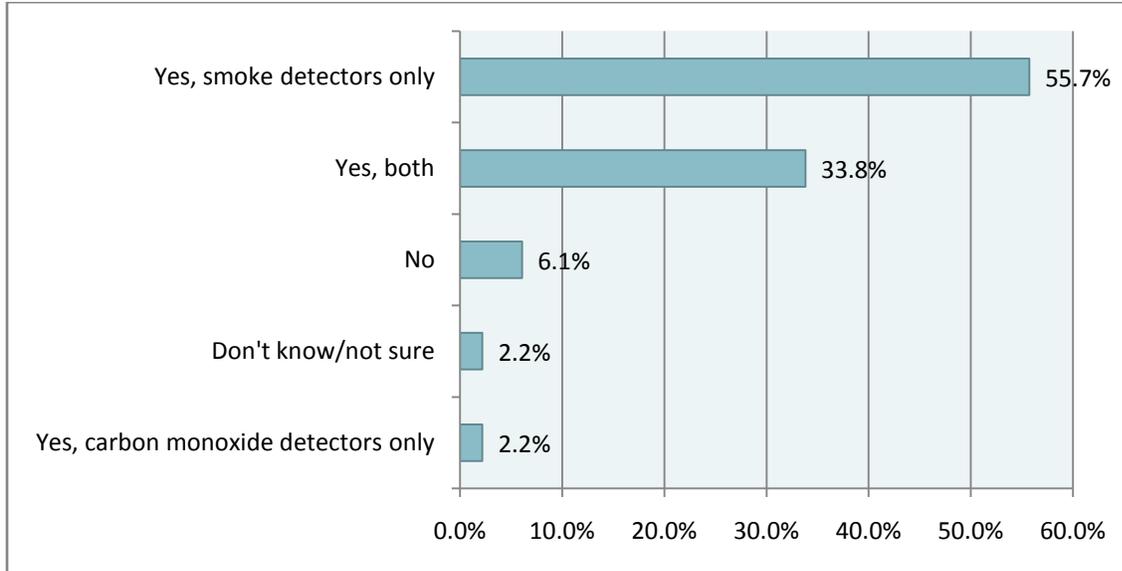


*PART 9: EMERGENCY PREPAREDNESS

INTRODUCTION

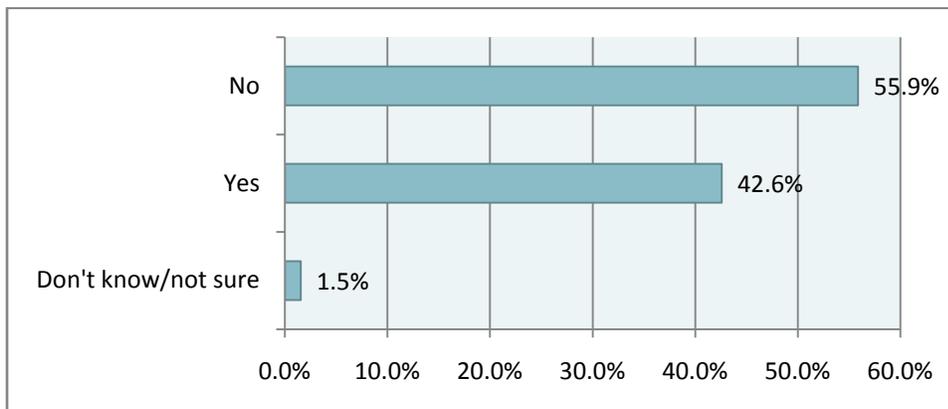
Questions in this section queried respondents about emergency preparedness related behaviors. The first set of questions asked if respondents had smoke detectors and carbon monoxide detectors in their homes. A majority of respondents had at least a smoke detector in their homes; 6% indicating not having either in their homes.

Figure 62. Smoke/Carbon monoxide detectors in home



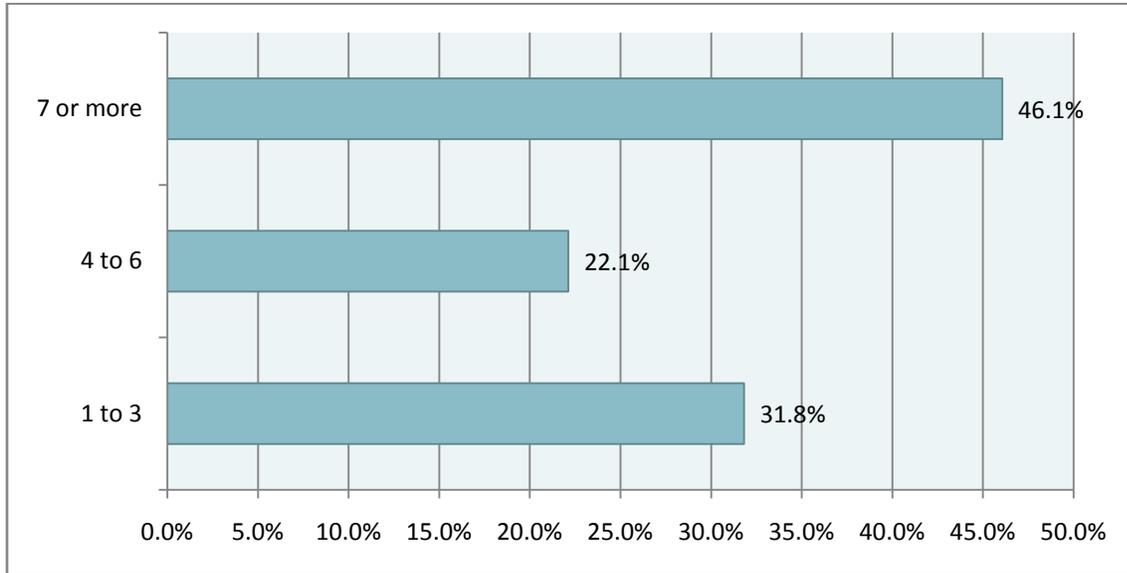
The next set of questions asked respondents about emergency preparedness kits in their homes. A majority of respondents indicated they did not have a basic emergency supply kit in their home.

Figure 63. Have a basic emergency supply kit in home



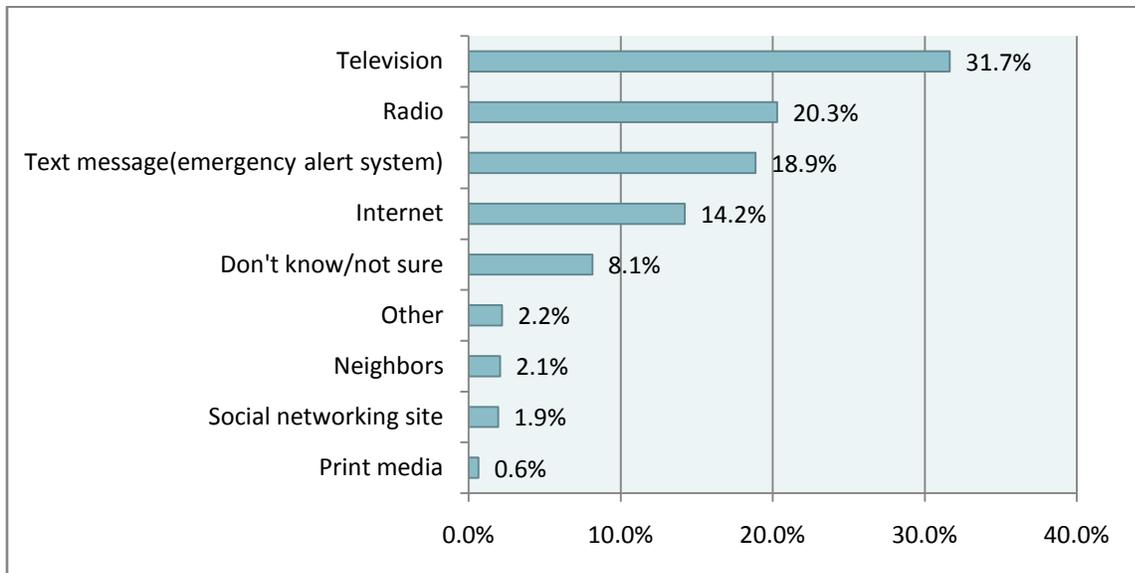
Those respondents that indicated they did have a basic emergency supply kit were asked how many days these supplies would last in case of an emergency. Close to 50% of those indicating they had an emergency supply kit said their supplies would last them 7 or more days in the event of an emergency.

Figure 64. Days emergency kit would last



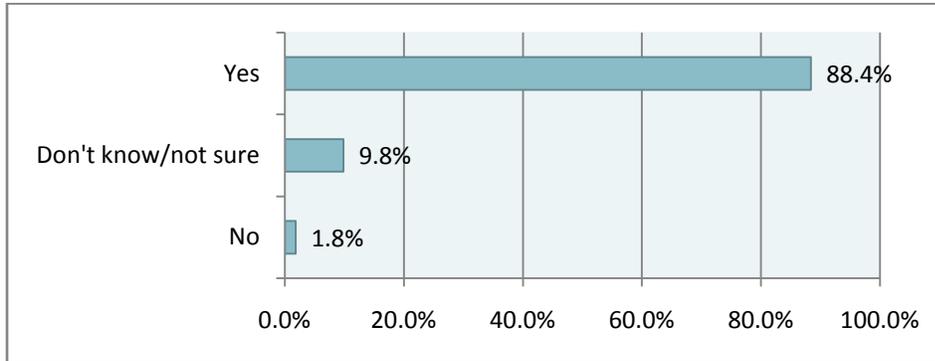
Next, respondents were asked to comment on the main way they would get information in the event of an emergency or large scale disaster. The top methods of gaining information in an emergency were television, radio, and text message via emergency alert system.

Figure 65. Main way of getting info in emergency



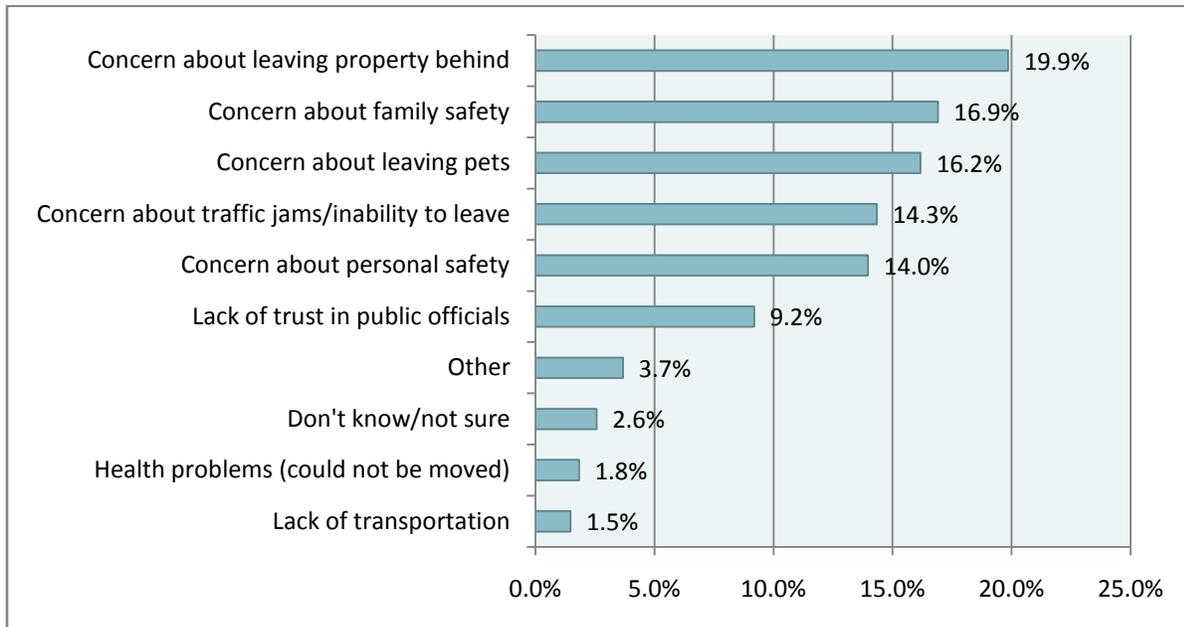
Online respondents were asked if public authorities announced a mandatory evacuation from their neighborhood or community due to a large scale disaster or emergency, would they evacuate. A vast majority of respondents indicated they would evacuate if public authorities announced a mandatory evacuation.

Figure 66. Would evacuate if authorities announced mandatory evacuation



Those who indicated they did not know if they would evacuate or not were asked to select reasons why they would not evacuate. The top 3 reasons selected were concern about leaving property behind, concern about family's safety, and concern about leaving pets behind.

Figure 67. Reasons would not evacuate



Local Public Health System Assessment Report



Program Partner Organizations

American Public Health Association

www.apha.org

Association of State and Territorial Health Officials

www.astho.org

Centers for Disease Control and Prevention

www.cdc.gov

National Association of County and City Health Officials

www.naccho.org

National Association of Local Boards of Health

www.nalboh.org

National Network of Public Health Institutes

www.nnphi.org

Public Health Foundation

www.phf.org

The findings and conclusions stemming from the use of NPHPS tools are those of the end users. They are not provided or endorsed by the Centers for Disease Control and Prevention, nor do they represent CDC's views or policies.

