COMMUNITY HEALTH ASSESSMENT

FOR JEFFERSON COUNTY, ALABAMA

August 2014

COMMUNITY MATTERS 20/20

ASSESSMENT, VISIONING AND PLANNING
FOR A HEALTHY JEFFERSON COUNTY

COMMUNITY HEALTH ASSESSMENT FOR JEFFERSON COUNTY, ALABAMA

OVERVIEW OF COMMUNITY MATTERS 20/20

In October 2013, the Jefferson County Department of Health (JCDH) began preparing for the next county-wide community health assessment and strategic planning process. Building on the framework and processes developed during the initial community health assessment and strategic planning process conducted from 2005-2007, JCDH formed a Core Team to begin the planning and design for a comprehensive, community-based assessment and strategic planning initiative utilizing the Mobilizing for Action Through Planning and Partnerships (MAPP) process to be concluded in late 2014. The title for the 2014 assessment and strategic planning process, *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County, AL,* distinguishes the current effort and sets a course for the next anticipated full assessment and strategic planning process; *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County, AL* is led by a steering committee chaired by Jefferson County's Health Officer, Mark E. Wilson, MD, and is composed of fifteen community leaders.

A STRATEGIC APPROACH TO COMMUNITY HEALTH IMPROVEMENT: MAPP

WHAT IS MAPP?

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-wide strategic planning tool for improving community health. Facilitated by the Jefferson County Department of Health, this tool helps the community prioritize public health issues and identify resources for addressing these issues.

BACKGROUND OF COMMUNITY HEALTH ASSESSMENT AND HEALTH STRATEGIC PLANNING USING MAPP IN JEFFERSON COUNTY, ALABAMA

In 2005, the Jefferson County Department of Health (JCDH) led the completion of a comprehensive assessment of the county's public health system utilizing MAPP. After multiple stakeholder meetings and extensive community engagement, JCDH published *Our Community Roadmap to Health,* a document outlining the goals for community health in 2007. JCDH is again initiating this community health strategic planning process to define the community's current and future health-related goals.

HOW MAPP WORKS

The phases of MAPP are shown in the center of Diagram 1, while the four MAPP Assessments, the key content areas driving the process, are shown in the four arrows surrounding the phases.

To initiate the health strategic planning process, lead organizations in the community begin organizing and preparing to implement MAPP (**Organize for Success/Partnership Development**). Community-wide strategic planning requires a high level of commitment from the partners, stakeholders and community residents recruited to participate.

The second phase of MAPP is **Visioning**. A shared vision and common values provide the framework for pursuing long-range community goals. During this phase, the community answers questions such as, *"What would we like our community to look like in ten years?"*

Next, the **four Assessments** are conducted, providing critical insight into challenges and opportunities experienced by the community:

- The **Community Themes and Strengths Assessment** provides a deep understanding of the issues residents believe are important;
- The **Local Public Health System Assessment** offers a comprehensive assessment of how well the local public health system delivers the 10 Essential Public Health Services;
- The **Community Health Status Assessment** identifies priority issues related to community health and quality of life by assessing data about health status, quality of life and risk factors in the community, and
- The **Forces of Change Assessment** focuses on the identification of forces such as legislation, technology and other issues that affect the context in which the community and its public health system operate.

DIAGRAM 1.

While each of these assessments provides important information independently, taken together, these provide a robust assessment of health and quality of life. A list of challenges and opportunities is generated from each of the four assessments.

The fourth phase of MAPP is to **Identify Strategic Issues**. During this phase, participants identify linkages among the

While each of these assessments provides important information independently, taken together, these provide a robust assessment of health and quality of life. A list of challenges and opportunities is generated from each of the four assessments.

The fourth phase of MAPP is to **Identify Strategic Issues**. During this phase, participants identify linkages among the results from the MAPP Assessments to determine the most critical issues to be addressed to enable the community to achieve its vision. After issues have been prioritized, participants **Formulate Goals and Strategies** for addressing each issue.

The sixth and final phase of MAPP is the **Action Cycle**. During this phase, participants plan, implement and evaluate strategies to address the identified strategic issues supporting the shared vision. These activities build upon one another in a continuous and interactive manner to create continued success.

With community input, the following vision statement was endorsed by the Community Matters 20/20 Steering Committee on March 14, 2014 for Jefferson County's health strategic planning process, *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County:*

"JEFFERSON COUNTY, ALABAMA IS AN INCLUSIVE, THRIVING COMMUNITY OF HEALTHY AND CONNECTED PEOPLE."

The following description of terms further defines Jefferson County's vision:

Inclusive reflects the purposeful invitation and acceptance of individuals from all backgrounds within the county - social, economic and cultural. No one is left behind.

Thriving describes the growth and flourishing of the community – economically, educationally, socially, culturally and in other dimensions.

Community represents Jefferson County as a whole: its cities, municipalities, unincorporated areas, neighborhoods and their residents.

Healthy reflects the community's experience of physical, mental, social and spiritual well-being.

Connected describes people working together cohesively to support the improvement of the community as a whole.

This vision statement provides the focus, purpose and direction for Jefferson County's health strategic planning process conducted by the community and coordinated by the Jefferson County Department of Health.

Following the adoption of the vision statement, the *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County, AL,* the Steering Committee planned, implemented and evaluated the results from the four MAPP assessments.

The remainder of this document provides the Executive Summary and full results from the Community Health Status Assessment.

ANALYSIS AND SYNTHESIS OF COMMUNITY HEALTH ASSESSMENT DATA INTO STRATEGIC ISSUES

During the third phase of the Mobilizing for Action through Planning and Partnerships, the four assessments: Community Health Status, Community Themes and Strengths, Local Public Health System and Forces of Change were conducted within and by the community. Details regarding how these assessments were conducted are contained within this document in the sub-sections for each assessment. These four documents comprise the bulk of this document, Jefferson County's Community Health Assessment.

The data informing the Community Health Assessment were both quantitative and qualitative. The rich qualitative data generated through the Community Themes and Strengths and Local Public Health System Assessments were analyzed using a qualitative software package, NVivo 10, to code and classify responses from the Community Themes and Strengths Assessment into three major themes: assets, strengths and weaknesses and into strengths, weaknesses and short and long-term opportunities from the Local Public Health System Assessment. The Qualitative data generated through the Forces of Change Assessment were transcribed from flipcharts where participants' comments were captured and sorted as either an opportunity, threat or concurrent opportunity and threat.

Summaries from the four assessments were provided to the community for review and comment, with a request for the identification of two to three potential strategic issues for improving the health of Jefferson County. All feedback received on the potential strategic issues was incorporated into either the draft list of strategic issues or the goals and tactics supporting the strategic issue. The distribution of the Community Health Assessment was made through the media, placement of the assessments and response tools on the Jefferson County Department of Health's website, www.jcdh.org, and through email distribution to the Community Matters 20/20 Partnership Directory and the Health Action Partnership of Jefferson County's distribution list. No changes to the Community Health Assessment were suggested by the community; however, a number of recommendations for strategic issues for improving the county's health were received and utilized in the fourth phase of Mobilizing for Action through Planning and Partnerships, Identify Strategic Issues.

Phase four of Mobilizing for Action through Planning and Partnerships is the identification of strategic issues. Strategic issues are fundamental policy choices or critical challenges that must be addressed for Jefferson County to achieve its vision of becoming "an inclusive, thriving community of healthy and connected people."

The process of strategic issue identification began with the analysis of the quantitative and qualitative data from the Community Health Assessment. Lists of challenges and opportunities from each assessment were developed from the questions answered by each of the four assessments. Specifically, the Forces of Change Assessment answered the question, "What is occurring or might occur that will affect the local public health system or the community?" Responses to "What is important to Jefferson County, how is quality of life perceived and what assets does Jefferson County have to improve health and quality of life?" were answered through the Community Themes and Strengths Assessment. The Community Health Status Assessment provided answers to "What does Jefferson County's health status look like?" and "How healthy are residents of Jefferson County?" The Local Public Health System Assessment provided response to the question, "What are the activities, competencies and capacities of Jefferson County's Local Public Health System?"

Following discussion of the findings from the four assessments, national data, benchmarks and improvement strategies such as those provided through Healthy People 2020 and the National Prevention Strategy, and the recommended strategic issues generated by the community, the Community Matters 20/20 Core Team developed a draft, non-prioritized master list of the thematic challenges and opportunities identified through the analysis of data from the four assessments with supporting data points. During analysis of the master list of themes, it became apparent that some themes represented the root causes of sub-optimal health and community conditions within Jefferson County while others represented goals and tactics to address those root causes. Each root cause was further assessed for its relevance to the Community Matters 20/20 vision, the extent to which the issue impacts the county and the long-term consequences of not managing the root cause. This process resulted in the identification of the following ten potential strategic issues phrased with the desired direction of change:

- Optimize Healthcare Access, Availability and Utilization
- Encourage Mental Well-being
- Support Educational Processes and Systems to Maximize Individual and Population Health
- Optimize the Built Environment, Transportation System and Safety
- Enhance Environmental Quality
- Freedom from Crime and Violence
- Increase the Responsiveness of Local and Governmental Leadership to the Community and Its Needs
- Diminish Health Disparities Associated with Race, Ethnicity and Economic Status
- Promote Physical Well-being through Healthy Lifestyles
- Prevent and Reduce Homelessness.

The draft list of ten potential strategic issues was presented to the Community Matters 20/20 Steering Committee on August 15, 2014 with a request to prioritize three to five strategic issues to form the base for the Community Health Improvement Plan. To support this process, a presentation of key data findings from the four assessments comprising the Community Health Assessment was provided to supplement the previously distributed Community Health Assessment.

From these presentations, particularly striking were the significant disparities in health and quality of life-related issues experienced by minority and uninsured/low income populations within Jefferson County. Life expectancy for black residents of Jefferson County in 2012 was 3.7 years less than that for white residents. Black residents have significantly higher all cause and childhood mortality rates than white residents, as well as higher mortality rates from heart disease, cancer, cerebrovascular disease, diabetes, septicemia, hypertension, renal disease HIV, homicide and asthma. Especially concerning is that the rate of infant mortality which was over 260% higher in the black population than in the white population in 2012.

One of the key social determinants of health, poverty, is experienced at a much higher rate at 28.4% in the black population than among the white population at 10.1%. As has been denoted in Place Matters for Health in Jefferson County, Alabama: The Status of Health Equity on the 50th Anniversary of the Civil Rights Movement in Birmingham, Alabama, lower life expectancy, poverty and food deserts in Jefferson County map along the areas of the county with the highest population of black residents. The percentage of uninsured white residents was 8.4%, almost half the rate at 16.0% in the black population. Over 39% of Jefferson County's Hispanic residents lacked health insurance. With the exception of children who are United States citizens or lawfully present and some adults with Medicare, health care access remains limited in Jefferson County for adults and children living in poverty.

Contributing to health status and disparities in health outcomes of residents of Jefferson County are the facts that 18.6% of residents are living below the Federal Poverty Level and 40.2% more of Jefferson County's residents were lacking health insurance in 2012 than in 2002. While Jefferson County has experienced a greater than 5% reduction in its total population reporting currently smoking between 2002 and 2012, 20% of the county's residents still smoke. Despite multiple initiatives to reduce the percentage of residents with obesity, the adult obesity rate increased to 34.8%, while the rate of overweight remained static.

Following the data presentations and discussion, the ten draft strategic issues were presented. Wording for five of the draft strategic issues was adjusted slightly to the following: Improve Mental Health, Support Education to Maximize Individual and Population Health, Reduce Crime and Violence, Increase the Responsiveness of Governmental and Other Local Leadership to the Community and Its Needs and Reduce Health Disparities Associated with Race, Ethnicity and Economic Status.

The following criteria were provided to assist in the prioritization process:

- Data supports the inclusion of the strategic issue in the Community Health Improvement Plan;
- Community interest and engagement is present for this strategic issue;
- There are resources currently available or resources can be reasonably expected to be available to address this strategic issue, and
- There are measurable outcomes associated with this strategic issue.

Prioritization was accomplished using a multi-voting process. Each member of the Community Matters 20/20 Steering Committee was given a total of 100 votes to be distributed among any or all of the draft strategic issues after consideration of the prioritization criteria. The votes were then tallied to create a summary score for the strategic issue.

The total votes were as follows:

- Reduce Health Disparities Associated with Race, Ethnicity and Economic Status ..... 314 votes
- Promote Physical Well-being through Healthy Lifestyles ..... 160 votes
- Optimize the Built Environment, Transportation System and Safety ..... 152 votes
- Optimize Healthcare Access, Availability and Utilization ..... 126 votes
- Improve Mental Health ..... 121 votes
- Support Education to Maximize Individual and Population Health ..... 76 votes
- Increase the Responsiveness of Governmental and Other Local Leaders to the Community and Its Needs ..... 62 votes
- Prevent and Reduce Homelessness ..... 43 votes
- Reduce Crime and Violence ..... 30 votes
- Enhance Environmental Quality ..... 15 votes

When placed in rank order, there was a clear distinction between the top and bottom five Strategic Issues. The Community Matters 20/20 Steering Committee, based on the review of the Community Health Assessment and prioritization scores, approved the following strategic issues for Jefferson County:

- **Reduce Health Disparities Associated with Race, Ethnicity and Economic Status**
- **Promote Physical Well-being through Healthy Lifestyles**
- **Optimize the Built Environment, Transportation System and Safety**
- **Optimize Healthcare Access, Availability and Utilization**
- **Improve Mental Health.**

The approved strategic issues were communicated to the community and Jefferson County's Local Public Health System through the Jefferson County Department of Health website, email communication to the Community Matters 20/20 Partnership Directory and the Health Action Partnership Directory and through presentation at community meetings. A request was made during these communications for the submission of goals, strategies and tactics to achieve the strategic issues. The critical feedback received is being utilized in completing the fifth phase of Mobilizing for Action through Planning and Partnerships, Formulate Goals and Strategies, which will result in a community health improvement plan to be operationalized during the sixth and final phase of Mobilizing for Action through Planning and Partnerships. The work plan for achieving these five approved strategic issues and will be published in a forthcoming Community Health Improvement Plan for Jefferson County.

Jefferson County's Local Public Health System, working together with the community to address these issues, will move Jefferson County forward in its vision to be an inclusive, thriving community of healthy and connected people.

The work of Community Matters 20/20 is supported by the Jefferson County Department of Health

Jefferson County
Department of Health

I. JEFFERSON COUNTY, ALABAMA'S
COMMUNITY HEALTH STATUS ASSESSMENT

COMMUNITY MATTERS 20/20

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OVERVIEW OF COMMUNITY MATTERS 20/20

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COMMUNITY HEALTH STATUS ASSESSMENT EXECUTIVE SUMMARY

The Community Health Status Assessment is one of four assessments completed as part of a community health strategic planning process for Jefferson County called *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County.* The Community Health Status Assessment identifies and monitors, over time, quantitative data related to demographics, health status, quality of life and risk factors, as well as social and economic indicators of individual and community health. The Community Health Status Assessment addresses the following questions:

- *How healthy is the community?*
- *What does the health status of the community look like?*

The Community Health Status Assessment identified 165 potential indicators of community health in eleven categories[i]. The assessment captured data for a total of 144 indicators from a variety of national, state and local data sources, both primary and secondary[ii]. Where adequate data were available, trends were evaluated to determine changes in community health status.

An eight member Community Health Status Assessment Subcommittee[iii] identified the potential indicators and data sources, abstracted data, evaluated the data for trends and prioritized opportunities for health improvement. This Executive Summary presents a subset of the indicators.

JEFFERSON COUNTY DEMOGRAPHIC PROFILE

Table 1 presents the demographic profile by sex, race, ethnicity and age of the 2012 Jefferson County population compared to the 2000 population. These data depict the population changes and trends from 2000 through 2012.

TABLE 1.

DEMOGRAPHIC PROFILE				
Indicator	**Unit**	**Index data (2000)**	**Endpoint data (2012)**	**Relative Percent Change**
Total Population	----	662,033	660,009	-0.3%
Male	% of population	47.2	47.3	0.2%
Female	% of population	52.8	52.7	-0.2%
White	% of population	58.6	54.3	-7.3%
Black	% of population	39.6	42.6	7.6%
All Other	% of population	1.8	3.1	72.2%
Hispanic	% of population	1.6	3.8	137.5%
Non-Hispanic	% of population	98.4	96.2	-2.2%
Age 0 to 19 years	% of population	27.5	26.0	-5.2%
Age 20 to 64 years	% of population	58.9	60.4	2.5%
Age over 65 years	% of population	13.6	13.6	-0.2

JEFFERSON COUNTY NATALITY PROFILE

Natality is defined as the birth rate of a population. Table 2 presents Jefferson County data related to maternal and child health outcomes such as birth rates, adequacy of prenatal care and infant mortality rates.

TABLE 2.

NATALITY PROFILE					
Indicator	**Unit**	**Index data (year)**	**Endpoint data (year)**	**Relative Percent Change**	**Movement**
Women of Child Bearing Age (15-44)	% of female population	42.6 (2000)	39.3 (2012)	-7.7%	Not Applicable
Pregnancy Rate	per 1,000 women ages 15-44	97.2 (2000)	87.7 (2008)	-9.8%	Not Applicable
	per 1,000 women ages 10-19	47.8 (2000)	41.0 (2008)	-14.2%	Desirable
Fertility Rate (live births)	per 1,000 women ages 15-44	64.1 (2000)	59.4 (2008)	-7.4%	Not Applicable
	per 1,000 women ages 10-19	30.6 (2000)	26.4 (2008)	-13.7%	Desirable
Infant Mortality (0-364 days for birth cohort[1])	per 1,000 live births	12.1 (2000)	9.6 (2012)	-20.7%	Desirable
White		6.8 (2000)	4.3 (2012)	-36.8%	Desirable
Black		18.4 (2000)	15.5 (2012)	-15.8%	Desirable

Indicator	Unit	Index data (year)	Endpoint data (year)	Relative Percent Change	Movement
Neonatal Mortality (0- 27 days for birth cohort)	per 1,000 live births	8.5 (2000)	6.7 (2012)	-21.2%	Desirable
White		4.6 (2000)	3.1 (2012)	-32.6%	Desirable
Black		13.0 (2000)	10.7 (2012)	-17.7%	Desirable
Post-neonatal Mortality (28-364 days for birth cohort)	per 1,000 live births	3.7 (2000)	2.9 (2012)	-21.6%	Desirable
White		2.2 (2000)	1.1 (2012)	-50.0%	Desirable
Black		5.4 (2000)	4.9 (2012)	-9.3%	Desirable
Adequate Prenatal Care	% of live births with appropriate care based on month of entry into care	76.2	81.5	7.0%	Desirable
White		80.1	85.0	6.1%	Desirable
Black		71.8	77.8	8.4%	Desirable
Adults		77.0	81.9	6.4%	Desirable
Teens		62.8	66.0	5.1%	Desirable
Very Low Birthweight < 1,500 grams	% of live births	2.3	2.1	-8.7%	Desirable
White		1.2	1.0	-16.7%	Desirable
Black		3.6	3.4	-5.6%	Desirable
Smoked During Pregnancy	% of live births	8.1	5.4	-33.3%	Desirable
White		10.9	7.0	-35.8%	Desirable
Black		5.2	3.9	-25.0%	Desirable
Age 18 and older		8.3	5.9	-28.9%	Desirable
White		10.7	6.4	-40.2%	Desirable
Black		5.6	4.0	-28.6%	Desirable
Age less than 18		5.6	4.2	-25.0%	Desirable
White		17.3	12.5	-27.7%	Desirable
Black		1.4	0.6	-57.1%	Desirable
Cesarean Section Deliveries	% of live births	23.3	32.4	39.1%	Undesirable
White		24.0	34.2	42.5%	Undesirable
Black		23.2	31.9	37.5%	Undesirable
Age 18 and older		23.9	33.3	39.3%	Undesirable
Age less than 18		14.8	13.1	-11.5%	Desirable

JEFFERSON COUNTY MORTALITY PROFILE

Mortality is defined as the frequency of deaths within a specific population. Table 3 presents the age adjusted death rates of selected diseases in Jefferson County, including the ten leading causes of death.

TABLE 3.

MORTALITY PROFILE					
Indicator	**Unit**	**Index data (2000)**	**Endpoint data (2012)**	**Relative Percent Change**	**Movement**
All Cause	Age Adjusted Rate[v]/100,000	1,017.7	911.7	-10.4%	Desirable
Male		1,264.6	1,114.1	-11.9%	Desirable
Female		845.3	759.6	-10.1%	Desirable
White		936.2	865.4	-7.6%	Desirable
Black		1,202	1,003.2	-16.6%	Desirable
White Male		1,145.6	1,019.2	-11.0%	Desirable
Black Male		1,559.6	1,314.0	-15.7%	Desirable
White Female		786.6	745.4	-5.2%	Desirable
Black Female		972.0	793.2	-18.4%	Desirable
Childhood Mortality	Rate per 100,000 population 1-14 years of age	22.1	19.8	-10.4%	Desirable
White		21.1	12.3	-41.6%	Desirable
Black		24.6	27.3	10.7%	Undesirable
Heart Disease	Age Adjusted Rate/100,000	258.4	189.9	-26.5%	Desirable
White		250.9	189.9	-24.3%	Desirable
Black		230.6	218.5	-5.2%	Desirable
All Cancer	Age Adjusted Rate/100,000	213.6	175.3	-17.9%	Desirable
White		203.5	166.3	-18.3%	Desirable
Black		239.8	199.0	-17.0%	Desirable
Liver Cancer	Age Adjusted Rate/100,000	4.6	7.0	52.2%	Undesirable
White		5.1	6.5	27.5%	Undesirable
Black		3.6	8.2	127.8%	Undesirable
Lung Cancer	Age Adjusted Rate/100,000	55.9	32.1	-42.6%	Desirable
White		58.2	22.2	-61.9%	Desirable
Black		51.1	48.9	-4.3%	Desirable

Indicator	Unit	Index data (2000)	Endpoint data (2012)	Relative Percent Change	Movement
Breast Cancer	Age Adjusted Rate/ 100,000	17.1	14.7	-14.1%	Desirable
White		16.0	12.3	-23.3%	Desirable
Black		19.7	20.1	2.0%	Undesirable
Colorectal Cancer	Age Adjusted Rate/100,000	24.6	23.0	-6.4%	Desirable
White		23.4	20.8	-11.1%	Desirable
Black		27.7	27.9	0.7%	Static
Prostate Cancer	Age Adjusted Rate/100,000 males	49.8	24.1	-51.6%	Desirable
White		39.1	14.2	-63.6%	Desirable
Black		78.5	52.7	-32.9%	Desirable
Cerebrovascular Disease	Age Adjusted Rate/100,000	79.9	54.7	-31.5%	Desirable
White		72.2	50.1	-30.6%	Desirable
Black		98.3	63.0	-35.9%	Desirable
Chronic Obstructive Pulmonary Disease	Age Adjusted Rate/100,000	46.4	40.9	-11.9%	Desirable
White		52.3	49.7	-5.0%	Desirable
Black		32.4	22.0	-32.1%	Desirable
Unintentional Injuries	Age Adjusted Rate/100,000	38.6	39.0	1.0%	Inconclusive
White		40.4	45.3	12.1%	Undesirable
Black		35.7	32.0	-10.4%	Desirable
Motor Vehicle Accident Mortality	Age Adjusted Rate/100,000	13.4	15.5	15.7%	Undesirable
White		13.9	14.8	6.5%	Undesirable
Black		16.1	16.4	1.9%	Static
Diabetes	Age Adjusted Rate/100,000	35.1	23.8	-32.2%	Desirable
White		25.8	15.6	-39.5%	Desirable
Black		58.6	40.5	-30.9%	Desirable

Indicator	Unit	Index data (2000)	Endpoint data (2012)	Relative Percent Change	Movement
Septicemia	Age Adjusted Rate/100,000	18.7	20.8	11.2%	Undesirable
White		12.4	18.3	47.6%	Undesirable
Black	Rate dropped in 2001 and remained level to 2012	33.6	26.0	-22.6%	Static
Alzheimer's Disease	Age Adjusted Rate/100,000	24.8	14.5	-41.5%	Desirable
White		23.9	21.3	-10.9%	Desirable
Black		19.0	16.3	-14.2%	Desirable
Kidney Disease	Age Adjusted Rate/100,000	22.1	17.9	-19.0%	Desirable
White		15.2	12.5	-17.8%	Desirable
Black		38.7	28.4	-26.6%	Desirable
Pneumonia and Influenza	Age Adjusted Rate/100,000	27.1	17.2	-36.5%	Desirable
White		29.9	16.9	-43.5%	Desirable
Black		21.4	17.1	-20.1%	Desirable

JEFFERSON COUNTY QUALITY OF LIFE AND SOCIOECONOMIC PROFILE

Table 4 presents data and selected indicators related to the quality of life and socioeconomic characteristics of Jefferson County and its residents.

TABLE 4.

QUALITY OF LIFE/ SOCIOECONOMIC PROFILE					
Indicator	Unit	Index data (year)	Endpoint data (year)	Relative Percent Change	Movement
Life Expectancy	(years at birth)	71.3 (2000)	72.2 (2012)	1.3%	Desirable
Male		70.7 (2000)	72.2 (2012)	2.1%	Desirable
Female		72.0 (2000)	72.3 (2012)	0.4%	Static
White		76.0 (2000)	76.9 (2012)	1.1%	Desirable
Black		70.5 (2000)	73.2 (2012)	3.7%	Desirable
White Male		73.1 (2000)	74.5 (2012)	1.9%	Desirable
Black Male		66.3 (2000)	68.5 (2012)	3.3%	Desirable
White Female		78.7 (2000)	79.7 (2012)	0.5%	Desirable
Black Female		74.3 (2000)	77.4 (2012)	4.2%	Desirable
Persons with any Disability	% of total population	14.6 (2008)	14.0 (2012)	-4.1%	Desirable
	% of population 65 years of age and older	41.7 (2008)	38.4 (2012)	-5.5%	Desirable

Indicator	Unit	Index data (year)	Endpoint data (year)	Relative Percent Change	Movement
Persons ≥ 25 Years with Less than High School Education	% of specified age population	14.1 (2005)	11.5 (2012)	-18.4%	Desirable
Adults 25-44 Years with Bachelor's Degree or Higher	% of specified age population	31.0 (2005)	37.2 (2012)	20.0%	Desirable
Unemployment	% of working age population (16 to 65 years)	7.8 (2005)	9.3 (2012)	19.2%	Undesirable
Total Population < 100% of Poverty Level	% of population	12.8 (2000)	18.6 (2012)	45.3%	Undesirable
Children < 18 years of age	% of specified age population	25.3 (2005)	28.0 (2012)	10.7%	Undesirable
Adults > 64 years of age	% of specified age population	63.6 (2005)	77.9 (2012)	22.5%	Undesirable
Total Population < 200% of Poverty Level	% of population	34.9 (2003)	35.8 (2012)	2.6%	Undesirable
Median Income					
Household		$42,013 (2005)	$43,959 (2012)	4.6%	Desirable
Family		$51,350 (2005)	$58,415 (2012)	13.8%	Desirable
Miles of Trails in Jefferson County	miles				
On Street Bike Infrastructure		4.4 (2012)	7.4 (2014)	68.3%	Desirable
Multi-Use Trails		12.3 (2012)	13.4 (2014)	9.0%	Desirable
Population per Mental Health Provider	number of people for every provider	1,957 (2008)	1,024 (2013)	-47.7%	Desirable
Pap Smear	% females over 18 years reporting a Pap Smear in the last 3 years	87.0 (2004)	80.6 (2012)	-7.4%	Undesirable
Current Tobacco Use	% of adult population	25.7 (2002)	20.0 (2012)	-22.2%	Desirable
Obesity	% of adult population	24.4 (2002)	34.8 (2012)	42.6%	Undesirable

DESIRABLE FINDINGS:

- Life expectancy has increased from 71.3 years to 72.2 years.
  - o The increase in life expectancy was observed across race and gender, but had a greater increase among blacks and males.
  - o This trend shows a closing gap in life expectancy between whites and blacks.

- The percent of pregnant women receiving adequate prenatal care is a strength.
  - o In 2012, 81.5% of pregnant women received adequate prenatal care as measured by the Adequacy of Prenatal Care Utilization Index which includes the timing of entry into prenatal care and the number and time of prenatal visits received.
  - o Jefferson County exceeds the national Healthy People 2020 goal of 77.6% of all pregnant women receiving adequate prenatal care.

- Homicide rates have decreased by 17% since 2000.
  - o A decreasing trend was observed among both the white and black populations, as well as among males and females.

- The ratio of population per mental health provider improved from 1,957 people for every mental health provider in 2007-08 to 1,024 people per mental health provider in 2012-13.

- Self-reported tobacco use decreased from 25.7% of the adult population in 2002 to 20% in 2012.
  - o The national Healthy People 2020 goal is 12% of the population reporting tobacco use, indicating the need for continued efforts to decrease tobacco use.
  - o The associated mortalities of lung cancer and emphysema have decreased; however, Chronic Obstructive Pulmonary Disease mortality has remained static since 2000.

- The number of outdoor recreation areas is increasing.
  - o In 2012, there were 4.38 miles of on-street bike infrastructure and 12.28 miles of multi-use trails. Currently, the number of on-street bike infrastructure miles has increased to 7.37 miles and 13.38 miles of multi-use trails.

- Both indoor and outdoor air quality improved over time.
  - o The percent of residents protected by a tobacco-free public ordinance increased to 76.3% in 2013.
  - o The first comprehensive smoke-free public ordinance in Jefferson County passed in 2011 and protected 2.1% of the population. In 2013, 39.1% of the population was protected by comprehensive smoke-free policies.
  - o Outdoor air quality improved. The number of noncompliance days for Ozone and 2.5 micron Particulate Matter air pollutants decreased. Both the 2.5 micron Particulate Matter annual and 24-hour national Environmental Protection Agency compliance standards have become more stringent. Even with the more stringent standards, air quality improved with zero days of non-compliance with the 24-hour 2.5 Particulate Matter standard in 2009, 2010 and 2012.

- Infant mortality rates decreased from 12.1 deaths per 1,000 live births in 2000 to 9.6 deaths per 1,000 live births in 2012.
  - o This decreasing trend is observed in neonatal and post neonatal mortality and among the black and white populations.

- While heart disease, cancer and stroke remain the three leading causes of death in Jefferson County, mortality rates for these three diseases are decreasing across all gender and race groups.

UNDESIRABLE FINDINGS:

- Poverty and unemployment are social determinants of health which are increasing.
  - o In 2012, 18.6% of the total population lived at or below 100% of the Federal Poverty Level for income. Poverty is increasing across all age groups. The US percentage of people with a household income less than the Federal Poverty Level was 15.9% in 2012, placing Jefferson County above the national average.
  - o Unemployment continues to increase, with 9.3% of the working age population unemployed.
- While the percent of adults over the age of 25 with a high school education has increased, high school graduation rates for public school systems have declined to 79.8% for on-time graduation. Graduation rates vary widely across school systems. Education is an important social determinant of health, and low high school graduation rates threaten the health of residents.
- Obesity rates continue to increase.
  - o In 2012, 34.8% of the population self-reported being obese. This represents a 42.6% increase from the 2002 rate of 24.4% self-reporting as obese.
- Hypertension is related to overweight and obesity and is a risk factor for kidney disease, heart disease, diabetes and stroke. Self-reported hypertension rates have increased to 37.9% of Jefferson County's adult population.
- Access to health care is inadequate.
  - o Among women, Pap smear screening rates declined from 87% in 2000 to 80.6% of women over age 18 reporting receipt of a Pap smear within the last 3 years.
  - o The total percent of the population living below 200% of the Federal Poverty Level served by either the Jefferson County Department of Health or a Federally Qualified Health Center has decreased to 19.2%. It is undetermined whether these individuals are receiving care through other clinics, private providers or are not receiving care at all.
- While overall infant mortality rates improved from 12.1 deaths per 1,000 live births in 2000 to 9.6 deaths per 1,000 live births in 2012, the infant mortality rate continues to be significantly higher than the 2010 national rate of 6.14 per 1,000 live births.
  - o The Healthy People 2020 target is 6.6 infant deaths per 1,000 live births.
- Caesarean Section deliveries increased to 32.4% of all deliveries in 2012.
  - o This increasing trend is occurring among women in the white and black populations.
- Diabetes mortality and prevalence among the black population and males continues to be an issue.
  - o While the mortality rate has been decreasing since 2000, data analysis beginning in 1990 shows that the diabetes 2012 mortality rate among males has risen 17.5%, with black males having the largest rate increase of 19.3%. Diabetes prevalence has increased from 6.5% of the adult population reporting diabetes in 2004 to 12.3% in 2012.

Septicemia is one of the ten leading causes of death in Jefferson County. Septicemia mortality rates increased 11.2% from 2000 to 2012.

The work of Community Matters 20/20 is supported by the Jefferson County Department of Health.

[i] Categories of data indicators were Demographic Characteristics, Socioeconomic Characteristics, Health Resource Availability, Quality of Life, Behavioral Risk Factors, Environmental Health Indicators, Social and Mental Health, Maternal and Child Health, Death, Illness and Injury, Communicable Diseases and Sentinel Events.

[ii] Data sources include, but are not limited to, the US Census Bureau, the Alabama Department of Public Health, the Jefferson County Department of Health, the Centers for Disease Control and Prevention, the Behavioral Risk Factor Surveillance Survey, Jefferson County Public School Systems, the Alabama Primary Health Care Association, the Freshwater Land Trust, County Health Rankings, the Alabama Quality Assurance Foundation, St. Vincent's Health System, the Jefferson County Medical Society, the Jefferson County Dental Society, etc. For a full data source listing, see the complete Community Health Status Assessment Report.

[iii] Subcommittee members included Richard Sinsky, Jefferson County Department of Health; Elisabeth Welty, Jefferson County Department of Health; Brian Massey, St. Vincent Health System of Alabama; Bart Prevallet, Alabama Quality Assurance Foundation; Rodney Holmes, Jefferson County Department of Health; Dale Quinney, Alabama Department of Public Health; Lee Pearce, Alabama Quality Assurance Foundation; Bryn Manzella, Jefferson County Department of Health.

[iv] The birth cohort mortality represents the mortality experience of the group of infants born within that particular year and is a more accurate measure of infant mortality. The other method of calculating infant mortality rates uses the total number of infant deaths for a particular year divided by the total number of live births during that same year, regardless of the year in which the infant was born.

[v] Age Adjusted Mortality rates are adjusted to a standard population age distribution in order to be able to provide an accurate comparison between communities of differing age structures.

OVERVIEW OF COMMUNITY HEALTH STATUS ASSESSMENT

The Community Health Status Assessment identifies and monitors, over time, quantitative data related to demographics, health status, quality of life and risk factors, as well as social and economic indicators of individual and community health. The Community Health Status Assessment addresses the following questions:

- How healthy is the community?
- What does the health status of the community look like?

The Community Health Status Assessment identified 165 potential indicators of community health in eleven categories. Data was collected from the following categories: Demographic Characteristics, Socioeconomic Characteristics, Health Resource Availability, Quality of Life, Behavioral Risk Factors, Environmental Health Indicators, Social and Mental Health, Maternal and Child Health, Death, Illness and Injury, Communicable Diseases, and Sentinel Events. With data from each of these categories, the Community Health Status Assessment supports a robust picture of the health and health status of Jefferson County, Alabama.

Demographic Characteristics include measures of the total population, as well as percent of total population by age group, gender, race and ethnicity, description of where these populations and subpopulations are located, and the rate of change in population density over time due to births, deaths and migration patterns.

Socioeconomic Characteristics include measures affecting health status, such as income, education and employment, and the proportion of the population represented by various levels of these variables.

Health Resource Availability represents factors associated with health system capacity, which may include both the number of licensed and credentialed health personnel and the physical capacity of health care facilities. In addition, the category of health resources includes measures of access, utilization, cost and quality of health care and prevention services. Service delivery patterns and roles of public and private sector payers and providers may also be relevant.

Quality of Life (QOL) is a construct that "connotes an overall sense of well-being when applied to an individual and a community" (Moriarty, 1996). While some dimensions of QOL can be quantified using a supportive environment when applied to indicators, research has shown QOL to be related to the determinants of health and community well-being. Other valid dimensions of QOL include the perceptions of community residents regarding aspects of their neighborhoods and communities that enhance or diminish quality of life.

Behavioral Risk Factors include behaviors which are believed to cause or to be contributing factors to injury, disease and death during youth and adolescence and to significant morbidity and mortality in later life. Examples of these risk factors include tobacco use, obesity rate and health screening.

The physical environment directly impacts health and quality of life. Clean air and water, as well as safely prepared food, are essential to physical health. Exposure to environmental substances such as lead or hazardous waste increase risk for preventable disease. Environmental Health Indicators measure the health of the environment and exposure to potential environmental hazards.

The category of Social and Mental Health reflects social and mental factors and conditions directly or indirectly influencing overall health status and individual and community quality of life. Mental health conditions and overall psychological well-being and safety may be influenced by substance abuse and violence within the home and the community.

One of the most significant areas for monitoring and comparison relates to the health of vulnerable populations: infant health and correlations with birth outcomes, as well as measures of maternal access to and utilization of medical care. Maternal and Child Health focuses on birth data and outcomes and mortality data for infants and children. Because maternal care is correlated with birth outcomes, measures of maternal access to and utilization of care are included. Live births to teen mothers are a critical indicator of increased risk for both mother and child.

Health status in a community can be measured in terms of mortality (rates of death within a population) and morbidity (rates of the incidence and prevalence of disease). Mortality may be represented by crude rates or age-adjusted rates (AAM), by degree of premature death (Years of Productive Life Lost or YPLL), and by cause (disease-cancer and non-cancer or injury – intentional and unintentional). Morbidity may be represented by age-adjusted (AA) incidence of cancer and chronic disease. Measures of Death, Illness and Injury represent both mortality and morbidity rates for a variety of diseases.

