

Cochise County Arizona Community Health Improvement Plan



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CHA Process/Results Executive Summary

Beginning early in 2012, Cochise Health and Social Services (CHSS) received funding and technical assistance from the Arizona Department of Health Services (ADHS) to conduct a comprehensive, county-wide Community Health Assessment (CHA). The purpose of the Cochise County CHA was to determine the self-identified current health status of our residents, what they identified as barriers to accessing health care, what types of services they are currently using, the residents' definition of what would constitute a healthy community, our major health challenges, and what would improve access to healthcare throughout Cochise County.

Data was collected from September through December 2012. A total of 558 surveys were started online in Survey Monkey. Of these, 505 (90.5%) were completed. All responses were tabulated, including those received on the incomplete surveys. Just over 68% of those completing the survey were female. This is not representative of the County's population which is 51% male. Secondary data provided by ADHS from the Behavioral Risk Factor Surveillance System (BRFSS) was also used to compare Cochise County results with Arizona as a whole for those indicators that matched the questions in our CHA. The following Health Priorities were identified by respondents:

The top five **serious health concerns** were diabetes (39.4%), obesity (39.4%), aging problems (33.3%), availability of medical services (32.0%), and cancer (31.6%).

The top three **social issues** identified were immigration (49.0%), domestic violence (37.2%), and dropping out of school (32.8%).

The top three items **most important for a healthy community** were good jobs and healthy economy (65.5%), good schools (51.5%), and strong family life (30.4%). Healthy behaviors and lifestyles received 30.0% rating, just slightly below strong family life.

The top six items that would **improve our community's access to healthcare** were improved quality of care (54.6%), more specialty providers (45.6%), more primary care providers (42.6%), greater health education services (37.8%), outpatient services expanded hours (37.3%), and transportation assistance (34.7%).

Serious Health Concerns

1) Diabetes; 2) Obesity; 3) Aging Problems; 4) Availability of Medical Services (will be addressed in Access to Care Section); and 5) Cancer

It is interesting to note that of these top five identified concerns in the survey, the only two in the top ten leading causes of death in Cochise County in 2008 are cancer (rank #2) and diabetes (rank #8). Heart disease/stroke received 30.4% and this would correspond with the number 1 and 3 causes of death in Cochise County. Diabetes ranks as the number one serious health concern in our CHA and is the eighth leading cause of death in Cochise, yet only 13.4% of respondents report having been diagnosed with diabetes and in the secondary data, BRFSS data indicate 8.02% of County residents have been told they have “pre-diabetes”.

Another unanticipated response was that only 1.3% rate their own overall health as poor and only 0.2% as very poor. We expected these numbers to be higher. Another unexpected response was that 30% of respondents reported having no chronic health conditions at all. This does not seem possible given the fact that 57.1% of respondents were 50 years of age or older. Hypertension was reported at 29.2% when the question was asked about chronic health conditions; however, this is contradictory with the specific question about hypertension to which 42.7% of respondents reported being told that they have hypertension and 35.4% report taking prescription medications to treat. These discrepancies could be attributed to the fact that respondents do not consider hypertension a “chronic disease” and/or that there are a significant number of county residents who have undiagnosed hypertension. This also indicates that even among those who have been diagnosed, they are not taking medications as prescribed.

As with other chronic disease conditions, respondents are not taking medication as prescribed for diabetes and do not identify diabetes as a chronic health condition. Diabetes rates self-reported in survey (13.4%) are higher than ADHS dashboard rates (8.9%).

Social Issues

- 1) Immigration; 2) Domestic Violence; and 3) Dropping Out of School

In reviewing the responses to these survey questions, it became immediately apparent that we did not have all of the community partners we needed on the initial CHA planning committee. We should have (and will now) involve members of our law enforcement community including County Sheriff, City Police Departments, and Border Patrol/Homeland Security, School Superintendent (or designee), representatives from our Regional Behavioral Healthcare Authority (RHBA) Cenpatico and/or their local contractors.