Acknowledgements

The National Public Health Performance Standards (NPHPS) was developed collaboratively by the program's national partner organizations. The NPHPS partner organizations include: Centers for Disease Control and Prevention (CDC); American Public Health Association (APHA); Association of State and Territorial Health Officials (ASTHO); National Association of County and City Health Officials (NACCHO); National Association of Local Boards of Health (NALBOH); National Network of Public Health Institutes (NNPHI); and then Public Health Foundation (PHF). We thank the staff of these organizations for their time and expertise in the support of the NPHPS.

Background

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

The NPHPS assessments are intended to help users answer questions such as "What are the components, activities, competencies, and capacities of our public health system?" and "How well are the ten Essential Public Health Services being provided in our system?" The dialogue that occurs in the process of answering the questions in the assessment instrument can help to identify strengths and weaknesses, determine opportunities for immediate improvements, and establish priorities for long term investments for improving the public health system.

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

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

The information obtained from assessments may then be used to improve and better coordinate public health activities at state and local levels. In addition, the results gathered provide an understanding of how state and local public health systems and governing entities are performing. This information helps local, state and national partners make better and more effective policy and resource decisions to improve the nation's public health as a whole.

INTRODUCTION

The NPHPS Local Public Health System Assessment Report is designed to help health departments and public health system partners create a snapshot of where they are relative to the National Public Health Performance Standards and to progressively move toward refining and improving outcomes for performance across the public health system.

The NPHPS state, local, and governance instruments also offer opportunity and robust data to link to health departments, public health system partners and/or community-wide strategic planning processes, as well as to Public Health Accreditation Board (PHAB) standards. For example, assessment of the environment external to the public health organization is a key component of all strategic planning, and the NPHPS assessment readily provides a structured process and an evidence-base upon which key organizational decisions may be made and priorities established. The assessment may also be used as a component of community health improvement planning processes, such as Mobilizing for Action through Planning and Partnerships (MAPP) or other community-wide strategic planning efforts, including state health improvement planning and community health improvement planning. The NPHPS process also drives assessment and improvement activities that may be used to support a Health Department in meeting PHAB standards. Regardless of whether using MAPP or another health improvement process, partners should use the NPHPS results to support quality improvement.

The self-assessment is structured around the Model Standards for each of the ten Essential Public Health Services, (EPHS), hereafter referred to as the Essential Services, which were developed through a comprehensive, collaborative process involving input from national, state and local experts in public health. Altogether, for the local assessment, 30 Model Standards serve as quality indicators that are organized into the ten essential public health service areas in the instrument and address the three core functions of public health. Figure I below shows how the ten Essential Services align with the three Core Functions of Public Health.

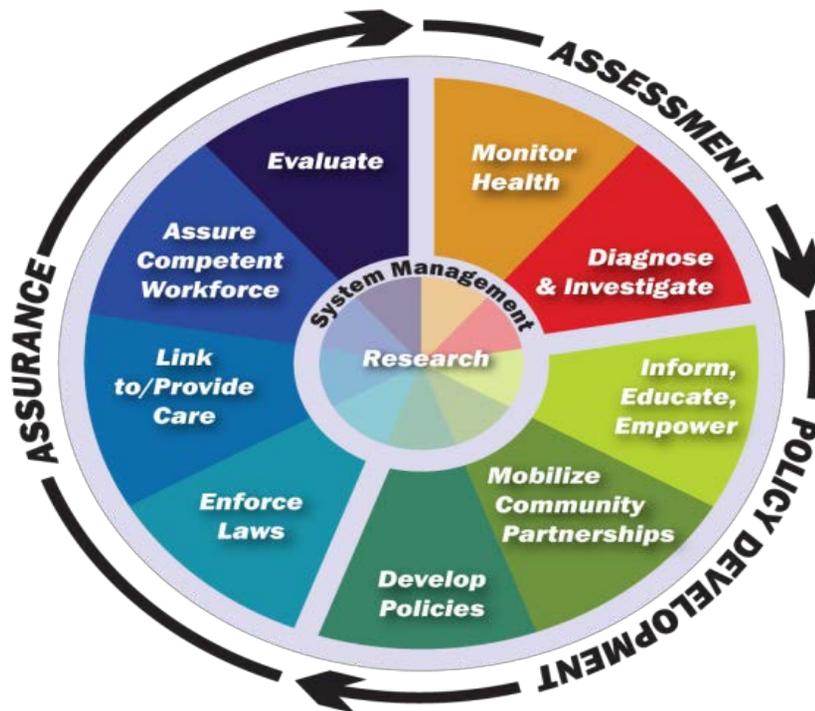


Figure I. The ten Essential Public Health Services and how they relate to the three Core Functions of Public Health.

PURPOSE

The primary purpose of the NPHPS Local Public Health System Assessment Report is to promote continuous improvement that will result in positive outcomes for system performance. Local health departments and their public health system partners can use the Assessment Report as a working tool to:

- Better understand current system functioning and performance;
- Identify and prioritize areas of strengths, weaknesses, and opportunities for improvement;
- Articulate the value that quality improvement initiatives will bring to the public health system;
- Develop an initial work plan with specific quality improvement strategies to achieve goals;
- Begin taking action for achieving performance and quality improvement in one or more targeted areas; and
- Re-assess the progress of improvement efforts at regular intervals.

This report is designed to facilitate communication and sharing among and within programs, partners, and organizations, based on a common understanding of how a high performing and effective public health system can operate. This shared frame of reference will help build commitment and focus for setting priorities and improving public health system performance. Outcomes for performance include delivery of all ten essential public health services at optimal levels.

ABOUT THE REPORT

Calculating the Scores

The NPHPS assessment instruments are constructed using the ten Essential Services as a framework. Within the Local Instrument, each Essential Service includes between 2-4 Model Standards that describe the key aspects of an optimally performing public health system. Each Model Standard is followed by assessment questions that serve as measures of performance. Responses to these questions indicate how well the Model Standard - which portrays the highest level of performance or "gold standard" - is being met.

Table I below characterizes levels of activity for Essential Services and Model Standards. Using the responses to all of the assessment questions, a scoring process generates score for each Model Standard, Essential Service, and one overall assessment score.

Table I. Summary of Assessment Response Options

Optimal Activity (76-100%)	Greater than 75% of the activity described within the question is met.
Significant Activity (51-75%)	Greater than 50%, but no more than 75% of the activity described within the question is met.
Moderate Activity (26-50%)	Greater than 25%, but no more than 50% of the activity described within the question is met.
Minimal Activity (1-25%)	Greater than zero, but no more than 25% of the activity described within the question is met.
No Activity (0%)	0% or absolutely no activity.

Understanding Data Limitations

There are a number of limitations to the NPHPS assessment data due to self-report, wide variations in the breadth and knowledge of participants, the variety of assessment methods used, and differences in interpretation of assessment questions. Data and resultant information should not be interpreted to reflect the capacity or performance of any single agency or organization within the public health system or used for comparisons between jurisdictions or organizations. Use of NPHPS generated data and associated recommendations are limited to guiding an overall public health infrastructure and performance improvement process for the public health system as determined by organizations involved in the assessment.

All performance scores are an average; Model Standard scores are an average of the question scores within that Model Standard, Essential Service scores are an average of the Model Standard scores within that Essential Service and the overall assessment score is the average of the Essential Service scores. The responses to the questions within the assessment are based upon processes that utilize input from diverse system participants with different experiences and perspectives. The gathering of these inputs and the development of a response for each question incorporates an element of subjectivity, which may be minimized through the use of particular assessment methods. Additionally, while certain assessment methods are recommended, processes differ among sites. The assessment methods are not fully standardized and these differences in administration of the self-assessment may introduce an element of measurement error. In addition, there are differences in knowledge about the public health system among assessment participants. This may lead to some interpretation differences and issues for some questions, potentially introducing a degree of random non-sampling error.

Presentation of results

The NPHPS has attempted to present results - through a variety of figures and tables - in a user-friendly and clear manner. For ease of use, many figures and tables use short titles to refer to Essential Services, Model Standards, and questions. If you are in doubt of these definitions, please refer to the full text in the assessment instruments.

Sites may have chosen to complete two additional questionnaires, the Priority of Model Standards Questionnaire assesses how performance of each Model Standard compares with the priority rating and the Agency Contribution Questionnaire assesses the local health department's contribution to achieving the Model Standard. Sites that submitted responses for these questionnaires will see the results included as additional components of their report.

RESULTS

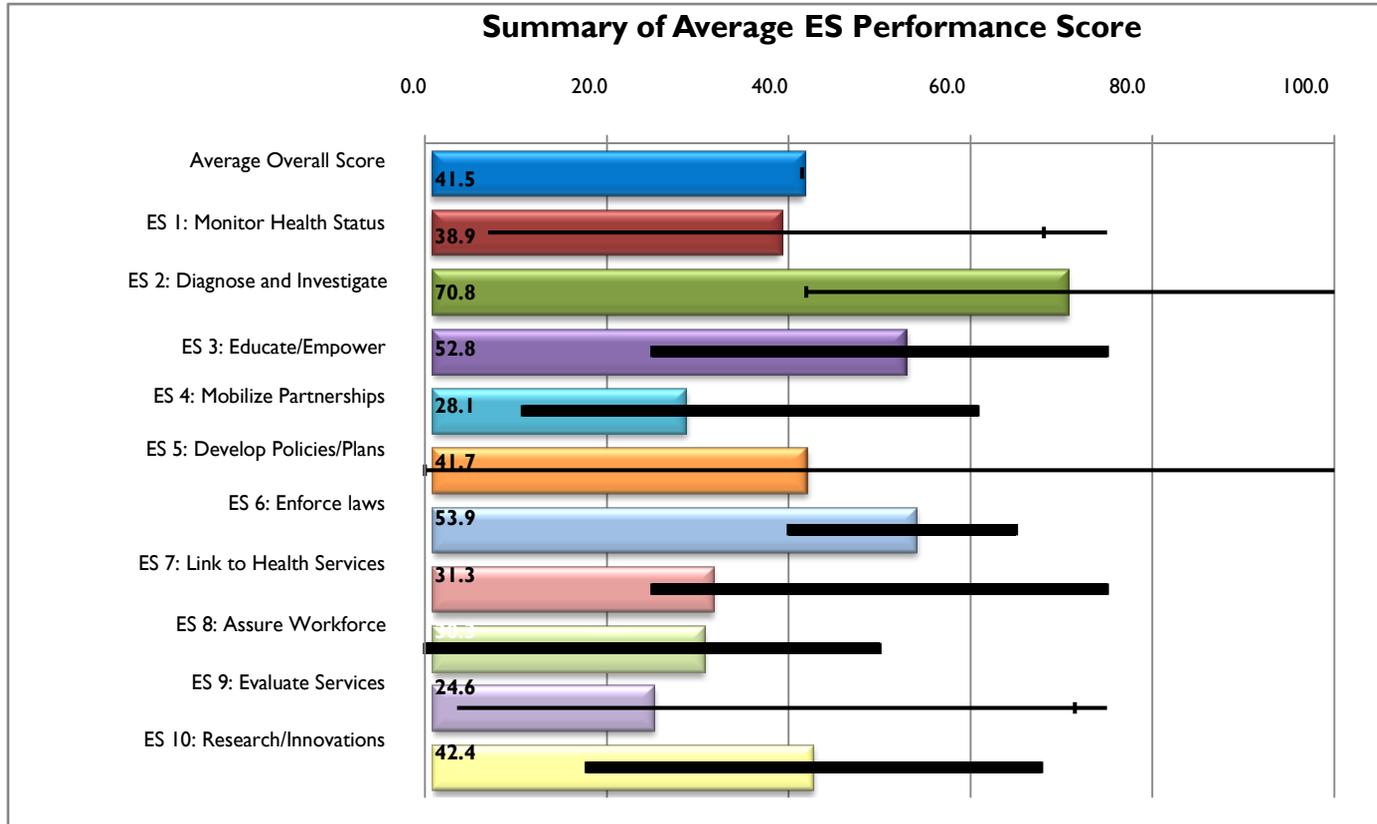
Now that your assessment is completed, one of the most exciting, yet challenging opportunities is to begin to review and analyze the findings. As you recall from your assessment, the data you created now establishes the foundation upon which you may set priorities for performance improvement and identify specific quality improvement (QI) projects to support your priorities.

Based upon the responses you provided during your assessment, an average was calculated for each of the ten Essential Services. Each Essential Service score can be interpreted as the overall degree to which your public health system meets the performance standards (quality indicators) for each Essential Service. Scores can range from a minimum value of 0% (no activity is performed pursuant to the standards) to a maximum value of 100% (all activities associated with the standards are performed at optimal levels).

Figure 2 displays the average score for each Essential Service, along with an overall average assessment score across all ten Essential Services. Take a look at the overall performance scores for each Essential Service. Examination of these scores can immediately give a sense of the local public health system's greatest strengths and weaknesses. Note the black bars that identify the range of reported performance score responses within each Essential Service.