Measures of Communicable Disease include diseases which are usually transmitted through person-to-person contact or shared use of contaminated instruments/materials. Vaccine preventable diseases can be avoided through a high level of vaccine coverage. Measures of sexually-transmitted diseases in vulnerable populations and the use of protective measures such as condoms are indicators assessed in this category.

Sentinel events are those cases of unnecessary disease, disability or untimely death that could be avoided if appropriate and timely medical care or preventive services were provided. These include vaccine-preventable illnesses, late stage cancer diagnosis and unexpected syndromes or infections. Sentinel events may alert the community to health system problems such as inadequate vaccine coverage, lack of primary care and/or screening, a bioterrorist event or the introduction of globally transmitted infections.

An eight member Community Health Status Assessment Subcommittee identified potential indicators within each of these eleven categories and identified data sources for each indicator, abstracted data, evaluated the data for trends and prioritized opportunities for health improvement. Subcommittee members included Richard Sinsky, Jefferson County Department of Health; Elisabeth Welty, Jefferson County Department of Health; Brian Massey, St. Vincent Health System of Alabama; Bart Prevallet, Alabama Quality Assurance Foundation; Rodney Holmes, Jefferson County Department of Health; Dale Quinney, Alabama Department of Public Health; Lee Pearce, Alabama Quality Assurance Foundation, and Bryn Manzella, Jefferson County Department of Health.

The Subcommittee met on March 24, 2014 to review the 165 potential indicators and to identify potential data sources for the indicators of interest. Indicators from each category were reviewed and the Subcommittee determined whether the data indicator was informative for Jefferson County and whether a data source existed for that indicator. If an indicator was deemed to be informative and had an available data source, the indicator was included in the assessment. Additional indicators were added based on the recommendations of Subcommittee members.

Of the 165 potential indicators, the assessment captured data for a total of 144 indicators. Once data for each of the indicators had been gathered, the data were analyzed. Where adequate data were available, trends were evaluated to determine changes in community health status. Trends are patterns over time, such as decreasing infant mortality rate, shifts in population distributions or changes in socioeconomic indicators.

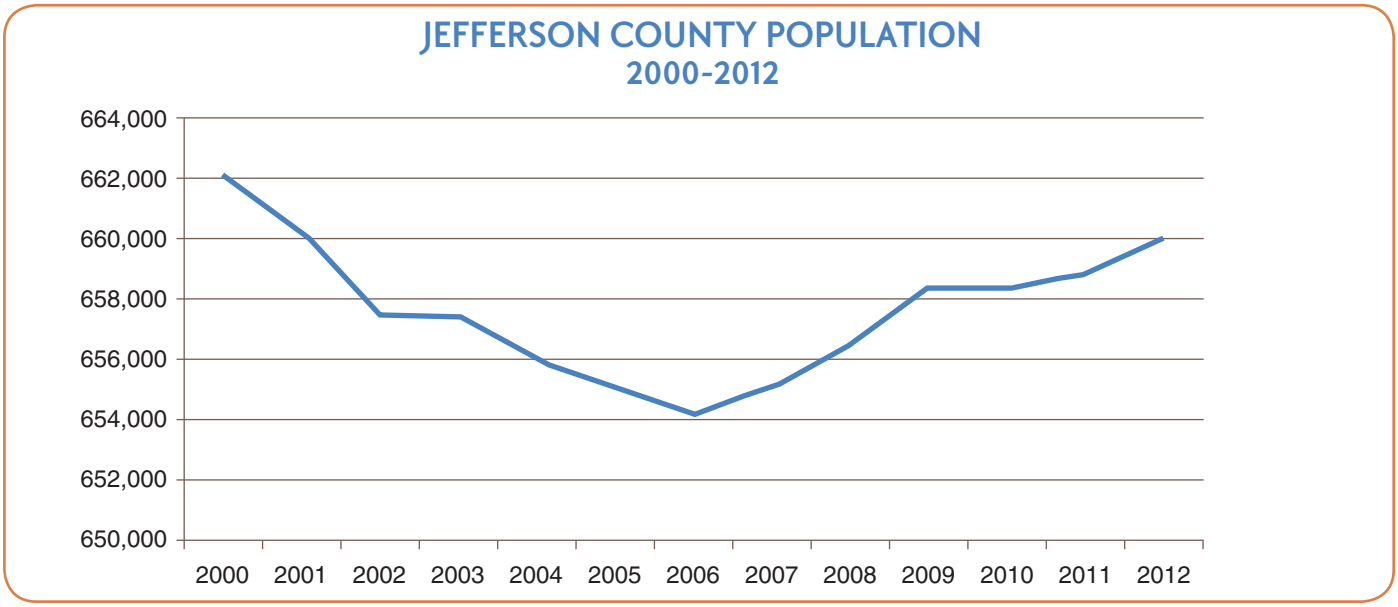
The remainder of this document provides the evaluation of the 144 indicators of community health status in Jefferson County, Alabama.

DEMOGRAPHIC CHARACTERISTICS

This first category of data presents the current and historic demographic profile of Jefferson County, Alabama. These data show population shifts and changes over time.

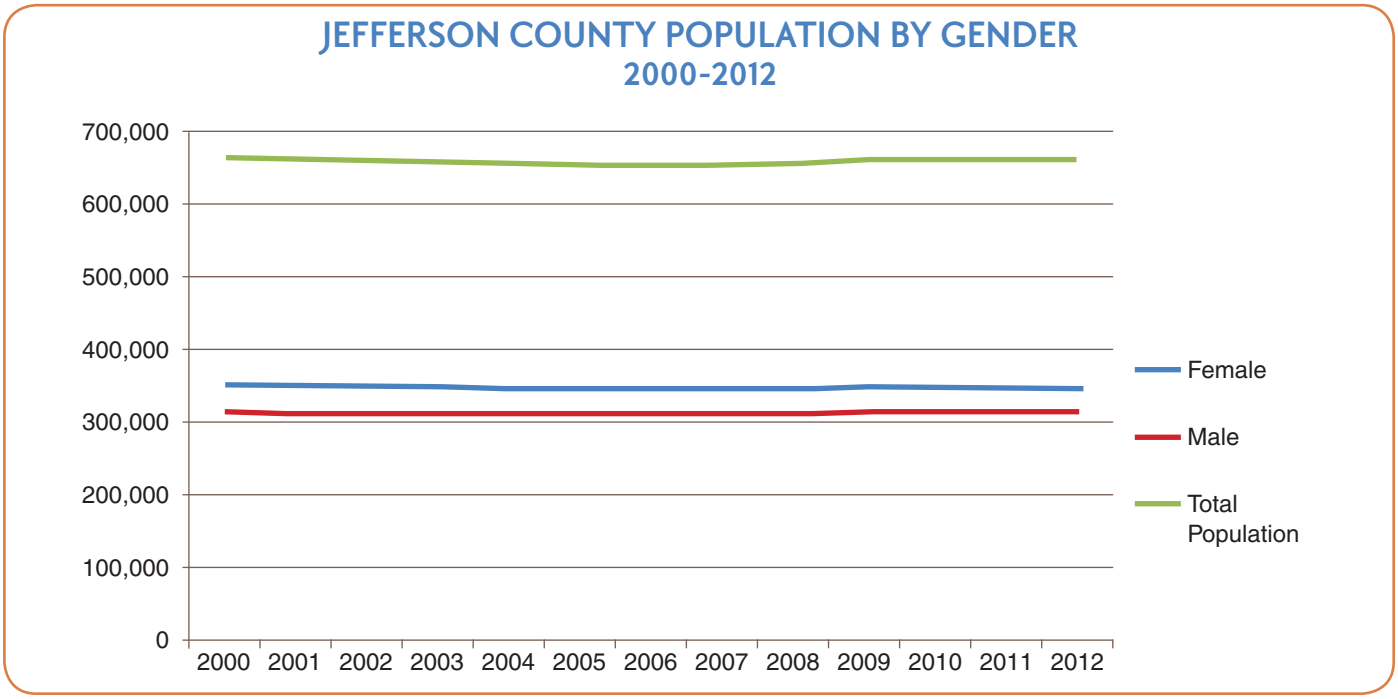
OVERALL JEFFERSON COUNTY POPULATION

While the net change in the population for Jefferson County from 2000 to 2012 shows a decrease by 0.5% (662,037 to 660,009), this is not reflective of the population change over the full time frame. The population fell steadily until it reached a low of 654,217 in 2006 at which point the population has steadily recovered.



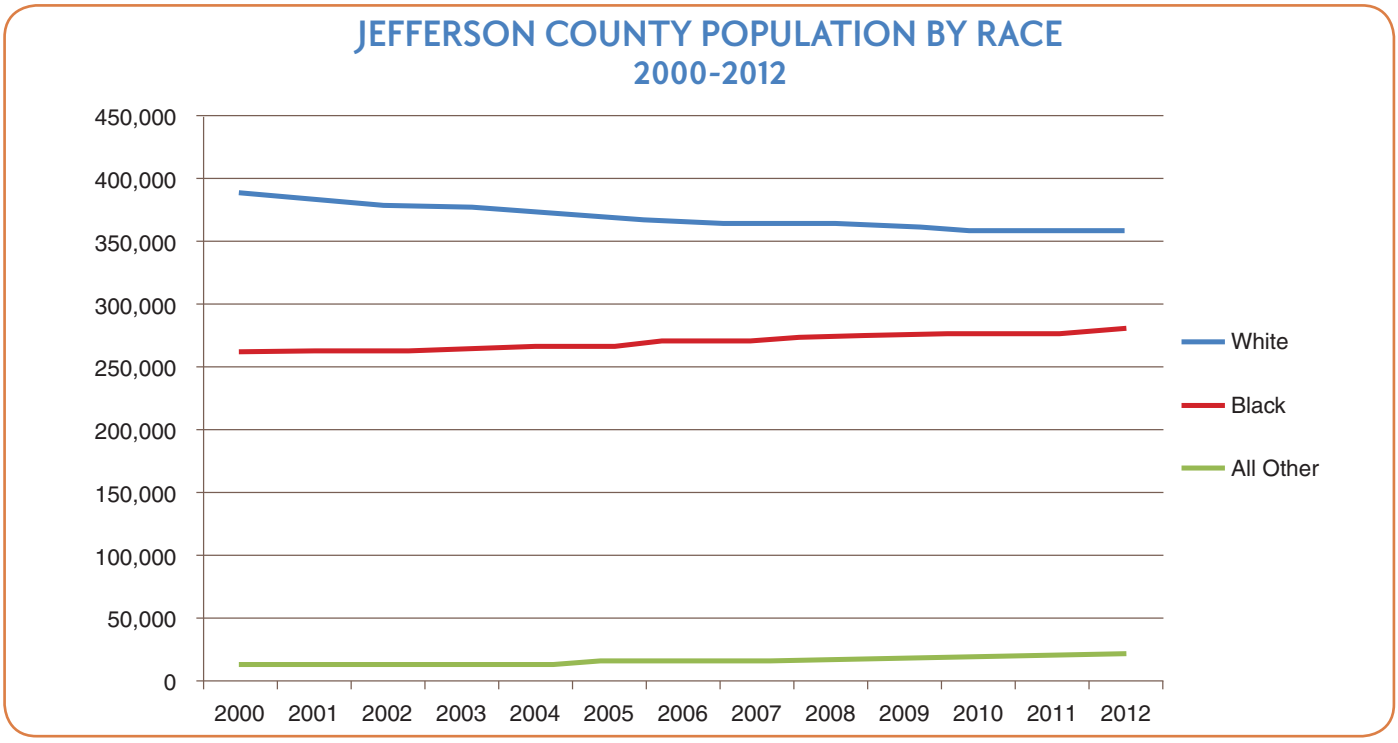
JEFFERSON COUNTY POPULATION BY GENDER

The percent of Jefferson County's male population increased by 0.2% since 2000, from 47.2% of the population, to 47.3% of the 2012 population. Among the population, the percent of females decreased 0.2% since 2000 from 52.8% to 52.7% in 2012.



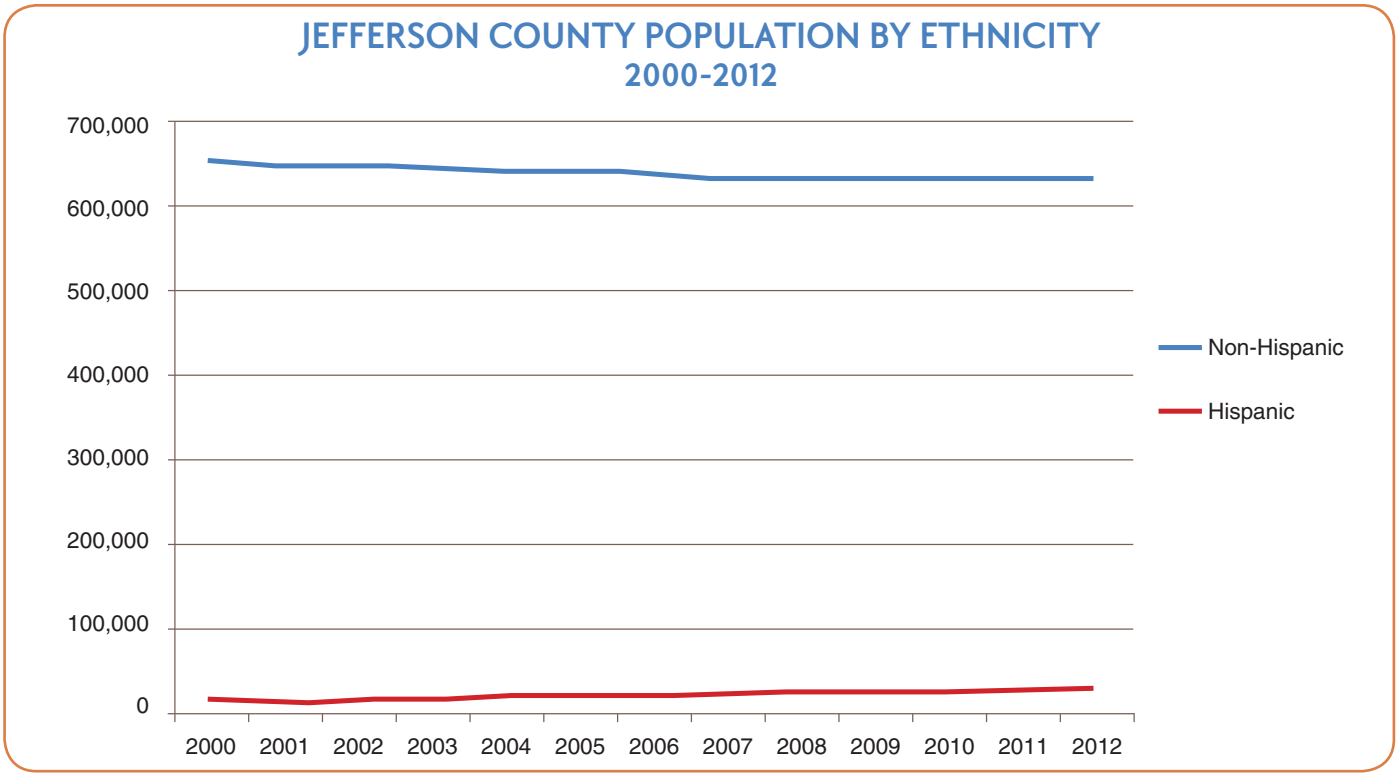
JEFFERSON COUNTY POPULATION BY RACE

Since 2000, the percent of the population of Jefferson County that is white has decreased by 7.3% from 58.6% to 54.3% in 2012. The percent of the population that is black increased by 7.6% from 39.6% in 2000 to 42.6% in 2012. The population of all other races increased by 72.2% between 2000 and 2012 from 1.8% to 3.1%. All other races In Jefferson County includes individuals from the following racial groups listed from the highest population in 2012 to the lowest: 10,121 Asian residents, 7,133 Multi-racial residents, 2,514 American Indian/Eskimo residents, and 537 Pacific Islander residents.



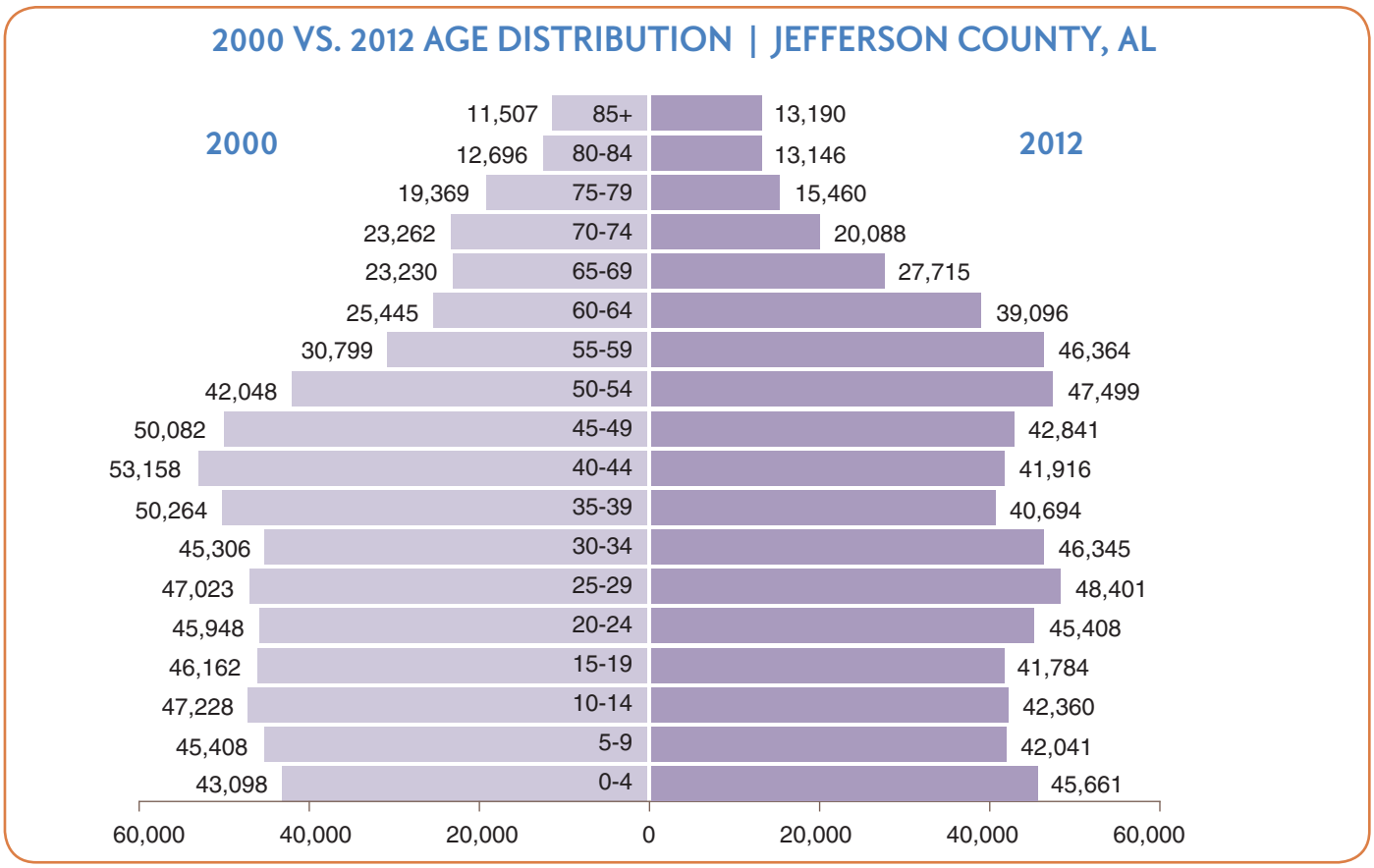
JEFFERSON COUNTY POPULATION BY ETHNICITY

The Hispanic population of Jefferson County has increased by 137.5% since 2000. In 2000, the Jefferson County Hispanic population was 1.6% of the total population, and in 2012, it was 3.8% of the total population.



JEFFERSON COUNTY POPULATION BY AGE

The age structure of the Jefferson County population has changed since 2000 to indicate an aging population.



LIFE EXPECTANCY

Overall, life expectancy at birth has increased from 71.3 years in 2000 to 72.2 years in 2012. This increase is seen in all races and genders. According to the US Census Bureau, the national life expectancy at birth in 2008 was 77.8 years; therefore, Jefferson County's life expectancy is lower than the national average.

	Index data (2000)	Endpoint data (2012)	Relative Percent Change	Movement
Life Expectancy (years at birth)	71.3	72.2	1.3%	Desirable
Male	70.7	72.2	2.1%	Desirable
Female	72.0	72.3	0.4%	Static
White	76.0	76.9	1.1%	Desirable
Black	70.5	73.2	3.7%	Desirable
White Male	73.1	74.5	1.9%	Desirable
Black Male	66.3	68.5	3.3%	Desirable
White Female	78.7	79.7	0.5%	Desirable
Black Female	74.3	77.4	4.2%	Desirable

YEARS OF POTENTIAL LIFE LOST

The total years of potential life lost prior to age 75 decreased 0.1% from 65,405 years in 2000 to 65,367 in 2012. Among black males, the overall years of potential life lost has increased over time; however, years of potential life lost per person has remained static at 19.7 from 2000 to 2012.

	Index data (2000)	Endpoint data (2012)	Relative Percent Change	Movement
Overall Population Years of Potential Life Lost – (prior to age 75) (years)	65,405	65,367	-0.1%	Desirable
Male	39,590	39,852	0.7%	Undesirable
Female	25,815	25,515	-1.2%	Desirable
White	30,408	29,941	-1.5%	Desirable
Black	34,808	35,086	0.8%	Undesirable
White Male	18,542	17,702	-4.5%	Desirable
Black Male	20,886	22,068	5.7%	Undesirable
White Female	11,866	12,239	3.1%	Static
Black Female	13,922	13,018	-6.5%	Desirable

	Index data (2000)	Endpoint data (2012)	Relative Percent Change	Movement
Per Person Years of Potential Life Lost – (prior to age 75) (years)	19.7	19.7	0.4%	Static
Male	20.3	20.3	-0.4%	Static
Female	18.7	19	1.4%	Undesirable
White	16.7	17.4	4.3%	Undesirable
Black	23.3	22.3	-4.1%	Desirable
White Male	17.3	17.6	1.7%	Undesirable
Black Male	24.1	23.2	-3.7%	Desirable
White Female	15.9	17.2	8.2%	Undesirable
Black Female	22.1	21.0	-5.3%	Desirable

AGE AT DEATH

Both the mean and the median age at death have decreased between 2000 and 2012 for the total population in Jefferson County. Notably, the mean age and median age of death among the black population declined between 2000 and 2012, while the rate among the white population remained static or increased.

	Index data (2000)	Endpoint data (2012)	Relative Percent Change	Movement
Mean Age at Death (years)	71.0	70.8	-0.3%	Undesirable
Male	66.7	66.8	0.1%	Static
Female	74.9	74.7	-0.3%	Static
White	74.1	74.4	0.4%	Static
Black	65.9	64.9	-1.5%	Undesirable
White Male	70.0	70.9	1.3%	Desirable
Black Male	61.4	60.5	-1.5%	Undesirable
White Female	77.5	77.5	0%	Static
Black Female	70.2	69.7	-0.7%	Undesirable

	Index data (2000)	Endpoint data (2012)	Relative Percent Change	Movement
Median Age at Death (years)	76	75	-1.3%	Undesirable
Male	72	70	-2.8%	Undesirable
Female	79	80	1.3%	Desirable
White	78	79	1.3%	Desirable
Black	71	67	-4.2%	Undesirable
White Male	74	74	0%	Static
Black Male	66	63	-4.5%	Undesirable
White Female	81	82	1.2%	Desirable
Black Female	76	75	-1.3%	Undesirable

DEMOGRAPHIC CHARACTERISTICS FINDINGS

In 2000, the overall population of Jefferson County was on a declining trend. The population low occurred in 2006; since then, the population has been increasing, although it has not rebounded to the 2000 population level. With population increases, diversity within the population is increasing as well. The black and other non-white populations have increased, as has the Hispanic population. The age structure of the 2012 population as compared to the 2000 population indicates that the Jefferson County population is aging. It is important to note these population shifts as they inform the community of potential changes related to health status and health care access to be considered for the future.

Life expectancy at birth is increasing for Jefferson County residents overall and among all race and gender groups. While the white population continues to have higher life expectancy as compared to the black population, the racial gap between the white and black population has reduced from 5.5 years in 2000 to 3.7 years in 2012. Even with these improvements in life expectancy, Jefferson County lags behind the US national life expectancy. Years of potential life lost has also decreased slightly since 2000; however, this change is not statistically significant. Mean and median age at death has decreased slightly, indicating a younger age at death for Jefferson County as a whole.

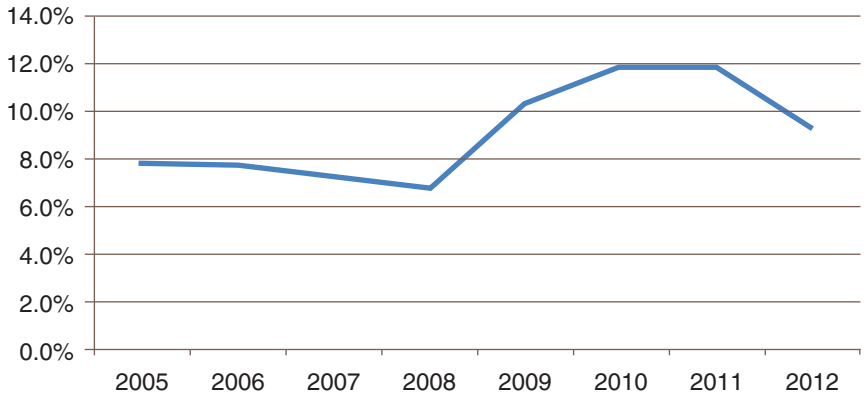
SOCIOECONOMIC CHARACTERISTICS

Indicators in this category provide a picture of the economic and social structures of Jefferson County. This category includes indicators related to poverty and income, employment, education, disabilities and family structures.

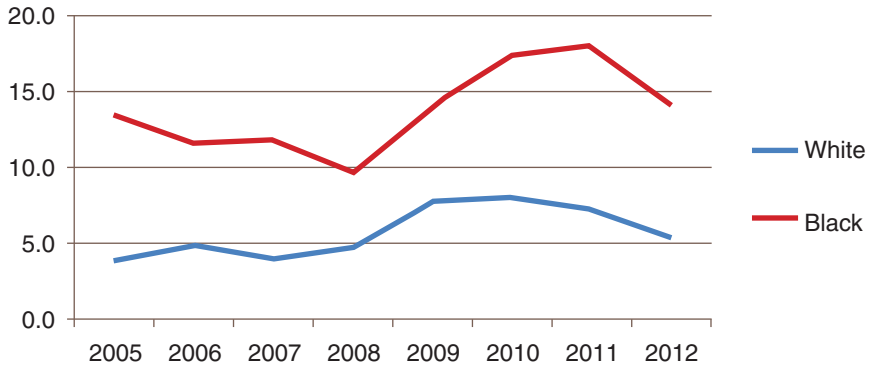
EMPLOYMENT

The percent of the Jefferson County population that is unemployed increased from 7.8% in 2005 to 9.3% in 2012 (6.4% increase). Unemployment was highest in 2010 and 2011 at 11.8%, with a decrease observed in 2012. The black population experienced higher rates of unemployment than the white population.

JEFFERSON COUNTY PERCENT UNEMPLOYMENT 2005-2012



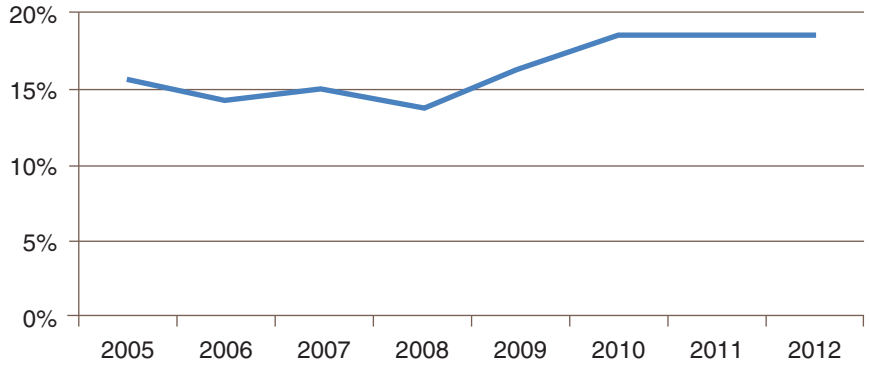
PERCENT OF THE POPULATION AGE 16 AND OLDER UNEMPLOYED BY RACE 2005-2012



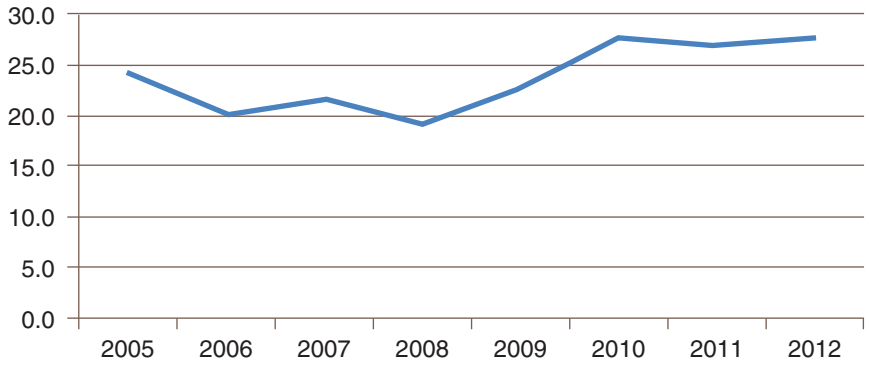
POVERTY

The percent of the population living in poverty increased across all categories and age groups. The percent of the population living below the Federal Poverty Level as defined by the Department of Health and Human Services increased from 15.7% in 2005 to 18.6% in 2012. In 2012, the US percentage of people living with an income less than the Federal Poverty Level was 15.9%, indicating Jefferson County's poverty rate is higher than the national average.

JEFFERSON COUNTY PERCENT OF THE POPULATION <100% OF FEDERAL POVERTY LEVEL 2005-2012

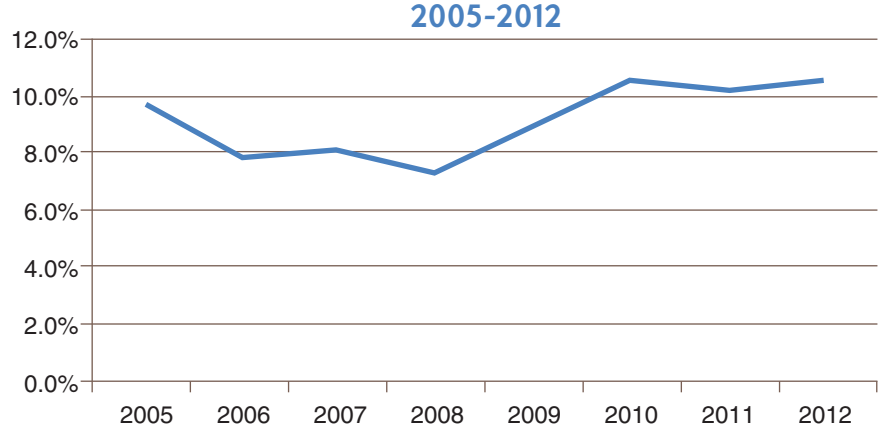


PERCENT OF THE POPULATION UNDER AGE 18 LIVING AT <100% FEDERAL POVERTY LEVEL 2005-2012



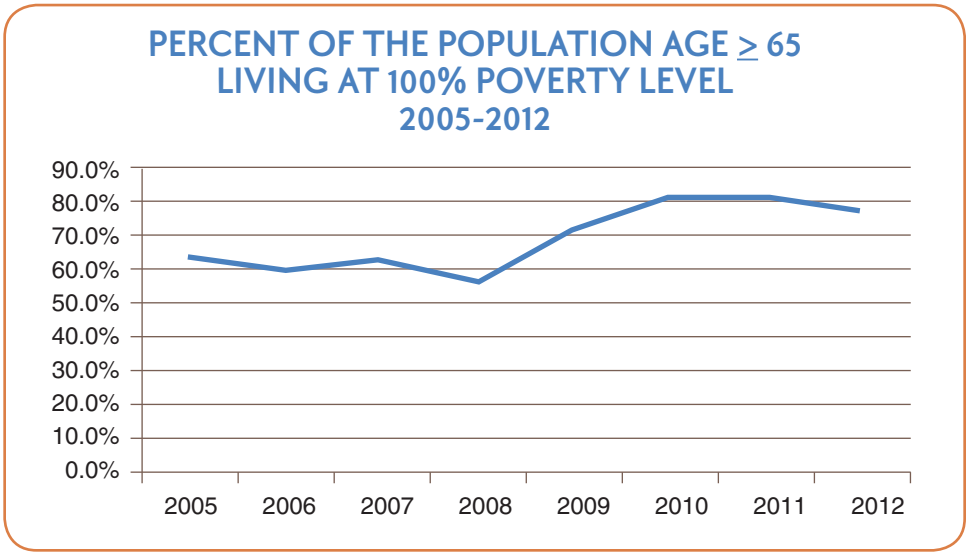
The percent of children living in poverty has increased from 24.2% of the population in 2005 to 27.6% of the population in 2012.

PERCENT OF THE POPULATION AGES 18 TO 64 LIVING AT <100% FEDERAL POVERTY LEVEL 2005-2012

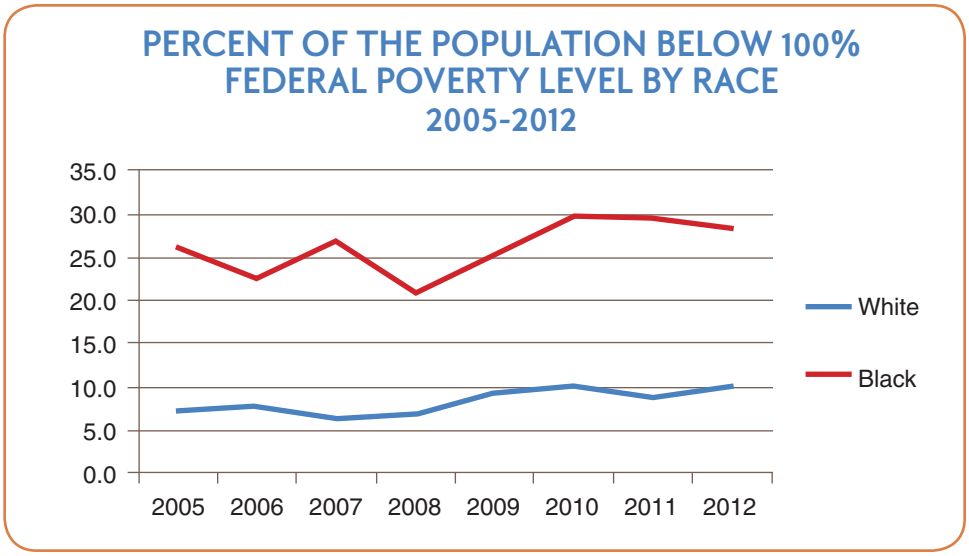


The percent of the adult population, ages 18 to 64, living in poverty increased from 9.7% of the population in 2005 to 10.6% of the population in 2012.

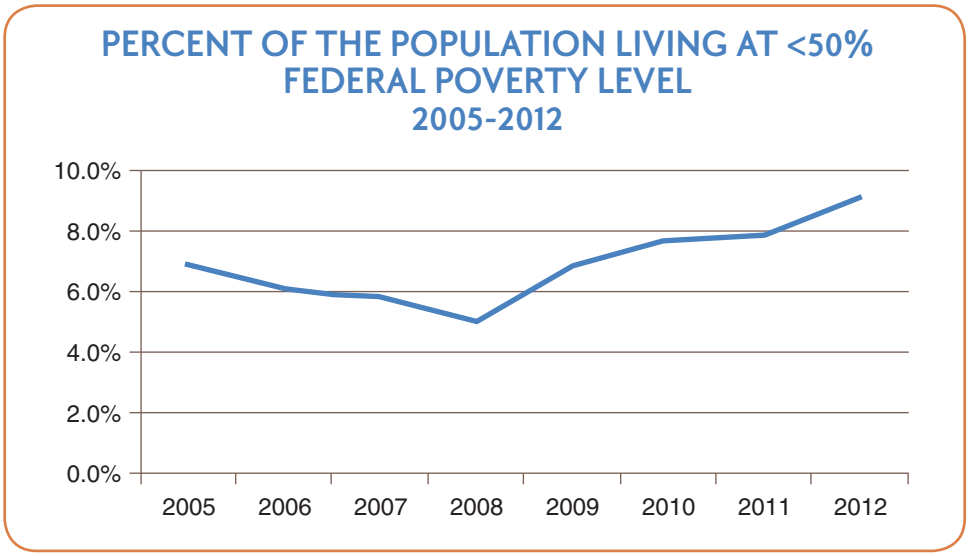
The percent of adults 65 and older living in poverty increased from 63.6% in 2005 to 77.9% in 2012.



The percent of the black population living below 100% of the Federal Poverty Level is significantly higher than the percent of the white population living in poverty.