Building Health Communities

- 1) Good Jobs/Healthy Economy; 2) Good Schools; 3) Strong Family Life; and
- 4) Healthy Behaviors/Lifestyles

There were several questions relating to healthy behaviors/lifestyles in the survey. In the area of **weight and nutrition**, only 31% of respondents felt their weight was just right and only 31.6% knew their BMI. Also of concern is that over 16% of respondents do not always have enough money for food for their families. In the area of **tobacco use**, responses indicate that tobacco use in Cochise County is higher than statewide averages and 19.1% report that they do not want to quit. As with the Social Issues noted above, the inclusion of additional community partners will be helpful in addressing this priority as well.

Improving Access to Healthcare

- 1) Improved Quality of Care; 2) More Specialty Providers; 3) More Primary Care Providers; 4) Greater Health Education Services; 5) Outpatient Services Expanded Hours; and 6) Transportation Assistance

Nearly 50% of respondents learned about health care services by word of mouth or internet/websites. It is concerning that 15.8% of respondents travel more than 50

miles for health care services. Also of concern is that a full 48% of respondents said that they would choose a hospital in Tucson for services needed in the future, even though 88.1% reported that they were somewhat satisfied, satisfied or very satisfied with the care they received locally in the last year. Not surprisingly considering our proximity to the border, 13.6% of respondents report receiving care in Mexico. We were happily surprised that only 6.7% of respondents had received **no** prevention testing or services at all in the last year. The responses about use of emergency room indicate a need for education about other service options.

We were surprised that 56.5% of respondents had health insurance covering everyone in their households. However, in what seems to be a contradictory response, over 77% of respondents reported that they had delayed care because they were unable to pay for it.

Due to the small percentage of respondents living with young children, it is hard to feel good about the high rate of immunization reported (97.4%) as well as the responses that almost 90% are current with immunization schedule.

Just over 77% of respondents report they had delayed getting care because they were unable to pay for it. There are three RHC and four FQHC facilities in Cochise County and the FQHC has a mobile unit that travels to the more rural and medically underserved areas of the County. All of these facilities offer sliding fee schedule or free services based upon income, but apparently a high percentage of respondents are not aware of this option for health care.

One challenge consistently identified by all of the healthcare providers in Cochise County is the lack of and/or access to **Behavioral Health Services** for our population. While a relatively low percentage (11.8%) of survey respondents had interacted with the mental health service providers in the last year, those who responded to this question (449) identified drug abuse, depression and alcohol abuse as the biggest behavioral or mental health issues facing Cochise County.

Strategies for Addressing Healthcare Priorities

In an article published in *Preventing Chronic Disease* in 2012 entitled “Tools for Implementing an Evidence-Based Approach in Public Health Practice” by Jacobs, Jones, Gabella, Spring, and Brownson, the importance of implementing evidence-based practices was highlighted. The authors define the practice of evidence-based public health (EBPH) as “an integration of science-based interventions with community preferences for improving population health”. The concept of EBPH has evolved simultaneously in the disciplines of medicine, nursing, psychology, and social work. The authors note that “scholars in these related fields seem to agree that the evidence-based decision-making process integrates: 1) best available research evidence; 2) practitioner expertise and other available resources; and 3) the characteristics, needs, values, and preferences of those who will be affected by the intervention.”