Overall Scores for Each Essential Public Health Service

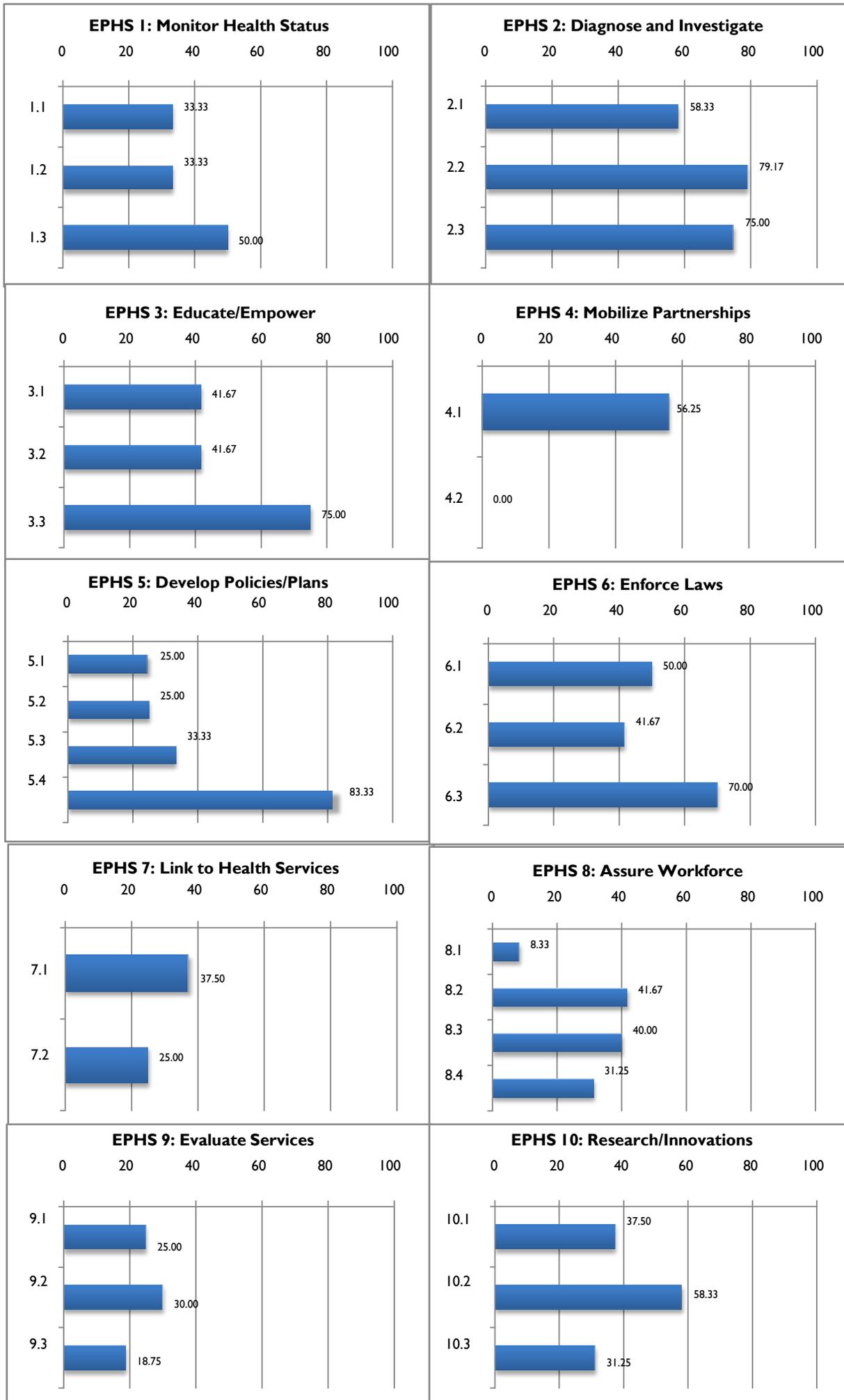
Figure 2. Summary of Average Essential Public Health Service Performance Scores



Performance Scores by Essential Public Health Service for Each Model Standard

Figure 3 and Table 2 on the following pages display the average performance score for each of the Model Standards within each Essential Service. This level of analysis enables you to identify specific activities that contributed to high or low performance within each Essential Service.

Figure 3. Performance Scores by Essential Public Health Service for Each Model Standard



In Table 2 below, each score (performance, priority, and contribution scores) at the Essential Service level is a calculated average of the respective Model Standard scores within that Essential Service. Note – The priority rating and agency contribution scores will be blank if the Priority of Model Standards Questionnaire and the Agency Contribution Questionnaire are not completed.

Table 2. Overall Performance, Priority, and Contribution Scores by Essential Public Health Service and Corresponding Model Standard

Model Standards by Essential Services	Performance Scores	Priority Rating	Agency Contribution Scores
ES 1: Monitor Health Status	38.9	7.3	66.7
1.1 Community Health Assessment	33.3	8.0	75.0
1.2 Current Technology	33.3	7.0	50.0
1.3 Registries	50.0	7.0	75.0
ES 2: Diagnose and Investigate	70.8	7.7	75.0
2.1 Identification/Surveillance	58.3	8.0	75.0
2.2 Emergency Response	79.2	8.0	75.0
2.3 Laboratories	75.0	7.0	75.0
ES 3: Educate/Empower	52.8	7.0	75.0
3.1 Health Education/Promotion	41.7	7.0	75.0
3.2 Health Communication	41.7	7.0	75.0
3.3 Risk Communication	75.0	7.0	75.0
ES 4: Mobilize Partnerships	28.1	7.0	62.5
4.1 Constituency Development	56.3	7.0	50.0
4.2 Community Partnerships	0.0	7.0	75.0
ES 5: Develop Policies/Plans	41.7	7.3	75.0
5.1 Governmental Presence	25.0	7.0	75.0
5.2 Policy Development	25.0	7.0	75.0
5.3 CHIP/Strategic Planning	33.3	7.0	75.0
5.4 Emergency Plan	83.3	8.0	75.0
ES 6: Enforce Laws	53.9	7.3	58.3
6.1 Review Laws	50.0	7.0	50.0
6.2 Improve Laws	41.7	7.0	50.0
6.3 Enforce Laws	70.0	8.0	75.0
ES 7: Link to Health Services	31.3	7.0	75.0
7.1 Personal Health Service Needs	37.5	7.0	75.0
7.2 Assure Linkage	25.0	7.0	75.0
ES 8: Assure Workforce	30.3	7.0	62.5
8.1 Workforce Assessment	8.3	7.0	75.0
8.2 Workforce Standards	41.7	7.0	75.0
8.3 Continuing Education	40.0	7.0	50.0
8.4 Leadership Development	31.3	7.0	50.0
ES 9: Evaluate Services	24.6	7.0	50.0
9.1 Evaluation of Population Health	25.0	7.0	50.0
9.2 Evaluation of Personal Health	30.0	7.0	50.0
9.3 Evaluation of LPHS	18.8	7.0	50.0
ES 10: Research/Innovations	42.4	7.0	50.0
10.1 Foster Innovation	37.5	7.0	50.0
10.2 Academic Linkages	58.3	7.0	50.0
10.3 Research Capacity	31.3	7.0	50.0
Average Overall Score	41.5	7.2	65.0
Median Score	40.3	7.0	64.6

Performance Relative to Optimal Activity

Figures 4 and 5 display the proportion of performance measures that met specified thresholds of achievement for performance standards. The five threshold levels of achievement used in scoring these measures are shown in the legend below. For example, measures receiving a composite score of 76-100% were classified as meeting performance standards at the optimal level.

Figure 4. Percentage of the system's Essential Services scores that fall within the five activity categories. This chart provides a high level snapshot of the information found in Figure 2, summarizing the composite performance measures for all 10 Essential Services.

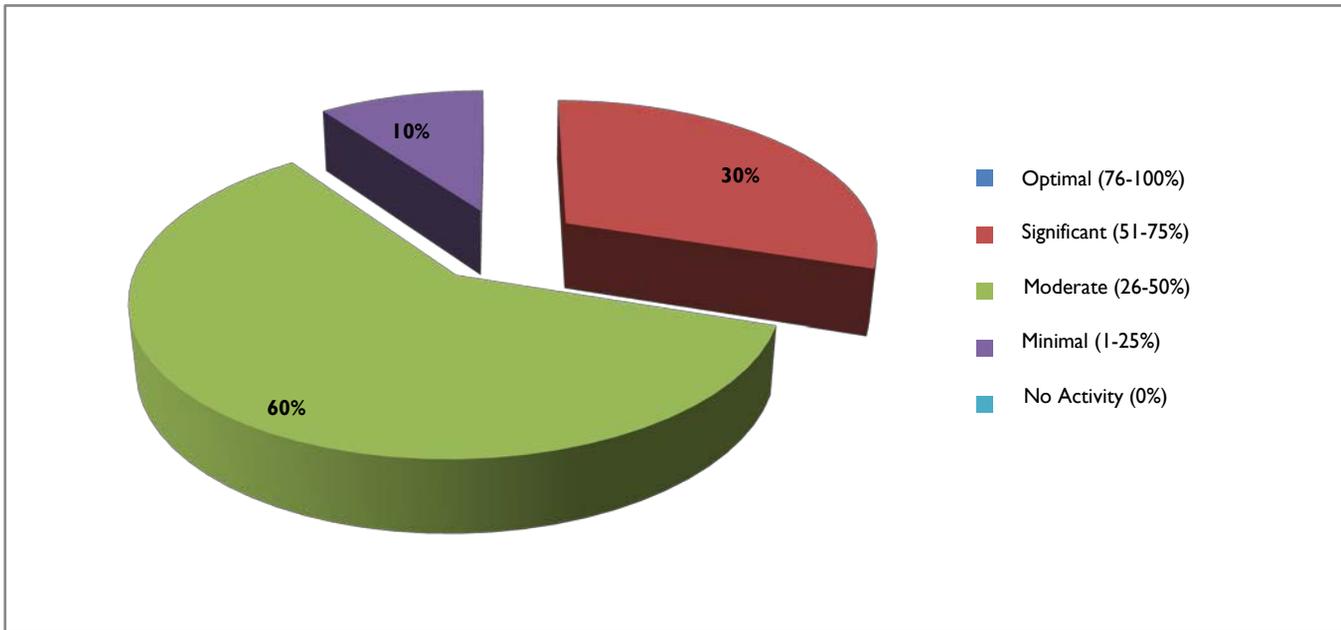
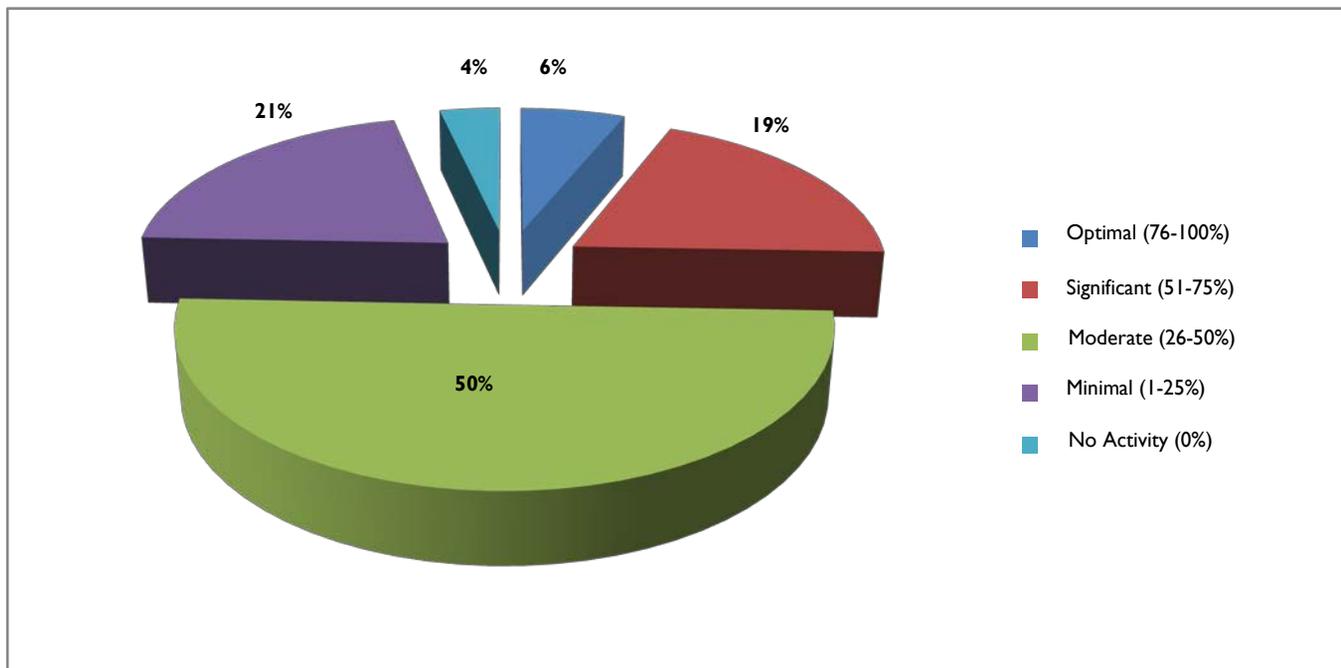


Figure 5. Percentage of the system's Model Standard scores that fall within the five activity categories. This chart provides a high level snapshot of the information found in Figure 3, summarizing the composite measures for all 30 Model Standards.