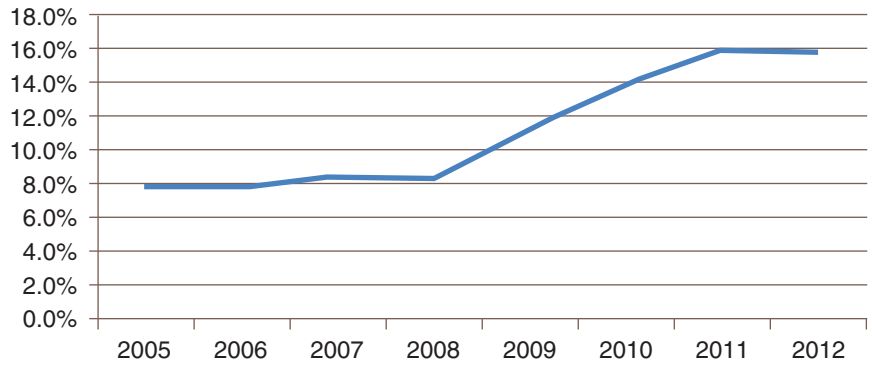
The percent of the population living below 50% of the Federal Poverty Level also increased from 6.9% in 2005 to 9.2% in 2012.



SUPPLEMENTAL NUTRITIONAL ASSISTANCE PROGRAM (FOOD STAMP) PARTICIPATION

The Supplemental Nutrition Assistance Program (SNAP) provides nutritional assistance to low income individuals. The percent of the Jefferson County population receiving SNAP or food stamps increased significantly from 7.8% in 2005 to 15.8% in 2012 (102.6% increase). While there have been interventions to enroll eligible persons for SNAP, the eligibility criteria has been expanded resulting in more people eligible for the program.

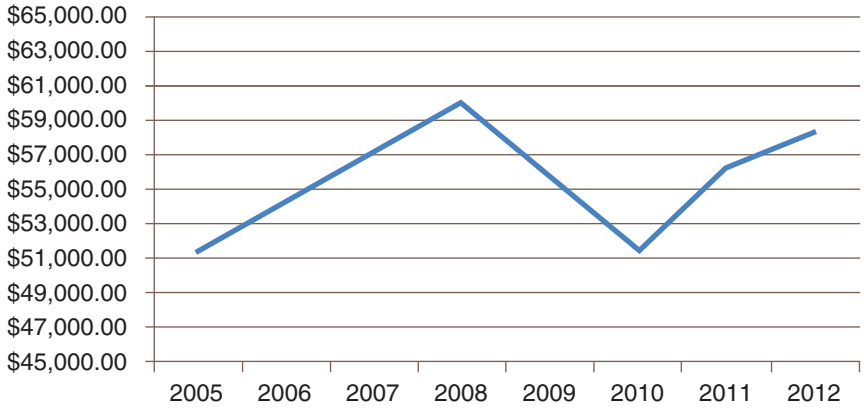
PERCENT OF JEFFERSON COUNTY HOUSEHOLDS RECEIVING SNAP (FOOD STAMPS) 2005-2012



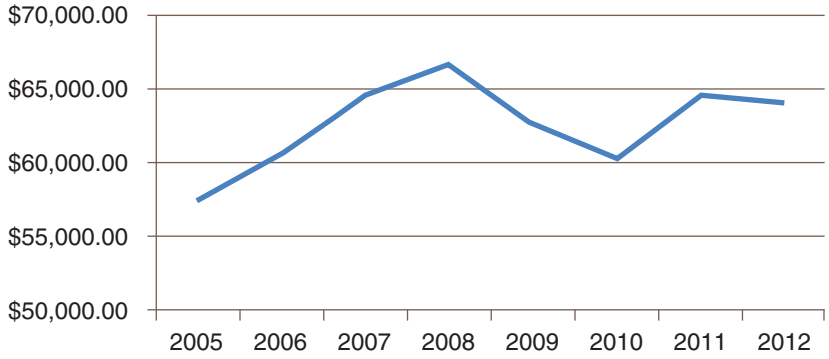
INCOME

Median income levels in Jefferson County are increasing. The median family income increased by 13.7% from $51,350 in 2000 to $58,415 in 2012. Median household income also increased by 11.3% from $57,459 in 2005 to $63,958 in 2012. The per capita income increased by 6.9% from $24,234 in 2005 to $25,802 in 2012.

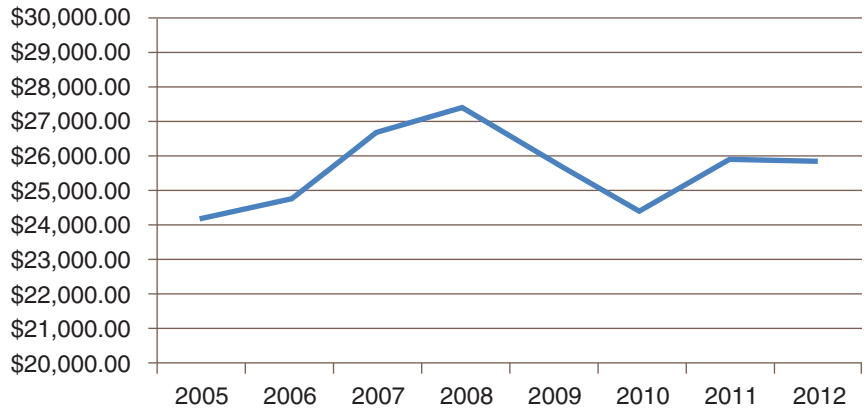
JEFFERSON COUNTY MEDIAN FAMILY INCOME 2005-2012



JEFFERSON COUNTY MEDIAN HOUSEHOLD INCOME
2005-2012



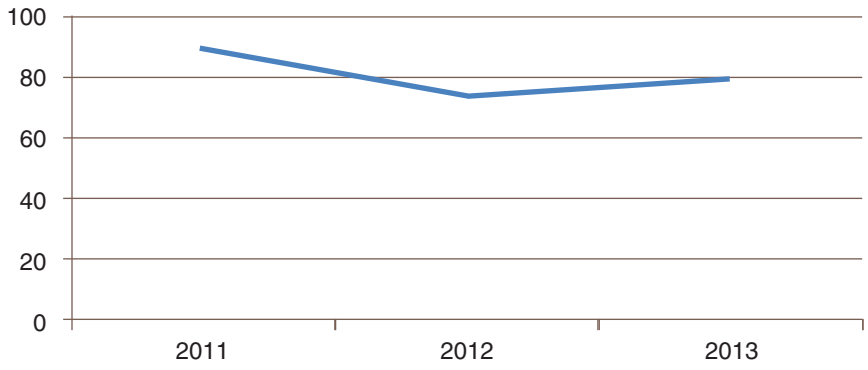
JEFFERSON COUNTY PER CAPITA INCOME
2005-2012



HIGH SCHOOL GRADUATION RATES

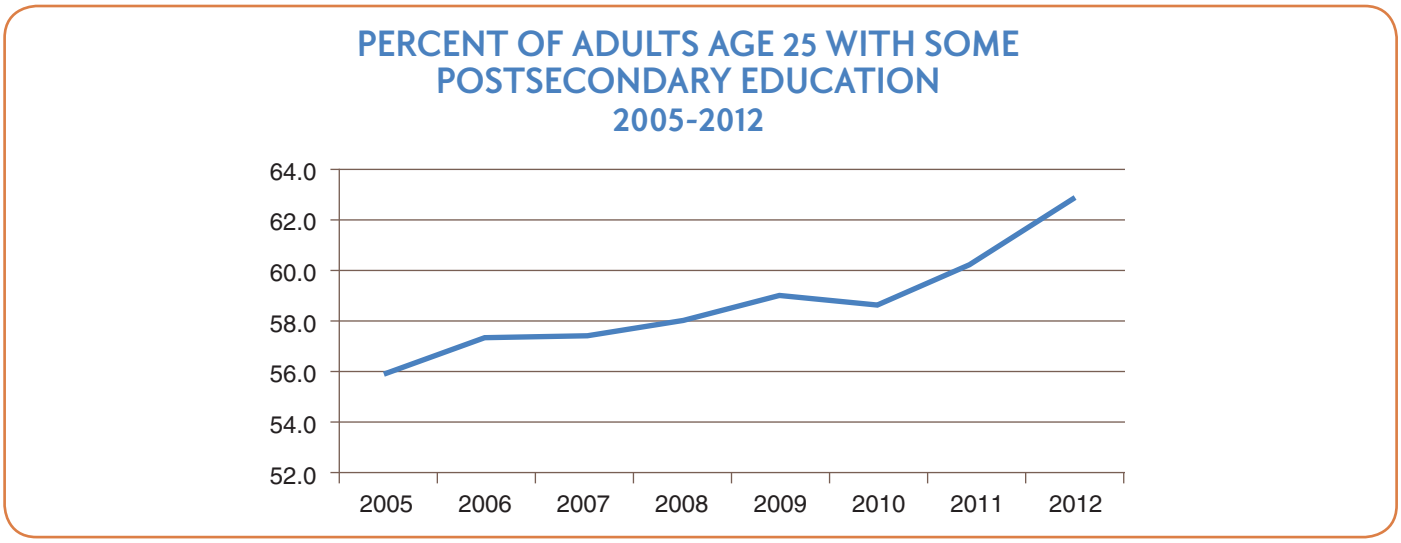
The overall rate of on time high school graduation for public school students in Jefferson County dropped 11.2% between 2011 (89.8%) to 2013 (79.8%). Graduation rates, however, vary widely between school systems. The on-time high school graduation rate for all Alabama public schools for the 2010-2011 school -year was 74%.

PUBLIC SCHOOL GRADUATION RATES FOR JEFFERSON COUNTY
2011-2013



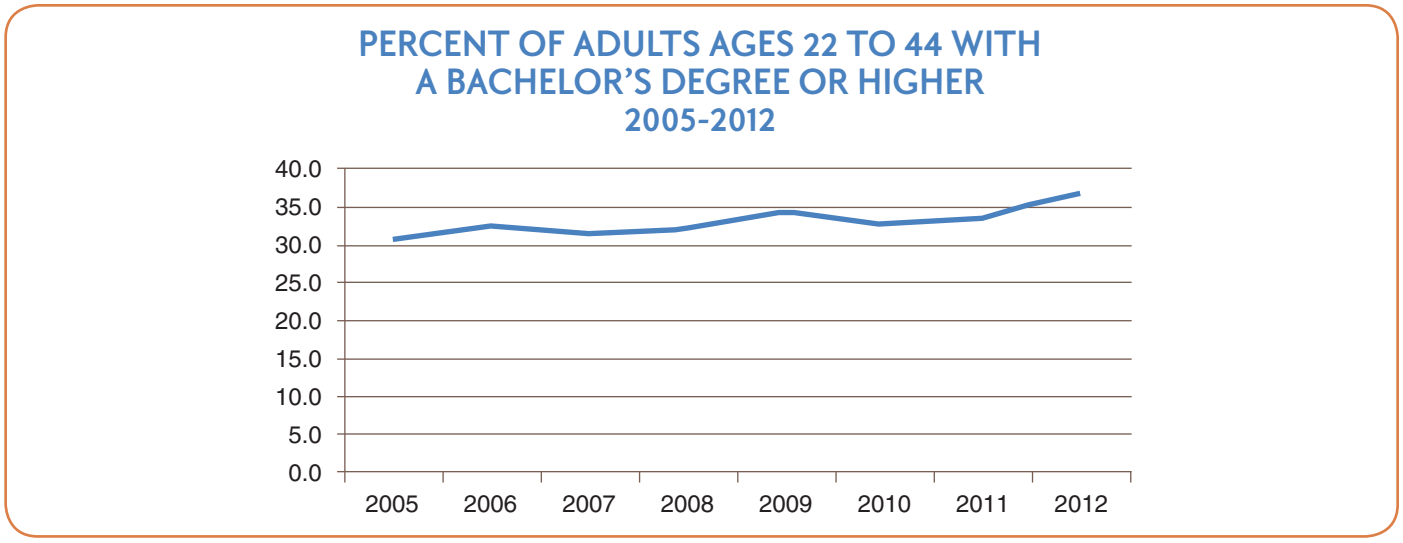
PERCENT OF ADULTS OVER THE AGE OF 25 WITH SOME POSTSECONDARY EDUCATION

The percent of Jefferson County adults completing some postsecondary education increased 12.5% from 55.9% in 2005 to 62.9% in 2012.



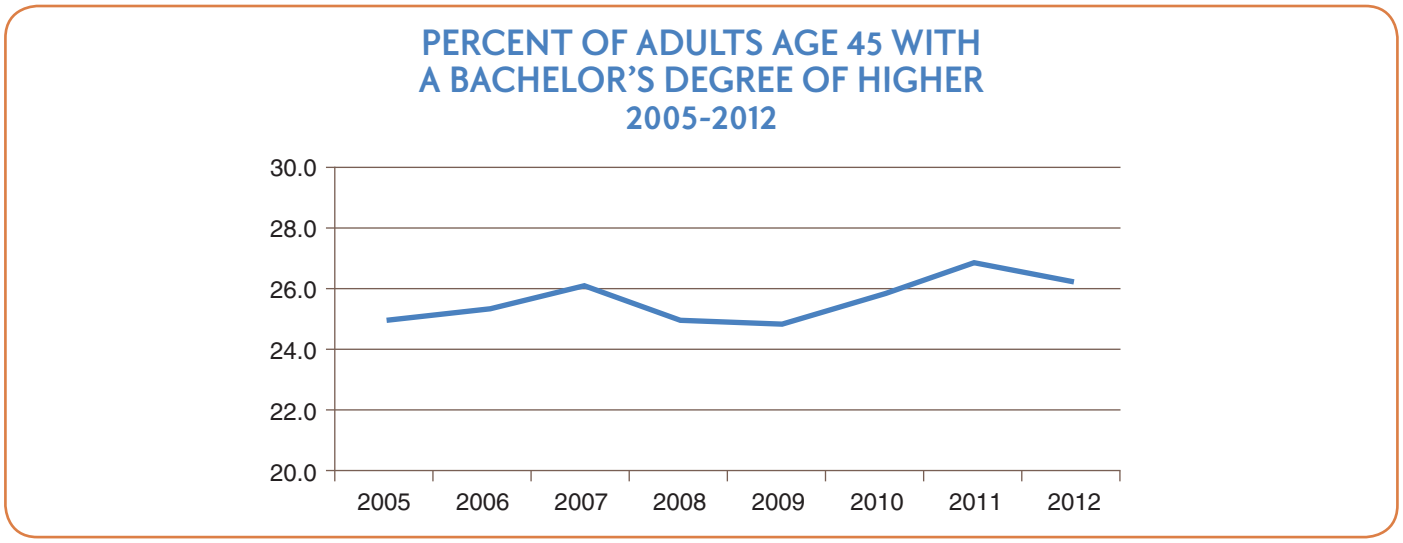
PERCENT OF ADULTS AGES 22 TO 44 WITH BACHELOR'S DEGREE OR HIGHER EDUCATION

The percent of Jefferson County adults ages 22 to 44 with a Bachelor's degree or higher increased by 20% from 31% in 2005 to 37.2% in 2012.



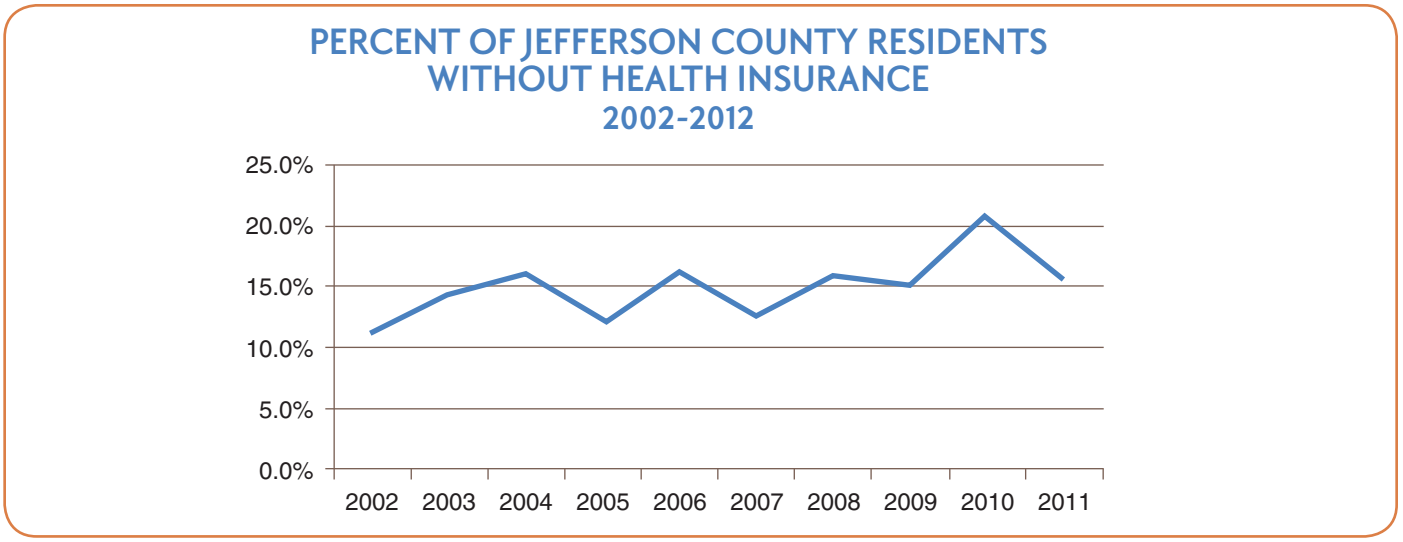
PERCENT OF ADULTS OVER AGE 45 WITH A BACHELOR'S DEGREE OR HIGHER

The percent of Jefferson County adults over age 45 with a Bachelor's Degree of higher also increased by 5.6% from 24.9% in 2005 to 26.3% in 2012.



PERSONS WITHOUT HEALTH INSURANCE

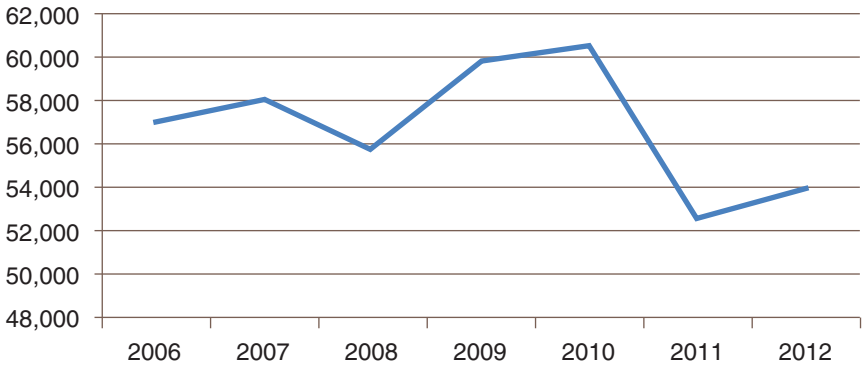
The percent of Jefferson County's population without health insurance has increased by 40.2% since 2002 from 11.2% to 15.7% in 2012.



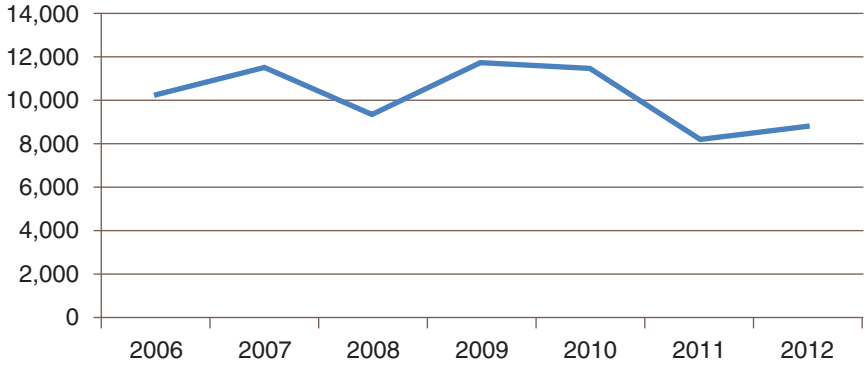
SINGLE PARENT FAMILIES

The overall number of single parent family households decreased by 5.6% from 2006 at 57, 139 in 2006 to 53,959 in 2012. Both the number of male and female single parent family households showed a decline when comparing 2006 and 2012 data.

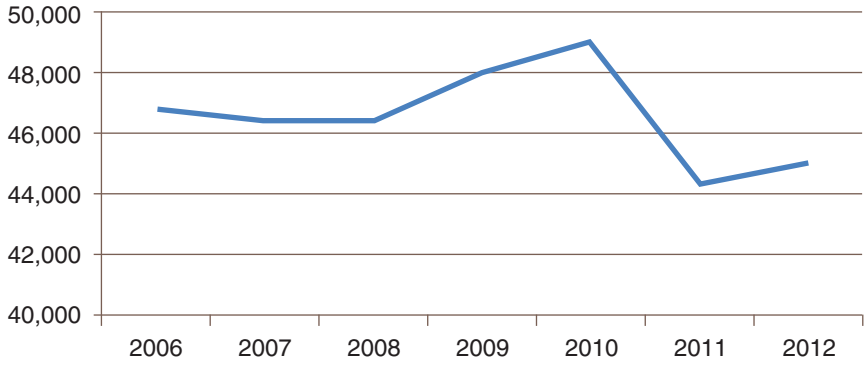
NUMBER OF SINGLE PARENT FAMILIES IN JEFFERSON COUNTY 2006-2012



MALE SINGLE PARENT FAMILY HOUSEHOLDS IN JEFFERSON COUNTY 2006-2012



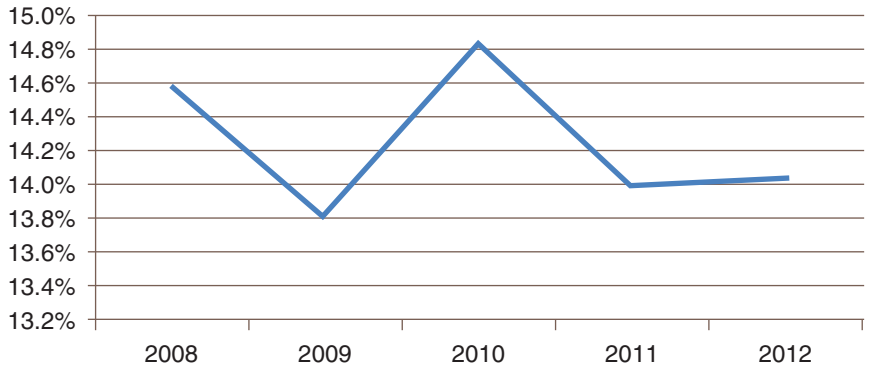
FEMALE SINGLE PARENT FAMILY HOUSEHOLDS IN JEFFERSON COUNTY 2006-2012



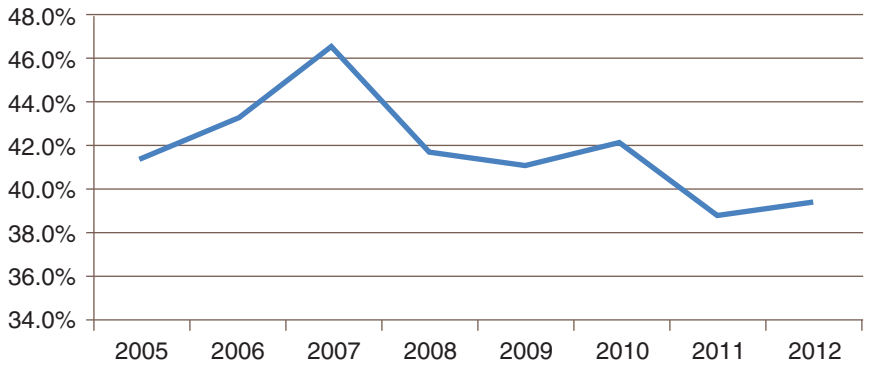
PERSONS WITH DISABILITIES

The number of people in Jefferson County with disabilities fluctuated widely from 2008 to 2012. The percent of people over 65 with disabilities decreased during this timeframe.

PERCENT OF THE TOTAL POPULATION WITH ANY DISABILITY 2008-2012



PERCENT OF THE POPULATION AGE 65 OR OLDER WITH ANY DISABILITY 2005-2012



SOCIOECONOMIC FINDINGS

Jefferson County's socioeconomic findings indicate, despite the increases in household, family and per capita incomes that the rates of poverty and unemployment have increased from the baseline observation. Poverty rates are increasing among all age groups. Following the trend of increasing poverty, the percent of the population receiving SNAP (food stamps) has also increased. Education rates within the county paint an interesting picture. The percentage of adults over age 22 with a Bachelor's Degree or higher are increasing, yet high school graduation rates from public schools throughout Jefferson County are declining. Another concerning finding is that the percent of Jefferson County residents reporting not having health insurance has been increasing since 2002.

Household and family structure data indicate that the number of single parent family households has decreased for both male and female single parent families. People that are living with disabilities remain an important health consideration for Jefferson County; however, the number of person over age 65 and overall number of individuals living with a disability has decreased since 2008.

HEALTH RESOURCE AVAILABILITY

Indicators in this category demonstrate the opportunities available for residents of Jefferson County to access needed health care resources. Data included in this category is expressed as the proportion of providers to population, the number of hospital beds, the number of Federally Qualified Health Centers and the local health department's number of full time equivalent employees and its spending per resident.

PROVIDERS

The table below shows the proportion of the Jefferson County population per provider. These data demonstrate gaps in primary care service provision. Among mental health providers, Jefferson County has a lower provider to resident ratio than the state of Alabama which averages one mental health provider for every 1,870 residents, but Jefferson County lags behind the top US counties, which average one mental health provider for every 536 residents. A mental health provider is defined as a psychiatrist, psychologist, licensed clinical social worker, counselor or advanced practice nurse specializing in mental health care.

Type of Provider	Proportion of Population Per Provider (Year)
Licensed Dentists	1 dentist per 1,148 residents (2013)
Licensed Primary Care Physicians	1 primary care physician per 473.7 residents (2013)
Mental Health Providers	1 mental health provider per 1,024 residents (2012-2013)

HOSPITAL BEDS

The table below shows the number hospital beds per 100,000 Jefferson County residents and the percent bed occupancy during 2013.

Type of Hospital Bed	Number of Beds per 100,000 Population (% Occupancy) (2013)
Total Beds	680.8 per 100,000 (61% occupancy)
Acute Care	590.7 per 100,000 (61.2% occupancy)
Specialty Beds	90.1 per 100,000 (60% occupancy)

FEDERALLY QUALIFIED HEALTH CENTERS

Federally Qualified Health Centers (FQHCs) are safety net providers that provide primary care services in underserved urban and rural communities. The table below shows the percentage of the eligible population, those with an income less than 200% of the Federal Poverty Level, receiving care from an FQHC or the Jefferson County Department of Health. It cannot be determined whether individuals not seen by a FQHC or the Jefferson County Department of Health are receiving care from private providers, other public providers or are not receiving care at all.

	Index data (Year)	Endpoint data (Year)	Relative Percent Change	Movement
Total Population < 200% Federal Poverty Level	224,314 (2005)	236,374 (2012)	5.4%	Undesirable
Percent of Eligible Population Served by FQHC	6.4% (2010)	4.6% (2012)	-28.1%	Undesirable
Percent of Eligible Population Served by JCDH	24.2% (2005)	19.2% (2012)	-20.7%	Undesirable

JEFFERSON COUNTY DEPARTMENT OF HEALTH (JCDH)

The Jefferson County Department of Health (JCDH) is a local health department serving Jefferson County, Alabama. The table below provides data regarding the number of JCDH employees, JCDH's expenditures per Jefferson County resident and its expenditures related to the primary care it provides.

	Index data (Year)	Endpoint data (Year)	Relative Percent Change	Movement
JCDH Full Time Equivalent Employees (number)	650 (1993)	357 (2013)	-45.1%	Undesirable
JCDH Operating Budget per Jefferson County Resident (dollars per resident)	$48 (1993)	$91 (2013)	89.6%	Desirable
Total Cost of JCDH Primary Care Services (dollars)	$14,526,987 (2010)	$12,503,922 (2013)	-13.9%	Not Applicable
Cost of Clinical Services as % of JCDH's Total Budget (%)	31.1% (2010)	20.8% (2013)	-33.1%	Not Applicable
JCDH Expenditure per Patient (dollars)	$270.38 (2010)	$280.79 (2013)	3.9%	Not Applicable

HEALTH RESOURCE AVAILABILITY FINDINGS

Adequate availability and accessibility of dentists, primary care physicians and mental health providers is a continued necessity for Jefferson County. While the ratio of mental health providers to residents in Jefferson County is lower than for the state of Alabama, Jefferson County has almost double the ratio of residents per mental health provider as the best performing counties nationally. This indicates continued need to increase the number of and access to mental health and other primary care providers within the county. The bed occupancy rate for both acute and specialty care hospital beds averaged about 60% county-wide.

According to US Department of Health and Human Services, Federally Qualified Health Centers serve the population with an income of less than 200% of the Federal Poverty Level. Despite the fact that the overall number of Jefferson County residents falling into this category has increased, the percentage of residents served by a Federally Qualified Health Center or the Jefferson County Department of Health's clinics has decreased. While it cannot be determined if these individuals are receiving care from private physicians, other clinics or are not receiving care at all, these decreasing percentages may indicate that this population has increased need for primary health care services.

While the number of full time employees at the Jefferson County has decreased, JCDH is investing more money per resident. While the total cost of primary cares services and the percent clinical care as a percentage of the total JCDH budget have decreased, the volume of patients served by JCDH has declined.

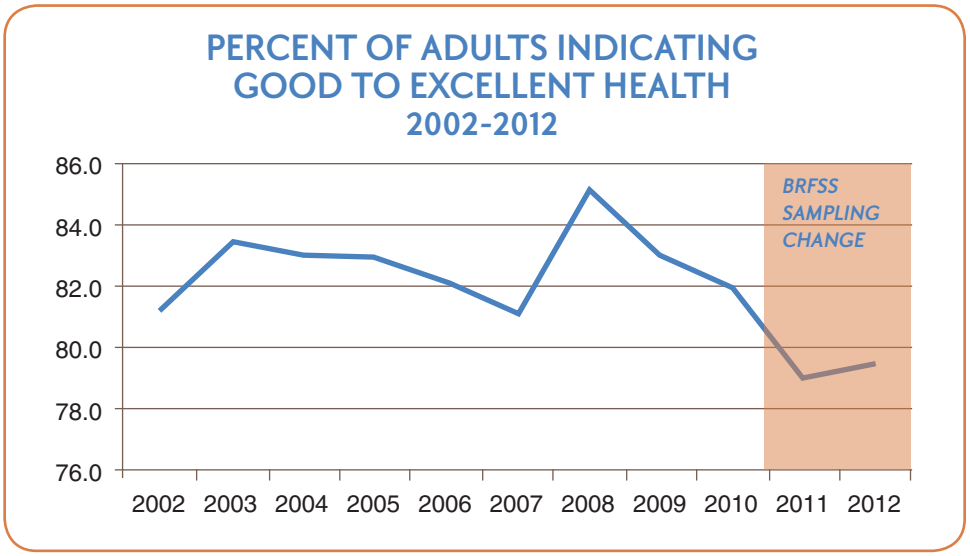
QUALITY OF LIFE

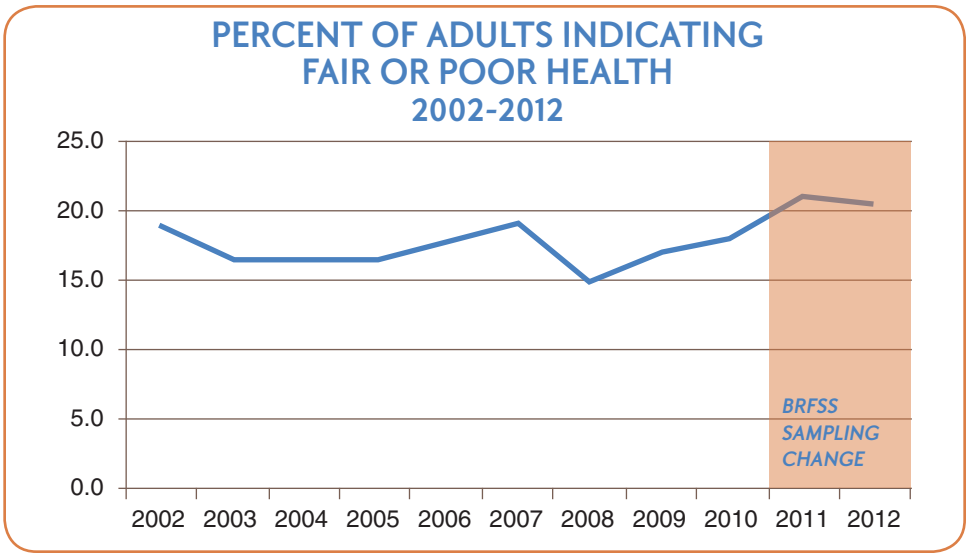
Quality of life indicators include general description of health, number of reported poor mental and physical health days, voter registration and turnout, as well as data on violent crimes. These indicators represent aspects of daily residential life that play a role in overall health and well-being.

GENERAL HEALTH

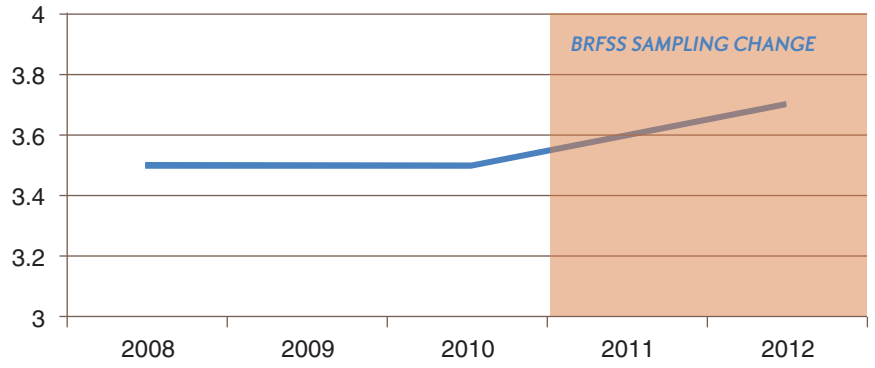
The Behavioral Risk Factor Surveillance System (BRFSS) asks each telephone respondent to describe his or her general health as excellent, very good, good, fair or poor. In 2011, the BRFSS changed its telephone sampling methodology to include cell phone numbers. With this change in methodology, results following 2011 cannot be accurately compared to results prior to the 2011 sampling change.

From 2002 to 2010, the BRFSS results of those indicating that their health rated between excellent and good remained static at an average of 82.8% of survey respondents. In the same timeframe, those indicating fair or poor health remained static at an average of 17.2%. Following the 2011 sampling change, the percent of the population indicating excellent to good health declined to an average of 79.3% and an average of 20.7% indicating fair or poor health.





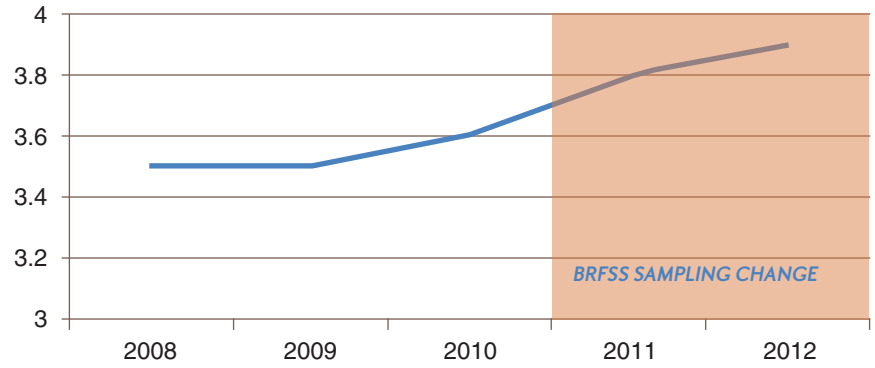
AVERAGE NUMBER OF POOR PHYSICAL HEALTH DAYS IN THE LAST 30 DAYS 2008-2012



POOR PHYSICAL HEALTH DAYS

This measure represents the age-adjusted average number of physically unhealthy days reported in the last 30 days reported by BRFSS telephone respondents. The numbers have increased over time, with more poor physical health days being reported; however, this increase is not statistically significant. Numbers are reported as the last year of a six year rolling average.

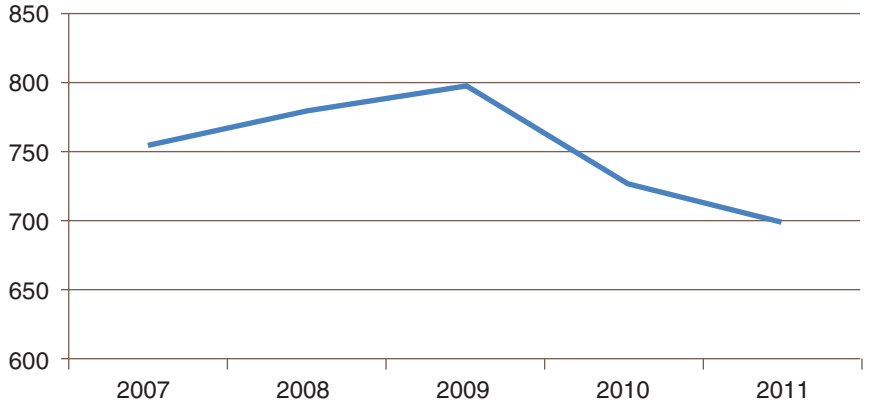
NUMBER OF POOR MENTAL HEALTH DAYS REPORTED IN THE LAST 30 DAYS 2002-2012



POOR MENTAL HEALTH DAYS

This measure represents the age-adjusted average number of mentally unhealthy days reported by BRFSS respondents during the 30 days prior to the survey. An increasing of mean of poor mental health days have been reported since 2008 however, this increase is not statistically significant. Data are reported as the last year of a six year rolling average.