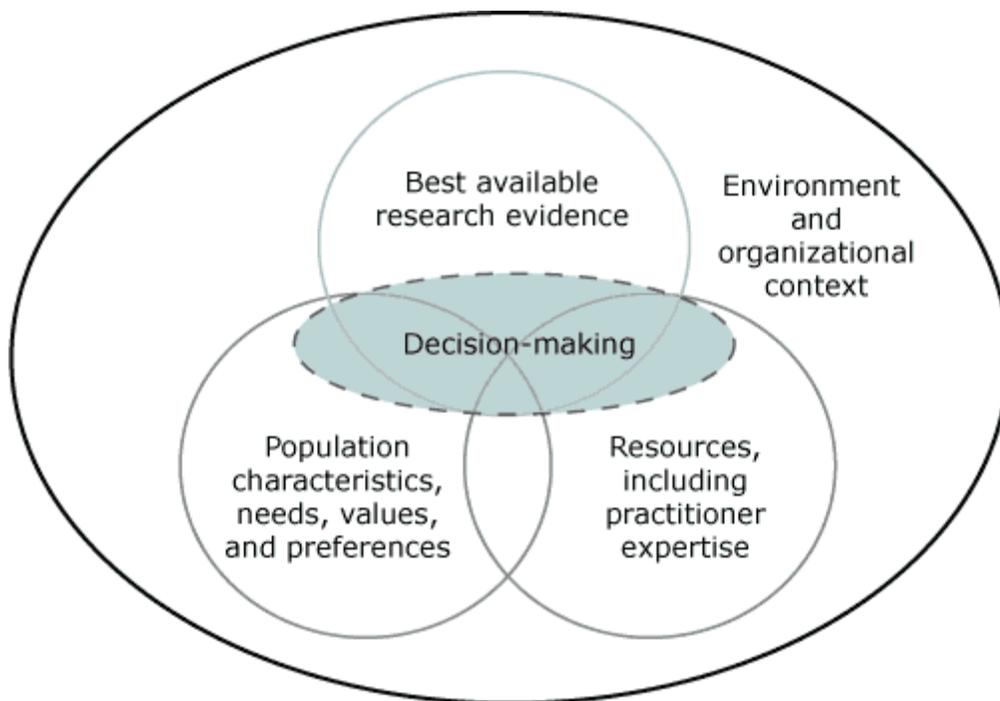


Figure. Satterfield JM, Spring B, Brownson RC, Mullen EJ, Newhouse RP, Walker BB, et al. Toward a transdisciplinary model of evidence-based practice. *Milbank Q* 2009;87(2):368-90

With that model in mind, the following strategies were developed by the CHSS Leadership Team in early 2013. They have not been prioritized or finalized until reviewed with our community partners to develop a work plan for implementation.

Serious Health Concerns (Chronic Diseases)

- 1) Diabetes; 2) Obesity; 3) Aging Problems; 4) Availability of Medical Services (to be addressed in Access to Care Section); and 5) Cancer

Strategy	Lead	Initial Actions	EBPH?	Date
Convene CHIP Partners Meeting	Local Health Officer (LHO)	Schedule next meeting Aug 2013		Aug 2013
Convene stakeholders meetings twice/yr	LHO	Schedule initial meetings for Sept, 2013		Sept 2013
Distribute data from CHA to community partners and county-wide	LHO	Meeting with BOS (7/9/13) and then CHIP Steering Committee		Aug 2013
Support community efforts for healthcare exchange enrollment	LHO	Meet with County Librarian to plan set up of kiosks in all county libraries		Aug 2013
Increase # of health screening opportunities county-wide	TBD	TBD	Y	TBD
Increase availability of nutrition and exercise programs in schools and in workplaces	Dir Prev Svcs (DPS)	Meet with Prevention Services staff to identify current programs and potential add'l sites	Y	Aug 2013
Promote enrollment in CDSMPs	DPS	Meet with CDSMP Master Trainers to review current schedule of classes and means to promote	Y	Aug 2013

Social Issues

1) Immigration; 2) Domestic Violence; and 3) Dropping Out of School

Strategy	Lead	Initial Actions	EBPH?	Date
Convene CHIP Partners Meeting	LHO	Schedule next meeting Aug 2013		Aug 2013
Invite members of law enforcement, homeland security and school admin to participate in CHIP steering committee	LHO	July 2013		Jul 2013
Convene stakeholders meetings twice/yr	LHO	Schedule initial meeting for Sept, 2013		Sept 2013
Distribute data from CHA to community partners and county-wide	LHO	Meeting with BOS (7/9/13) and then CHIP Steering Committee		Aug 2013
Identify key issues affecting immigration concerns in Cochise	CHIP Steering	TBD		Aug 2013

Building Healthy Communities

1) Good Jobs/Health Economy; 2) Good Schools; 3) Strong Family Life; and
4) Healthy Behaviors/Lifestyles

Strategy	Lead	Initial Actions	EBPH?	Date
Convene CHIP Partners Mtg	LHO	Schedule next mtg Aug 2013		Aug 2013