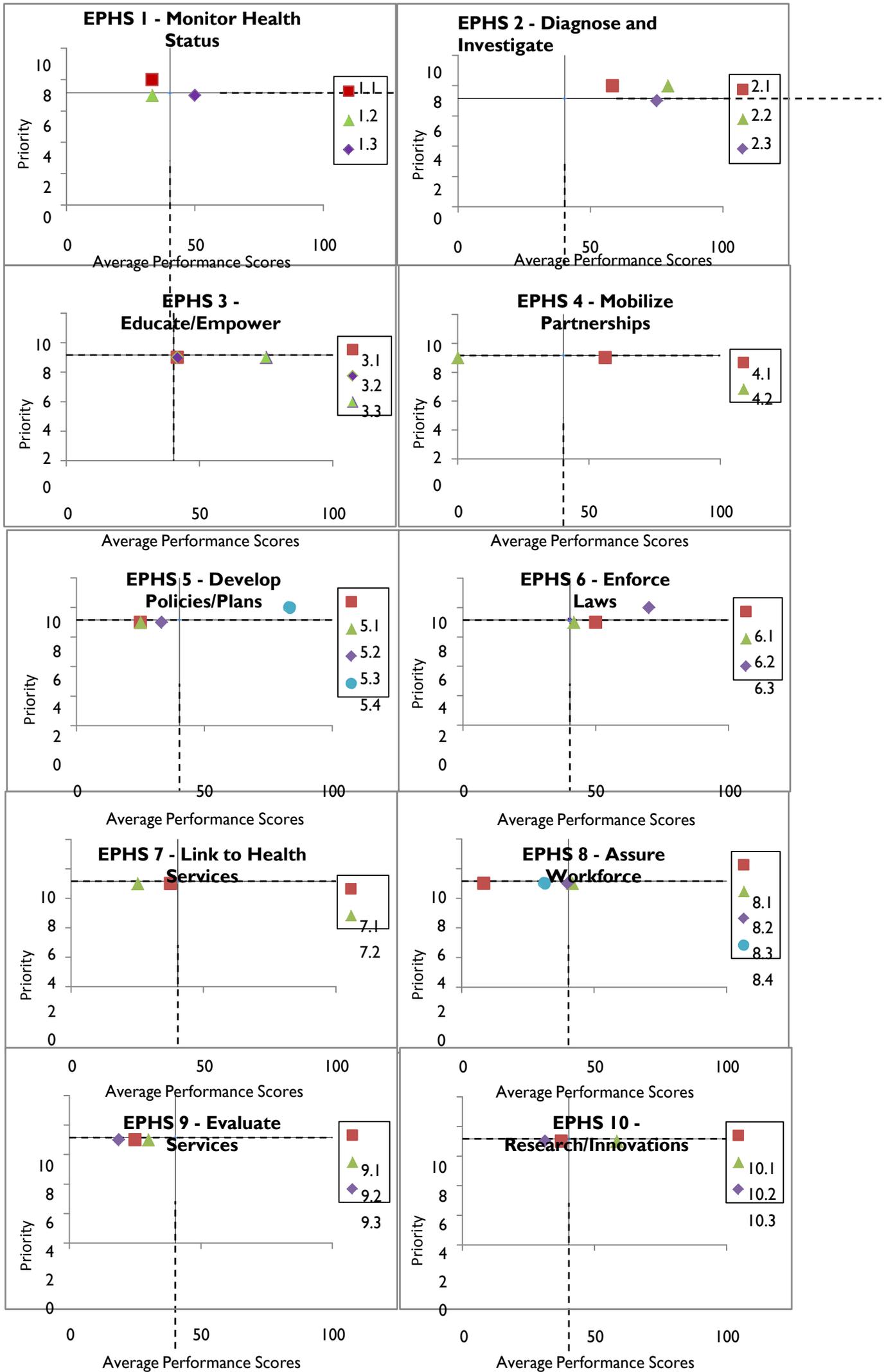
Priority of Model Standards Questionnaire Section (Optional Survey)

If you completed the Priority Survey at the time of your assessment, your results are displayed in this section for each Essential Service and each Model Standard, arrayed by the priority rating assigned to each. The four quadrants, which are based on how the performance of each Essential Service and/or Model Standard compares with the priority rating, should provide guidance in considering areas for attention and next steps for improvement.

Quadrant A	(High Priority and Low Performance) – These activities may need increased attention.
Quadrant B	(High Priority and High Performance) – These activities are being done well, and it is important to maintain efforts.
Quadrant C	(Low Priority and High Performance) – These activities are being done well; consideration may be given to reducing effort in these areas.
Quadrant D	(Low Priority and Low Performance) – These activities could be improved, but are of low priority. They may need little or no attention at this time.

Note - For additional guidance, see Figure 4: Identifying Priorities - Basic Framework in the *Local Implementation Guide*.

Figure 7. Summary of Essential Public Health Service Model Standard Scores and Priority Ratings



Note – Figure 7 will be blank if the Priority of Model Standards Questionnaire is not completed.

Table 3 below displays priority ratings (as rated by participants on a scale of 1-10, with 10 being the highest priority) and performance scores for Model Standards, arranged under the four quadrants. Consider the appropriateness of the match between the importance ratings and current performance scores and also reflect back on the qualitative data in the Summary Notes section to identify potential priority areas for action planning. Note – Table 3 will be blank if the Priority of Model Standards Questionnaire is not completed.

Table 3. Model Standards by Priority and Performance Score

Quadrant	Model Standard	Performance Score (%)	Priority Rating
Quadrant A	8.3 Continuing Education	40.0	8
Quadrant A	1.1 Community Health Assessment	33.3	8
Quadrant B	6.3 Enforce Laws	70.0	8
Quadrant B	5.4 Emergency Plan	83.3	8
Quadrant B	3.2 Health Communication	41.7	8
Quadrant B	3.1 Health Education/Promotion	41.7	8
Quadrant B	2.2 Emergency Response	79.2	8
Quadrant B	2.1 Identification/Surveillance	58.3	8
Quadrant C	10.2 Academic Linkages	58.3	7
Quadrant C	8.2 Workforce Standards	41.7	7
Quadrant C	6.2 Improve Laws	41.7	7
Quadrant C	6.1 Review Laws	50.0	7
Quadrant C	4.1 Constituency Development	56.3	7
Quadrant C	3.3 Risk Communication	75.0	7
Quadrant C	2.3 Laboratories	75.0	7
Quadrant C	1.3 Registries	50.0	7
Quadrant D	10.3 Research Capacity	31.3	7
Quadrant D	10.1 Foster Innovation	37.5	7
Quadrant D	9.3 Evaluation of LPHS	18.8	7
Quadrant D	9.2 Evaluation of Personal Health	30.0	7
Quadrant D	9.1 Evaluation of Population Health	25.0	7
Quadrant D	8.4 Leadership Development	31.3	7
Quadrant D	8.1 Workforce Assessment	8.3	7
Quadrant D	7.2 Assure Linkage	25.0	7
Quadrant D	7.1 Personal Health Services Needs	37.5	7
Quadrant D	5.3 CHIP/Strategic Planning	33.3	7
Quadrant D	5.2 Policy Development	25.0	7
Quadrant D	5.1 Governmental Presence	25.0	7
Quadrant D	4.2 Community Partnerships	0.0	7
Quadrant D	1.2 Current Technology	33.3	7

Agency Contribution Questionnaire Section (Optional Survey)

Table 4 and Figures 8 and 9 on the following pages display Essential Service and Model Standard Scores arranged by Local Health Department (LHD) contribution, priority and performance scores. Note – Table 4 and Figures 8 and 9 will be blank if the Agency Contribution Questionnaire is not completed.

Table 4. Summary of Contribution and Performance Scores by Model Standard

Quadrant	Model Standard	LHD Contribution (%)	Performance Score (%)
Quadrant A	8.1 Workforce Assessment	75.0	8.3
Quadrant A	7.2 Assure Linkage	75.0	25.0
Quadrant A	7.1 Personal Health Services Needs	75.0	37.5
Quadrant A	5.3 CHIP/Strategic Planning	75.0	33.3
Quadrant A	5.2 Policy Development	75.0	25.0
Quadrant A	5.1 Governmental Presence	75.0	25.0
Quadrant A	4.2 Community Partnerships	75.0	0.0
Quadrant A	1.1 Community Health Assessment	75.0	33.3
Quadrant B	8.2 Workforce Standards	75.0	41.7
Quadrant B	6.3 Enforce Laws	75.0	70.0
Quadrant B	5.4 Emergency Plan	75.0	83.3
Quadrant B	3.3 Risk Communication	75.0	75.0
Quadrant B	3.2 Health Communication	75.0	41.7
Quadrant B	3.1 Health Education/Promotion	75.0	41.7
Quadrant B	2.3 Laboratories	75.0	75.0
Quadrant B	2.2 Emergency Response	75.0	79.2
Quadrant B	2.1 Identification/Surveillance	75.0	58.3
Quadrant B	1.3 Registries	75.0	50.0
Quadrant C	10.2 Academic Linkages	50.0	58.3
Quadrant C	6.2 Improve Laws	50.0	41.7
Quadrant C	6.1 Review Laws	50.0	50.0
Quadrant C	4.1 Constituency Development	50.0	56.3
Quadrant D	10.3 Research Capacity	50.0	31.3
Quadrant D	10.1 Foster Innovation	50.0	37.5
Quadrant D	9.3 Evaluation of LPHS	50.0	18.8
Quadrant D	9.2 Evaluation of Personal Health	50.0	30.0
Quadrant D	9.1 Evaluation of Population Health	50.0	25.0
Quadrant D	8.4 Leadership Development	50.0	31.3
Quadrant D	8.3 Continuing Education	50.0	40.0
Quadrant D	1.2 Current Technology	50.0	33.3

Figure 8. Summary of Essential Public Health Service Performance Scores and Contribution Ratings

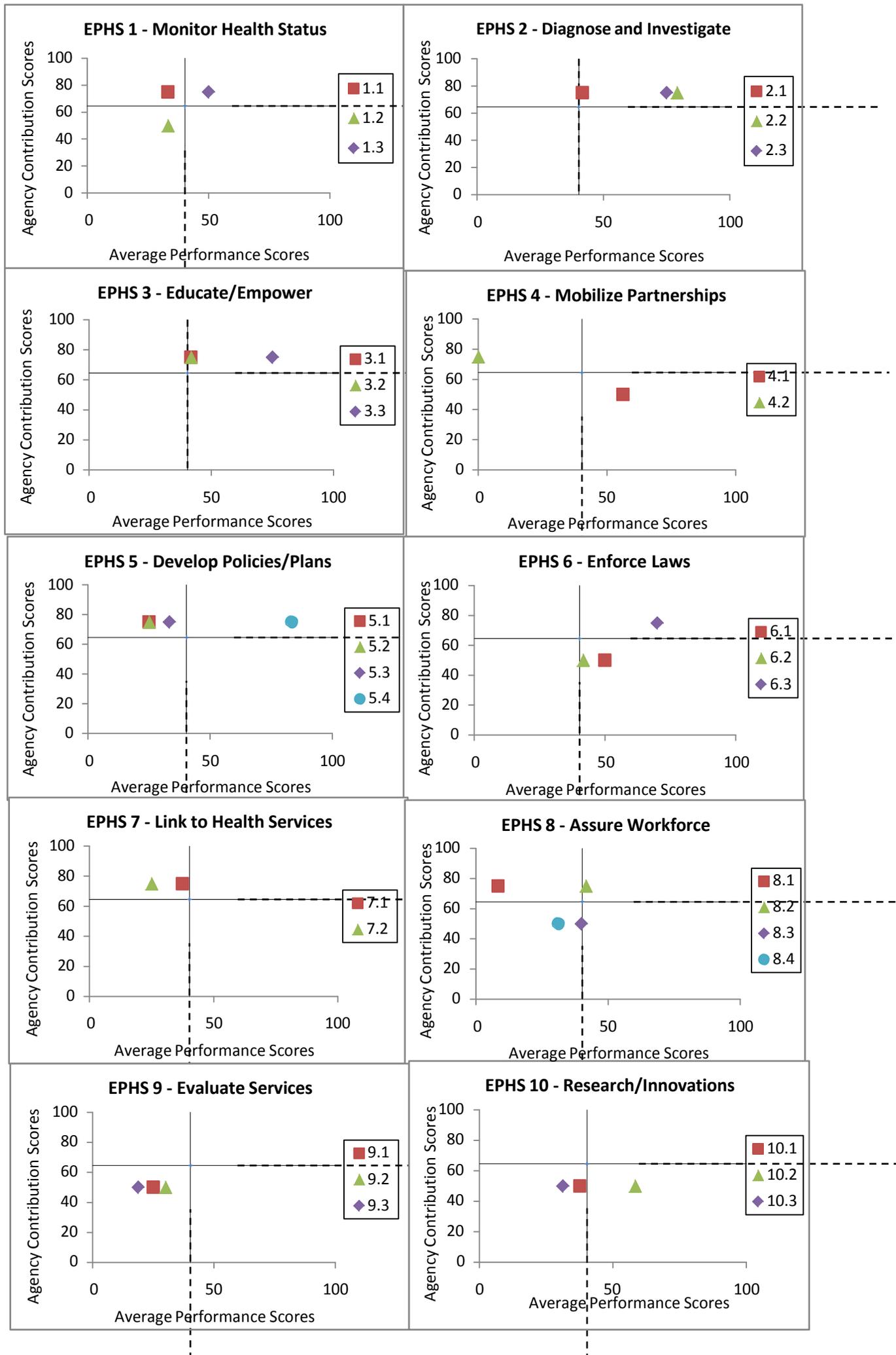
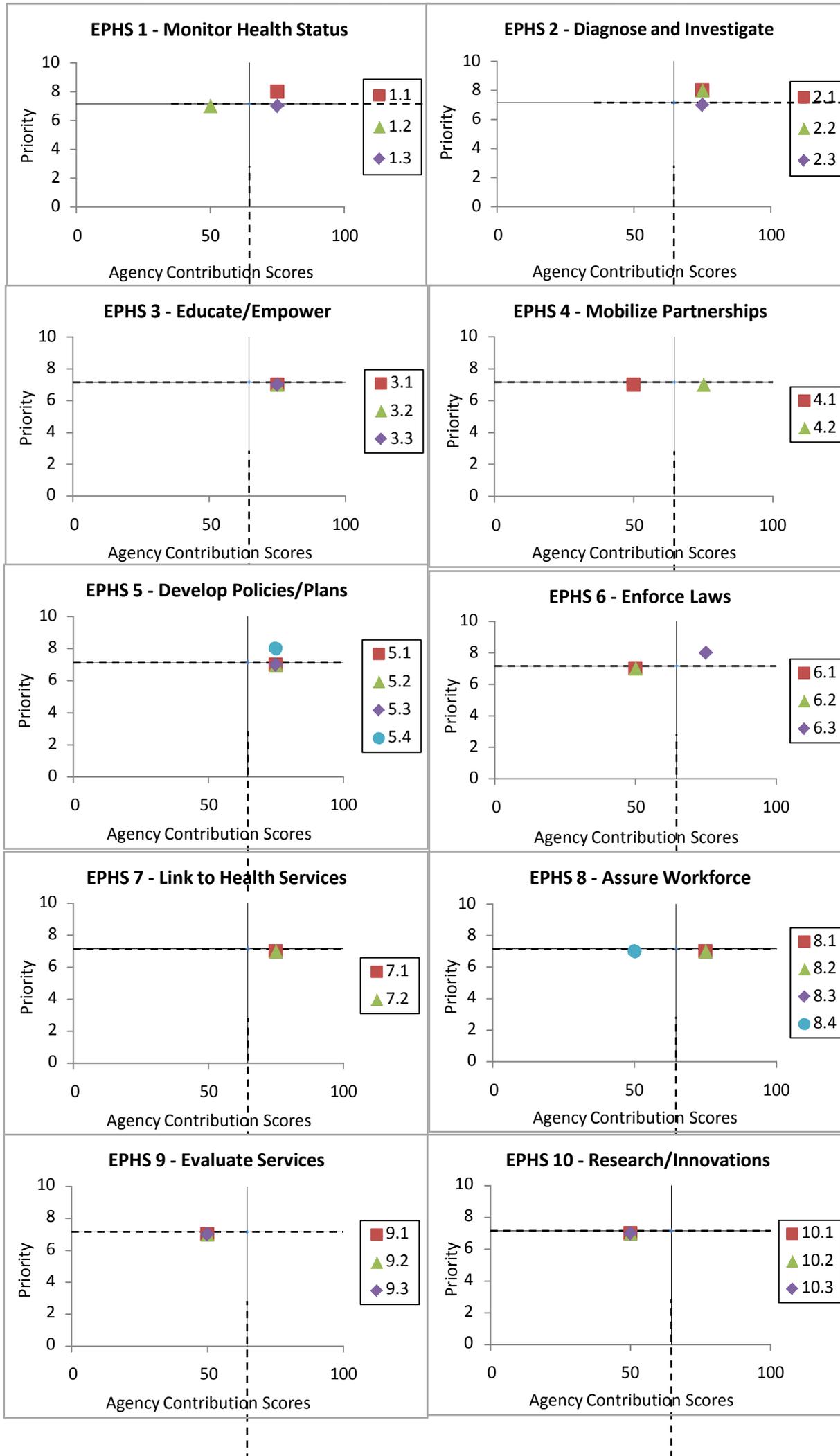