RATE OF VIOLENT CRIME PER 100,000 POPULATION 2007-2011



VIOLENT CRIME

Violent crime is defined as offenses that involve face-to-face confrontation between the victim and the perpetrator and is represented as a rate per 100,000 population. Crimes included in this rate are homicide, forcible rape, robbery and aggravated assault. The violent crime rate is represented as a two year rolling average and the rate is reported as the last year. Although the rolling two year rate per 100,000 rose from 755 to 797 from 2006-07 to 2008-09 then dropped to 698 for 2010-11, there has not been enough time to ascertain if a true trend has developed. Jefferson County's violent crime rates are higher than the overall rate of violent crime in Alabama, at 435 violent crimes per 100,000 people in 2011.

VOTER REGISTRATION AND TURNOUT

Voter registration and turnout for elections represents Jefferson County's residents' level of engagement in the local, state and national political process.

LOCAL ELECTIONS:

Data for the table below represent the primary run-off election on July 15, 2014. Data from other local elections are not provided due to difficulties in combining data from the variety of local municipalities and differing local items considered by each municipality.

	Registered Voters	Number Voted	Percent Voted
Primary Run-off Election- July 15, 2014	425,580	58,532	13.8%

STATEWIDE ELECTIONS:

Statewide elections, held every four years, include elections for statewide representatives and statewide issues. While the percent of registered voters increased during statewide election years, the percentage of registered voters that actually voted in the election fluctuated.

Year	Eligible to Vote	Registered to Vote	Percent Registered	Number Voted	Percent Voted
2002	497,029	343,861	69.2%	216,211	62.9%
2006	499,219	356,242	71.4%	180,792	50.7%
2010	503,804	380,260	75.5%	213,704	56.2%

NATIONAL ELECTIONS:

National elections, held every four years, include presidential elections. The percent of registered voters has fluctuated during election years; however, the percent of registered voters who voted has increased over the past three election years.

Year	Eligible to Vote	Registered to Vote	Percent Registered	Number Voted	Percent Voted
2004	497,763	385,386	77.4%	293,355	76.1%
2008	500,578	414,002	82.7%	318,968	77%
2012	504,877	385,364	76.3%	305,014	79.1%

QUALITY OF LIFE FINDINGS

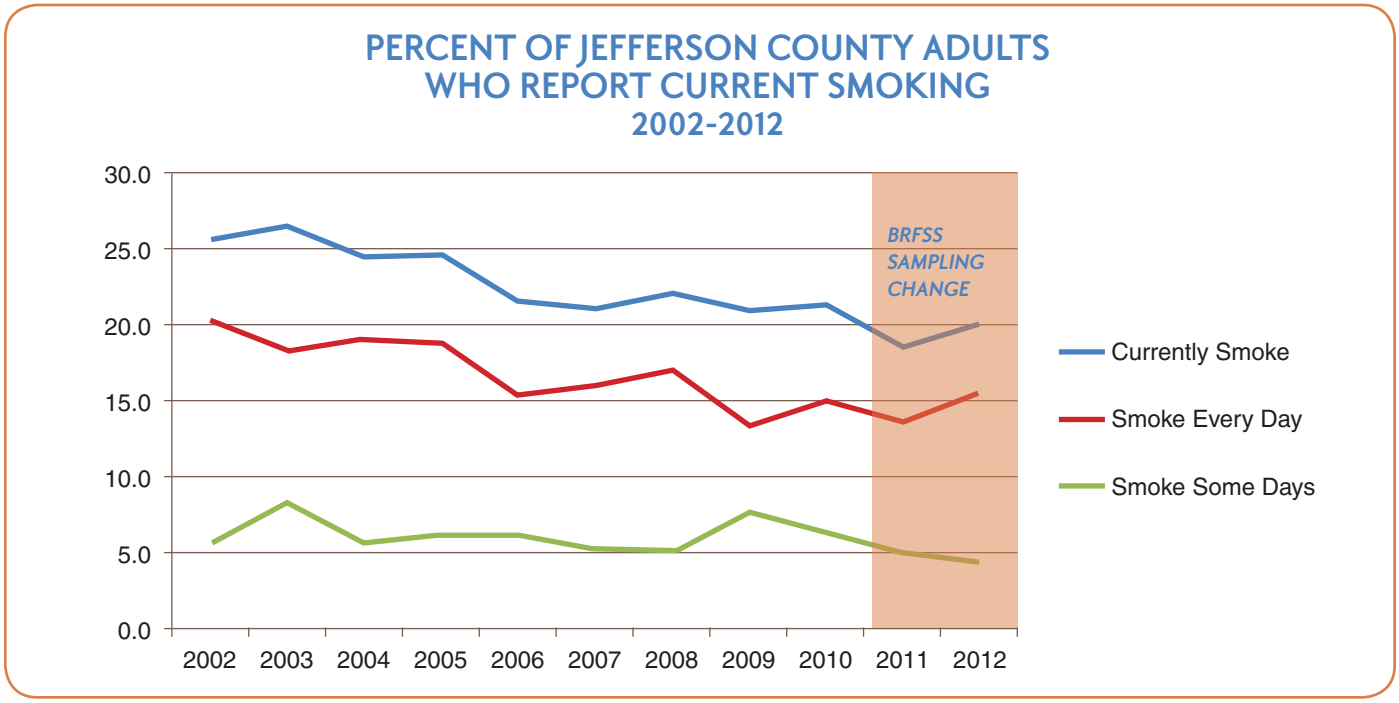
Trends among the quality of life indicators are difficult to determine. While the percent of the population reporting less than good health has increased, the sampling methodology change means that a trend cannot be determined. Poor physical and mental health days have increased, but these increases have not been statistically significant. Rates of violent crime have decreased, but adequate data points have not been attained to determine trending. While voter registration and turnout trends have fluctuated by election year, it appears that more voters are registering during state election years and more voters are voting during national election years.

BEHAVIORAL RISK FACTORS

Behavioral risk factors represent individual behaviors that play a role in determining an individual's health status. Measures included in this category are tobacco use, alcohol use, exercise, overweight and obesity, seatbelt use and depression.

SMOKING

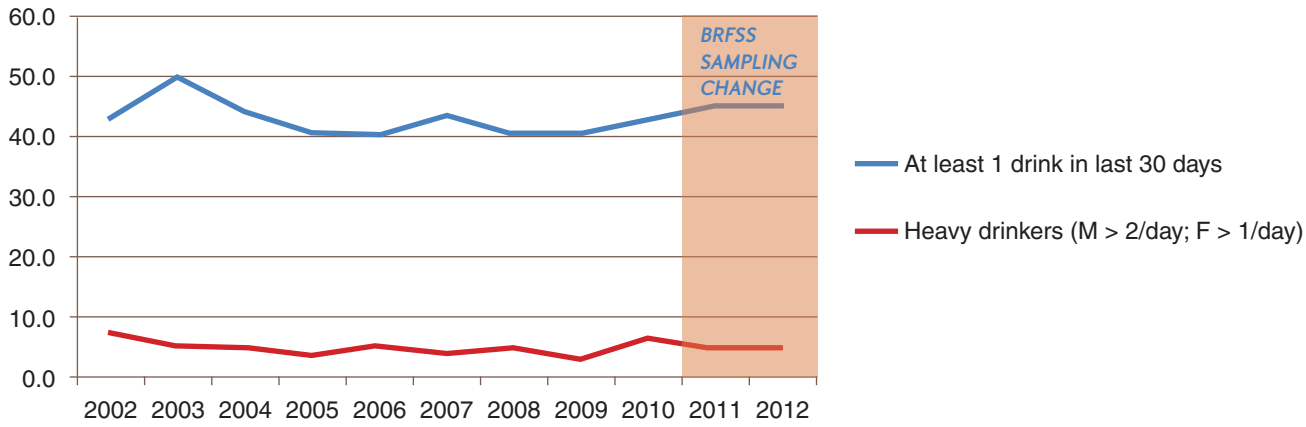
The percent of the Jefferson County population reporting current smoking has decreased over time. In 2012, 20% of Jefferson County adults reported currently smoking. The US national Healthy People 2020 goal is 12% of the adult population reporting current smoking.



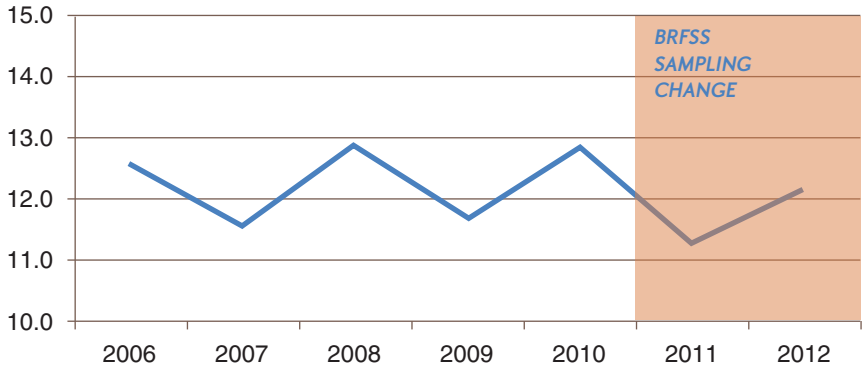
ALCOHOL USE

Alcohol use is reported for drinkers, defined as having an alcoholic beverage within the last 30 days, heavy drinkers, defined as males who drink two or more alcoholic drinks per day or females who drink one or more alcoholic drinks per day and binge drinking, which is defined as five or more alcoholic drinks on one occasion for a male or four or more alcoholic drinks on one occasion for a female. The percent of the adult population reporting alcohol use in each of these categories has not changed significantly over time. However, in 2012, 16% of Jefferson County driving deaths were associated with alcohol impairment. Jefferson County's percentage of heavy and binge drinkers is lower than the Healthy People 2020 goal of 25.4% and 24.4% respectively.

PERCENT OF JEFFERSON COUNTY ADULTS REPORTING ALCOHOL USE 2002-2012



PERCENT OF JEFFERSON COUNTY ADULTS REPORTING BINGE DRINKING 2006-2012

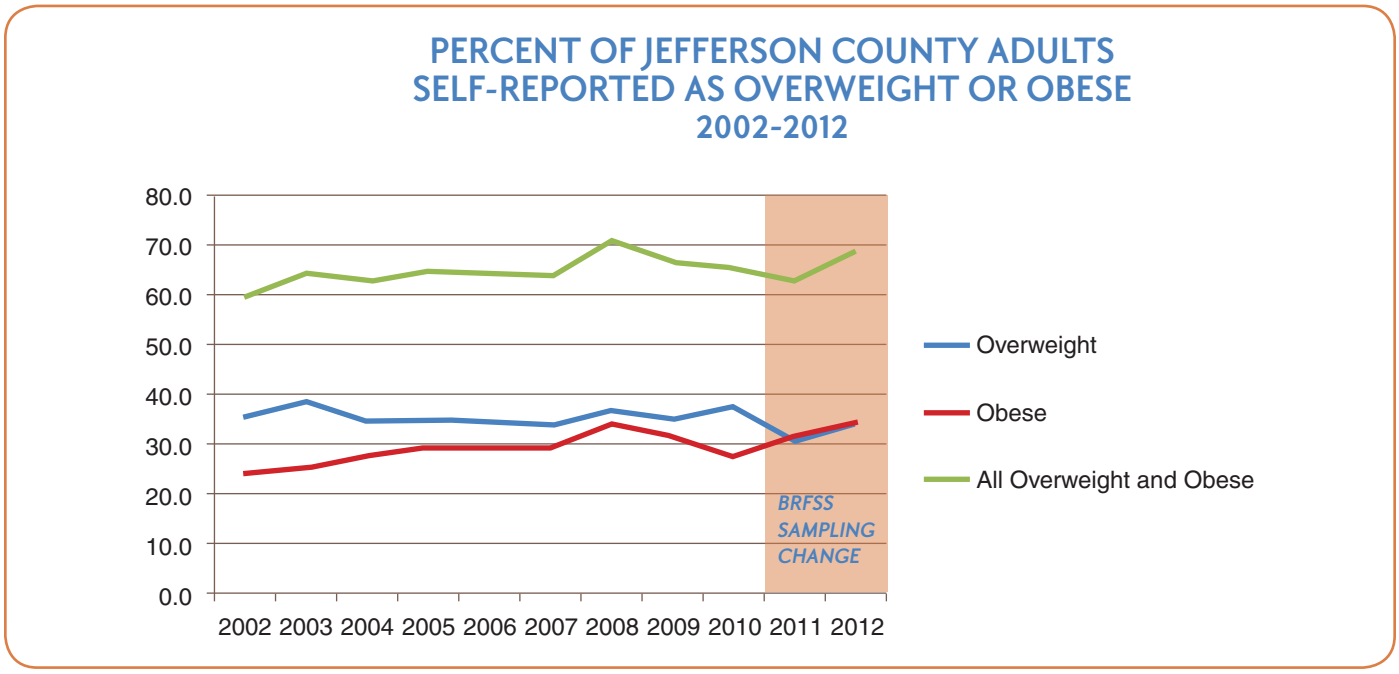


PHYSICAL ACTIVITY

The data from the Behavioral Risk Factor Surveillance System (BRFSS) related to physical activity is inconclusive. Data were collected beginning in 2011; therefore, with only two data points, no trends can be discerned. When survey participants were asked, "During the past month, did you participate in any physical activity?" 66.6% of the adult population reported physical activity in 2011. In 2012, 75.5% of the adult population reported physical activity within the past month.

OVERWEIGHT AND OBESITY

The percent of the Jefferson County population self-reported as overweight or obese has increased. Obesity rates have increased, while the percent of adults reported as overweight remained static. Jefferson County reported higher obesity rates at 34.8% of the adult population than the Healthy People 2020 US goal of 30% of the adult population reporting obesity.



SEATBELT USE

Seatbelt use data is inconclusive as only two data points are available to date. In 2011, 94.3% of Jefferson County adults self-reported always using a seatbelt. In 2012, 94% of adults reported seatbelt use.

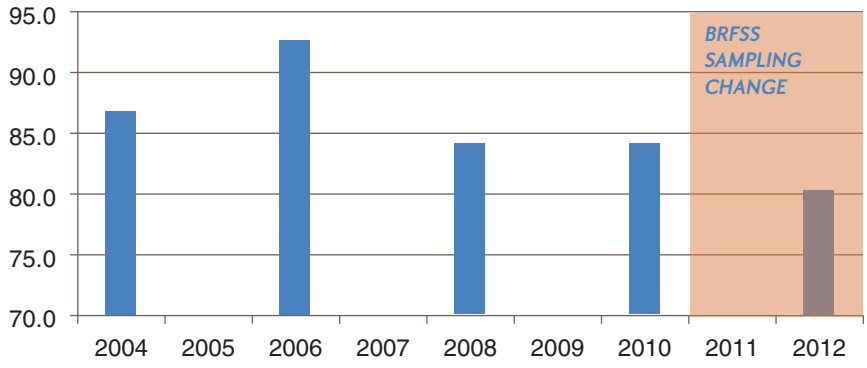
SCREENINGS

Overall, the self-reported disease screening rates for Jefferson County residents are declining for some diseases and are remaining static for other disease states.

PAP SMEARS

The percent of females over age 18 reporting having received a Pap Smear within the last three years has significantly decreased from a screening high in 2006. Jefferson County's 2012 rate of 80.6% of age appropriate females receiving a Pap smear is substantially less than the Healthy People 2020 goal of 93% of females ages 21 to 65 receiving a Pap smear every three years.

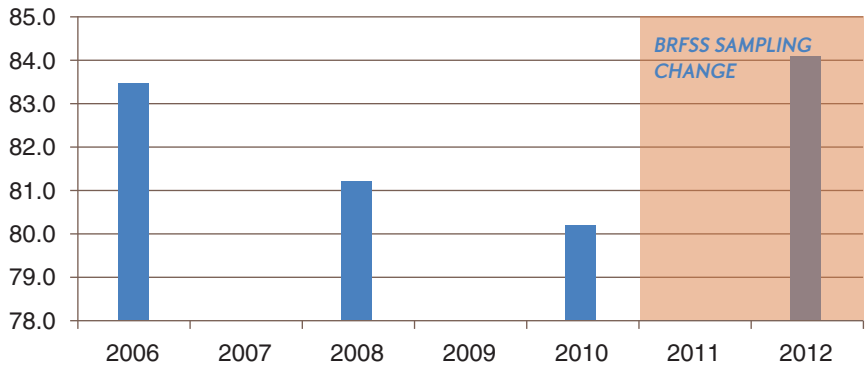
PERCENT OF FEMALES OVER AGE 18 REPORTING A PAP SMEAR WITHIN THE LAST 3 YEARS 2004-2012



MAMMOGRAMS

The percent of women over age 50 reporting receiving a mammogram within the past two years has demonstrated no significant change between 2006 and 2012.

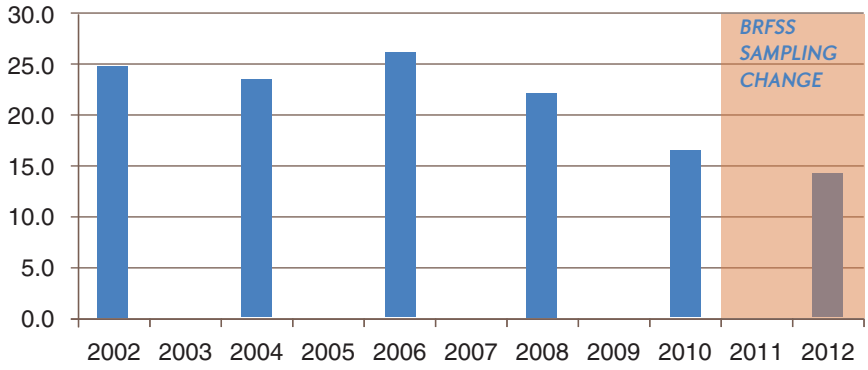
PERCENT OF FEMALES OVER AGE 50 REPORTING A MAMMOGRAM WITHIN THE LAST 2 YEARS 2006-2012



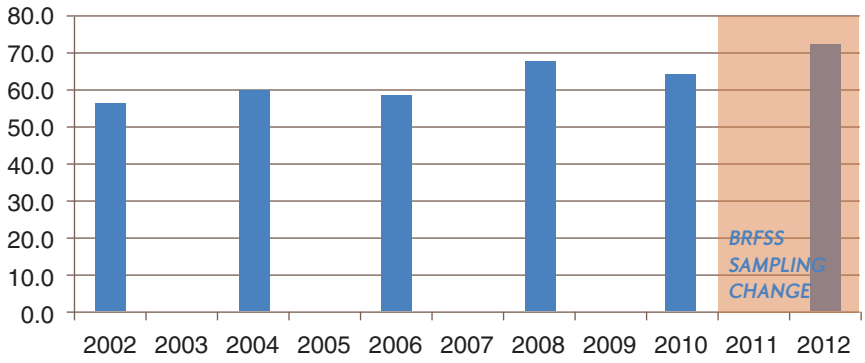
COLORECTAL CANCER SCREENINGS

The US national Healthy People 2020 goal for colorectal cancer screenings is for 70% of adults over age 50 to receive any type of colorectal screening. The percent of Jefferson County adults reporting a blood stool test within the last two years has reduced significantly by 33.9% from 24.8% in 2002 to 14.3% in 2012. The percent of the county's population reporting a colonoscopy/ sigmoidoscopy, however, increased from 56.7% in 2002 to 72.5% in 2012, a 27.9% increase.

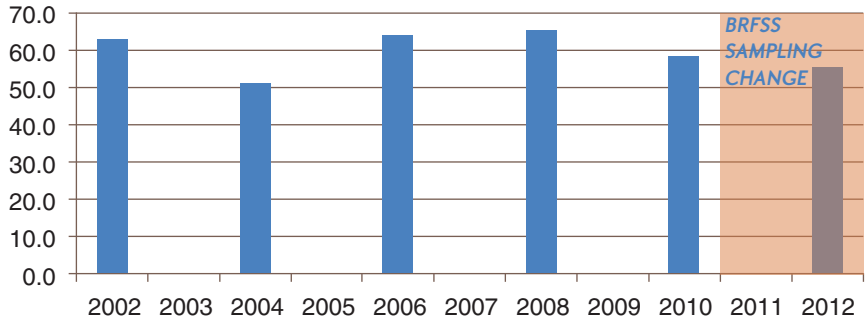
PERCENT OF ADULTS OVER AGE 50 REPORTING A BLOOD STOOL TEST WITHIN THE LAST 2 YEARS 2002-2012



PERCENT OF ADULTS OVER 50 REPORTING EVER HAVING A COLONOSCOPY OR SIGMOIDOSCOPY 2002-2012



PERCENT OF MALES OVER AGE 50 REPORTING A PROSTATE SPECIFIC ANTIGEN TEST WITHIN THE LAST 2 YEARS 2002-2012



PROSTATE CANCER SCREENING

Prostate cancer screening has remained static with approximately 60% of males over age 50 reporting a Prostate Specific Antigen test within the last 2 years.

BEHAVIORAL RISK FACTOR FINDINGS

Tobacco use, the number one cause of preventable death in the United States, remains an issue of importance in Jefferson County. While smoking rates have decreased over the past ten years, at 20% of the adult population, Jefferson County continues to have a significantly higher percentage of current smokers than the recommended national Healthy People 2020 goal of 12%. Another behavioral risk factor that represents a large risk for the Jefferson County population is obesity. With the rates of obesity exceeding the national Healthy People 2020 target of 30% and continuing to climb, obesity represents a significant health concern for Jefferson County.

Screening rates in Jefferson County vary by disease state. Among women, Pap smear rates continue to decline and are below the Healthy People 2020 goal of 93% of age appropriate women receiving a Pap smear. Mammography rates for age appropriate women have remained stable. Among men, Prostate Specific Antigen screenings remain static with about 60% of age appropriate men reporting this testing. While blood stool screenings for colorectal cancer have decreased, the rates of colonoscopy or sigmoidoscopy have increased significantly since 2002.

Alcohol use by Jefferson County adults remains lower than the Healthy People 2020 goal and has remained static over time, indicating that it does not represent an accelerated behavioral risk in Jefferson County. While reported rates of physical activity increased from 2011 to 2012, the fact that only two data points exist makes it impossible to determine trending. Seatbelt use appears to have remained static at 94% of the population reporting regular seat belt use, but no trend could be determined.

ENVIRONMENTAL HEALTH

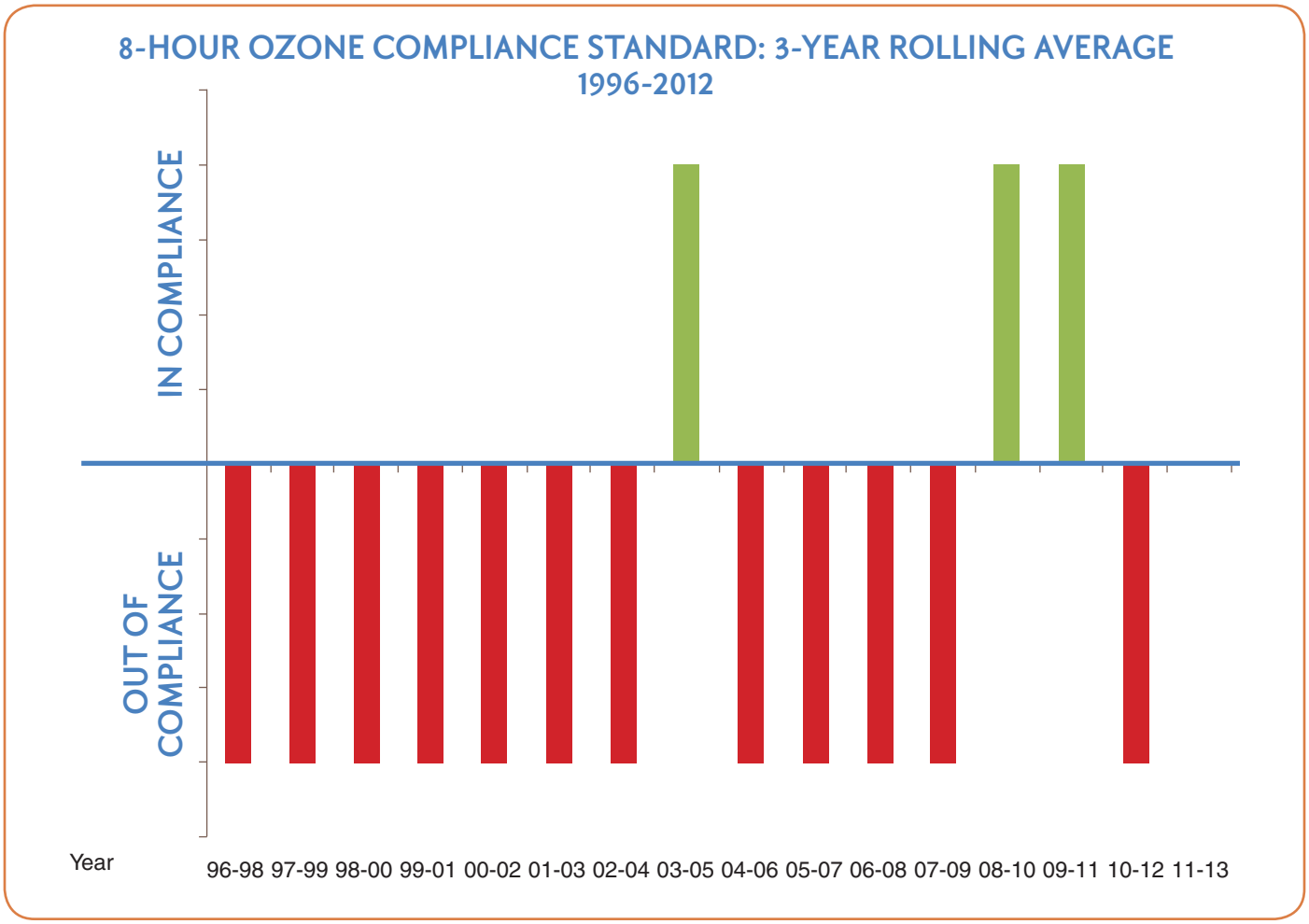
Indicators within the Environmental Health category represent measures of environmental health that can impact human health and disease states. Environmental Health indicators include measures of outdoor air quality, indoor air quality, food safety, water safety, lead exposure, and the miles of trails in Jefferson County.

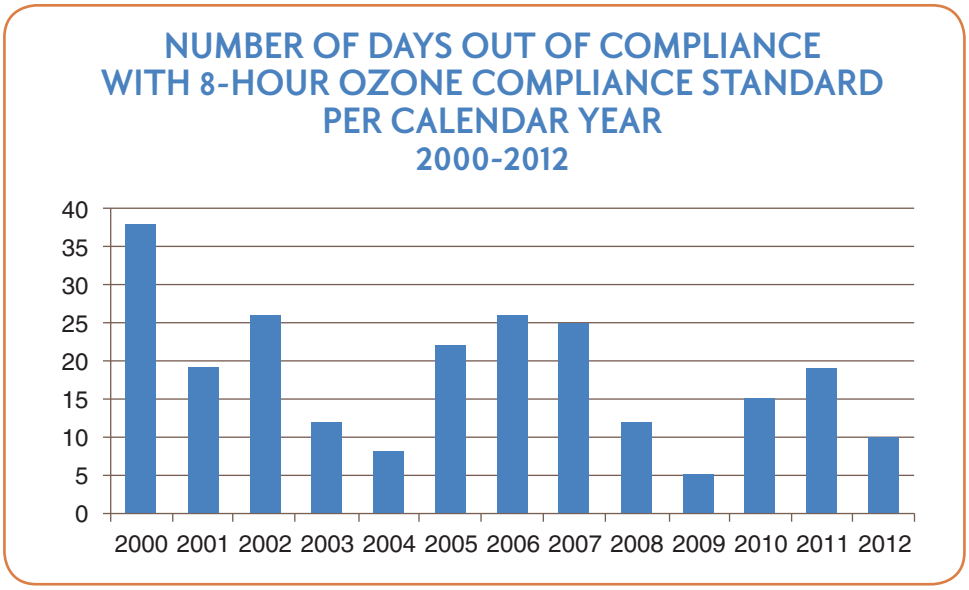
OUTDOOR AIR QUALITY

Outdoor air quality standards for air pollutants are established by the Environmental Protection Agency (EPA) for each air pollutant. The Jefferson County Department of Health enforces pollution regulations for major air polluters to assure outdoor air quality.

OZONE

Ozone is the principal component of smog and represents a health risk if inhaled in high concentrations. In 1997, the eight hour Ozone Compliance Standard was set at 0.08 parts per million; this standard was revised in 2008 to 0.075 parts per million. The eight hour ozone standard is determined by taking the three year average of the fourth highest daily maximum 8-hour average at any Jefferson County air monitor. While the average number of days out of compliance has declined over time, Jefferson County was deemed to be out of compliance for 12 of the last 15 three year reporting cycles. Two of the three cycles where Jefferson County was in compliance with the eight hour Ozone Compliance Standard ended in 2010 and 2011.

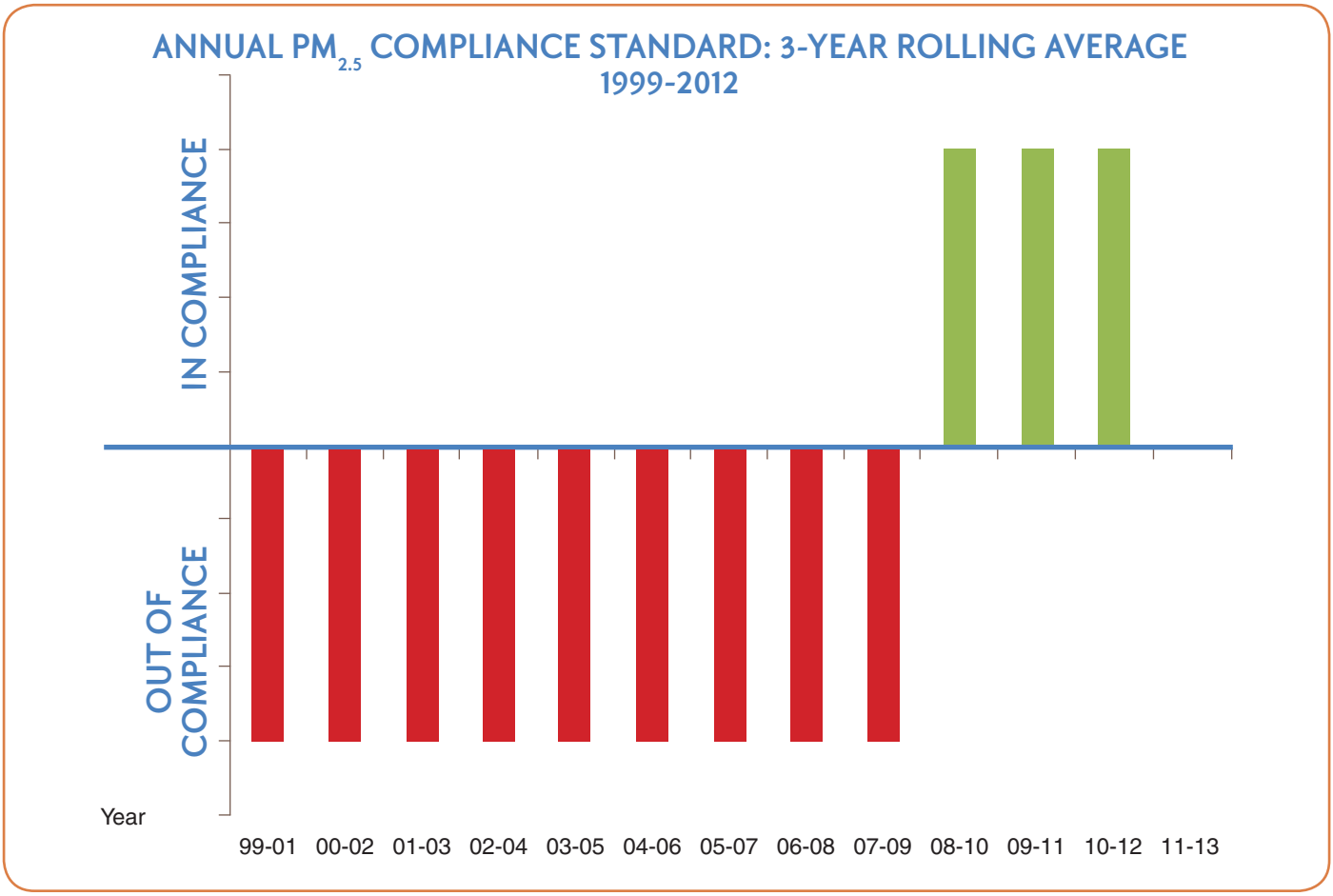




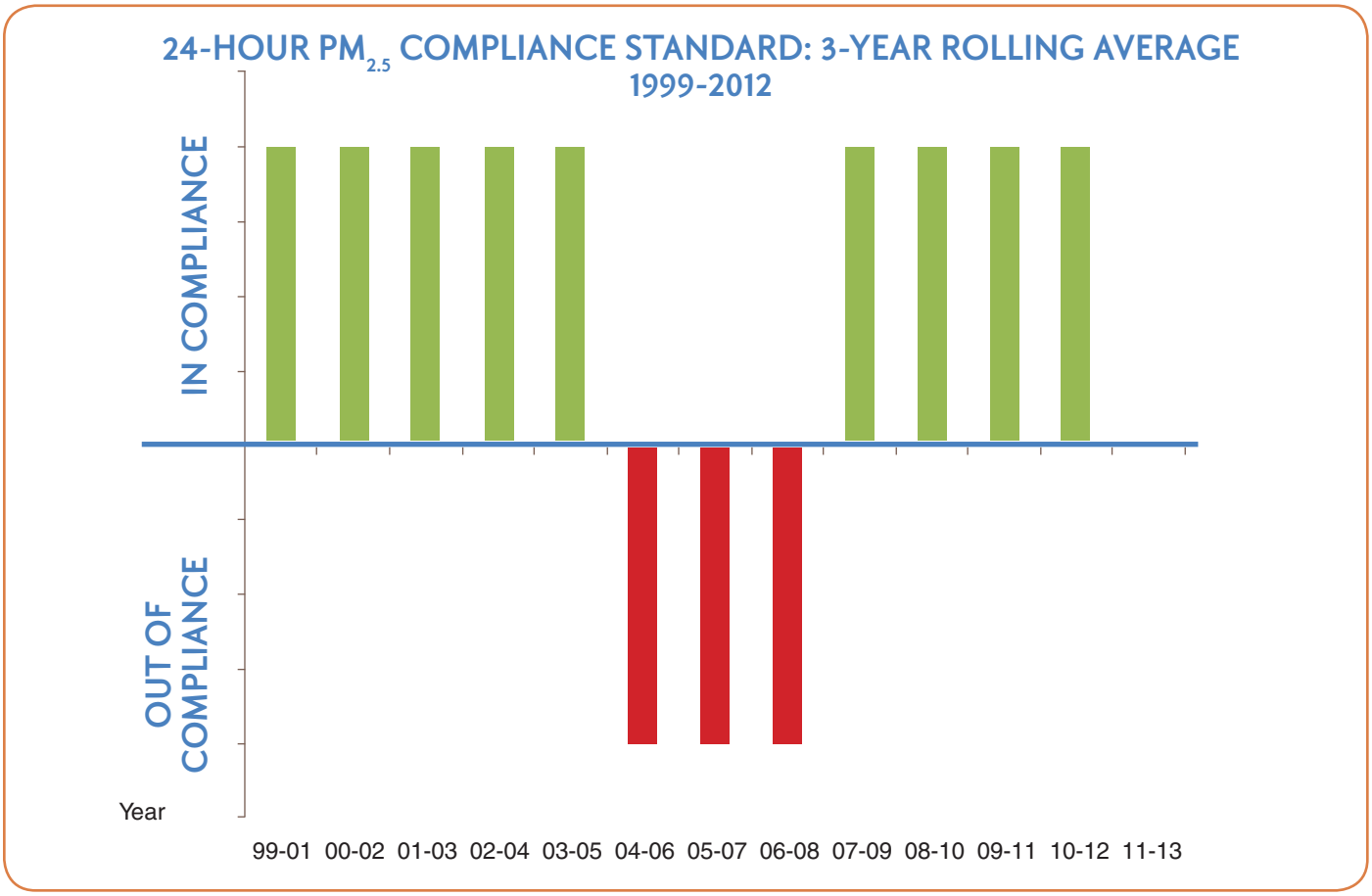
There has been a decrease in number of days per year in which Jefferson County exceeded the eight hour Ozone compliance standard, but weather is a driving factor for this indicator, in addition to the actual "output" both local and from out-of-county air pollution sources.