Convene stakeholders meetings twice/yr	LHO	Schedule initial meeting for Sept, 2013		Sept 2013
Distribute data from CHA to community partners and county-wide	LHO	Meeting with BOS (7/9/13) and then CHIP Steering Committee		Aug 2013
Increase availability of nutrition and exercise programs in schools and in workplaces	DPS	Meet with Prevention Services staff to identify current programs and potential add'l sites	Y	Aug 2013
Advocate for healthy food choices in all establishments providing food to public – publish nutrition info on menus	DPS	Meet with Prevention Services staff to identify current programs and potential add'l sites	Y	Aug 2013
Food served or sold in govt facilities adhere to USDA nutritional guidelines	LHO	Meet with County Admin and then BOS to discuss feasibility	Y	Oct 2013
Create community gardens	DPS	Meet with Prevention Services staff to identify current programs and potential add'l sites	Y	Aug 2013
Support creation of worksite wellness programs	DPS	Meet with Prevention Services staff to identify current programs and potential add'l sites – equip Fitness rooms in 4 of 5 County Service Centers	Y	Aug 2013

County-wide campaigns to increase physical activity/fitness	DPS	Meet with Prevention Services staff to identify current programs and potential add'l sites	Y	Aug 2013
Facilitate joint use agreements between communities and schools	DPS	Meet with Prevention Services staff to identify current programs and potential add'l sites	Y	Aug 2013
Increase # of tobacco use cessation program referrals	DPS	Meet with Prevention Services staff to identify current programs and potential add'l sites	Y	Aug 2013
Increase # of smoke-free public campuses, public housing	DPS	Meet with Prevention Services staff to identify current programs and potential add'l sites	Y	Aug 2013
Increase policies and practices to support breastfeeding in the workplace	DPS	Meet with Prevention Services staff to identify current programs and potential add'l sites	Y	Aug 2013
Rx Medication Disposal Program	Admin Svcs Mgr & Bd of Health	Meet with City of SV about their program. Discuss expansion plans with BOH next meeting 7/29/13	Y	July 2013

Improving Access to Healthcare

- 1) Improved Quality of Care; 2) More Specialty Providers; 3) More Primary Care Providers; 4) Greater Health Education Services; 5) Outpatient Services Expanded Hours; and 6) Transportation Assistance

Strategy	Lead	Initial Actions	EBPH?	Date
Convene CHIP Partners Meeting	LHO	Schedule next meeting Aug 2013		Aug 2013
Convene stakeholders meetings twice/yr	LHO	Schedule initial meeting for Sept, 2013		Sept 2013
Distribute data from CHA to community partners and county-wide	LHO	Meeting with BOS (7/9/13) and then CHIP Steering Committee		Aug 2013
Support community efforts for healthcare exchange enrollment	LHO	Meet with County Librarian to set up kiosks in all county libraries		Aug 2013
Develop & Distribute Healthcare Resource Guide of all available low and no cost healthcare services	CHIP Steering Committee	TBD		Jan 2014
Promote community awareness of mental and behavioral health services	TBD	Meet with Crisis System Committee 7/10/13 to discuss resources and how currently being promoted		Jan 2014
Identify potential funding sources for regular medical	TBD	TBD		TBD

transport services				
Encourage use of Culturally and Linguistically Appropriate Service (CLAS) standards	TBD	TBD	Y	TBD

Next Steps

- Continue data collection in general with focus on demographics that were under-represented in respondents to date. Specific targeted populations would be males, Hispanics (especially in households speaking other than English), and population under 50 years of age. Distribution of surveys in Spanish should be a priority. Plan circulation of new CHA mid-2014.
- Share current report with community partners and ask for input about distribution methodology. Keep in mind that online and word of mouth communications seem to be preferred methods for outreach. Explore ways to increase use of social media for distribution of surveys and outreach opportunities.
- Education is needed about chronic disease self-management and the importance of early detection and treatment. Need to explore self-reporting of diabetes specifically since incidence and morbidity do not seem to match the high level of importance respondents give diabetes.
- Need to compare CHA responses to questions about childhood immunizations with data from PMMIS to determine if CHA respondents are typical of population.
- Population needs education about RHCs and FOHCs throughout County.
- In this CHA process, we discovered that the Benson Hospital, Sierra Vista Regional Health Center, and the University of Arizona Extension office have also completed CHAs in the recent past. We need to review the results of those CHAs, compare with our results, and use all of these documents to continue to shape our CHIP.