Figure 9. Summary of Agency Contribution and Priority Rating



Analysis and Discussion Questions

Having a standard way in which to analyze the data in this report is important. This process does not have to be difficult; however, drawing some initial conclusions from your data will prove invaluable as you move forward with your improvement efforts. It is crucial that participants fully discuss the performance assessment results. The bar graphs, charts, and summary information in the Results section of this report should be helpful in identifying high and low performing areas. Please refer to Appendix H of the Local Assessment Implementation Guide. This referenced set of discussion questions will help guide you as you analyze the data found in the previous sections of this report.

Using the results in this report will help you to generate priorities for improvement, as well as possible improvement projects. Your data analysis should be an interactive process, enabling everyone to participate. Do not be overwhelmed by the potential of many possibilities for QI projects – the point is not that you have to address them all now. Consider this step as identifying possible opportunities to enhance your system performance. Keep in mind both your quantitative data (Appendix A) and the qualitative data that you collected during the assessment (Appendix B).

Next Steps

Congratulations on your participation in the local assessment process. A primary goal of the NPHPS is that data is used proactively to monitor, assess, and improve the quality of essential public health services. This report is an initial step to identifying immediate actions and activities to improve local initiatives. The results in this report may also be used to identify longer-term priorities for improvement, as well as possible improvement projects.

As noted in the Introduction of this report, NPHPS data may be used to inform a variety of organization and/or systems planning and improvement processes. Plan to use both quantitative data (Appendix A) and qualitative data (Appendix B) from the assessment to identify improvement opportunities. While there may be many potential quality improvement projects, do not be overwhelmed – the point is not that you have to address them all now. Rather, consider this step as a way to identify possible opportunities to enhance your system performance and plan to use the guidance provided in this section, along with the resources offered in Appendix C, to develop specific goals for improvement within your public health system and move from assessment and analysis toward action.

Note: Communities implementing Mobilizing for Action through Planning and Partnerships (MAPP) may refer to the MAPP guidance for considering NPHPS data along with other assessment data in the Identifying Strategic Issues phase of MAPP.

Action Planning

In any systems improvement and planning process, it is important to involve all public health system partners in determining ways to improve the quality of essential public health services provided by the system. Participation in the improvement and planning activities included in your action plan is the responsibility of all partners within the public health system.

Consider the following points as you build an Action Plan to address the priorities you have identified

- Each public health partner should be considered when approaching quality improvement for your system
- The success of your improvement activities is dependent upon the active participation and contribution of each and every member of the system
- An integral part of performance improvement is working consistently to have long-term effects
- A multi-disciplinary approach that employs measurement and analysis is key to accomplishing and sustaining improvements

You may find that using the simple acronym, 'FOCUS' is a way to help you to move from assessment and analysis to action.

F **Find** an opportunity for improvement using your results.

O **Organize** a team of public health system partners to work on the improvement. Someone in the group should be identified as the team leader. Team members should represent the appropriate organizations that can make an impact.

C **Consider** the current process, where simple improvements can be made and who should make the improvements.

U **Understand** the problem further if necessary, how and why it is occurring, and the factors that contribute to it. Once you have identified priorities, finding solutions entails delving into possible reasons, or "root causes," of the weakness or problem. Only when participants determine why performance problems (or successes!) have occurred will they be able to identify workable solutions that improve future performance. Most performance issues may be traced to well-defined system causes, such as policies, leadership, funding, incentives, information, personnel or coordination. Many QI tools are applicable. You may consider using a variety of basic QI tools such as brainstorming, 5-whys, prioritization, or cause and effect diagrams to better understand the problem (refer to Appendix C for resources).

S **Select** the improvement strategies to be made. Consider using a table or chart to summarize your Action Plan. Many resources are available to assist you in putting your plan on paper, but in general you'll want to include the priority selected, the goal, the improvement activities to be conducted, who will carry them out, and the timeline for completing the improvement activities. When complete, your Action Plan should contain documentation on the indicators to be used, baseline performance levels and targets to be achieved, responsibilities for carrying out improvement activities and the collection and analysis of data to monitor progress. (Additional resources may be found in Appendix C.)

Monitoring and Evaluation: Keys to Success

Monitoring your action plan is a highly proactive and continuous process that is far more than simply taking an occasional "snap-shot" that produces additional data. Evaluation, in contrast to monitoring, provides ongoing structured information that focuses on why results are or are not being met, what unintended consequences may be, or on issues of efficiency, effectiveness, and/or sustainability.

After your Action Plan is implemented, monitoring and evaluation continues to determine whether quality improvement occurred and whether the activities were effective. If the Essential Service performance does not improve within the expected time, additional evaluation must be conducted (an additional QI cycle) to determine why and how you can update your Action Plan to be more effective. The Action Plan can be adjusted as you continue to monitor and evaluate your efforts.

APPENDIX A: Individual Questions and Responses

Performance Scores

ESSENTIAL SERVICE 1: Monitor Health Status to Identify Community Health Problems		
1.1	Model Standard: Population-Based Community Health Assessment (CHA) <i>At what level does the local public health system:</i>	
1.1.1	Conduct regular community health assessments?	50
1.1.2	Continuously update the community health assessment with current information?	25
1.1.3	Promote the use of the community health assessment among community members and partners?	25
1.2	Model Standard: Current Technology to Manage and Communicate Population Health Data <i>At what level does the local public health system:</i>	
1.2.1	Use the best available technology and methods to display data on the public's health?	25
1.2.2	Analyze health data, including geographic information, to see where health problems exist?	50
1.2.3	Use computer software to create charts, graphs, and maps to display complex public health data (trends over time, sub-population analyses, etc.)?	25
1.3	Model Standard: Maintenance of Population Health Registries <i>At what level does the local public health system:</i>	
1.3.1	Collect data on specific health concerns to provide the data to population health registries in a timely manner, consistent with current standards?	50
1.3.2	Use information from population health registries in community health assessments or other analyses?	50

ESSENTIAL SERVICE 2: Diagnose and Investigate Health Problems and Health Hazards		
2.1	Model Standard: Identification and Surveillance of Health Threats <i>At what level does the local public health system:</i>	
2.1.1	Participate in a comprehensive surveillance system with national, state and local partners to identify, monitor, share information, and understand emerging health problems and threats?	75
2.1.2	Provide and collect timely and complete information on reportable diseases and potential disasters, emergencies and emerging threats (natural and manmade)?	75
2.1.3	Assure that the best available resources are used to support surveillance systems and activities, including information technology, communication systems, and professional expertise?	25
2.2	Model Standard: Investigation and Response to Public Health Threats and Emergencies <i>At what level does the local public health system:</i>	

2.2.1	Maintain written instructions on how to handle communicable disease outbreaks and toxic exposure incidents, including details about case finding, contact tracing, and source identification and containment?	75
2.2.2	Develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters?	75
2.2.3	Designate a jurisdictional Emergency Response Coordinator?	100
2.2.4	Prepare to rapidly respond to public health emergencies according to emergency operations coordination guidelines?	75
2.2.5	Identify personnel with the technical expertise to rapidly respond to possible biological, chemical, or and nuclear public health emergencies?	75
2.2.6	Evaluate incidents for effectiveness and opportunities for improvement?	75
2.3	Model Standard: Laboratory Support for Investigation of Health Threats <i>At what level does the local public health system:</i>	
2.3.1	Have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring?	50
2.3.2	Maintain constant (24/7) access to laboratories that can meet public health needs during emergencies, threats, and other hazards?	50
2.3.3	Use only licensed or credentialed laboratories?	100
2.3.4	Maintain a written list of rules related to laboratories, for handling samples (collecting, labeling, storing, transporting, and delivering), for determining who is in charge of the samples at what point, and for reporting the results?	100

ESSENTIAL SERVICE 3: Inform, Educate, and Empower People about Health Issues		
3.1	Model Standard: Health Education and Promotion <i>At what level does the local public health system:</i>	
3.1.1	Provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies?	50
3.1.2	Coordinate health promotion and health education activities to reach individual, interpersonal, community, and societal levels?	50
3.1.3	Engage the community throughout the process of setting priorities, developing plans and implementing health education and health promotion activities?	25
3.2	Model Standard: Health Communication <i>At what level does the local public health system:</i>	
3.2.1	Develop health communication plans for relating to media and the public and for sharing information among LPHS organizations?	50
3.2.2	Use relationships with different media providers (e.g. print, radio, television, and the internet) to share health information, matching the message with the target audience?	50

3.2.3	Identify and train spokespersons on public health issues?	25
3.3	Model Standard: Risk Communication <i>At what level does the local public health system:</i>	
3.3.1	Develop an emergency communications plan for each stage of an emergency to allow for the effective dissemination of information?	75
3.3.2	Make sure resources are available for a rapid emergency communication response?	75
3.3.3	Provide risk communication training for employees and volunteers?	75

ESSENTIAL SERVICE 4: Mobilize Community Partnerships to Identify and Solve Health Problems

4.1	Model Standard: Constituency Development <i>At what level does the local public health system:</i>	
4.1.1	Maintain a complete and current directory of community organizations?	25
4.1.2	Follow an established process for identifying key constituents related to overall public health interests and particular health concerns?	50
4.1.3	Encourage constituents to participate in activities to improve community health?	75
4.1.4	Create forums for communication of public health issues?	75
4.2	Model Standard: Community Partnerships <i>At what level does the local public health system:</i>	
4.2.1	Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?	0
4.2.2	Establish a broad-based community health improvement committee?	0
4.2.3	Assess how well community partnerships and strategic alliances are working to improve community health?	0

ESSENTIAL SERVICE 5: Develop Policies and Plans that Support Individual and Community Health Efforts

5.1	Model Standard: Governmental Presence at the Local Level <i>At what level does the local public health system:</i>	
5.1.1	Support the work of a local health department dedicated to the public health to make sure the essential public health services are provided?	50
5.1.2	See that the local health department is accredited through the national voluntary accreditation program?	0
5.1.3	Assure that the local health department has enough resources to do its part in providing essential public health services?	25
5.2	Model Standard: Public Health Policy Development <i>At what level does the local public health system:</i>	
5.2.1	Contribute to public health policies by engaging in activities that inform the policy development process?	50