PARTICULATE MATTER

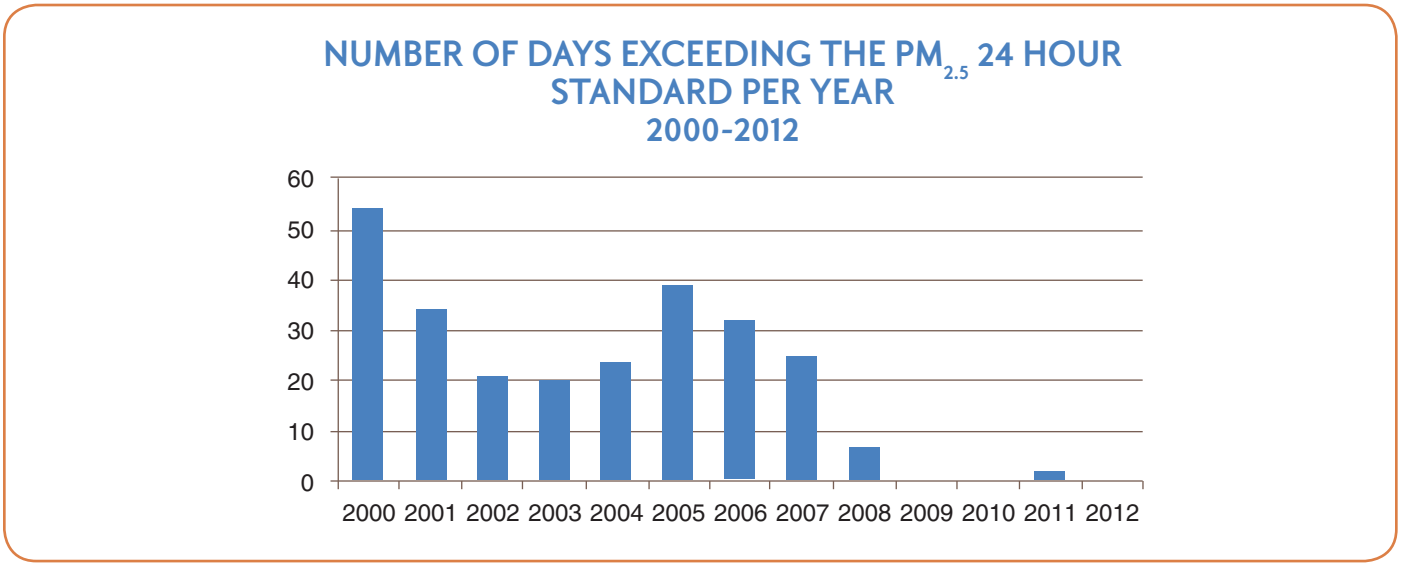
Particulate matter is pollution made of a variety of components, both particles and liquid, that is of concern based on particulate size. Smaller sized pollutants can pass through the nose and throat and enter the lungs presenting potential health risks. $PM_{2.5}$ is particulate matter pollution that is less than 2.5 microns in size and poses the greatest health risk. The Annual $PM_{2.5}$ standard is calculated as the annual mean $PM_{2.5}$ averaged over 3 years. In 1997, the Annual $PM_{2.5}$ standard was set at 15 $\mu g/m^3$. The standard was revised to 12 $\mu g/m^3$ in 2013, but this data is not available at this time. Jefferson County has achieved compliance with the Annual $PM_{2.5}$ standard for the last three single years of reporting under the existing threshold (15 mg/m^3) for those years. Reports for new lower threshold in 2013 are not yet released (12 mg/m^3).



The $PM_{2.5}$ 24-hour standard is calculated as the 98th percentile averaged over three years. In 1997, the $PM_{2.5}$ 24-hour standard was set at 65 µg/m³. In 2006, this standard was revised to 35 µg/m³. Jefferson County has been in compliance for the last four single years of reporting (35 mg/m³) and was in compliance 9 out of the 12 years reported. Jefferson County was out of compliance from 2006 to 2008 which were the first three years in which the stricter standard was enforced.



There has been a decrease in the number of days in which Jefferson County exceeded the $PM_{2.5}$ 24-hour Standard, from a high of 54 days in 2000 to 0 days in 2009, 2010 and 2012.



INDOOR AIR QUALITY

Indoor air quality is measured by the percent of Jefferson County residents protected from indoor smoke exposure through smoke-free public policies.

PERCENT OF JEFFERSON COUNTY MUNICIPALITIES AND RESIDENTS PROTECTED BY ANY SMOKE-FREE PUBLIC POLICY:

	Index Percent Protected (Year)	Endpoint Percent Protected (Year)
Municipalities	2.6% (1990)	52.6% (2013)
Residents	62.4% (2000)	76.3% (2013)

The first comprehensive smoke-free public ordinance was passed in Jefferson County in 2011. As of 2013, 39.1% of Jefferson County residents are protected under a comprehensive smoke-free policy.

PERCENT OF JEFFERSON COUNTY MUNICIPALITIES AND RESIDENTS PROTECTED BY COMPREHENSIVE SMOKE-FREE PUBLIC POLICY:

	Index Percent Protected (Year)	Endpoint Percent Protected (Year)
Municipalities	5.3% (2011)	10.5% (2013)
Residents	2.1% (2011)	39.1% (2013)

FOOD SAFETY

Food safety is important to prevent the spread of foodborne illness. In order to ensure a safe food supply, the Jefferson County Department of Health conducts regular health inspections for food vendors and establishments located within the county.

INSPECTIONS

The number of food establishments and mandated inspections fluctuates annually as facilities begin and end business. The type of food establishment determines the number of inspections required, so trends cannot reliably be established for these indicators. However, there have been an increasing number of food establishments in the county and mandated inspections overall from 1998 to 2014, based on number of food permits issued.

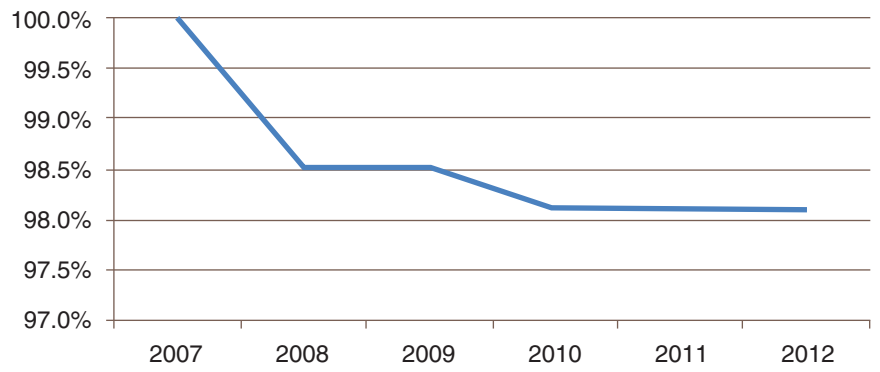
In October 2013, the number of food establishments in Jefferson County was 4,309 inspected by 19.5 full time equivalent inspectors at the Jefferson County Department of Health. JCDH's food inspector full time equivalent staffing has fluctuated between 18.5 and 22.0 during the tracked time period. Each food inspector is responsible for an average of 543 mandated inspections, based on the Food and Drug Administration recommended guidelines for 221 food establishments. Since 1998, there has been a widening gap between the number of mandated inspections required of the food inspectors and the number of food establishment inspections FDA Standards state each inspector should conduct in a year (an average of 300 inspections per year). Beginning with a 50% excess in 1998, the gap between the mandated inspections and the FDA standard has grown to an 81% excess in 2014.

FOODBORNE ILLNESS

While the case rate of known foodborne illness showed a slight downward trend from 2006 to present, the variation in the number of outbreaks associated with these cases has not coincided with changes in the number of outbreaks. Outbreak numbers are available beginning in 1997, but cases associated with these outbreaks have only been reported since 2006. Foodborne illness outbreaks peaked at 80 in 1999 and have gradually decreased to 12 in 2009 and remained static since that time.

WATER QUALITY

Fluoridated water is an important preventive intervention for dental caries. After the city of Irondale eliminated public water fluoridation in 2008, the proportion of Jefferson County residents on municipal water systems receiving fluoridated water dropped to 98.1% in 2012. No other Jefferson County municipality has eliminated public water fluoridation or is expected to do so. No data is available on the number of individuals utilizing unfluoridated wells.



LEAD EXPOSURE (CHILDREN)

Since 1992 when lead testing was first instituted, the total number of cases of Elevated Blood Lead Levels has steadily declined from 128 cases in 1992 to 22 cases in 2010; however, the threshold for the case definition has changed during this timeframe from >15mcg/dL to >10mcg/dL in 2000, then to >5mcg/dL in 2013. With each expansion of case inclusion, there was an expected increase in the number of cases. There has not been time for a trend using the latest case definition to develop.

TRAILS

Trails provide residents the opportunity for physical activity and add beauty to the Jefferson County environment by preserving natural resources. The number of miles of both on-street bike infrastructure and multi-use trails in Jefferson County has increased over the past two years.

	Index Miles (2012)	Endpoint Miles (2014)	Relative Percent Change
On-street Bike Infrastructure	4.4	7.4	68.3%
Multi-Use Trails	12.3	13.4	9.0%

ENVIRONMENTAL HEALTH FINDINGS

Environmental health indicators related to outdoor air quality show that air quality in Jefferson County is improving, with fewer days out of compliance with ozone and $PM_{2.5}$ standards. Indoor air quality in Jefferson County continues to improve as well with the implementation of comprehensive tobacco-free public ordinances. The opportunity to improve indoor air quality continues, as less than 50% of the Jefferson County population is protected with comprehensive smoke-free policies.

With an increasing number of food establishments and a higher number of recommended FDA standard inspections per food establishment, the gap in the number of inspections performed and the FDA standard inspections has continued to widen. This indicates an increased need for food inspectors to meet national food safety standards. It is difficult to track foodborne illness outbreak due to the difficulty is establishing the causative agent for the outbreak; however, the data indicates a decrease in food related outbreaks.

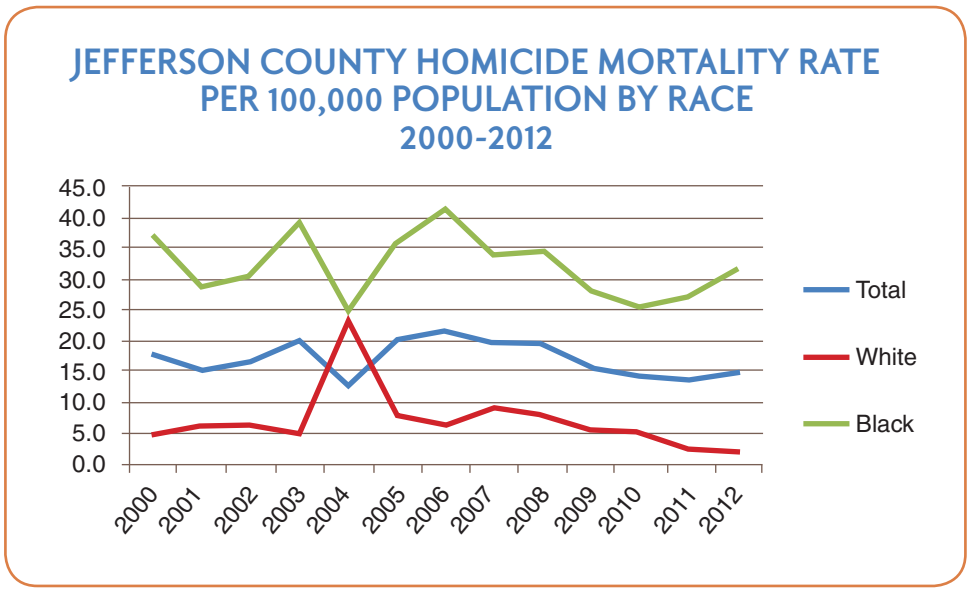
As the population of the city of Irondale has increased over the last five years, the city's decision to eliminate fluoridation from its public water supply in 2008 has increased the risk of dental cares.

The number of cases of elevated blood lead levels among children in Jefferson County has decreased despite the changing case definitions to the elevated blood lead level threshold. With a new threshold level established in 2013, no trend for this case definition can be determined at this time.

Opportunities for physical activity through the use of trails and bike lanes are increasing in Jefferson County.

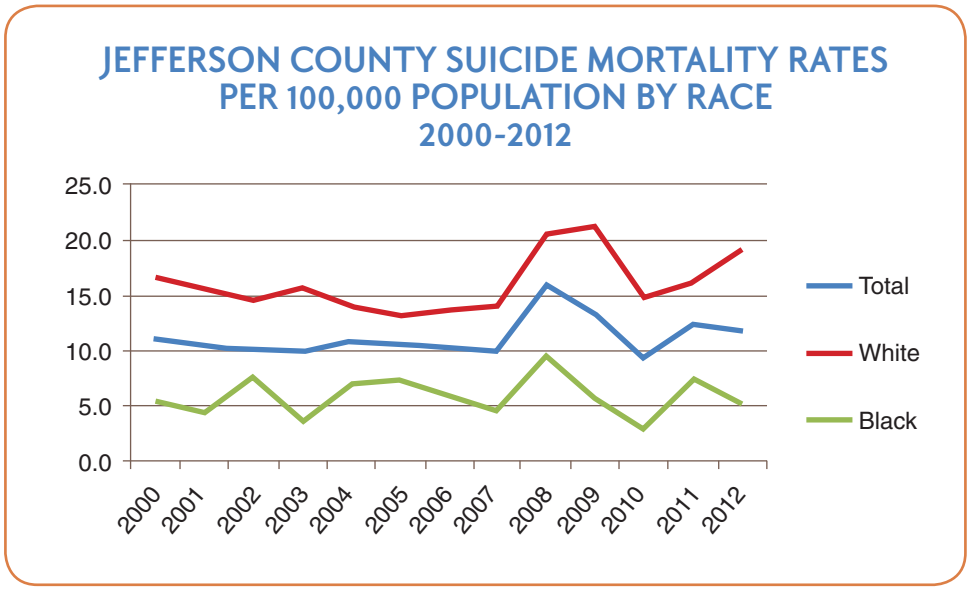
SOCIAL AND MENTAL HEALTH

Measures of social and mental health include suicide and homicide rates, as well as the number of poor mental health days and depression status.



HOMICIDE

Homicide rates decreased in Jefferson County by 16.8% from 17.8 per 100,000 population in 2000 to 14.8 per 100,000 population in 2012. This decline has been detected among both the white and black populations of Jefferson County.



SUICIDE

Suicide rates have remained relatively static over time within Jefferson County. There was spike in suicide mortality among the white and black populations in 2008. Since 2008, the suicide rate has declined and stabilized.

DEPRESSION

Depression data is inconclusive and no trend can be determined because only two data points are available. In 2011, 19.3% of Jefferson County adults indicated that they had ever been told they had depression by a physician. In 2012, 17.7% of the county's adults indicated that they had ever been told they had depression by a physician.

SOCIAL AND MENTAL HEALTH FINDINGS

While Jefferson County's homicide rate has decreased since 2000, homicide remains a concern, especially among the black population. Suicide rates, which spiked in 2008 and 2009, and have returned to the rates seen prior to 2008. In 2012, 17.7% of the Jefferson County adult population indicated that they had been told by a physician that they had depression.

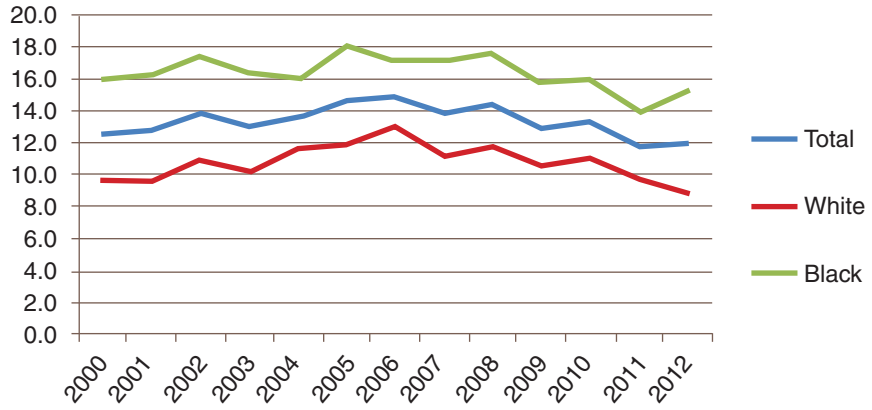
MATERNAL AND CHILD HEALTH

Indicators in this category represent measures related to the health of women and children. Data measures include infant mortality rates, adequate prenatal care, Caesarean Section deliveries, birth weight, preterm deliveries, smoking status during pregnancy, teen pregnancy and childhood mortality rates.

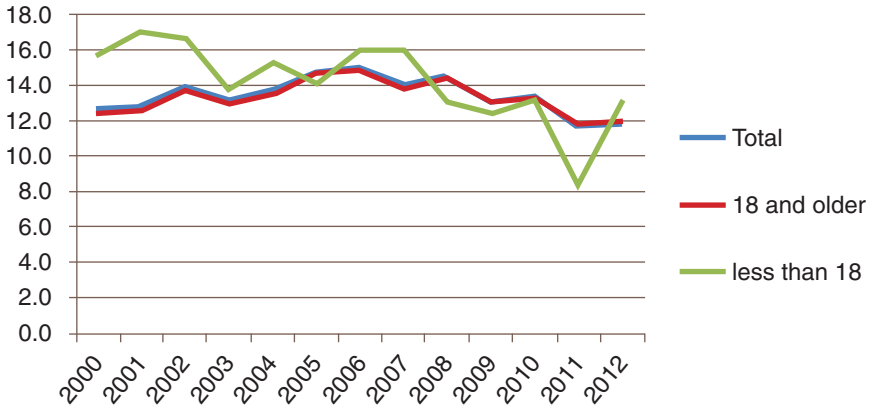
PRETERM BIRTHS

Preterm births are defined as births that occur before 37 weeks gestation. Preterm birth rates have decreased among the white and black populations since 2000; however this trend is inconclusive and will need continued monitoring to determine significance. Among teens, preterm births have decreased significantly, but have remained static since 2008 and remain higher than rates for women age 18 and over. The national Healthy People 2020 goal is 11.4% of live births are preterm deliveries. In 2012, the Jefferson County rate of preterm births was 12.0% which indicates continued need for improvement preventing preterm births.

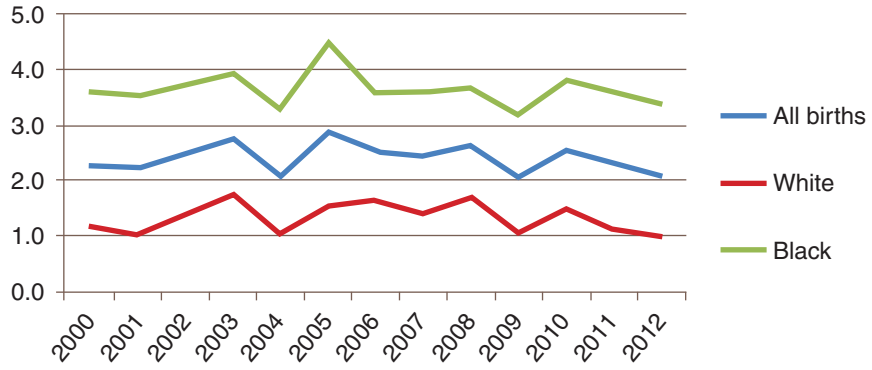
PERCENT OF PRE-TERM LIVE BIRTHS BY RACE 2000-2012



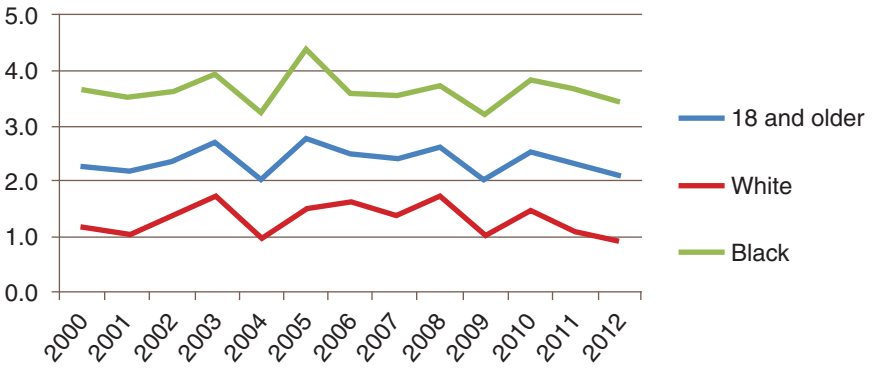
PERCENT OF PRE-TERM LIVE BIRTHS BY MATERNAL AGE 2000-2012



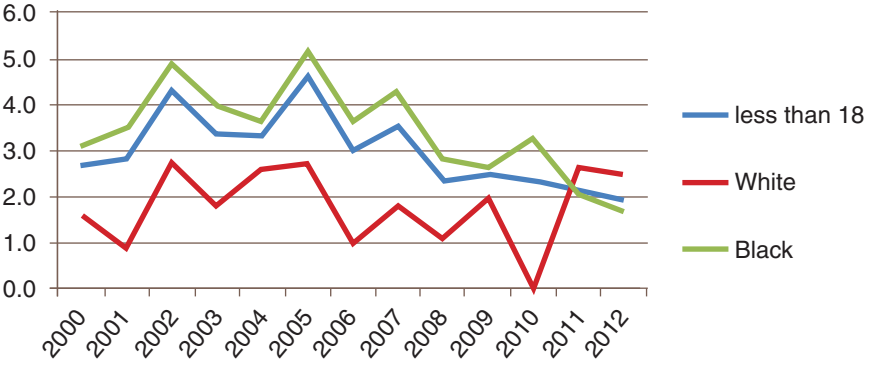
PERCENT OF LIVE BIRTHS THAT ARE VERY LOW BIRTH RATE BY RACE 2000-2012



PERCENT OF LIVE BIRTHS WITH VERY LOW BIRTH WEIGHT AMONG WOMEN AGE ≥ 18 BY RACE 2000-2012



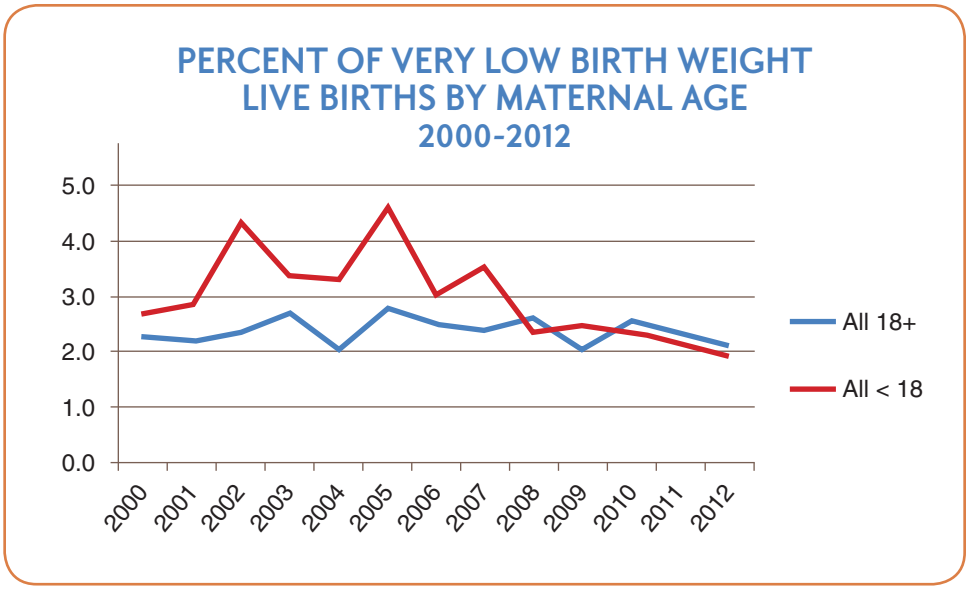
PERCENT OF LIVE BIRTHS WITH VERY LOW BIRTH WEIGHT AMONG WOMEN < AGE 18 BY RACE 2000-2012



VERY LOW BIRTH WEIGHT

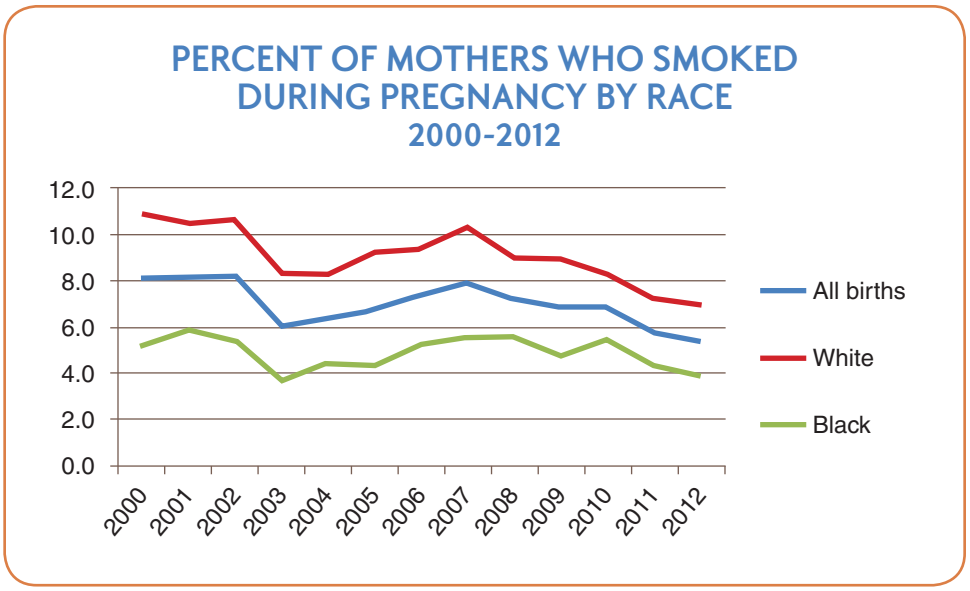
Infants that are very low birth weight, weighing less than 1,500 grams at birth, are often preterm and have more health risks than normal weight infants. The black population of Jefferson County has a higher percentage of very low birth weight infants than the white population. Although there are wide fluctuations year to year in the percentage of very low birth weight infants, the index measure is small, so even a small change from year to year leads to a large percent change. The US Healthy People 2020 goal is for 1.4% of live births to be very low birth weight infants; in 2012, 2.1% of Jefferson County live births were very low birth weight infants indicating a need for improvement in this measure.

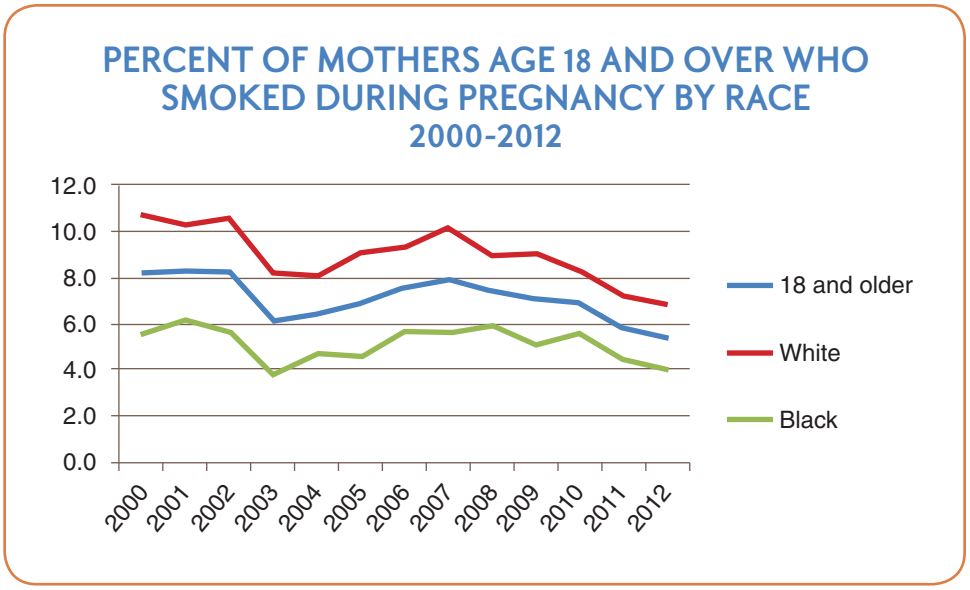
Among women less than 18 years of age, the percent of live births that are very low birth weight has decreased over time.



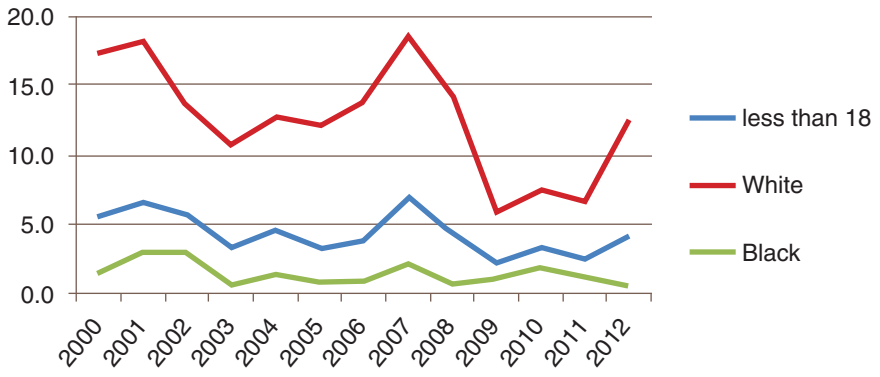
SMOKING DURING PREGNANCY

The percent of Jefferson County women who smoked during pregnancy has decreased since 2000 across all race and age categories. Jefferson County had 94.6% of women abstaining from smoking during pregnancy in 2012, which is higher than the national Healthy People 2020 goal of 89.6%.

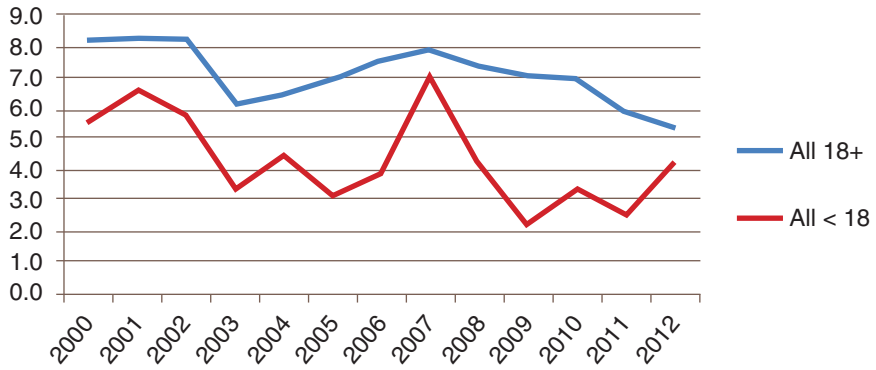




PERCENT OF MOTHERS LESS THAN 18 YEARS OF AGE WHO SMOKED DURING PREGNANCIES BY RACE 2000-2012



PERCENT OF WOMEN SMOKING DURING PREGNANCY BY AGE 2000-2012



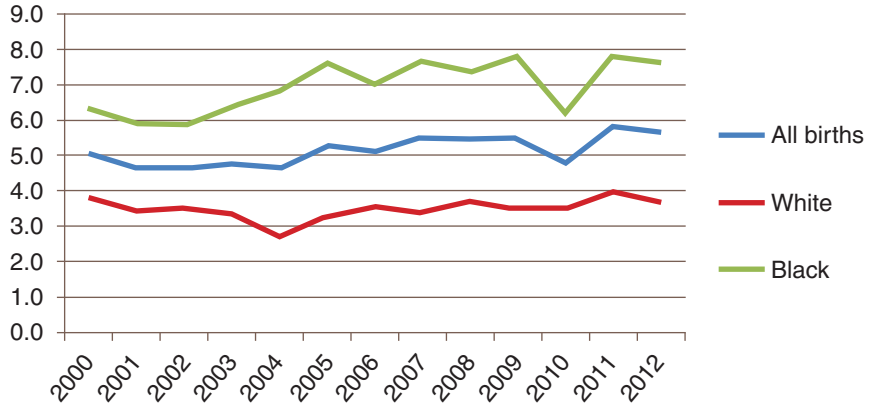
Among women less than 18 years of age, the percent of mothers who smoked during pregnancy was much higher among the white population as compared to the black population.

INTRAUTERINE GROWTH RESTRICTION

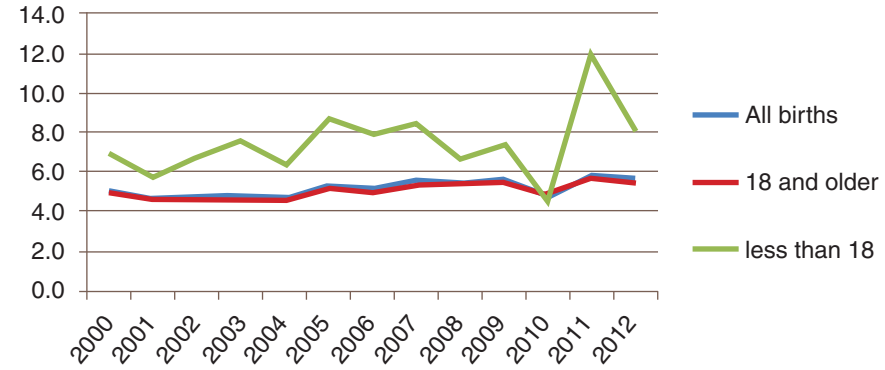
Intrauterine growth restriction indicates limited fetal growth potential and carries an increased risk of perinatal morbidity and mortality. Intrauterine growth restriction is defined as a fetus whose estimated weight is below the 10th percentile for gestational age and whose abdominal circumference is less than the 2.5th percentile. Accurate early dating in pregnancy is important for the diagnosis of intrauterine growth restriction. Intrauterine growth restriction (IUGR) has increased by 12.7% since 2000 in Jefferson County. The majority of this increase has been observed in the black population. As IUGR is present in only a small percentage of live births, a small change in cases can translate to large percent change in this indicator.

Rates of IUGR are higher among preterm deliveries than among full term deliveries.

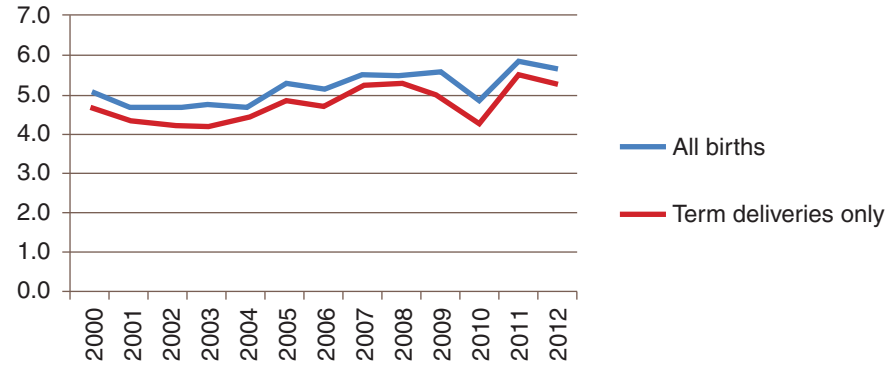
PERCENT OF LIVE BIRTHS WITH IUGR BY RACE 2000-2012



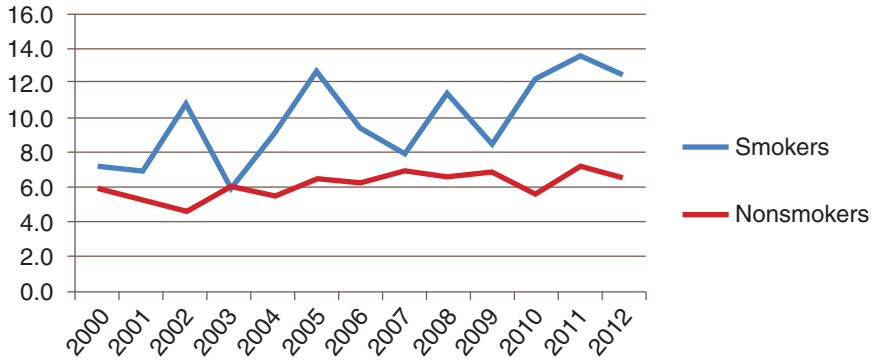
PERCENT OF LIVE BIRTHS WITH IUGR BY MATERNAL AGE 2000-2012



PERCENT OF LIVE BIRTHS WITH IUGR FOR ALL BIRTHS COMPARED TO TERM DELIVERIES 2000-2012

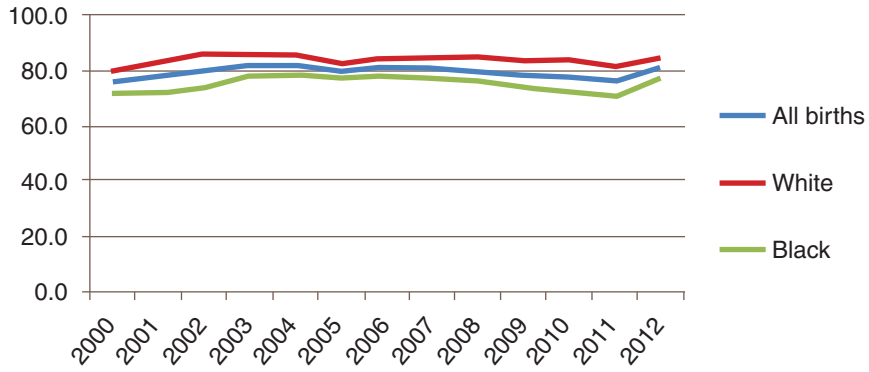


PERCENT OF LIVE BIRTHS WITH IUGR BY MATERNAL SMOKING STATUS 2000-2012

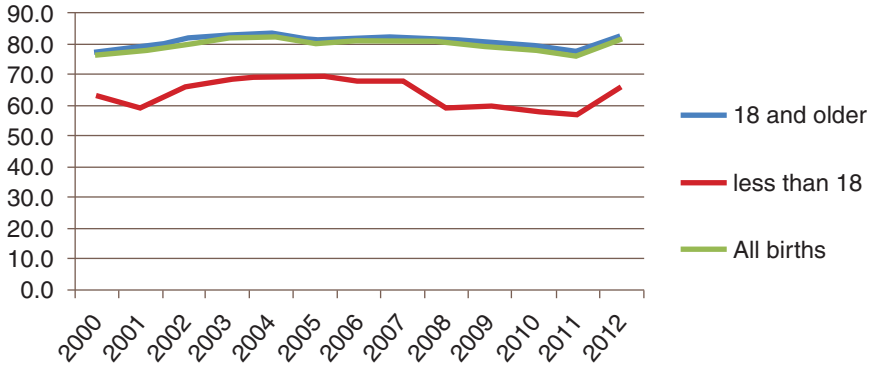


Among mothers who smoke, the percent of live births with IUGR is higher than the percent with IUGR among maternal non-smokers.