5.2.2	Alert policymakers and the community of the possible public health impacts (both intended and unintended) from current and/or proposed policies?	25
5.2.3	Review existing policies at least every three to five years?	25
5.3	Model Standard: Community Health Improvement Process and Strategic Planning <i>At what level does the local public health system:</i>	
5.3.1	Establish a community health improvement process, with broad-based diverse participation, that uses information from both the community health assessment and the perceptions of community members?	50
5.3.2	Develop strategies to achieve community health improvement objectives, including a description of organizations accountable for specific steps?	25
5.3.3	Connect organizational strategic plans with the Community Health Improvement Plan?	25
5.4	Model Standard: Plan for Public Health Emergencies <i>At what level does the local public health system:</i>	
5.4.1	Support a workgroup to develop and maintain preparedness and response plans?	75
5.4.2	Develop a plan that defines when it would be used, who would do what tasks, what standard operating procedures would be put in place, and what alert and evacuation protocols would be followed?	75
5.4.3	Test the plan through regular drills and revise the plan as needed, at least every two years?	100

ESSENTIAL SERVICE 6: Enforce Laws and Regulations that Protect Health and Ensure Safety

6.1	Model Standard: Review and Evaluation of Laws, Regulations, and Ordinances <i>At what level does the local public health system:</i>	
6.1.1	Identify public health issues that can be addressed through laws, regulations, or ordinances?	50
6.1.2	Stay up-to-date with current laws, regulations, and ordinances that prevent, promote, or protect public health on the federal, state, and local levels?	50
6.1.3	Review existing public health laws, regulations, and ordinances at least once every five years?	25
6.1.4	Have access to legal counsel for technical assistance when reviewing laws, regulations, or ordinances?	75
6.2	Model Standard: Involvement in the Improvement of Laws, Regulations, and Ordinances <i>At what level does the local public health system:</i>	
6.2.1	Identify local public health issues that are inadequately addressed in existing laws, regulations, and ordinances?	50

6.2.2	Participate in changing existing laws, regulations, and ordinances, and/or creating new laws, regulations, and ordinances to protect and promote the public health?	50
6.2.3	Provide technical assistance in drafting the language for proposed changes or new laws, regulations, and ordinances?	25
6.3	Model Standard: Enforcement of Laws, Regulations, and Ordinances <i>At what level does the local public health system:</i>	
6.3.1	Identify organizations that have the authority to enforce public health laws, regulations, and ordinances?	75
6.3.2	Assure that a local health department (or other governmental public health entity) has the authority to act in public health emergencies?	100
6.3.3	Assure that all enforcement activities related to public health codes are done within the law?	75
6.3.4	Educate individuals and organizations about relevant laws, regulations, and ordinances?	50
6.3.5	Evaluate how well local organizations comply with public health laws?	50

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

7.1	Model Standard: Identification of Personal Health Service Needs of Populations <i>At what level does the local public health system:</i>	
7.1.1	Identify groups of people in the community who have trouble accessing or connecting to personal health services?	75
7.1.2	Identify all personal health service needs and unmet needs throughout the community?	25
7.1.3	Defines partner roles and responsibilities to respond to the unmet needs of the community?	25
7.1.4	Understand the reasons that people do not get the care they need?	25
7.2	Model Standard: Assuring the Linkage of People to Personal Health Services <i>At what level does the local public health system:</i>	
7.2.1	Connect (or link) people to organizations that can provide the personal health services they may need?	25
7.2.2	Help people access personal health services, in a way that takes into account the unique needs of different populations?	25
7.2.3	Help people sign up for public benefits that are available to them (e.g., Medicaid or medical and prescription assistance programs)?	25
7.2.4	Coordinate the delivery of personal health and social services so that everyone has access to the care they need?	25

ESSENTIAL SERVICE 8: Assure a Competent Public and Personal Health Care Workforce

8.1	Model Standard: Workforce Assessment, Planning, and Development <i>At what level does the local public health system:</i>	
8.1.1	Set up a process and a schedule to track the numbers and types of LPHS jobs and the knowledge, skills, and abilities that they require whether those jobs are in the public or private sector?	25
8.1.2	Review the information from the workforce assessment and use it to find and address gaps in the local public health workforce?	0
8.1.3	Provide information from the workforce assessment to other community organizations and groups, including governing bodies and public and private agencies, for use in their organizational planning?	0
8.2	Model Standard: Public Health Workforce Standards <i>At what level does the local public health system:</i>	
8.2.1	Make sure that all members of the public health workforce have the required certificates, licenses, and education needed to fulfill their job duties and meet the law?	50
8.2.2	Develop and maintain job standards and position descriptions based in the core knowledge, skills, and abilities needed to provide the essential public health services?	50
8.2.3	Base the hiring and performance review of members of the public health workforce in public health competencies?	25
8.3	Model Standard: Life-Long Learning through Continuing Education, Training, and Mentoring <i>At what level does the local public health system:</i>	
8.3.1	Identify education and training needs and encourage the workforce to participate in available education and training?	50
8.3.2	Provide ways for workers to develop core skills related to essential public health services?	50
8.3.3	Develop incentives for workforce training, such as tuition reimbursement, time off for class, and pay increases?	25
8.3.4	Create and support collaborations between organizations within the public health system for training and education?	50
8.3.5	Continually train the public health workforce to deliver services in a cultural competent manner and understand social determinants of health?	25
8.4	Model Standard: Public Health Leadership Development <i>At what level does the local public health system:</i>	
8.4.1	Provide access to formal and informal leadership development opportunities for employees at all organizational levels?	25
8.4.2	Create a shared vision of community health and the public health system, welcoming all leaders and community members to work together?	25
8.4.3	Ensure that organizations and individuals have opportunities to provide leadership in areas where they have knowledge, skills, or access to resources?	50

8.4.4	Provide opportunities for the development of leaders representative of the diversity within the community?	25
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ESSENTIAL SERVICE 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

9.1	Model Standard: Evaluation of Population-Based Health Services <i>At what level does the local public health system:</i>	
9.1.1	Evaluate how well population-based health services are working, including whether the goals that were set for programs were achieved?	25
9.1.2	Assess whether community members, including those with a higher risk of having a health problem, are satisfied with the approaches to preventing disease, illness, and injury?	25
9.1.3	Identify gaps in the provision of population-based health services?	25
9.1.4	Use evaluation findings to improve plans and services?	25
9.2	Model Standard: Evaluation of Personal Health Services <i>At what level does the local public health system:</i>	
9.2.1	Evaluate the accessibility, quality, and effectiveness of personal health services?	25
9.2.2	Compare the quality of personal health services to established guidelines?	25
9.2.3	Measure satisfaction with personal health services?	25
9.2.4	Use technology, like the internet or electronic health records, to improve quality of care?	50
9.2.5	Use evaluation findings to improve services and program delivery?	25
9.3	Model Standard: Evaluation of the Local Public Health System <i>At what level does the local public health system:</i>	
9.3.1	Identify all public, private, and voluntary organizations that provide essential public health services?	25
9.3.2	Evaluate how well LPHS activities meet the needs of the community at least every five years, using guidelines that describe a model LPHS and involving all entities contributing to essential public health services?	0
9.3.3	Assess how well the organizations in the LPHS are communicating, connecting, and coordinating services?	25
9.3.4	Use results from the evaluation process to improve the LPHS?	25

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

10.1	Model Standard: Fostering Innovation <i>At what level does the local public health system:</i>	
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10.1.1	Provide staff with the time and resources to pilot test or conduct studies to test new solutions to public health problems and see how well they actually work?	25
10.1.2	Suggest ideas about what currently needs to be studied in public health to organizations that do research?	50
10.1.3	Keep up with information from other agencies and organizations at the local, state, and national levels about current best practices in public health?	50
10.1.4	Encourage community participation in research, including deciding what will be studied, conducting research, and in sharing results?	25
10.2	Model Standard: Linkage with Institutions of Higher Learning and/or Research	
	<i>At what level does the local public health system:</i>	
10.2.1	Develop relationships with colleges, universities, or other research organizations, with a free flow of information, to create formal and informal arrangements to work together?	75
10.2.2	Partner with colleges, universities, or other research organizations to do public health research, including community-based participatory research?	50
10.2.3	Encourage colleges, universities, and other research organizations to work together with LPHS organizations to develop projects, including field training and continuing education?	50
10.3	Model Standard: Capacity to Initiate or Participate in Research	
	<i>At what level does the local public health system:</i>	
10.3.1	Collaborate with researchers who offer the knowledge and skills to design and conduct health-related studies?	25
10.3.2	Support research with the necessary infrastructure and resources, including facilities, equipment, databases, information technology, funding, and other resources?	25
10.3.3	Share findings with public health colleagues and the community broadly, through journals, websites, community meetings, etc?	50
10.3.4	Evaluate public health systems research efforts throughout all stages of work from planning to impact on local public health practice?	25

APPENDIX B: Qualitative Assessment Data

Summary Notes

ESSENTIAL SERVICE 1: Monitor Health Status to Identify Community Health Problems			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
1.1	Model Standard: Population-Based Community Health Assessment (CHA)		
<ul style="list-style-type: none"> * In pockets, things are being done * Lot of activity going on throughout Shelby County * Efforts are there to push services to communities that need it * Have started to see lots of sharing among partners around assessment activities 	<ul style="list-style-type: none"> * Not necessarily being led by a particular group * Activity happening is not necessarily collaborative * Sharing is where we don't do as good of a job 	<ul style="list-style-type: none"> * Communication between partner 	<ul style="list-style-type: none"> * Moving towards more updated process

1.2	Model Standard: Current Technology to Manage and Communicate Population Health Data		
<p>* A lot of tools available at SCHD and hospitals - but they don't all "talk"</p> <p>* There are times when data is presented in multiple ways to the community, but not sure how much the public is aware of this</p>	<p>* Only tool to communicate with SCHD is the phone - this isn't as effective</p> <p>* Some of the local issues are driven by state requirements for reporting. If state doesn't require collection of certain data,, then it is more difficult to get hospitals to collect</p> <p>* Sometimes restricted by privacy laws so cannot present down to zip or neighborhood level</p>		

I.3	Model Standard: Maintenance of Population Health Registries		
<ul style="list-style-type: none"> * Do a good job with Infectious Disease data * Infectious disease outbreak investigations are done well * System is getting better at sharing data; there is an awareness of the need 	<ul style="list-style-type: none"> * Timeliness of the data is where the struggle is. * Still multiple ways that collecting data is being done - difficult to merge the methods * Not using the "best" technology * Data by its nature has a time lag - have to wait on reporting, cleaning, etc. * Chronic disease data needs to be more of a focus * The systems do not talk 	<ul style="list-style-type: none"> * Examine the different ways hospitals collect data and compare 	<ul style="list-style-type: none"> * Look at the possibilities of open source for sharing of data

ESSENTIAL SERVICE 2: Diagnose and Investigate Health Problems and Health Hazards

STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
2.1	Model Standard: Identification and Surveillance of Health Threats		
* New information is readily passed out and available	* There are some gaps in communication of data/info * Labs are sometimes left out because of State-level of dissemination - where does the local fit in?	* Have to move beyond the worry of "scarring" the public with data, but also have to worry about pushing too much information to the public	

2.2	Model Standard: Investigation and Response to Public Health Threats and Emergencies		
<ul style="list-style-type: none"> * There is always an after action process completed and evaluated after an incident. * Written guidelines exist for incidents, not sure where it is shared * Immediate response to events is extremely quick 	<ul style="list-style-type: none"> * Follow-up on after-action report is not necessarily checked on * The sharing of written instructions is sometimes difficult to find for some partners 	<ul style="list-style-type: none"> * Sharing of location of written plans/instructions for incidents 	

2.3	Model Standard: Laboratory Support for Investigation of Health Threats		
<ul style="list-style-type: none"> * Lots of access to labs * Optimal level of activity on written guidelines, rules for handling samples even if it might take awhile to get reports on handle some specimens. 	<ul style="list-style-type: none"> * Working together has not been done as well * No real standardized way of doing this * Might take awhile to get certain reports for how to handle specimens * Do not have the capacity for interoperability 		

ESSENTIAL SERVICE 3: Inform, Educate, and Empower People about Health Issues

STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
3.1	Model Standard: Health Education and Promotion		
<ul style="list-style-type: none"> * There is evidence of this work in the community * So much has happened/is happening in the community, just need more concrete evidence of outputs of efforts 	<ul style="list-style-type: none"> * Policy makers and the public are not informed as much about "good" decisions for healthier lifestyles. * room for improvement * No real coordination of efforts between partners * Need more promotion at the ground level * Stakeholders and partners might be aware of activities, but public is not as aware * Lack of media support 	<ul style="list-style-type: none"> * Need to reach out more at the ground level in the community * Need to ask what people need, not simply what they think about something that someone else has already set-up * Media needs to stay involved to keep residents involved 	

3.2	Model Standard: Health Communication		
<ul style="list-style-type: none"> * Messages are good * Some organizations are doing a lot to alert media * We are going in the right direction * When our message gets out it appears targeted to right audience 	<ul style="list-style-type: none"> * Media support is limited * Limited by funding about what we can get out * Public is not aware of great services available * Health is not seen as a priority (by media, public) * Adoption to message is slow * Despite efforts to engage media, the media is not picking up the message * No real proof of support * Our messages tend to be reactionary versus preventative * Local media sometimes don't pick up local health-related stories until national media picks it up * No local health reporter * Lack of diversity in spokespersons on public health issues - need more effective spokespeople 	<ul style="list-style-type: none"> * continued reaching out to media allies 	

3.3	Model Standard: Risk Communication		
<ul style="list-style-type: none"> * Excellent organized program * Each organization knows their role and there is a plan * Every PIO's # is in the SCHED's PIO's contact list * All partners in Local Public Health System are involve in emergency exercises * There is a significant amount of training available for employers, volunteers, and community members on risk and emergency responses 	<ul style="list-style-type: none"> * Usually more reactionary that proactive * Each organization has their own plan and it may seem fractured as a system at times 		

ESSENTIAL SERVICE 4: Mobilize Community Partnerships to Identify and Solve Health Problems

STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
4.1	Model Standard: Constituency Development		
<ul style="list-style-type: none"> * there is some activity around creating a list of community organizations * there is a desire to get more people at the table * representativeness has improved quite a bit * Active encouragement of participants * Plenty of meeting opportunities for people to gather and discuss issues 	<ul style="list-style-type: none"> * the maintenance of any list is problematic * everyone has their own process or list * no actual process * invitation to table is more result of social networks versus going into the community * Need to work on follow-thru from meeting discussions * Lack of community knowledge about what meetings are occurring 	<ul style="list-style-type: none"> * Establishing a 'action steps' list as an outcome of meetings 	<ul style="list-style-type: none"> * continued engagement and community outreach

4.2	Model Standard: Community Partnerships		
* Doing the best we can given the resources	* Lack of resources makes this challenging		

ESSENTIAL SERVICE 5: Develop Policies and Plans that Support Individual and Community Health Efforts

STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
5.1	Model Standard: Governmental Presence at the Local Level		
<ul style="list-style-type: none"> * Local public health system is addressing so many health issues despite funding challenges * More governmental support today than in the past * Good relationships in the system; able to convene people together to talk about their role in local public health system * Many elements of the local public health system are provided by agencies outside of SCHD and these agencies come to the table and support when asked and provide support * An increased visibility and support from local government of public health * Pockets of activity (eg, community health assessment) working towards accreditation process 	<ul style="list-style-type: none"> * Lack of funding an issue - for example, the City of Memphis pulled out funding from local health department, deductions in state funding * Limited communication between the universities (primarily UTHSC and UofM) * Not thinking "upstream" about public health from all sectors of the community * No awareness outside SCHD about accreditation and what that means for a local health department (accreditation is relatively new process) * Partners don't know their role to support SCHD in accreditation process * SCHD is the agency that is held responsible for the local public health system and that is how the public sees it * Elected officials, overall, do not see public health as a priority * Have to rely on grants to do prescribed work - need more flexible dollars to deliver innovative services * If issue does not present imminent danger, then public health does not push for funds 	<ul style="list-style-type: none"> * Need to do a better job about informing government level about social determinants * Build upon partnership support to encourage continued local government participation and support of public health system 	

5.2	Model Standard: Public Health Policy Development		
<ul style="list-style-type: none"> * There is evidence of engagement in activities to inform policy * Some health organizations do talk with policymakers about health issues * Discussions with policymakers are happening * Due to Affordable Care Act, elected officials are engaged in learning about health concerns and policies * Can't say efforts are minimal because there are large coalitions (Memphis Business Group on Health, Memphis Tomorrow, Healthy Shelby, etc) that are engaging in activities and discussions 	<ul style="list-style-type: none"> * While engagement may be high, the resulting action is low * Not all of the local public health system partners are involved in discussions/advocacy * Policy work is not addressing social determinants as much as it should * No review of policies - more of a reactive than proactive process 		

5.3	Model Standard: Community Health Improvement Process and Strategic Planning		
<p>* Activity is happening around assessments and engaging partners in this process</p> <p>* Plans have been developed (eg, Infant Mortality) but do not hold accountability to different partners</p> <p>* Some organizations have incorporated healthy living/eating components into their planning and mission, but in segments, not a cohesive process</p>	<p>* too early to see resulting actions</p> <p>* We have no idea how to properly articulate population health to entire local public health system</p> <p>* No real accountability built into any plans that have been developed</p> <p>* Other system partners may or may not have included public health improvement in their strategic plans</p> <p>* We don't have a Community Health Improvement Plan (CHIP), so difficult for partners to link to this or put into their mission</p> <p>* Any public health activity in a organization's mission is not tied to an overarching strategic CHIP for Shelby County</p>		

5.4	Model Standard: Plan for Public Health Emergencies		
<ul style="list-style-type: none"> * Multiple partners within the system are involved * Plans are in place and shared with various sectors * Regular drills occur every two years with multiple sectors involved 			

ESSENTIAL SERVICE 6: Enforce Laws and Regulations that Protect Health and Ensure Safety

STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
6.1	Model Standard: Review and Evaluation of Laws, Regulations, and Ordinances		
<p>* Awareness amongst some in the local public health systems about laws, regulations, and ordinances</p> <p>* Every level has available legal counsel</p>	<p>* Not all partners in the local public health system are aware of these regulations, laws, and ordinances</p> <p>* Laws are only reviewed as a reaction to an occurrence or new gained knowledge - not proactively reviewed</p> <p>* No standardized process for reviewing laws every 5 years</p> <p>* Capacity of legal counsel is an issue, not availability - lots of work to do for one person</p>		

6.2	Model Standard: Involvement in the Improvement of Laws, Regulations, and Ordinances		
<ul style="list-style-type: none"> * There has been some proactive work (eg, blight, healthy eating & active living) * Community is shouting for change, but as a reaction * See change of laws, regs, and ordinances in terms of environmental health issues 	<ul style="list-style-type: none"> * System tends to be more reactive than proactive * Need to understand how laws impacting social determinants impact health (eg, living wage, transportation funding, unified school district) * Change people seek usually has public health as a unintended result, not the fundamental call for change * See change of laws, regs, and ordinances in terms of environmental health issues, not as much as in community health 	<ul style="list-style-type: none"> * The issues calling for law change needs to "hit home" to get community support 	

6.3	Model Standard: Enforcement of Laws, Regulations, and Ordinances		
<ul style="list-style-type: none"> * Evidence of some general knowledge about which organization have authority to enforce laws, regs, ordinances * The system knows who with authority to pull into certain circumstances * Education about laws, regs, and ordinances are made available * Some work around evaluation of compliance with laws is visible (eg, immunization records at schools) 	<ul style="list-style-type: none"> * Public may not necessarily know the specifics of who to contact regarding some laws, but they are correct a lot of the time * Education of laws, regs, ords, available but retention of information not be available * System enforces laws but doesn't necessarily go on to the next step of evaluating reporting/complying with laws 		

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

STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
7.1	Model Standard: Identification of Personal Health Service Needs of Populations		
<p>* Everyone in the systems has good knowledge and is aware that some people do not have access to personal health services</p> <p>* System understands the big reasons people do not get the care they need</p>	<p>* Awareness is evident, however, people are discouraged because not enough action is seen taking place to address these barriers</p> <p>* For example, transportation, we know this is an issue but local public health system hasn't addressed this or put it into their strategic planning</p> <p>* We know who some are but not necessarily all populations in need of access to services</p> <p>* Residents are not active parts of the planning process</p> <p>* Not acknowledging social determinants the way we should in healthcare settings</p> <p>* Local public health system has not identified its role in addressing social determinants</p> <p>* Very little activity in defining partner roles and responsibilities to respond to unmet needs in the community</p> <p>* System does not get down to the granular level for understanding reasons people don't get the care they need</p> <p>* In terms of delivery of services we are fixed in the medical model versus the population health model</p>	<p>* Need to take services to where people are not vice versa</p>	

7.2	Model Standard: Assuring the Linkage of People to Personal Health Services		
<p>* We are good about communicating to people about the available services</p>	<p>* Good about communication of services but not necessarily following through to see if they actual got the services</p> <p>* Providers/hospitals may not know what exactly is the service people need or how to get them linked to that service</p> <p>* Need health navigators to close the loop of service needs and delivery of services</p> <p>* Some activity of signing up people for public benefits, but not much</p>	<p>* Need to focus on assurance and follow-thru; did people get the services they need</p>	

ESSENTIAL SERVICE 8: Assure a Competent Public and Personal Health Care Workforce

STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
8.1	Model Standard: Workforce Assessment, Planning, and Development		
<p>* The U of M School of Public Health, and private sector, is doing some workforce assessment work</p> <p>* Some sectors would be considered "optimal" at ensuring required certificates, licenses, and education to fulfill job duties</p>	<p>* There workforce assessment work is fragmented at best, there is no global review</p> <p>* If no global workforce assessment, then there cannot be a real gap assessment</p> <p>* Internal workforce assessments are not typically shared between agencies, so cannot compare to have an across the board assessment of workforce to base planning on</p> <p>* People are trained to do specific jobs but little coordination amongst partners about those jobs</p> <p>* Not all organizations in public health system have established competencies - particularly areas where it is not legally required.</p> <p>* We do what is required, but not above that</p> <p>* We are training people but they go outside of Memphis for work</p>		

8.2	Model Standard: Public Health Workforce Standards		
<ul style="list-style-type: none"> * Training and education opportunities are increasing * Some sectors are very good at basing hiring and performance on the public health competencies 	<ul style="list-style-type: none"> * Some job descriptions are not functional or specific * Sometimes certification or licensure for positions is not affordable for people who have been doing that specific job well for years (eg, home health care, childcare, etc) * Lack of coordination and communication between various sectors about competencies, planning, and development of workforce is the biggest issue 		

8.3	Model Standard: Life-Long Learning through Continuing Education, Training, and Mentoring		
<ul style="list-style-type: none"> * Training is available and present, the quality of training is a factor * Plans for U of M SPH and SCHD to meet and discuss linking training to needs of local public health system workforce * More training/education opportunities available with new School of Public Health * Getting better at supporting collaborations between organizations in local public health system for training and education. 	<ul style="list-style-type: none"> * We need to have more job opportunities for the talent we have * Access to life-long learning opportunities may not be accessible to everyone * Need to determine if the training available is meeting the needs of the workforce * Unsure of quality differences between online training and in-class training * Training opportunities for all local public health system partners is not always available 	<ul style="list-style-type: none"> * Plans for U of M SPH and SCHD to meet and discuss linking training to needs of local public health system workforce 	

8.4	Model Standard: Public Health Leadership Development		
<p>* Efforts like Leadership Memphis are working towards increasing opportunities for all to have leadership development</p> <p>* Some great work to include a diversity of community members and leaders</p> <p>* MAPP process is an example of a start toward increasing a shared vision of community health and encouraging participation from community for leadership in public health issues</p>	<p>* Not all partners (or employees at all levels) have access to leadership development and opportunities - opportunities seem to be very selective</p> <p>* Not all geographic and economic levels are given the same access</p> <p>* No real development as a leader, who are crowned or self-identify</p> <p>* Funding sources limit the potential to be flexible in grooming leaders; funding helps to create the place in which we find ourselves</p> <p>* All community members are not necessarily welcomed, so not all opinions are always included</p> <p>* We thinking of diversity in leadership, we typically just factor race (black/white) - diversity is more than just race alone. Tables are not inviting; it takes an active invitation to make people feel welcomed</p> <p>* There is no real understanding of how different organizations promote leaders across the board</p>		

ESSENTIAL SERVICE 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
9.1	Model Standard: Evaluation of Population-Based Health Services		
<ul style="list-style-type: none"> * Some client satisfaction surveys are being completed at various agencies * Some gap analysis activities are happening (Ryan White, Healthy Shelby, Memphis Health Center) just not a single effort * Some evaluation is required for funding purposes - that work is getting done 	<ul style="list-style-type: none"> * Little evaluation activity happening in regards to the delivery and quality of health services * Lots of activities happening around within organizations, but not in terms of a single effort to evaluate the system overall * Public health is more than just direct care services, we tend to go for lower hanging fruit because of the lack of resources * No knowledge if action is being taken based on the evaluation results 		

9.2	Model Standard: Evaluation of Personal Health Services		
<ul style="list-style-type: none"> * Activity is happening around evaluation of personal health services, but fractured * Many providers conduct customer satisfaction surveys * Technology being used to monitor services (eg, electronic medical records) 	<ul style="list-style-type: none"> * Much of the activity is in silos, no single evaluation * Technology is being used, but not a strategic ally * Little information on whether evaluation findings are being used to improve programs/services 		

9.3	Model Standard: Evaluation of the Local Public Health System		
<ul style="list-style-type: none"> * Many partners are being identified, but not ALL * Some activity to conduct an assessment of local public health system (currently) * Efforts being made to breakdown silos 	<ul style="list-style-type: none"> * still room at the table for additional partners * Some partners may not have even been considered * Still in a stage where everyone is in their silo * No real assessment of local public health system has occurred since 2006 		

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

STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT / PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
10.1	Model Standard: Fostering Innovation		
<p>* Some activity around research opportunities and suggestions, but is more in silos</p>	<p>* Lack of communication about innovation or research throughout the entire local public health system * True participatory research does not always happen</p>		

10.2	Model Standard: Linkage with Institutions of Higher Learning and/or Research		
<ul style="list-style-type: none"> * Relationship building between organizations and higher education have definitely started * Public health system has gotten better with an increase in coalitions and collaborations * Local public health system is strong with opportunities for higher ed to provide field training and continuing education 	<ul style="list-style-type: none"> * Some partners in the systems (law enforcement, neighborhood associations) need to be at the table more * Research collaborations between ALL higher ed institutions is not happening * True community-based participatory research isn't always happening - depends on who is the principal investigator (PI) * Still some fear about research among the community 		