PERCENT OF LIVE BIRTHS RECEIVING ADEQUATE PRENATAL CARE BY RACE 2000-2012



PERCENT OF LIVE BIRTHS WITH ADEQUATE PRENATAL CARE BY MATERNAL AGE 2000-2012



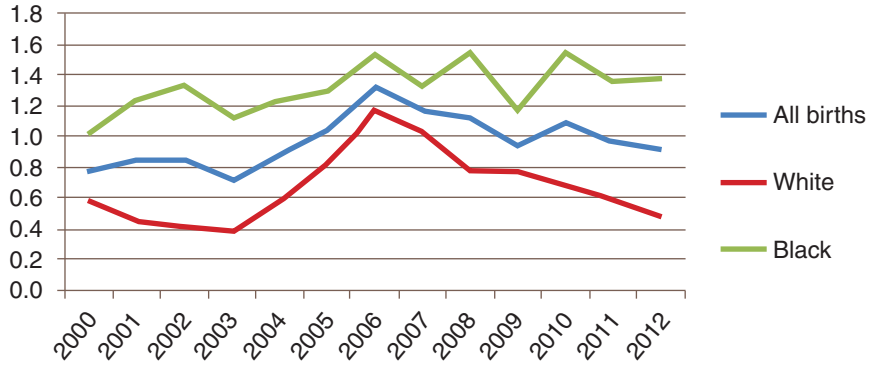
ADEQUATE PRENATAL CARE

Adequacy of prenatal care is measured by the Adequacy of Prenatal Care Utilization Index. This index measures adequacy of care based on the timing of initiation of prenatal care and the adequacy of received services once prenatal care is initiated. Adequate prenatal care is considered to be initiation of prenatal care in the first month of pregnancy, followed by prenatal visits every four weeks through 28 weeks gestation, a prenatal visit every 2 weeks from 28 weeks to 36 weeks gestation and weekly prenatal visits from 36 weeks gestation until delivery. The Adequacy of Prenatal Care Utilization Index measures the expected number of visits adjusted for the timing of the initial prenatal visit. In 2012, 81.5% of live births in Jefferson County received adequate prenatal care. Jefferson County's percentage of live births receiving adequate prenatal care exceeds the Healthy People 2020 goal of 77.6%.

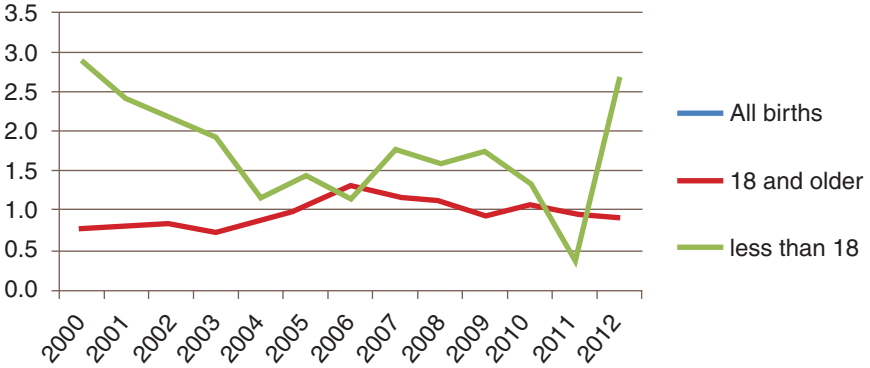
NO PRENATAL CARE

Prenatal care is important in a healthy and safe pregnancy and delivery. Without prenatal care, risk factors contributing to perinatal morbidity and mortality may not be identified and increase the risk of maternal and infant complications from the pregnancy. Jefferson County has experienced an increase in the percent of women not receiving prenatal care since 2000. The number of pregnant women receiving no prenatal care is very small however, and increasing a small amount results in a large percent change. The black population has a higher percentage of women who did not receive prenatal care, as did the population under age 18. In 2012, pregnant women less than age 18 receiving no prenatal care spiked to approximately 3%.

PERCENT OF LIVE BIRTHS WITH NO PRENATAL CARE BY RACE 2000-2012



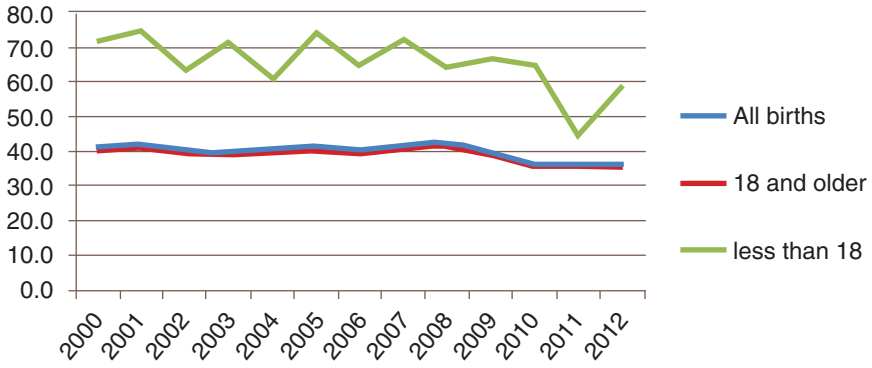
PERCENT OF LIVE BIRTHS WITH NO PRENATAL CARE BY MATERNAL AGE 2000-2012



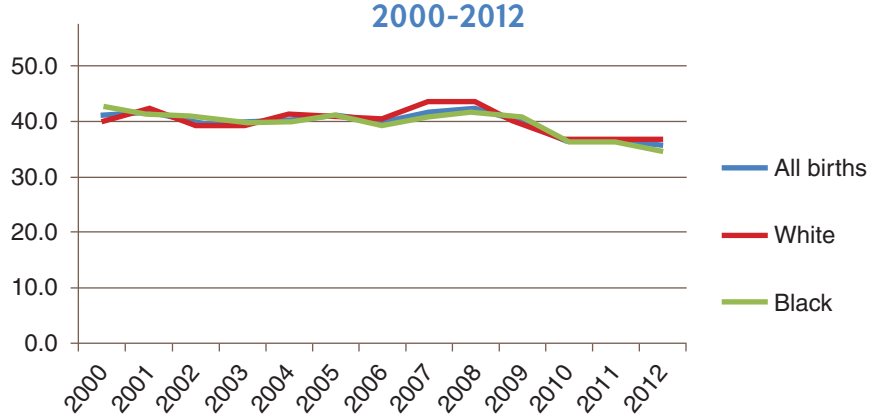
SHORT INTERCONCEPTIONAL INTERVAL

A short interconceptional interval is defined as less than two years between a woman's last delivery and current pregnancy conception. A woman with a multigravid pregnancy is one in which the woman has had more than one pregnancy. The percent of women with a short interconceptional interval increased during 2000-2008 but was decreased in 2009. The short interconceptional interval rate is significantly higher among multigravida women less than age 18.

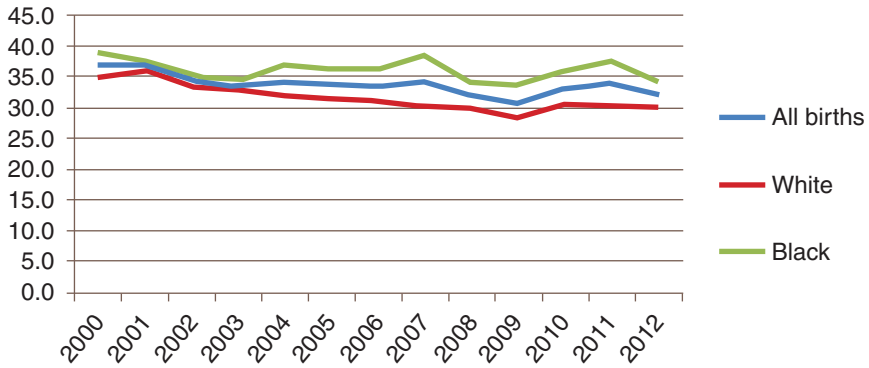
PERCENT OF MULTIGRAVID PREGNANCIES WITH A SHORT INTERCONCEPTIONAL INTERVAL BY MATERNAL AGE 2000-2012



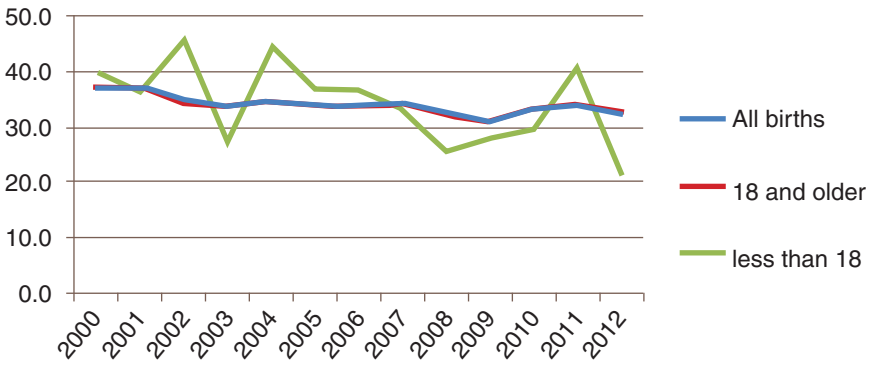
PERCENT OF MULTIGRAVID PREGNANCIES WITH A SHORT INTERCONCEPTIONAL INTERVAL 2000-2012



PERCENT OF MULTIGRAVID PREGNANCIES WITH A FETAL OR INFANT LOSS BY RACE 2000-2012



PERCENT OF MULTIGRAVID PREGNANCIES WITH A PREVIOUS FETAL OR INFANT LOSS BY MATERNAL AGE 2000-2012



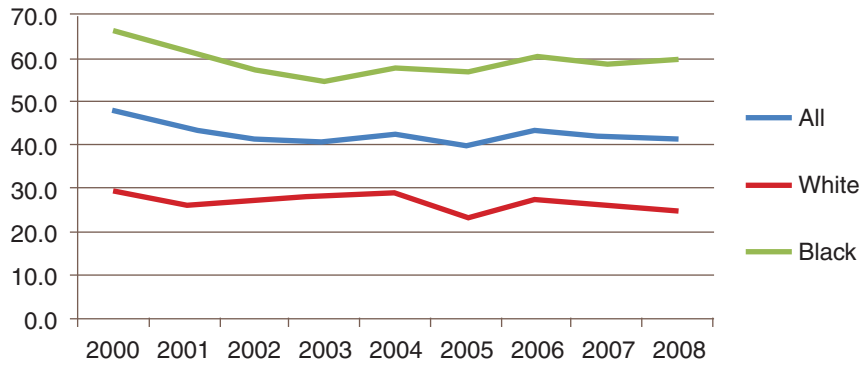
PREVIOUS LOSS (FETAL OR INFANT)

This indicator is the percent of pregnancies in which the mother has had a fetal or infant loss prior to the current pregnancy. The rate of previous loss for pregnancies has declined since 2000, especially among women less than 18 years of age.

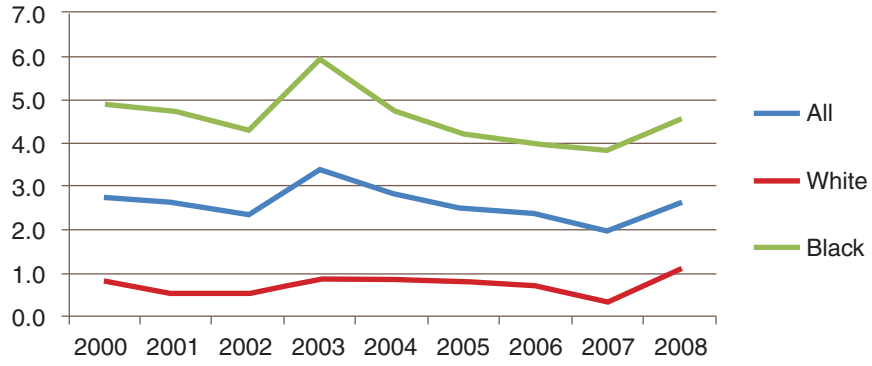
TEEN PREGNANCY RATES

The teen pregnancy rate is calculated as the rate of teen pregnancies per 1,000 women between the ages of 10 and 19. This rate includes live births to teens, as well as abortions and fetal losses. The overall teen pregnancy rate for Jefferson County has remained static since 2000, with the black population having a higher teen pregnancy rate than the white population. The decrease in the teen pregnancy rate has mainly occurred among women ages 15 to 19.

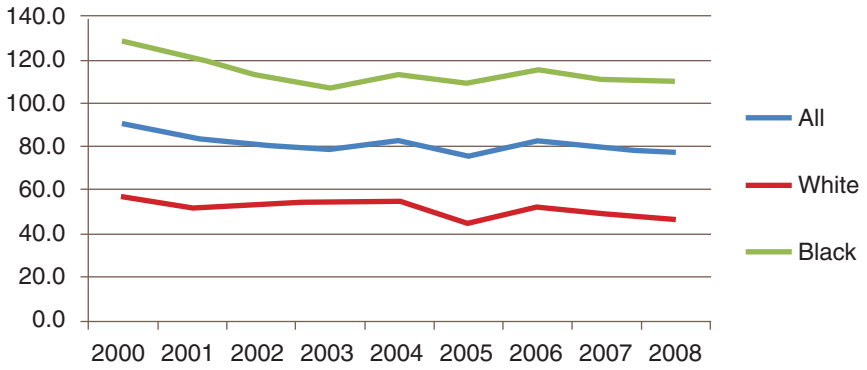
PREGNANCY RATE PER 1,000 WOMEN AGES 10-19 BY RACE 2000-2008



PREGNANCY RATE PER 1,000 WOMEN AGES 10-14 BY RACE 2000-2008



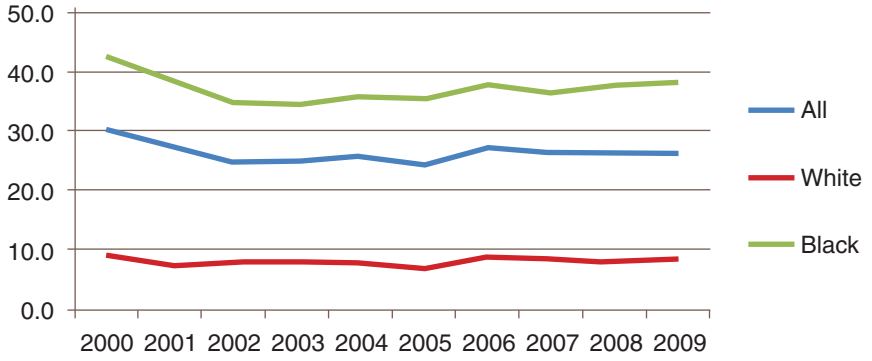
PREGNANCY RATE PER 1,000 WOMEN AGES 15-19 BY RACE 2000-2008



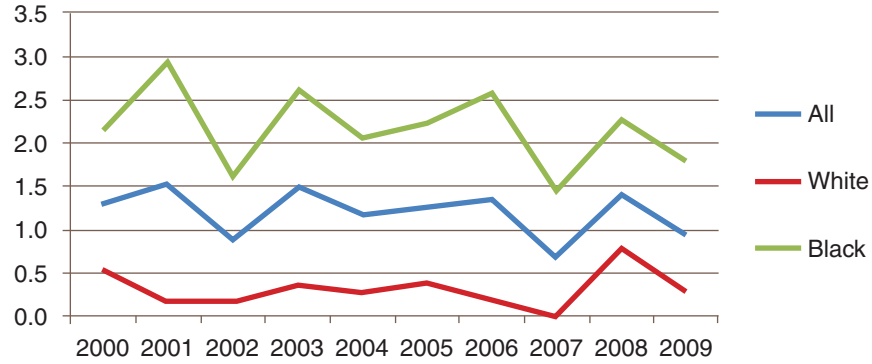
TEEN FERTILITY RATE

The teen fertility rate is the rate of live births to women ages 10 through 19. The teen fertility rate has remained static since 2000 in Jefferson County, with a slight rate increase in the black population. The teen fertility rate has decreased by 27% since 2000 for women ages 10 to 14.

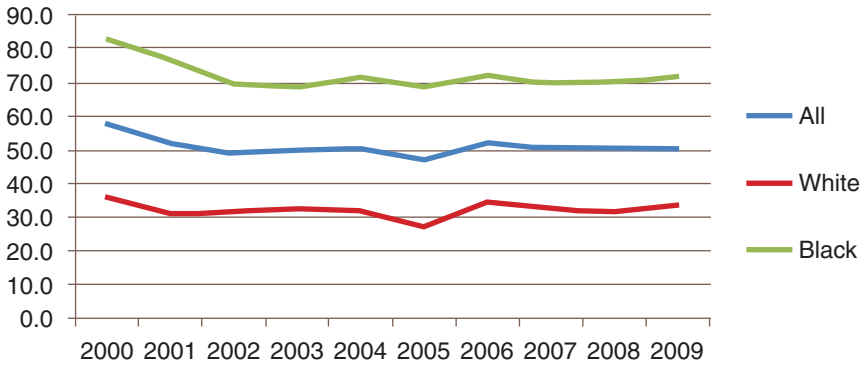
TEEN FERTILITY RATE: LIVE BIRTHS PER 1,000 WOMEN AGES 10 TO 19 2000-2009



TEEN FERTILITY RATE: LIVE BIRTHS PER 1,000 WOMEN AGES 10 TO 14 2000-2009



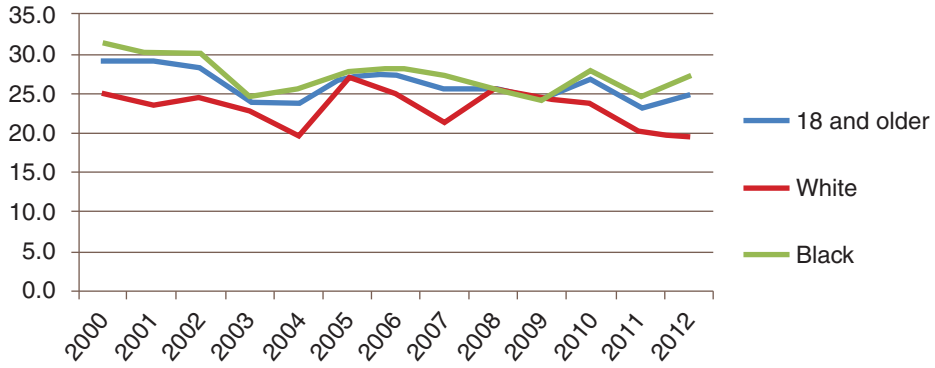
TEEN FERTILITY RATE: LIVE BIRTHS PER 1,000 WOMEN AGES 15 TO 19 2000-2009



TEENS WITH TWO OR MORE PREGNANCIES

The percent of live births to women ages 10 to 19 that have had two or more pregnancies has decreased overall since 2000.

PERCENT OF LIVE BIRTHS TO WOMEN AGE 10 TO 19 WITH A SECOND OR HIGHER PREGNANCY 2000-2012

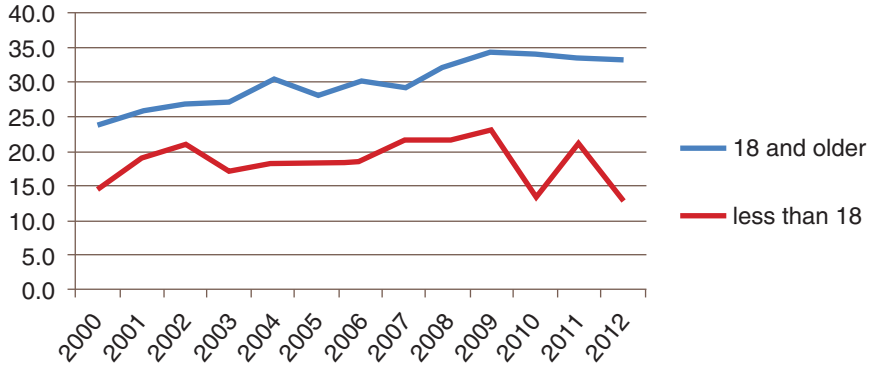


CESAREAN SECTION

Cesarean Sections are medical interventions that can reduce maternal or infant death during obstructed labor, as well as other medical indications of a complex delivery. Cesarean Section deliveries, however, can also result in adverse maternal and infant impact that may be avoided when the Cesarean Section delivery is not indicated. An increasing Cesarean Section delivery rate may indicate an increase in risky deliveries in Jefferson County or an increased rate for non-indicated Cesarean Section deliveries. The rate of Caesarean Section deliveries in Jefferson County has increased by 39.3% since 2000 to 32.4% of the total deliveries in 2012. The increasing rate of Caesarean Section deliveries is occurring mainly among women over age 18.

PERCENT CESAREAN SECTION DELIVERIES BY RACE 2000-2012

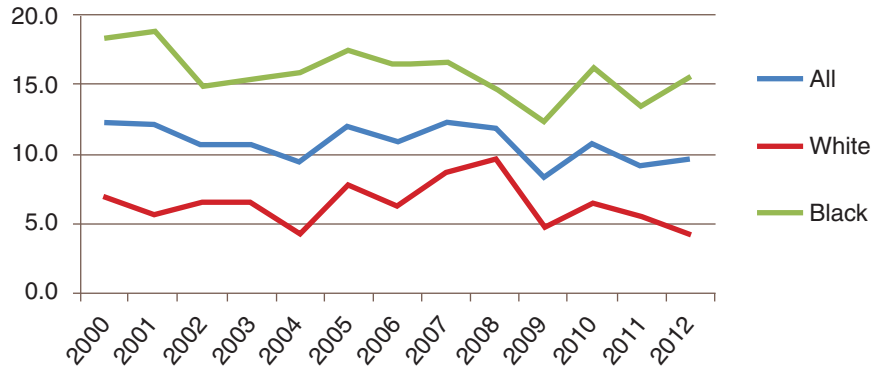
PERCENT CESAREAN SECTION DELIVERIES BY MATERNAL AGE 2000-2012



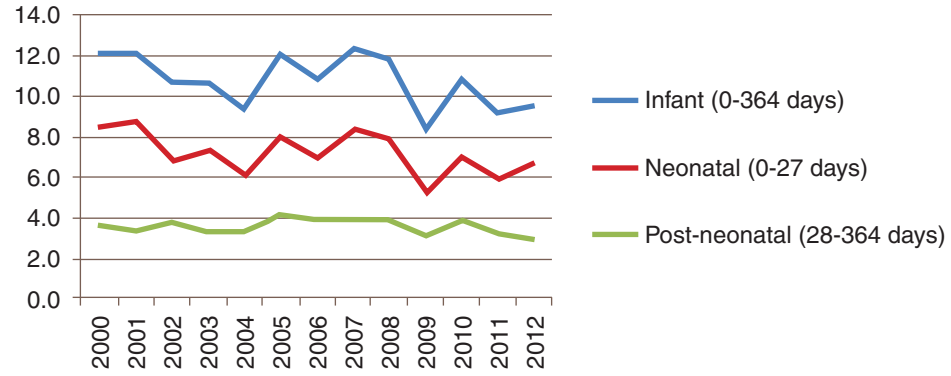
INFANT MORTALITY

The infant mortality rate is a critical indicator of community health. Infant mortality is defined as the death of an infant between live birth and 364 days after birth. There are two methods for calculating an infant mortality rate. The most common infant mortality calculation is to take the number of infant deaths occurring in a given year and divide that number by the total number of live births during the same year; however, this method does not take into consideration the year in which the infant that died was actually born. An infant born in 2013 may die in 2014 and have experienced mortality within his or her first year of life. The more accurate method of calculating infant mortality is to use the birth cohort which links the infant death record with the birth record for that infant. This method provides a more accurate representation of the actual mortality experience of a group of infants born within a particular year. The overall infant mortality rate for Jefferson County has been improving; it has decreased from 12.1 deaths per 1,000 live births in 2000 to 9.6 deaths per 1,000 live births in 2012. This trend is seen in the white and black populations; however, the 2012 infant mortality rate of 15.5 deaths per 1,000 live births in the black population was 260.4% higher than the infant mortality rate of 4.3 deaths per 1,000 live births in the white population. Jefferson County's infant mortality rate remains substantially higher than the 2010 US infant mortality rate of 6.14 deaths per 1,000 live births and is higher than the Healthy People 2020 goal of 6.6 infant deaths per 1,000 live births.

INFANT MORTALITY RATES PER 1,000 LIVE BIRTHS BY RACE 2000-2012



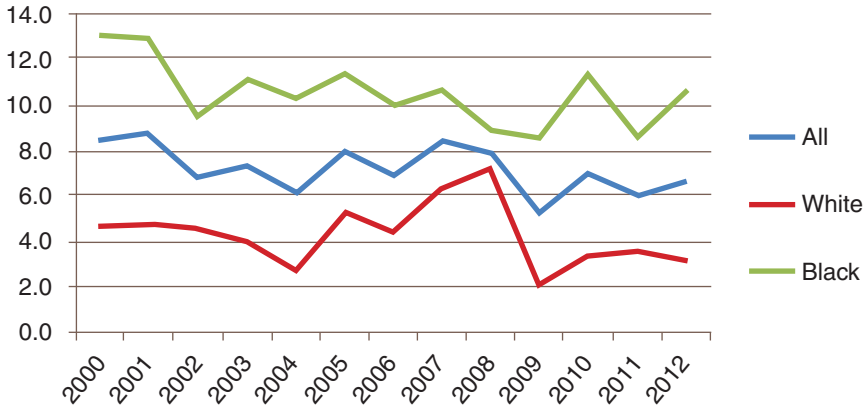
INFANT MORTALITY RATES PER 1,000 LIVE BIRTHS BY NATAL PERIOD 2000-2012



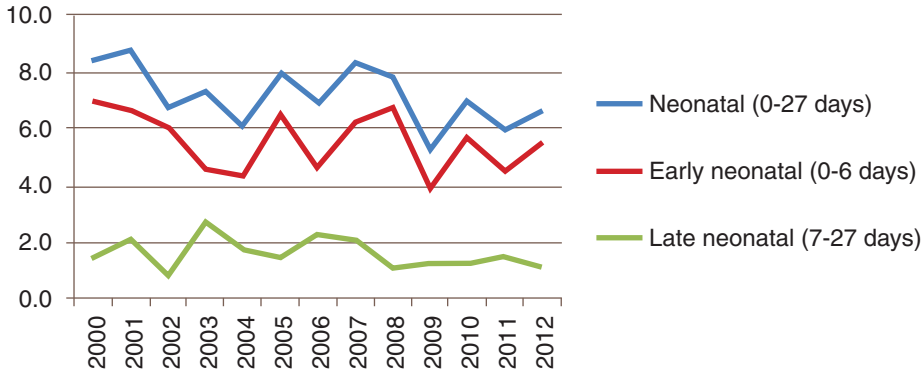
NEONATAL MORTALITY

Neonatal mortality is an infant death that occurs from live birth to 27 days following the birth. Most infant deaths occur during this period. Neonatal infant mortality rates are decreasing in both the white and black populations in Jefferson County. The Healthy People 2020 neonatal mortality goal is 4.1 neonatal deaths per 1,000 live births; the Jefferson County rate of 6.7 neonatal deaths per 1,000 live births exceeds the national goal.

NEONATAL MORTALITY PER 1,000 LIVE BIRTHS BY RACE 2000-2012

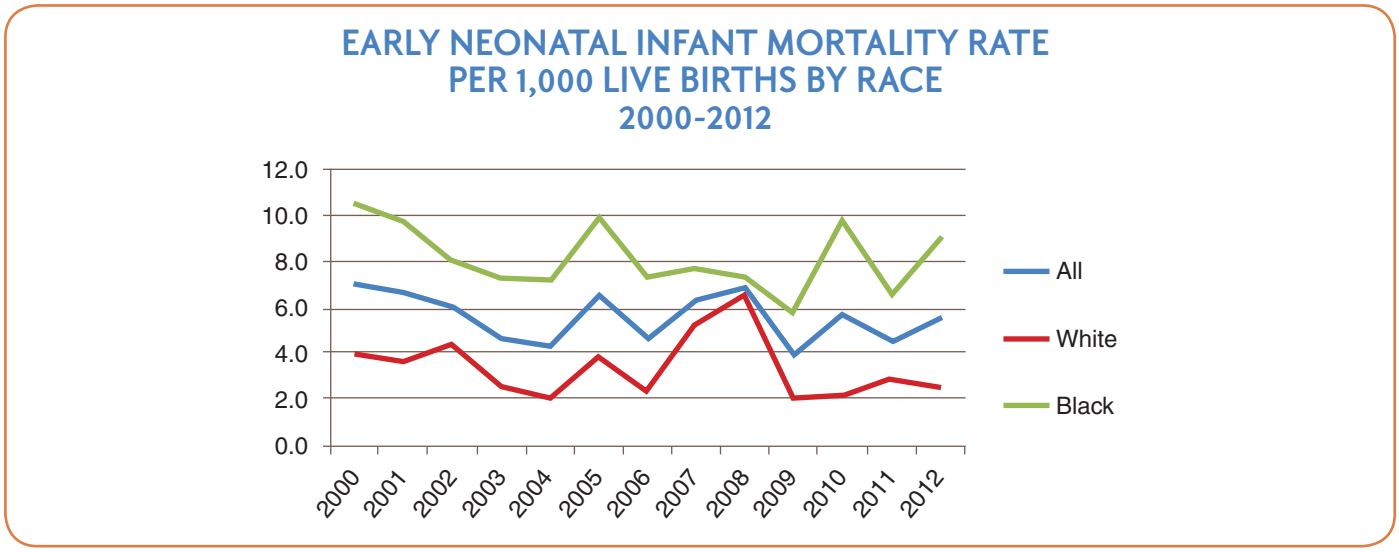


INFANT MORTALITY PER 1,000 LIVE BIRTHS BY NEONATAL PERIOD 2000-2012



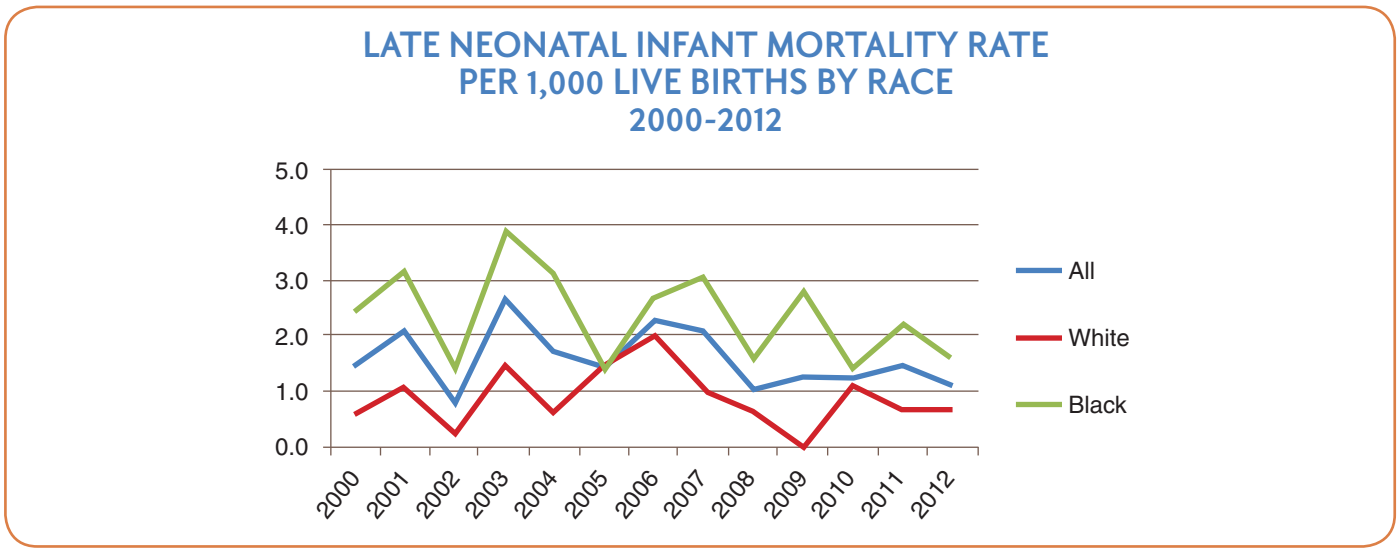
EARLY NEONATAL INFANT MORTALITY

Early neonatal infant mortality is infant death occurring between live birth and six days after live birth. Early neonatal mortality makes up the majority of neonatal infant deaths. Early neonatal mortality rates are decreasing for both the white and black populations.



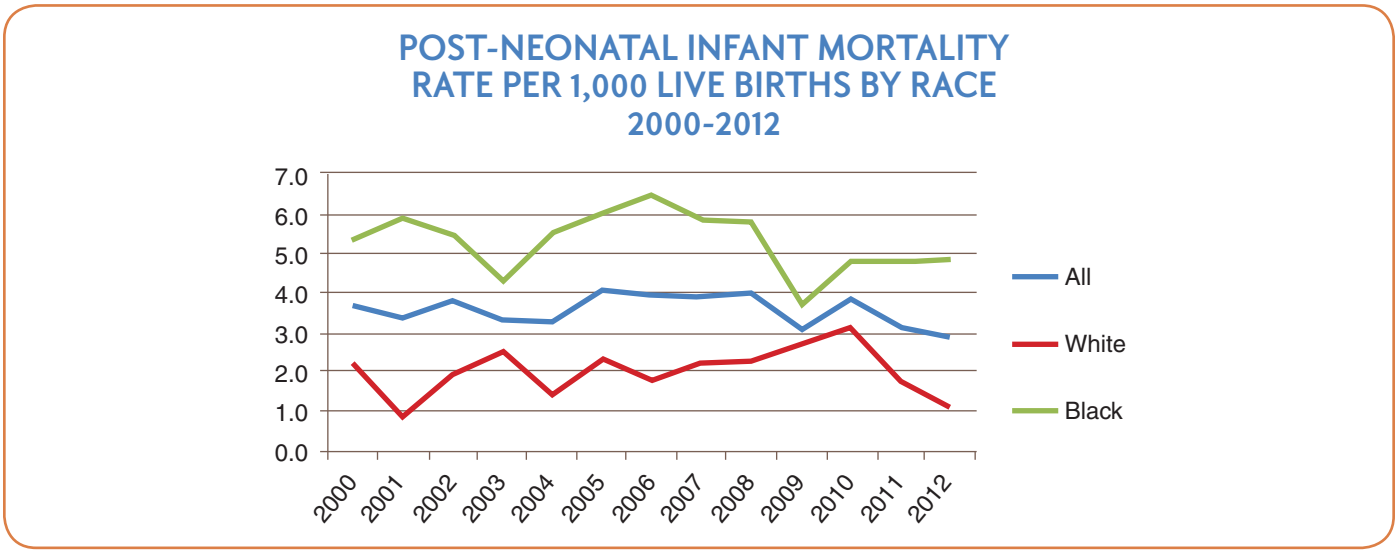
LATE NEONATAL INFANT MORTALITY

Late neonatal infant mortality is infant death that occurs between seven and 27 days following live birth. Late neonatal deaths are decreasing among the black population and have remained static among the white population in Jefferson County.



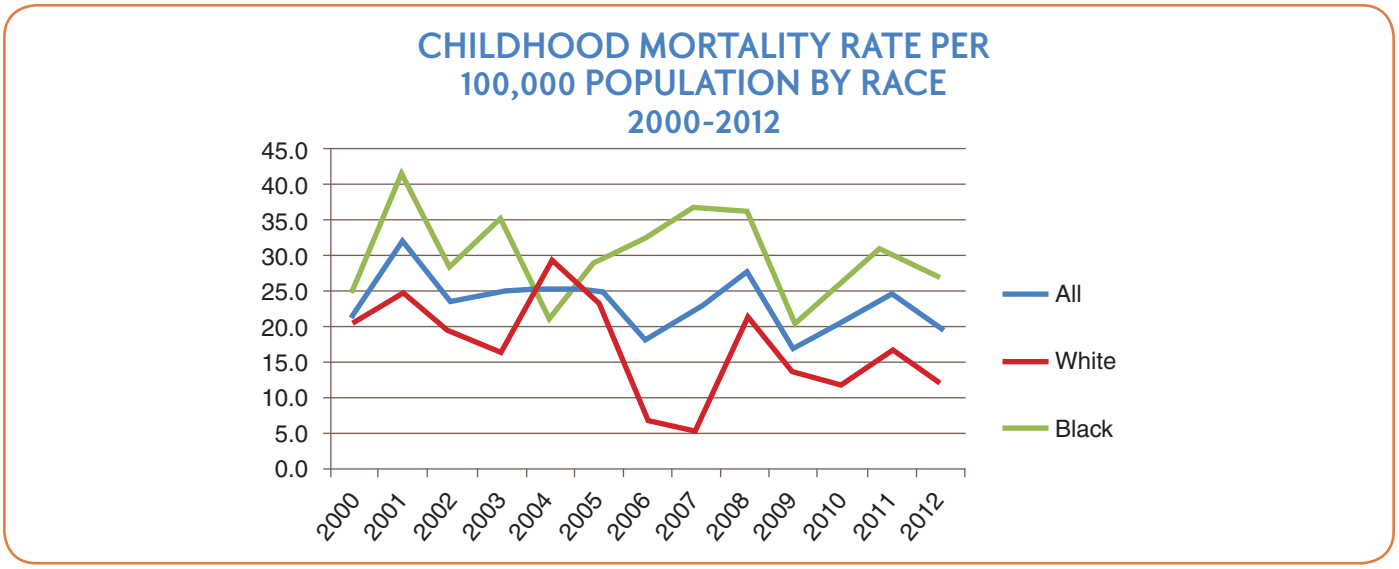
POST-NEONATAL INFANT MORTALITY

Post-neonatal mortality is infant death occurring between 28 and 364 days after live birth. Post-neonatal infant mortality rates have decreased among the black population and have fluctuated widely among the white population.



CHILDHOOD MORTALITY

Childhood mortality is defined as the death of a child between one and fourteen years of age. This measure is an important indicator of early death in a population. Jefferson County childhood mortality rates have decreased by 10.4% from the 2000 rate of 22.1 per 100,000 population to the 2012 rate of 19.8 per 100,000 population.



MATERNAL AND CHILD HEALTH FINDINGS

There is desirable change among many of Jefferson County's maternal and child health indicators which demonstrate many areas of improved maternal and child health. The rate of preterm births, the rate of smoking during pregnancy, the percent of multigravida pregnancies with a short interconceptional interval and previous fetal or infant loss and infant mortality rate are decreasing. Among teenagers, pregnancy in women between the ages of 10 and 19, overall pregnancy outcomes and birth outcomes are indicating improvement as well. The teen pregnancy rate has decreased, as has the rate of teen smoking during pregnancy, teen preterm birth rate, the percent of teen multigravida births with a short interconceptional interval, the percent of pregnant teens who have experienced a previous fetal or infant loss, the percent of very low birth weight infants born to teens and the percent of teen Cesarean Section deliveries. These indicators demonstrate that Jefferson County women exceed the national averages in the percentage of women who abstain from smoking during pregnancy and receive adequate prenatal care, both of which improve the potential health outcomes for the mother and infant.

Despite improvements in outcomes such as infant mortality and preterm births, Jefferson County continues to fall behind the national goals and averages for these birth outcomes. The wide gap between infant mortality in the black and white populations and in other maternal and child health indicators demonstrates health disparities that need to be addressed to improve maternal and child health in Jefferson County.

Rates of very low birth weight have remained static, but Intrauterine Growth Restriction has increased in Jefferson County. Rates of Cesarean Section deliveries, especially in women over the age of 18, have continued to increase since 2000. High rates of very low birth weight infants, Intrauterine Growth Restriction and Cesarean Section deliveries represent areas for continued health improvement in Jefferson County.

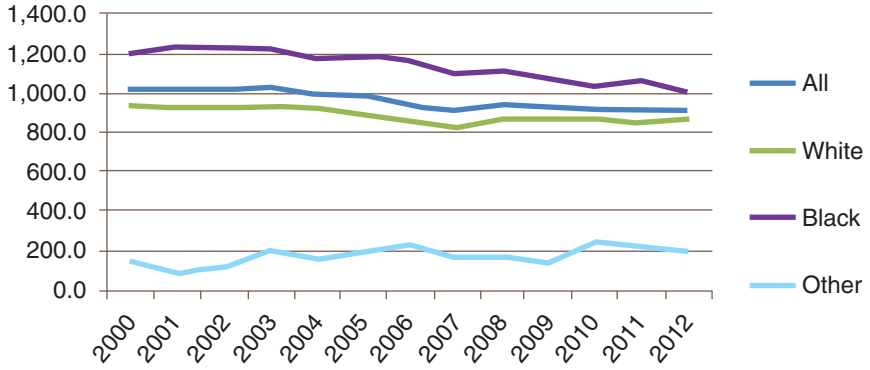
DEATH, ILLNESS AND INJURY

Indicators in this category demonstrate the morbidity and mortality experience of Jefferson County residents over time. Data measures for this category include mortality rates for a variety of causes of death and hospitalization rates for selected illnesses. All mortality rates reported in this section are age-adjusted mortality rates. Age-adjusted mortality rates are adjusted to the 2000 population standard age distribution to provide an accurate comparison rate between communities of differing age structures.

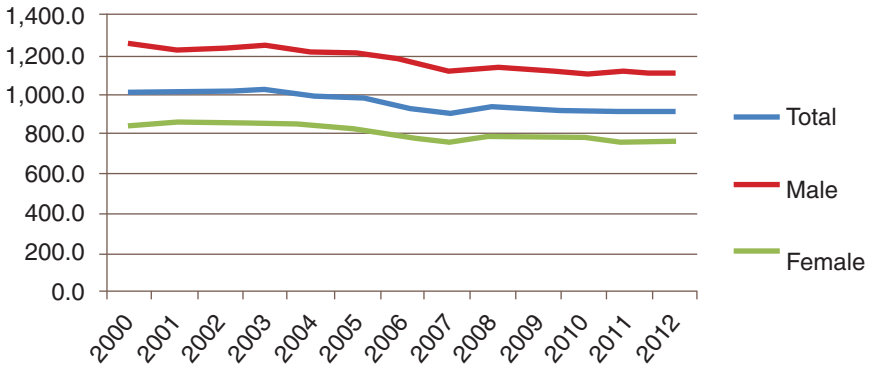
ALL-CAUSE MORTALITY

The all-cause mortality rate is the total mortality rate for all causes of death per 100,000 population Jefferson County residents. In 2003, the all-cause mortality rate increased to 1,025.6 deaths per 100,000 population and has shown a slight overall decreasing trend since that year. The most recent all-cause mortality rate was 911.7 deaths per 100,000 population in 2012, representing a 10.4% decrease in mortality since 2000. Overall mortality rates are decreasing among the black and white populations but are increasing among the population of other races. Males have higher mortality rates as compared to females.

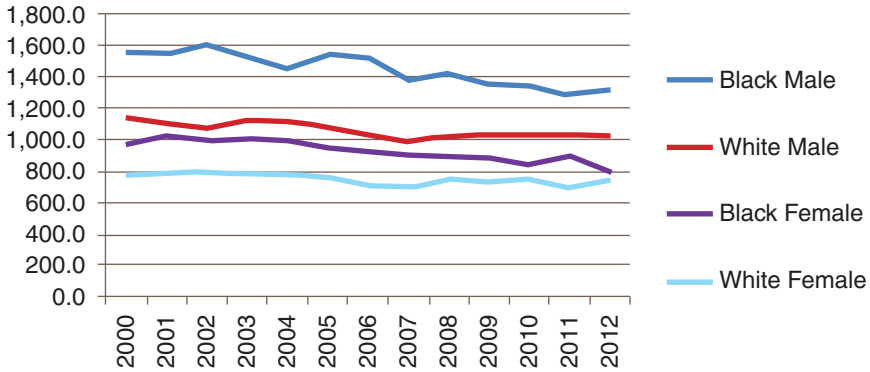
ALL-CAUSE MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



ALL-CAUSE MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



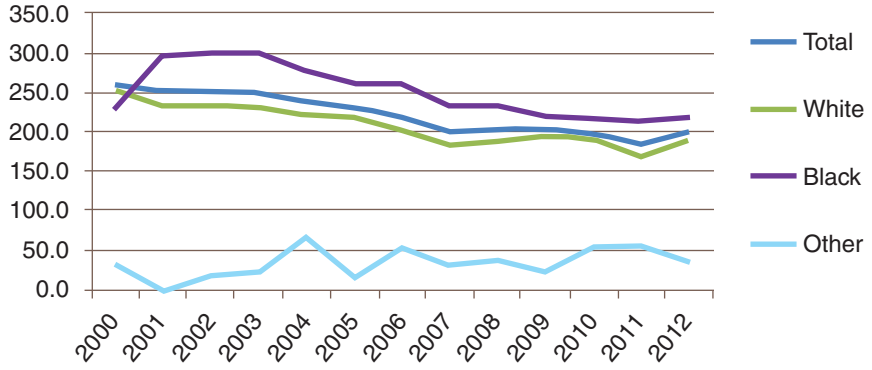
ALL-CAUSE MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



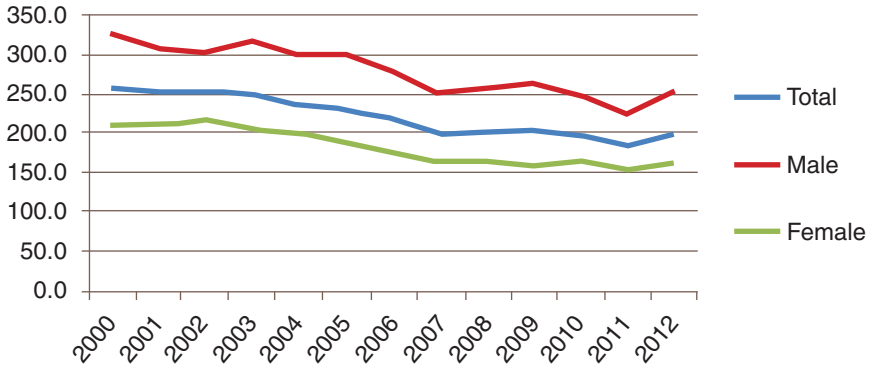
HEART DISEASE MORTALITY

Heart disease is the leading cause of death in Jefferson County. The overall heart disease mortality rate has been steadily declining since 2000. The 2012 heart disease mortality rate of 200.7 per 100,000 population is 22.3% lower than the 2000 rate of 258.4 per 100,000 population. This trend is observed across the white population and the black population, males and females. Heart disease mortality rates among individuals of other races are trending upward.

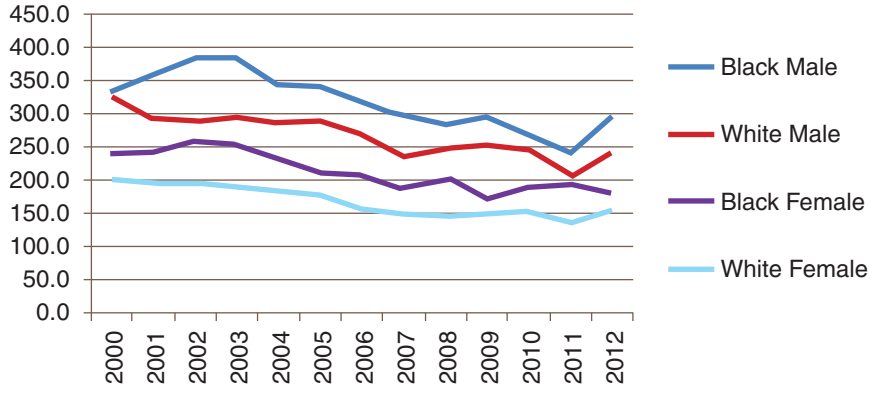
HEART DISEASE MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



HEART DISEASE MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



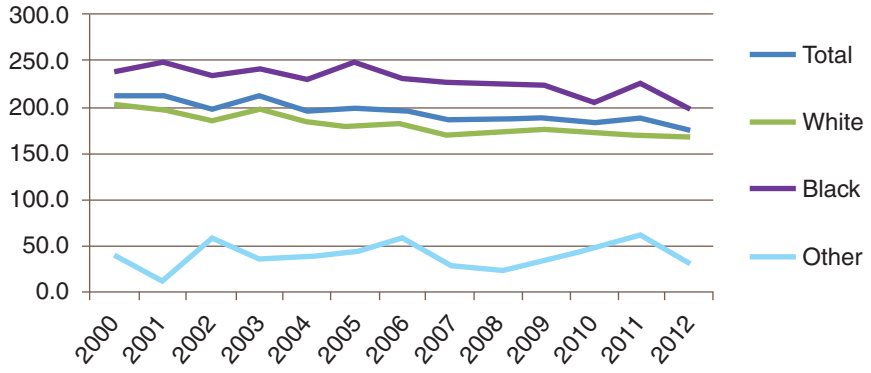
HEART DISEASE MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENT BY RACE AND SEX 2000-2012



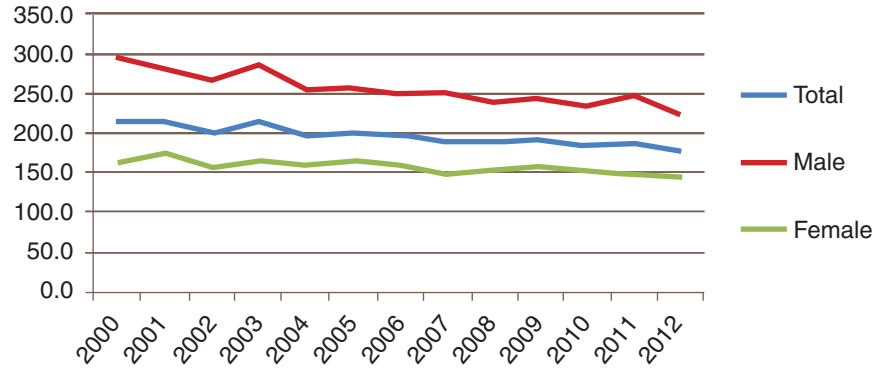
CANCER MORTALITY

Cancer is the second leading cause of death in Jefferson County. Overall cancer mortality has been steadily decreasing. The 2012 overall cancer mortality rate of 175.3 per 100,000 population is 17.9% less than the 2000 rate of 213.6 per 100,000 population. This decreasing trend is observed in males and females in the white and black populations. Among individuals of other races, the cancer mortality rate is increasing.

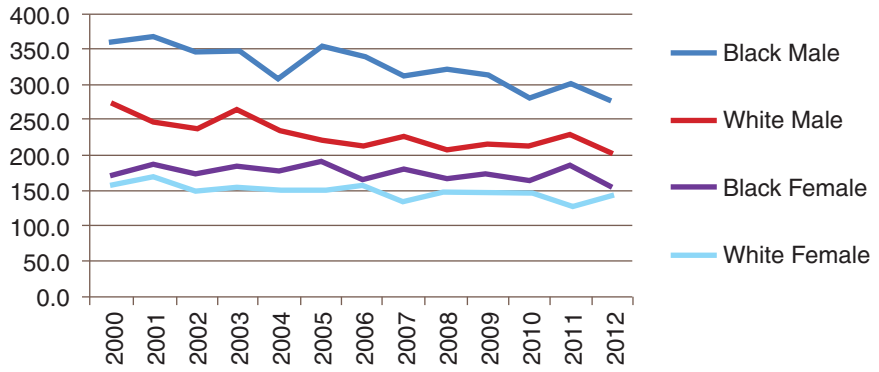
ALL CANCER MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



ALL CANCER MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



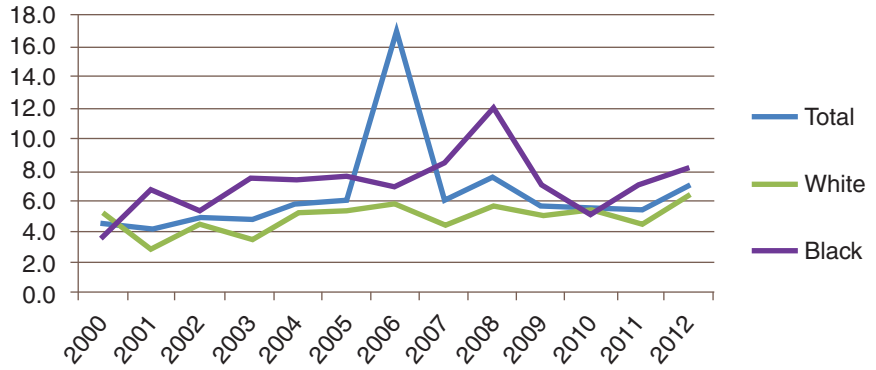
ALL CANCER MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



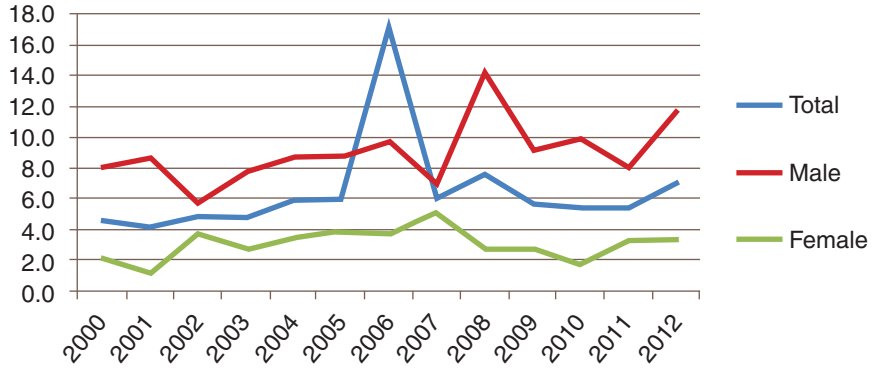
LIVER CANCER

Liver cancer is a cancer of concern because of the direct connection between liver cancer and infection with the Hepatitis C virus. Liver cancer rates have risen steadily to the 2012 rate of 7 per 100,000 population, which is 51.8% higher than the 2000 rate of 4.6 per 100,000 population. Liver cancer mortality is higher among the black population and is higher in males. The increased liver cancer mortality rate is especially pronounced in black male residents of Jefferson County.

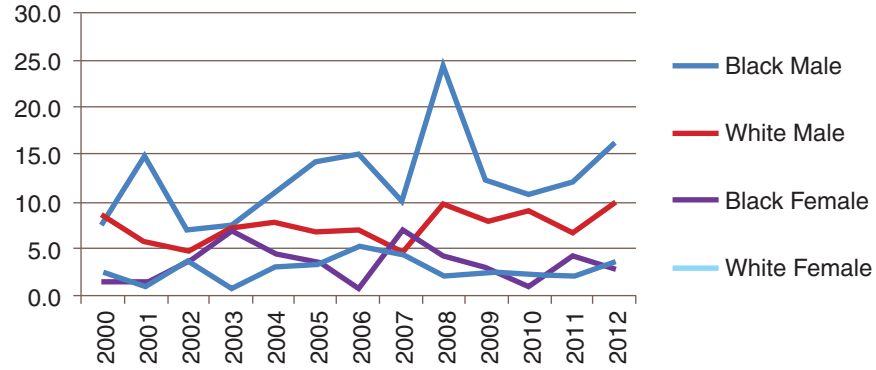
LIVER CANCER MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



LIVER CANCER MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



LIVER CANCER MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012

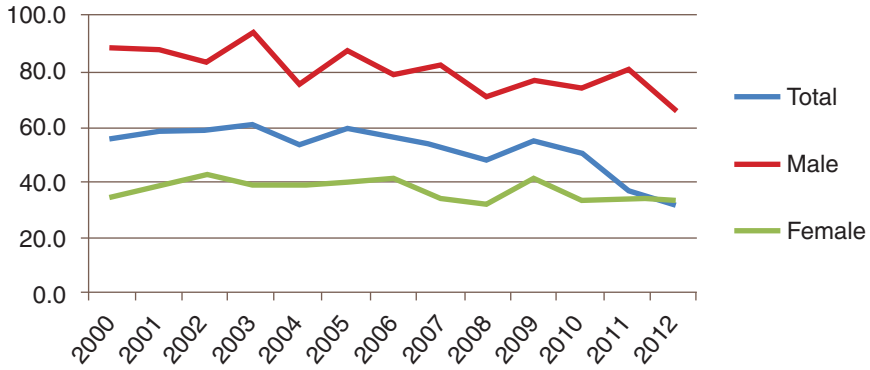


LUNG CANCER

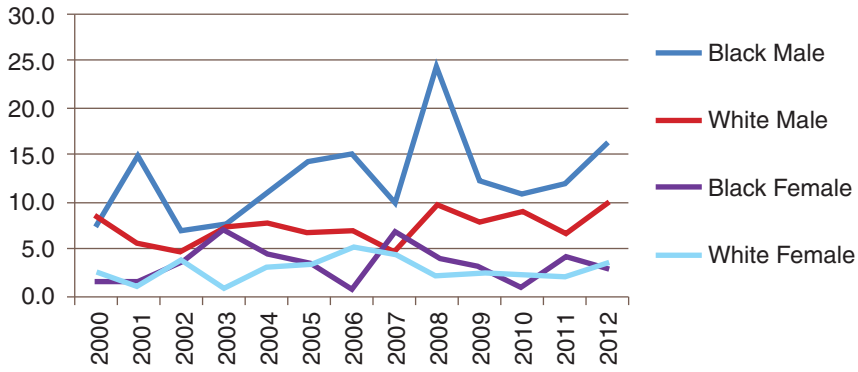
Lung cancer mortality is linked with smoking, exposure to second-hand smoke and other environmental risk factors such as asbestos exposure. Mortality rates for lung cancer gradually declined to 2010 and then began to drop steeply to a rate of 32.1 per 100,000 population in 2012, a 42.6% reduction in rate from 2000. Lung cancer mortality rates among men have reduced significantly; however, among women, the lung cancer mortality rate has remained static since 2000.

LUNG CANCER MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012

LUNG CANCER MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



LUNG CANCER MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012

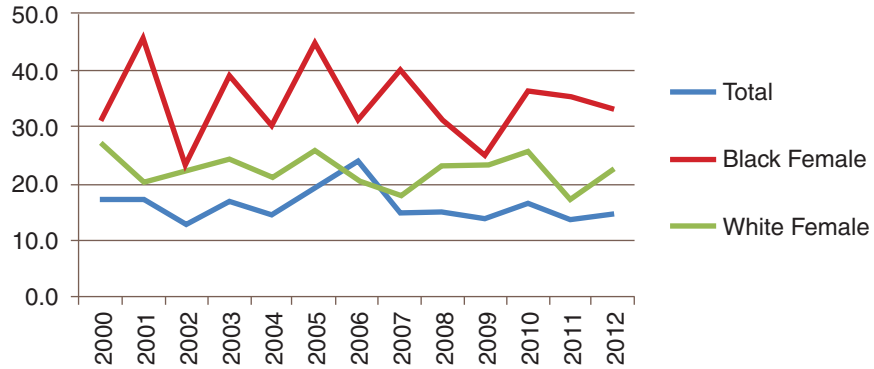


BREAST CANCER

Breast cancer mortality rates have fluctuated widely in Jefferson County, making it difficult to determine trending. Black females experienced a significantly higher breast cancer mortality rate than white females.

BREAST CANCER MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012

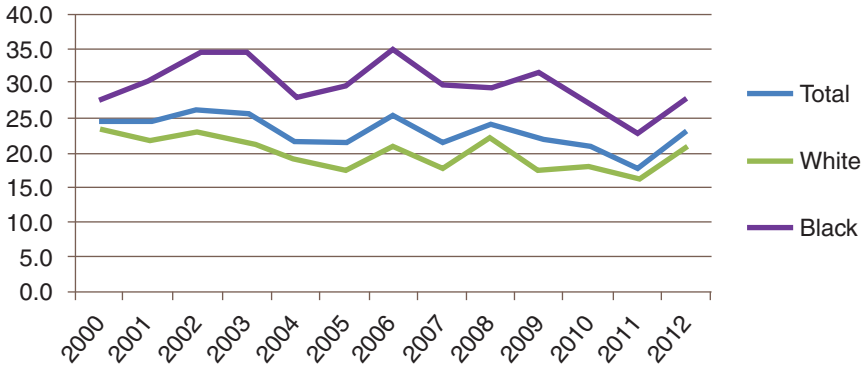
FEMALE BREAST CANCER MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



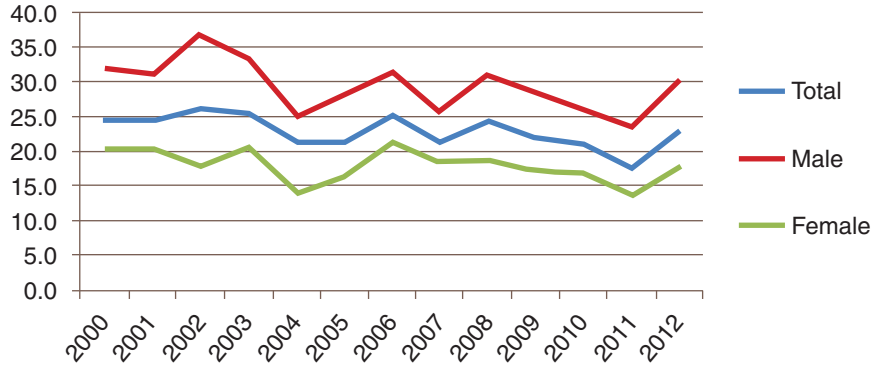
COLORECTAL CANCER

Overall, colorectal cancer mortality rates have declined by 6.4% from the 2000 rate of 24.6 deaths per 100,000 population to 23 deaths per 100,000 population in 2012. This decrease has occurred in males and females in the white and black populations.

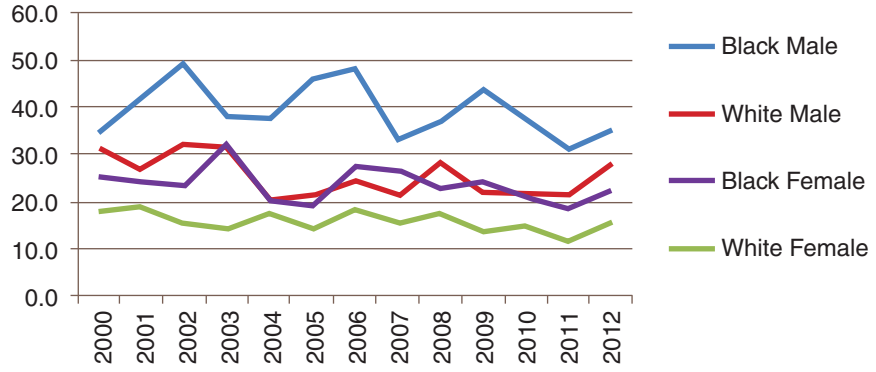
COLORECTAL CANCER MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



COLORECTAL CANCER MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



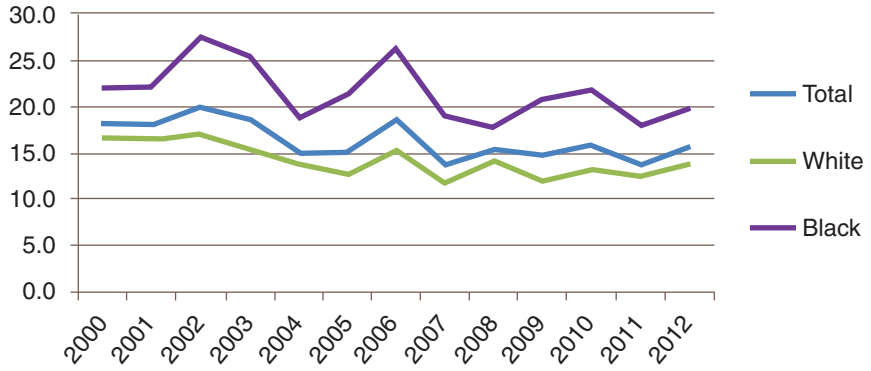
COLORECTAL CANCER MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



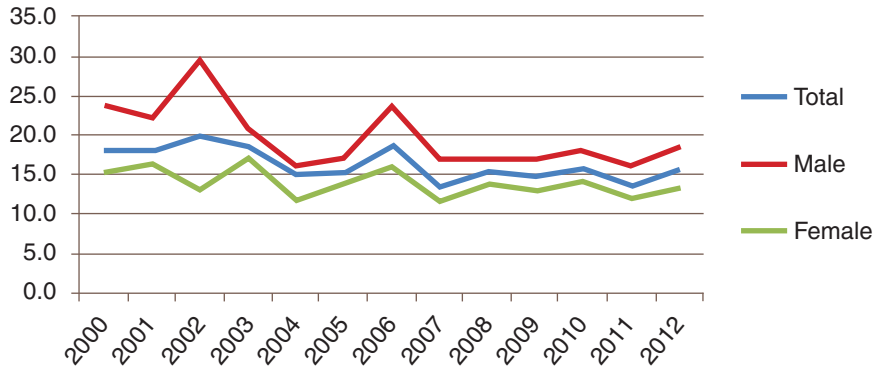
COLON CANCER

Colon cancer rates have decreased by 14.5% from the 2000 rate of 18.1 per 100,000 population. Colon cancer mortality rates have decreased among males and females of both the white and black populations, with the most pronounced decrease occurring among black males.

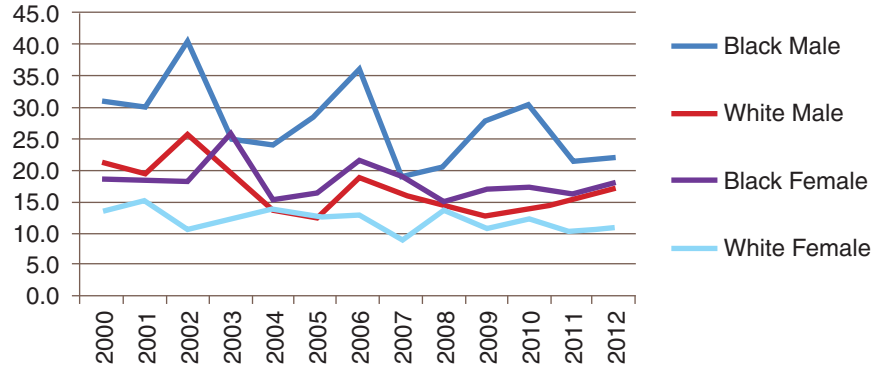
COLON CANCER MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



COLON CANCER MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



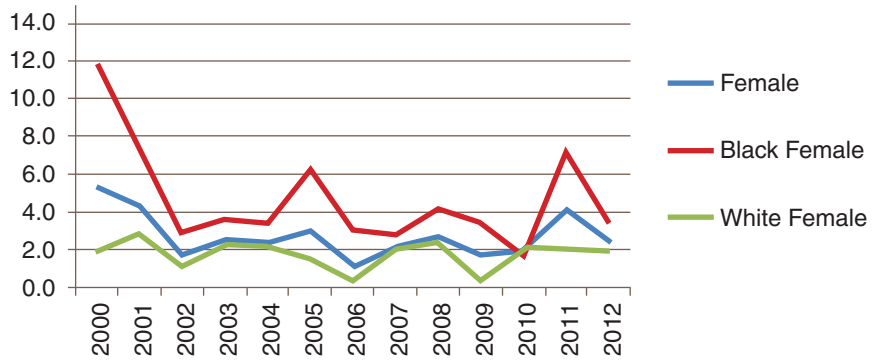
COLON CANCER MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



CERVICAL CANCER

Cervical cancer mortality rates declined dramatically between 2000 and 2002 and have remained static through 2012. The 2012 cervical cancer rate of 2.4 deaths per 100,000 females is 54.7% lower than the 2000 rate of 5.3 per 100,000 females. Cervical cancer rates among white females decreased slightly, while rates among black females decreased significantly.

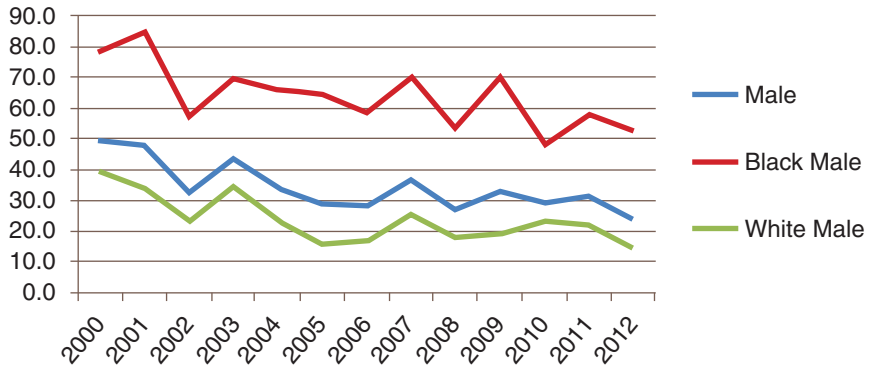
CERVICAL CANCER MORTALITY RATES PER 100,000 FEMALE JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



PROSTATE CANCER

Prostate cancer mortality decreased by 51.6% from the 2000 rate of 49.8 per 100,000 males to the 2012 rate of 24.1 per 100,000 males. Prostate cancer mortality rates declined among both white and black males.

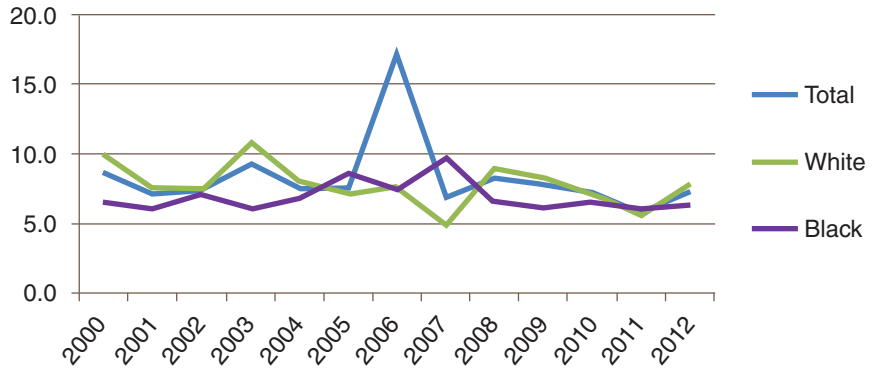
PROSTATE CANCER MORTALITY PER 100,000 MALE JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



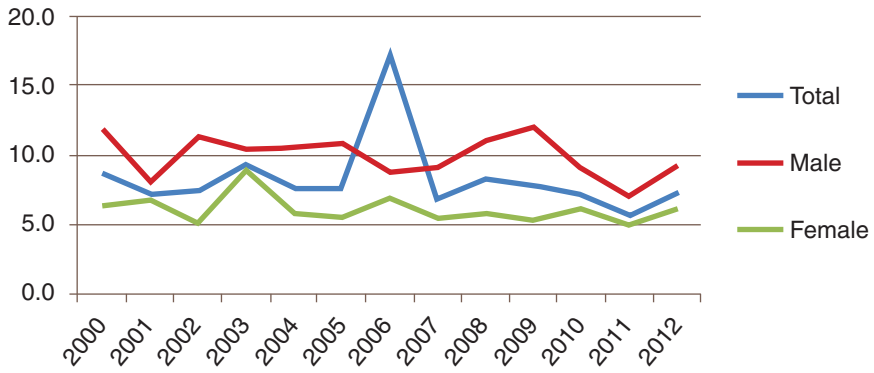
LEUKEMIA

Leukemia mortality rates have decreased by 15.4% from the 2000 rate of 8.6 per 100,000 population to 7.3 per 100,000 population in 2012. Decline in mortality rates were noted among males and females in the white and black populations.

LEUKEMIA MORTALITY RATES PER 100,000 JEFFERSON RESIDENTS BY RACE 2000-2012



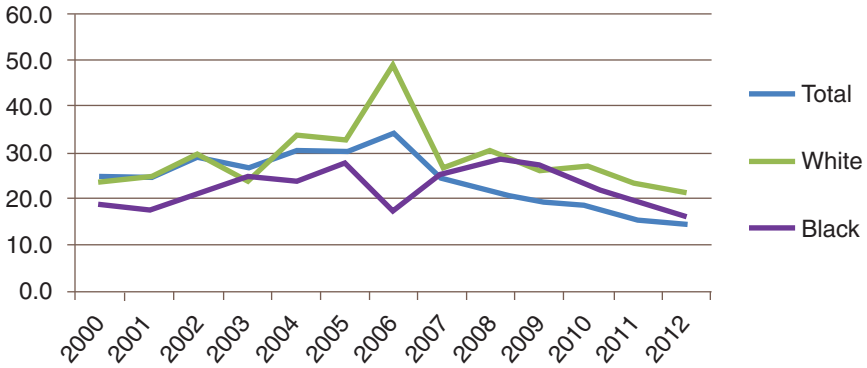
LEUKEMIA MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENT BY SEX 2000-2012



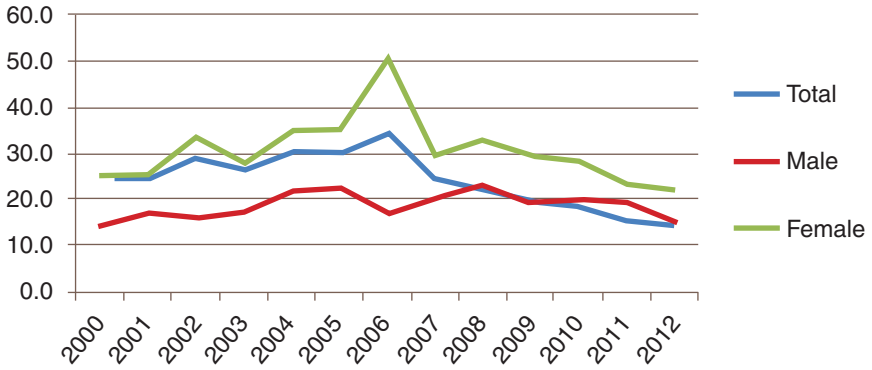
ALZHEIMER'S DISEASE MORTALITY

Alzheimer's Disease was the eighth leading cause of death in Jefferson County in 2012 and is the most common cause of dementia in older Americans. This irreversible progressive brain disease that destroys memory and cognitive abilities had increasing mortality rates from 2000 through 2006. After 2006, there has been a dramatic decline in Alzheimer's mortality. The 2012 mortality rate of 14.5 per 100,000 population is 41.4% lower than the 2000 Alzheimer's mortality rate of 24.8 per 100,000 population. White females experience the highest Alzheimer's Disease mortality rates within Jefferson County.