10.3	Model Standard: Capacity to Initiate or Participate in Research		
<ul style="list-style-type: none"> * Some isolated pockets making efforts to make data available to partners and public * Some efforts at collaboration happening, but not all partners are at the table 	<ul style="list-style-type: none"> * Not all collaborators/researchers participate without a hidden agenda * There are a few selective partners, not the whole community * Very little sharing or real resources for research - lots of territorialism - reluctant to share data or funds * Somewhat difficult to find data results publicly - rarely found at different educational levels or languages * Very minimal (only in very specific isolated instances) efforts to evaluate public health systems research throughout all stages - from planning to impact on local public health practice 		

APPENDIX C: Additional Resources

General

Association of State and Territorial Health Officers (ASTHO)

<http://www.astho.org/>

CDC/Office of State, Tribal, Local, and Territorial Support (OSTLTS)

<http://www.cdc.gov/ostlts/programs/index.html>

Guide to Clinical Preventive Services

<http://www.ahrq.gov/clinic/pocketgd.htm>

Guide to Community Preventive Services

www.thecommunityguide.org

National Association of City and County Health Officers (NACCHO)

<http://www.naccho.org/topics/infrastructure/>

National Association of Local Boards of Health (NALBOH)

<http://www.nalboh.org>

Being an Effective Local Board of Health Member: Your Role in the Local Public Health System

<http://www.nalboh.org/pdffiles/LBOH%20Guide%20-%20Booklet%20Format%202008.pdf>

Public Health 101 Curriculum for governing entities

http://www.nalboh.org/pdffiles/Bd%20Gov%20pdfs/NALBOH_Public_Health101Curriculum.pdf

Accreditation

ASTHO's Accreditation and Performance Improvement resources
<http://astho.org/Programs/Accreditation-and-Performance/>

NACCHO Accreditation Preparation and Quality Improvement
<http://www.naccho.org/topics/infrastructure/accreditation/index.cfm>

Public Health Accreditation Board
www.phaboard.org

Health Assessment and Planning (CHIP/ SHIP)

Healthy People 2010 Toolkit:

Communicating Health Goals and Objectives

<http://www.healthypeople.gov/2010/state/toolkit/12Marketing2002.pdf> Setting Health

Priorities and Establishing Health Objectives

<http://www.healthypeople.gov/2010/state/toolkit/09Priorities2002.pdf>

Healthy People 2020:

www.healthypeople.gov

MAP-IT: A Guide To Using Healthy People 2020 in Your Community

<http://www.healthypeople.gov/2020/implementing/default.aspx>

Mobilizing for Action through Planning and Partnership:

<http://www.naccho.org/topics/infrastructure/mapp/> MAPP Clearinghouse

<http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/> MAPP Framework

<http://www.naccho.org/topics/infrastructure/mapp/framework/index.cfm>

National Public Health Performance Standards Program

<http://www.cdc.gov/nphpsp/index.html>

Performance Management /Quality Improvement

American Society for Quality; Evaluation and Decision Making Tools: Multi-voting <http://asq.org/learn-about-quality/decision-making-tools/overview/overview.html>

Improving Health in the Community: A Role for Performance Monitoring

<http://www.nap.edu/catalog/5298.html>

National Network of Public Health Institutes Public Health Performance Improvement Toolkit

<http://nnphi.org/tools/public-health-performance-improvement-toolkit-2>

Public Health Foundation – Performance Management and Quality Improvement

<http://www.phf.org/focusareas/Pages/default.aspx>

Turning Point <http://www.turningpointprogram.org/toolkit/content/silostosystems.htm>

US Department of Health and Human Services Public Health System, Finance, and Quality Program

<http://www.hhs.gov/ash/initiatives/quality/finance/forum.html>

Evaluation

CDC Framework for Program Evaluation in Public Health

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm>

Guide to Developing an Outcome Logic Model and Measurement Plan (United Way)

http://www.yourunitedway.org/media/Guide_for_Logic_Models_and_Measurements.pdf

National Resource for Evidence Based Programs and Practices

www.nrepp.samhsa.gov

W.K. Kellogg Foundation Evaluation Handbook

<http://www.wkkf.org/knowledge-center/resources/2010/W-K-Kellogg-Foundation-Evaluation-Handbook.aspx>

W.K. Kellogg Foundation Logic Model Development Guide

<http://www.wkkf.org/knowledge-center/resources/2006/02/WK-Kellogg-Foundation-Logic-Model-Development-Guide.aspx>

Forces of Change Assessment Report



INTRODUCTION

The Forces of Change Assessment (FOCA) serves to identify and understand the forces (trends, factors, and/or events) that are influencing health and quality of life in Shelby County.

Methodology

The Forces of Change Assessment Work Group met throughout April and June 2013 to formulate the logistics of conducting the FOCA. The finalized approach involved a three hour brainstorming session held in lieu of the MAPP partnership meeting in July 2013. Prior to the session, participants were provided with a Forces of Change worksheet to stimulate thoughts about forces that are impacting community health in Shelby County.

Brainstorm session participants were divided into small groups to discuss forces and identify the threats and opportunities posed by these forces. At the conclusion of the session, the notes gathered from each small group were compiled into a single “Forces of Change Worksheet” and shared among all MAPP partners for edits, comments, and general feedback. At the end of this comment period, the FOCA identified twenty forces that could impact community health in Shelby County.

IDENTIFIED FORCES OF CHANGE

In the Forces of Change Assessment, MAPP partners were asked “*What is occurring or might occur that affects health of Shelby County?*” and, “*What specific threats or opportunities are generated by these forces?*” The following table provides some of the major forces identified by the MAPP partnership.

These forces are categorized as trends, events, and factors, defined as:

- Trends are patterns over time
- Events are one-time occurrences
- Factors are discreet elements

In compiling this list, we understand that forces will dissipate and rise, as will the threats and opportunities which each present. Therefore, this assessment should be viewed as a snapshot of forces of change versus a definitive list.

Table 1. Identified Forces of Change

Trends	Events	Factors
Changing demographics	School district merger	Racial & economic divisions in Shelby County
Decreases in local, state, and federal funding	Affordable Care Act	Elected officials and politics
Growing inequalities (health and wealth)	Local flooding	Public health language: Individual-minded vs. Community-minded
Urban planning initiatives	Extreme heat	High poverty rates
Culture and lifestyle	Obesity declared a disease	Geographic location (Tri-State area)
Crime and violence		Technology
Health disparities		Tax policy
Lack of mental health care		
Changes in local food system		

TRENDS: THREATS AND OPPORTUNITIES

Table 2. Trends: Threats, and Opportunities

Trends	Threats	Opportunities
Changing demographics:	<ul style="list-style-type: none"> • Aging population = increased health care costs • Immigrant and minority communities = limited access to care/health disparities • Aging population = changing funding formula for SW TN Aging Commission • Immigrant population = impacts on communicable disease control 	<ul style="list-style-type: none"> • Ingenuity that younger generation can bring • Growing Latino population will demand attention to linguistic challenges in U.S. and Shelby County
Decreases in local, state, and federal funding	<ul style="list-style-type: none"> • Uncertainty for programs • Loss of programs = loss of jobs, benefits, etc. • Decreased care for people in underserved neighborhoods • Fire fighter/police reductions in staff • Reduction in government services • Reduction in first responders puts us at risk in case of emergency events • Reduced funding for Environmental Protection Agency (impacts on health of air & water quality monitoring) • Impact on environmental safety 	<ul style="list-style-type: none"> • Pushes us towards need for increased collaboration • Changes mindset to embrace change, new ideas • Presents new tax opportunities • Capitalize on Governor's Health & Wellness Initiatives • Less duplication of services
Growing inequalities (health and wealth)	<ul style="list-style-type: none"> • Social determinants have an impact • Challenging problem to address • Lack of primary care providers 	<ul style="list-style-type: none"> • Makes Memphis and Shelby County a good candidate for funding opportunities • Addresses required community benefit for hospitals
Urban planning initiatives	<ul style="list-style-type: none"> • Current built environment not supportive of health • Blight, vacant properties 	<ul style="list-style-type: none"> • Mid-South Regional Greenprint Grant's focus on health • Renewed interest in inner city development • Urban planners are interested in public health linkages • Availability of vacant land that can be converted to gardens, parks, etc
Culture and lifestyle	<ul style="list-style-type: none"> • Quick access to information • Society more sexually permissive • Single parent families • Social media 	<ul style="list-style-type: none"> • Quick access to information • Single parent families • Social media

Crime and violence	<ul style="list-style-type: none"> • Violence may discourage use of parks, greenspace, or community gardens • Concealed weapons laws • Impact on perceived safety in community 	<ul style="list-style-type: none"> • Neighborhood watch programs are active • Shelby County Sheriff Office Crime Prevention workshops available
Health disparities	<ul style="list-style-type: none"> • Social determinants impact this • Challenging problem to address • Lack of primary care providers • Poverty, health literacy, etc 	<ul style="list-style-type: none"> • Makes us a good candidate for funding • Addresses required community benefit for hospitals
Lack of mental health care	<ul style="list-style-type: none"> • Lack of mental health providers • Lack of substance abuse treatment/care • Inadequate access for those in need 	
Changes in local food system	<ul style="list-style-type: none"> • Unequal access to healthy food • Failure of California law on food labeling • Genetically modified agriculture • Valuing convenience over healthy eating • Lack of grocery store options 	<ul style="list-style-type: none"> • Changing school food offerings • Food Advisory Council Work • Emerging food security support infrastructure • Local agriculture (community gardens, school gardens) • Community level education around fresh food preparation or gardening

EVENTS: THREATS AND OPPORTUNITIES

Table 3. Events: Threats and Opportunities

Events	Threats	Opportunities
School district merger	<ul style="list-style-type: none"> • Transition process • Lay-offs • Less money per pupil • Lack of quality education has grave impacts on health • Number of children in public vs. private schools • Uncertainty w/ municipalities school district • Availability of preschool • Proliferation of charter/private schools • Increased property taxes • Stress – parents, students, teachers • Uncertainty in personal benefits • Increase of bullying • Transition distractions may deter focus on important of student’s health 	<ul style="list-style-type: none"> • Services not part of SCS previously, can now be available and vice versa. • Utilizing partnerships from each system • Opportunity to fill some gaps in services • New leadership • More equity • More effective use of funds • Changes in special education • Employers may implement healthy living/activities at work
Affordable Care Act (ACA)	<ul style="list-style-type: none"> • All don’t understand ACA • Transition to ACA • Health exchange – understanding • For profit health insurance industry • Possible closing of smaller/rural hospital • Lots of poor still not covered by exchange and non-expansion of Medicaid • Young/healthy people may not buy in • Stalemate on State mandated change not good for us locally • Could lead to under-employment 	<ul style="list-style-type: none"> • May improve access • Health exchange • Preventative services coverage/well-care • Community benefit agreement for non-profit hospitals • Establishment of single-payer system; lower health care costs • Michele Obama’s anti-obesity efforts
Local flooding/ Extreme heat	<ul style="list-style-type: none"> • Increase in mosquitoes, vector-borne diseases (West Nile) • Dislocation 	<ul style="list-style-type: none"> • Awareness of the potential effects of global warming • Tests our emergency plans
Obesity declared a disease	<ul style="list-style-type: none"> • Economic gain by declaring it a disease • Market for new medications, treatments • May accelerate stigma 	<ul style="list-style-type: none"> • Impacts to how it is treated & paid for

FACTORS: THREATS AND OPPORTUNITIES

Table 4. Factors: Threats and Opportunities

Factors	Threats	Opportunities
Racial & economic divisions in Shelby County	<ul style="list-style-type: none"> • Internal classism • Health inequality/disparities • Social determinants of health 	
Elected officials and politics	<ul style="list-style-type: none"> • Discrimination in government • Political infighting • Political leadership not representative of people • Impacts funding decisions; creates uncertainty • Politicians who don't know implication of policies they support or don't support 	<ul style="list-style-type: none"> • Every election an opportunity • Taxes to address • Voting privilege/rights • Governor's Health & Wellness Initiatives
Public health language: Individual vs. Community-minded	<ul style="list-style-type: none"> • Poses a threat to public health's work towards "common good" • Focus on individual 	<ul style="list-style-type: none"> • Forces us to speak same language
High poverty rates	<ul style="list-style-type: none"> • Gap between rich & poor • Cost of eating & living healthy • Health disparities • Parents having to work more – lack of after-school or summer activities 	<ul style="list-style-type: none"> • Makes us a good candidate for funding • Addresses required community benefit for hospitals
Geographic location (Tri-State area)	<ul style="list-style-type: none"> • Tri-State area – spill effects from neighboring states 	<ul style="list-style-type: none"> • Potential for unique collaborations
Racial/ethnically diverse county	<ul style="list-style-type: none"> • 	
Technology	<ul style="list-style-type: none"> • Not all have access • Need for users to locate, critically evaluate, and apply information • Overwhelming amount of info 	<ul style="list-style-type: none"> • New platforms for addressing health • Could impact health literacy
Tax policy	<ul style="list-style-type: none"> • Effect on migration in/out of county • Impact on food prices • Impact on education • Tax burden inequality 	<ul style="list-style-type: none"> • Potential funding source for programs

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