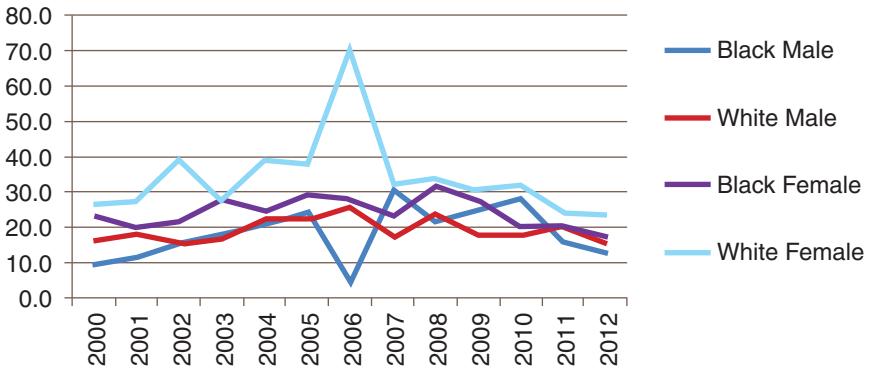
ALZHEIMER'S DISEASE MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



ALZHEIMER'S MORTALITY PER 100,000 RESIDENTS OF JEFFERSON COUNTY BY SEX 2000-2012



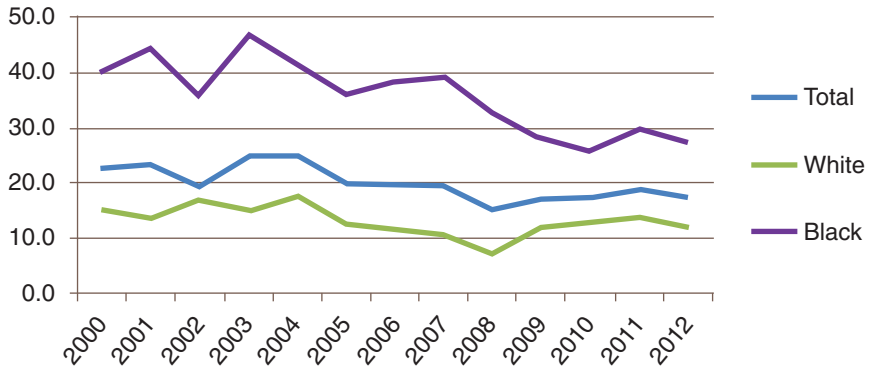
ALZHEIMER'S DISEASE MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



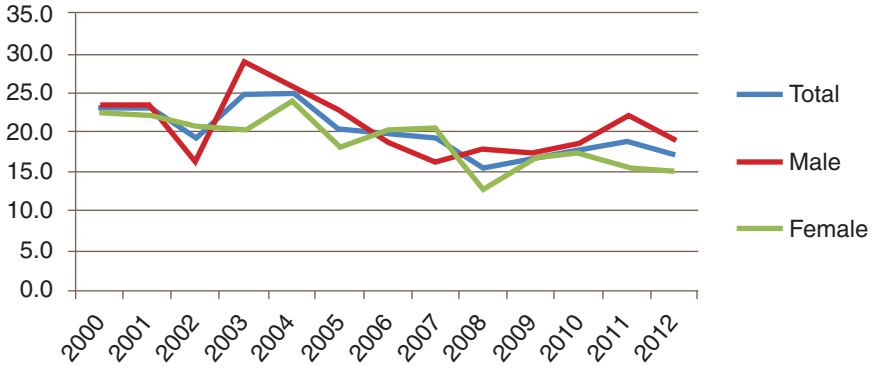
HYPERTENSION MORTALITY

Hypertension is the most common form of cardiovascular disease in the United States. Hypertension, or high blood pressure, is defined as a blood pressure reading of at least 140/90 or higher on two separate occasions. Hypertension mortality has declined steadily by 24.9% from the 2000 rate of 23.0 per 100,000 population to 17.3 per 100,000 population in 2012. Hypertension mortality rates remain higher in the black population as compared to the white population; however, the gap between the rates has decreased significantly since 2000.

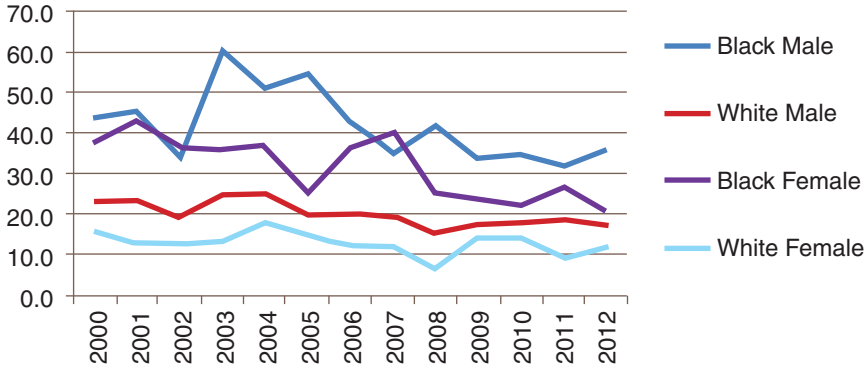
HYPERTENSION MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



HYPERTENSION MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



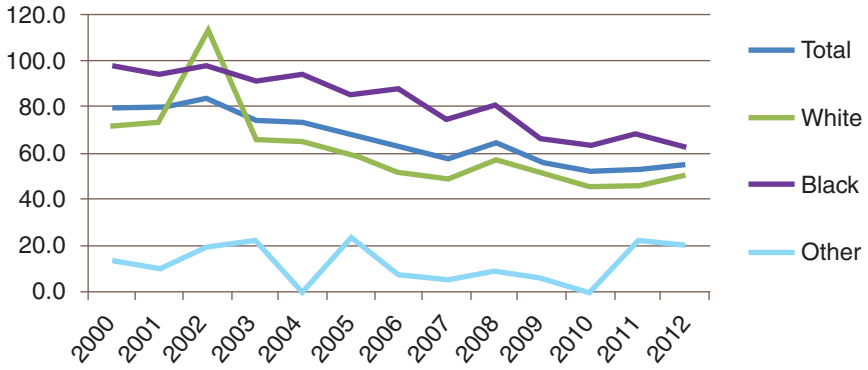
HYPERTENSION MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



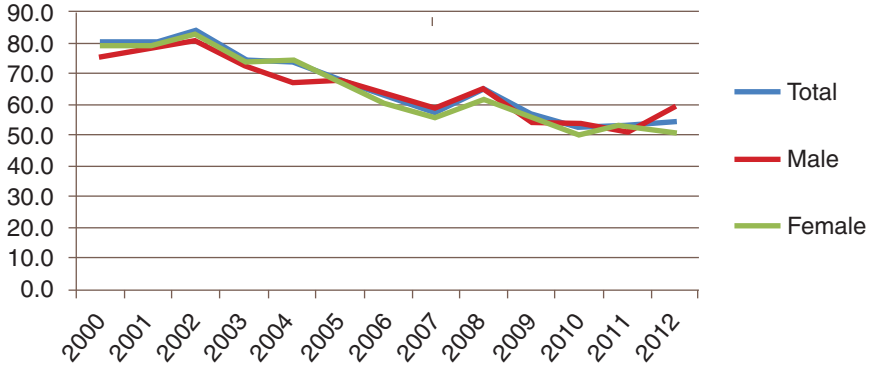
CEREBROVASCULAR DISEASE MORTALITY

Cerebrovascular diseases includes all disorders in which an area of the brain is temporarily or permanently damaged due to ischemia or bleeding from one or more of the cerebral blood vessels. Cerebrovascular disease includes stroke, aneurysms, stenosis of the carotid, vertebral or intracranial blood vessels and vascular malformations. Cerebrovascular disease mortality was the third leading cause of death in Jefferson County in 2012. Since 2000, overall cerebrovascular disease mortality rates have decreased to the 2012 rate of 54.7 deaths per 100,000 population which is 34.5% lower than the 2000 rate of 79.9 deaths per 100,000 population. Cerebrovascular disease mortality rates have decreased for the black and white populations. Among individuals of other races, this mortality rate has fluctuated widely and no trend can be determined at this time.

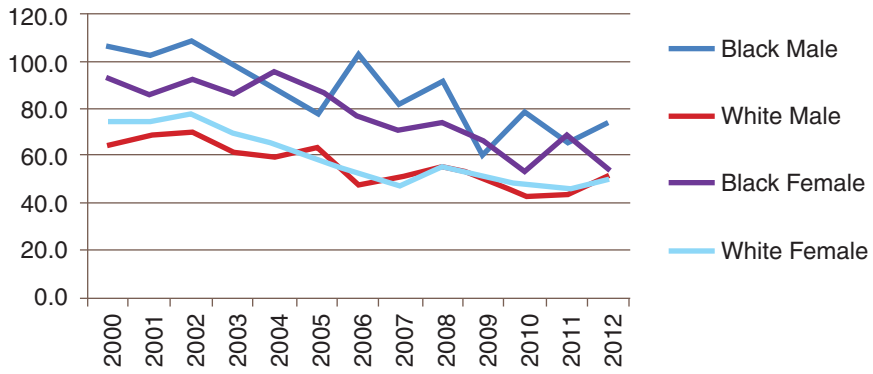
CEREBROVASCULAR DISEASE MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



CEREBROVASCULAR DISEASE MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



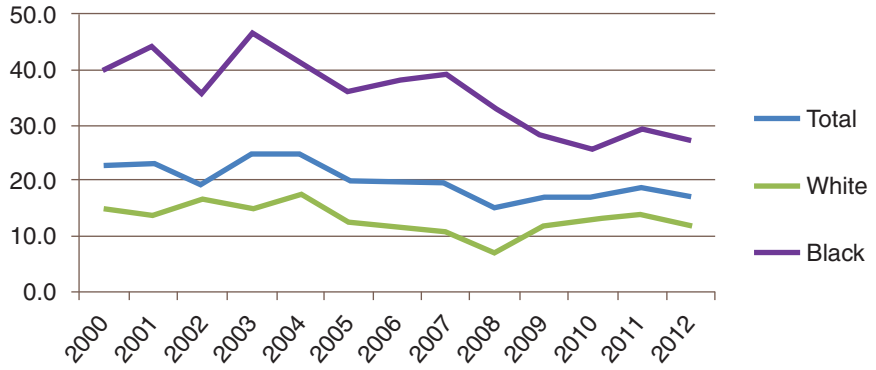
CEREBROVASCULAR DISEASE MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



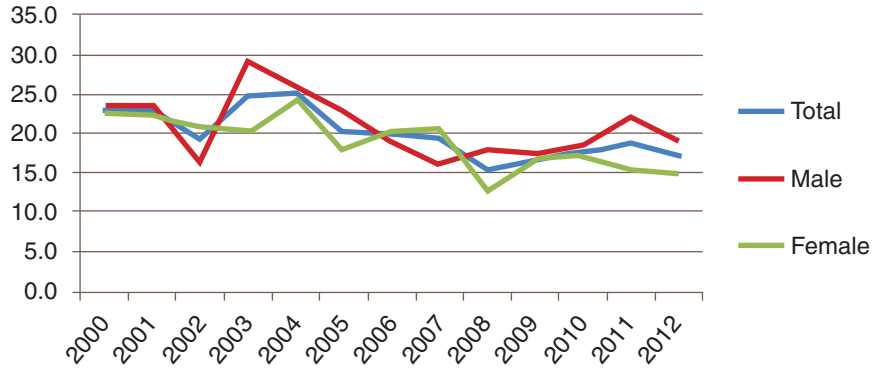
STROKE MORTALITY

Stroke is the leading cause of cerebrovascular disease mortality in the United States. Overall stroke mortality has declined in Jefferson County. There was a spike in stroke deaths in 2003 and 2004, followed by a decrease in stroke mortality. The 2012 stroke mortality rate of 17.3 deaths per 100,000 population is 24.8% lower than the 2000 rate of 23 deaths per 100,000 population. The stroke mortality rate is significantly higher among the black population as compared to the white population.

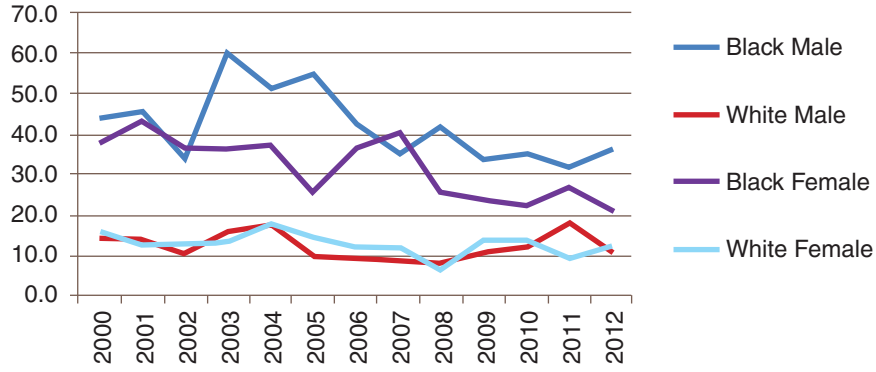
STROKE MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



STROKE MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



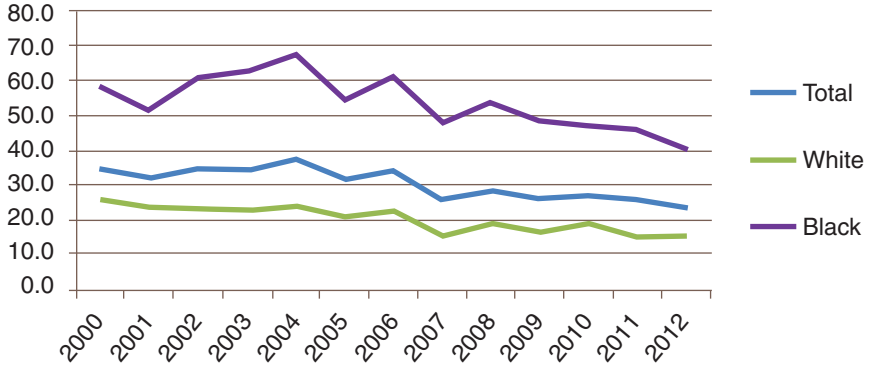
STROKE MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



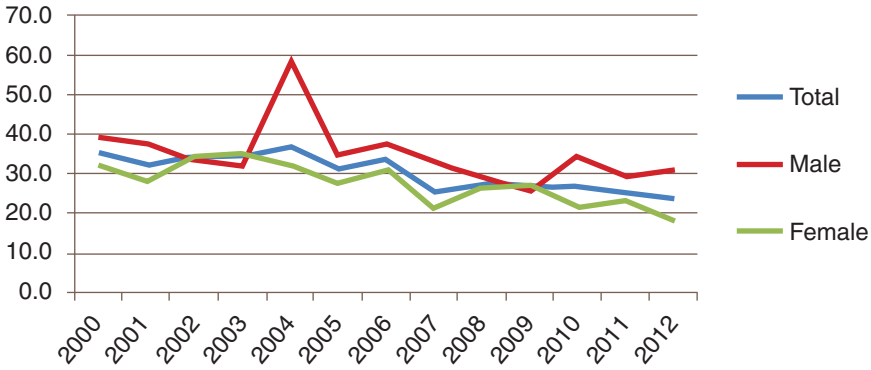
DIABETES MORTALITY

Diabetes is a group of diseases that affect how the body uses and metabolizes blood glucose. The Diabetes mortality rate increased through 2004 then gradually declined to the 2012 mortality rate of 23.8 deaths per 100,000 population. The 2012 diabetes mortality rate is 32.1% lower than the 2000 rate of 35.1 deaths per 100,000 population. Diabetes mortality has demonstrated decline in the black and white populations; however, mortality rates remain higher among the black population as compared to the white population for this disease.

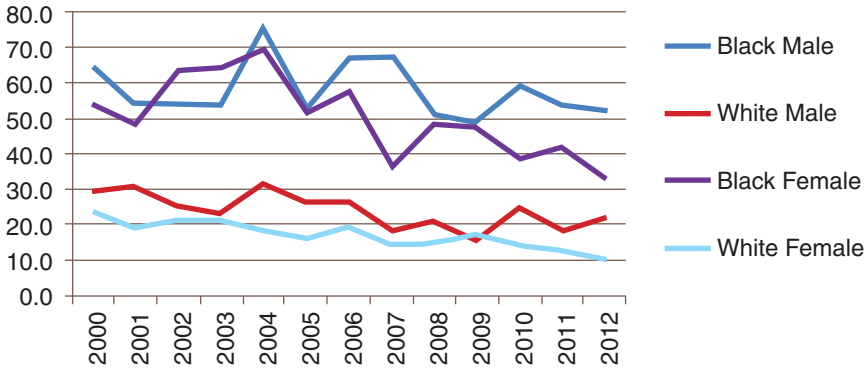
DIABETES MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



DIABETES MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



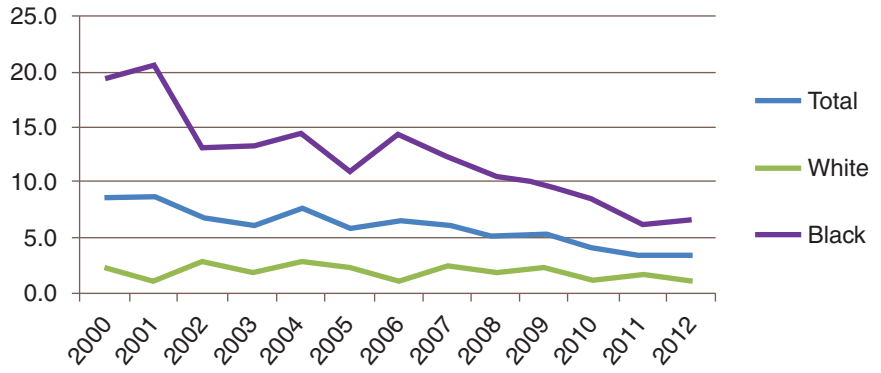
DIABETES MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



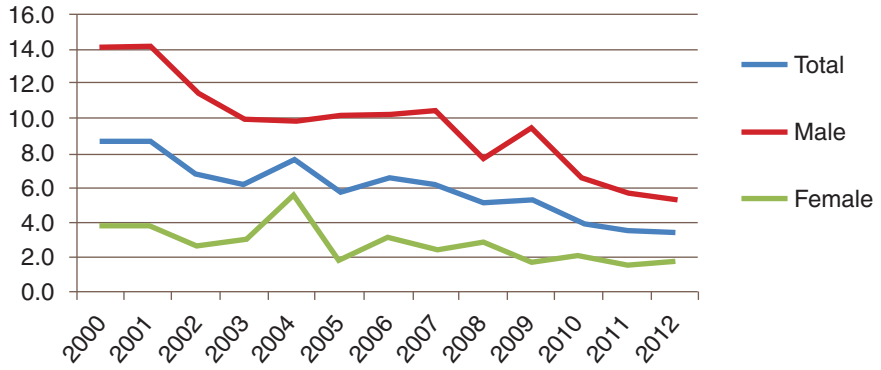
HIV MORTALITY

The Human Immunodeficiency Virus (HIV) is a sexually transmitted disease. Overall in Jefferson County, HIV mortality has decreased by 60.4% from the 2000 rate of 8.7 deaths per 100,000 population to the 2012 rate of 3.4 deaths per 100,000 population, much of this decrease has occurred within the black population, especially among black males.

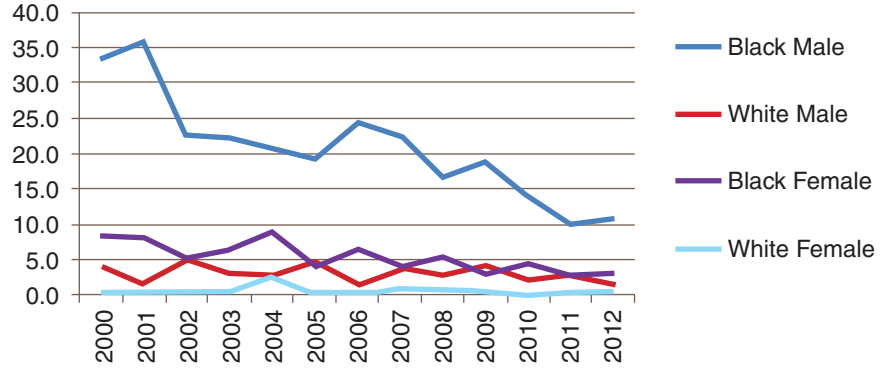
HIV MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



HIV MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



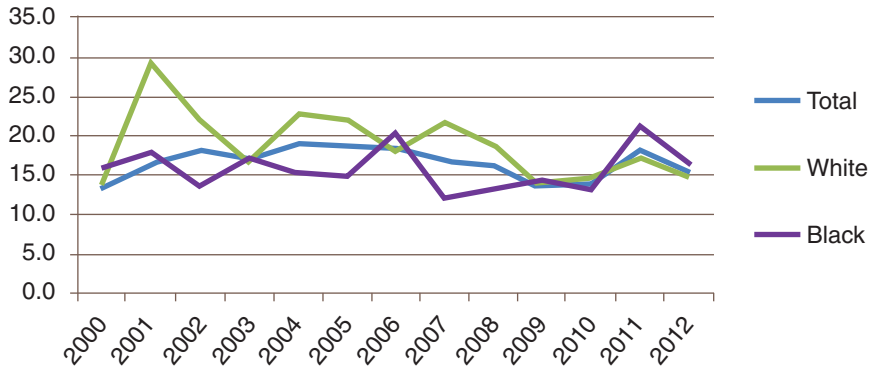
HIV MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



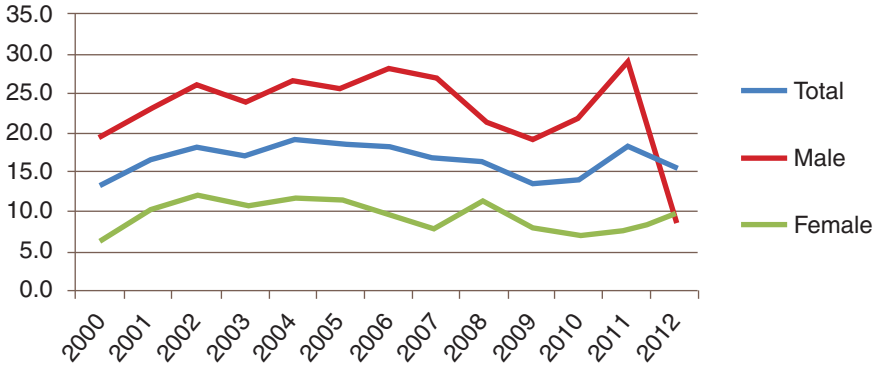
MOTOR VEHICLE ACCIDENT MORTALITY

Mortality from motor vehicle accidents in Jefferson County increased by 15.5% from the 2000 rate of 13.4 per 100,000 population to the 2012 rate of 15.5 per 100,000 population. Males have a higher rate of motor vehicle accident mortality than females. The motor vehicle accident mortality rate among teens is higher than the rate among adults.

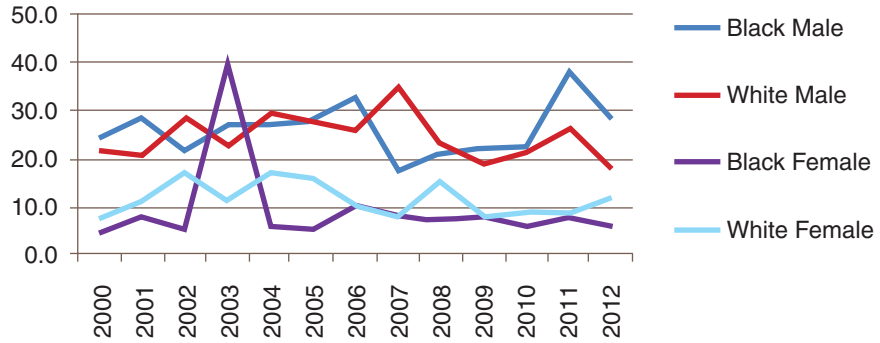
MOTOR VEHICLE ACCIDENT MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



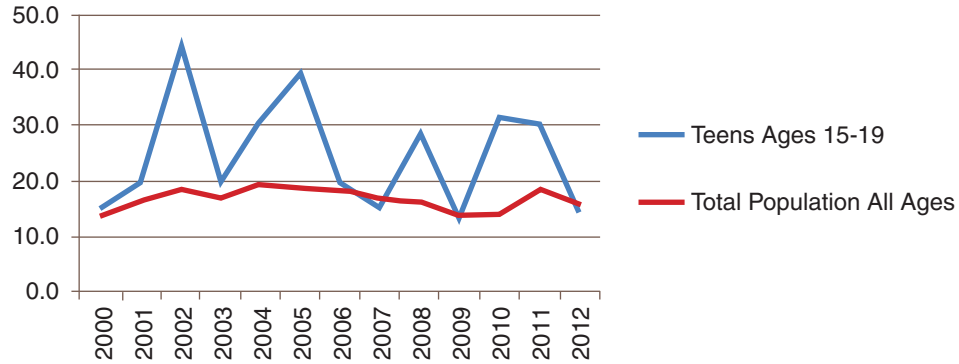
MOTOR VEHICLE ACCIDENT MORTALITY RATES PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



MOTOR VEHICLE ACCIDENT MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



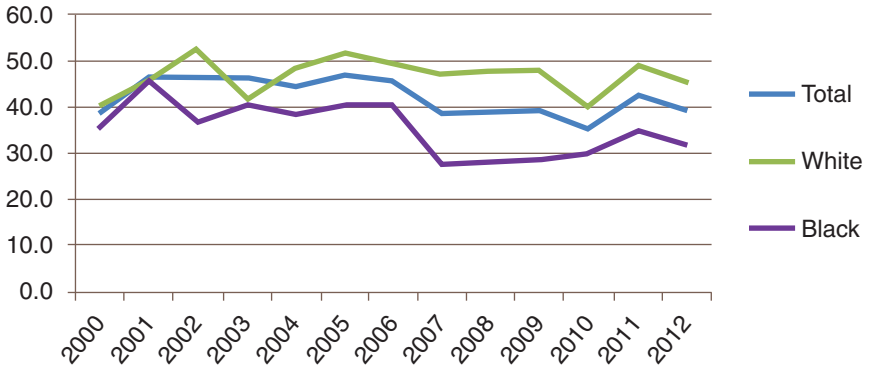
MOTOR VEHICLE ACCIDENT MORTALITY RATE PER 100,000 AMONG TEENS AGES 15 TO 19 2000-2012



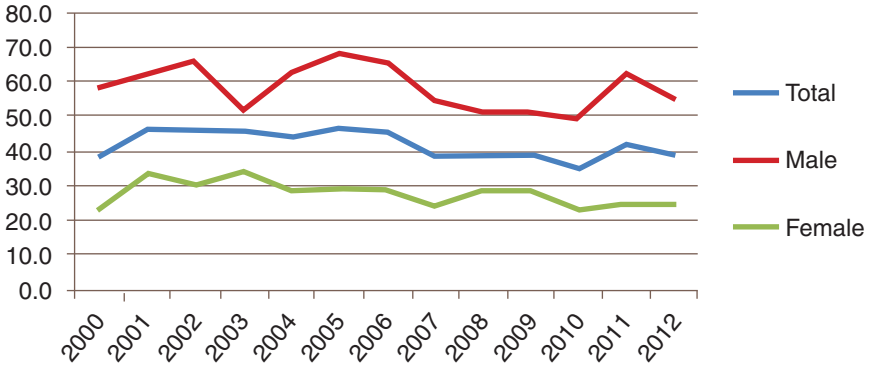
UNINTENTIONAL INJURY MORTALITY

Unintentional injury mortality is any death due to an accident that is not a homicide or suicide. There has been fluctuation in overall unintentional injury mortality rates between 2000 and 2012. Although the overall trend remains static, there has been a decrease in unintentional injury deaths in 2011 and 2012. The 2012 mortality rate of 39 per 100,000 population is 1.1% higher than the 2000 rate of 38.6 per 100,000 population. Rates of unintentional injury mortality are higher among males than females.

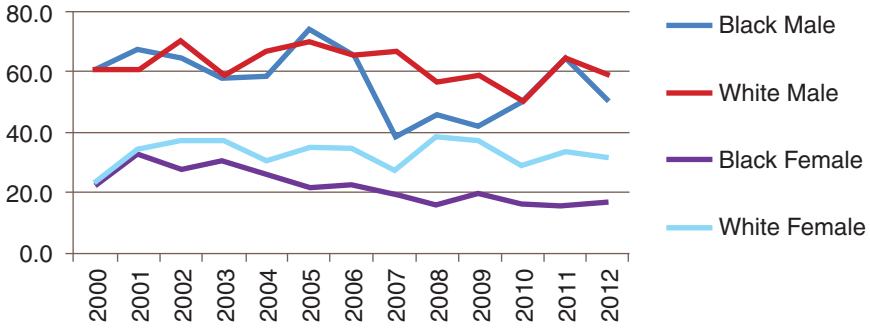
ALL UNINTENTIONAL INJURY MORTALITY PER 100,000 JEFFERSON RESIDENTS BY RACE 2000-2012



ALL UNINTENTIONAL INJURY MORTALITY PER 100,000 JEFFERSON RESIDENTS BY SEX 2000-2012



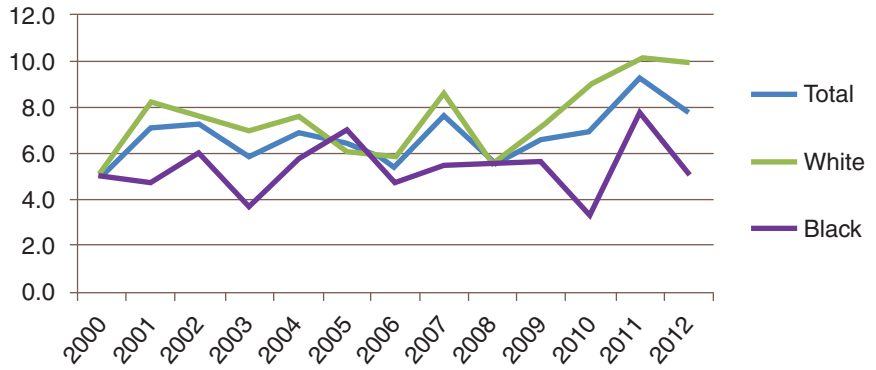
ALL UNINTENTIONAL INJURY MORTALITY PER 100,000 JEFFERSON RESIDENTS BY RACE AND SEX 2000-2012



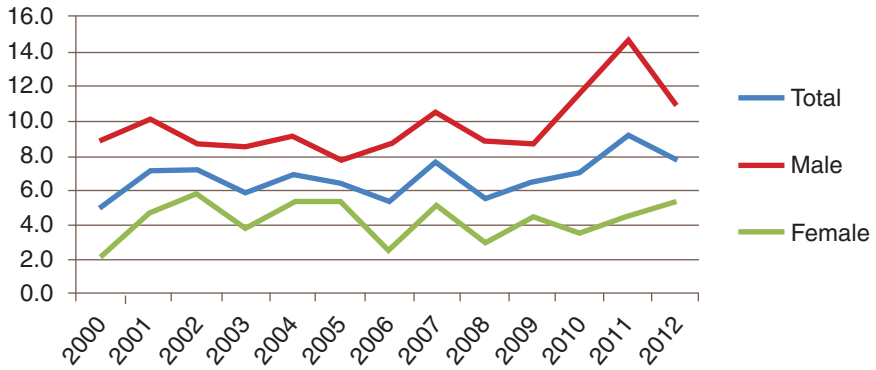
CIRRHOSIS MORTALITY

Cirrhosis of the liver is linked to alcoholism and other liver related diseases. Cirrhosis mortality within Jefferson County increased 55.9% from the 2000 rate of 5 per 100,000 population to the 2012 rate of 7.8 per 100,000 population. Mortality for this disease is higher among the white population and males.

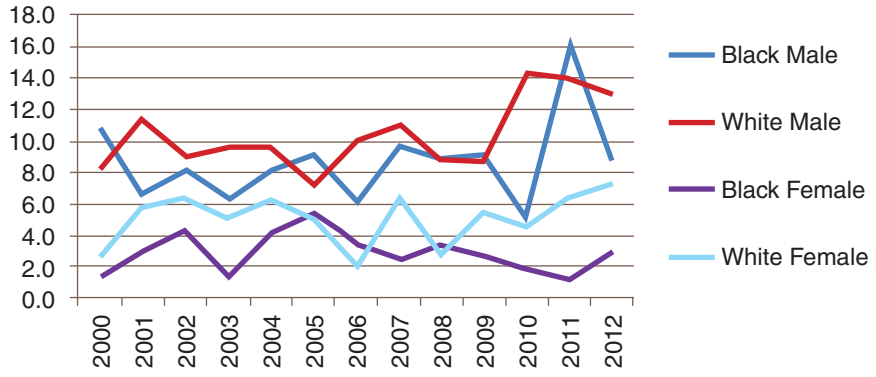
CIRRHOSIS MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



CIRRHOSIS MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



CIRRHOSIS MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012

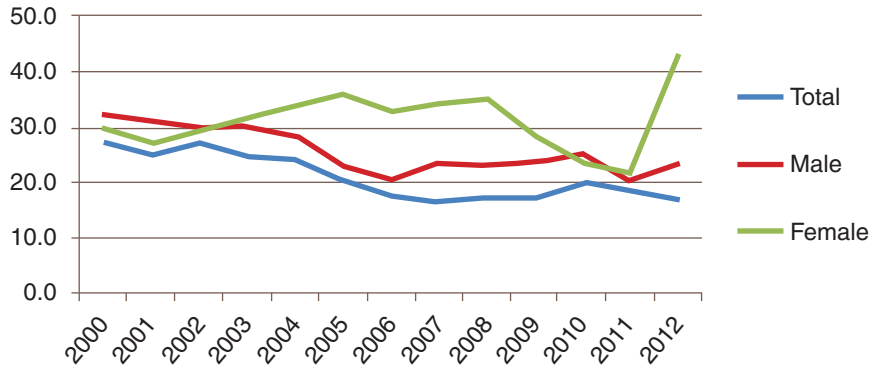


PNEUMONIA AND INFLUENZA MORTALITY

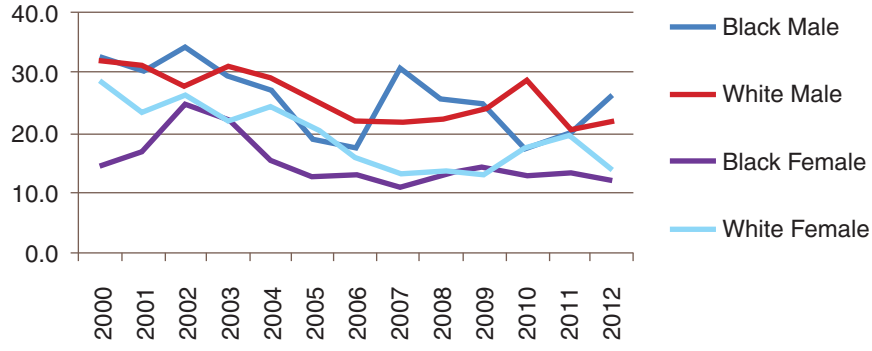
Pneumonia and influenza like illnesses were the tenth leading cause of death in Jefferson County in 2012. Rates of pneumonia and influenza like illness mortality have exhibited a downward trend since 2000, with the 2012 rate of 17.2 deaths per 100,000 population being 36.6% lower than the 2000 rate of 17.2 per 100,000 population. Pneumonia and influenza mortality rates are higher among females than males.

PNEUMONIA AND INFLUENZA MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012

PNEUMONIA AND INFLUENZA MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



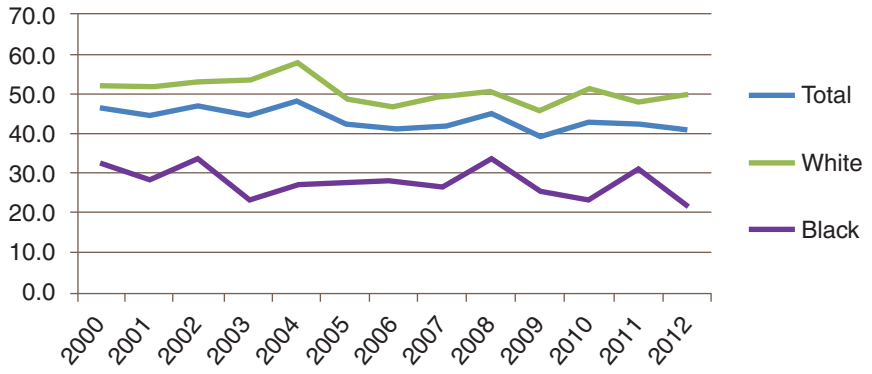
PNEUMONIA AND INFLUENZA MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



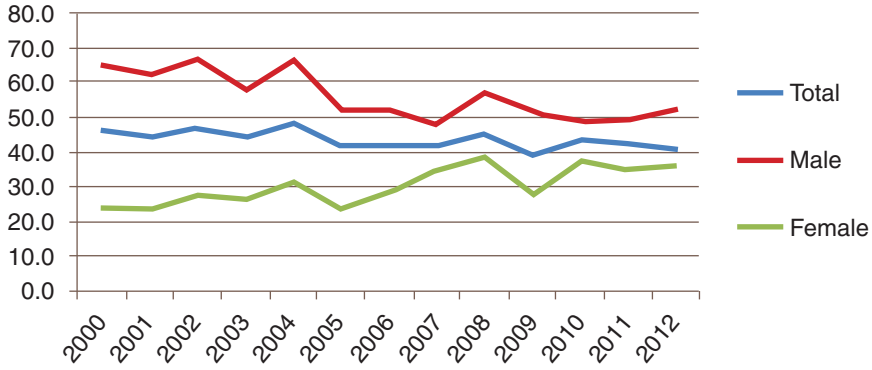
CHRONIC OBSTRUCTIVE PULMONARY DISEASE AND ALLIED DISEASE MORTALITY

Chronic Obstructive Pulmonary Disease (COPD) is associated with smoking and includes chronic bronchitis, emphysema, and chronic obstructive asthma. COPD mortality rates have gradually decreased from the 2000 rate of 46.4 per 100,000 population to the 2012 rate of 40.9 per 100,000 population, representing a 4.9% decrease. The white population has a higher rate of COPD mortality compared to the black population. While COPD mortality rates among males declined, the mortality rate among females is increasing.

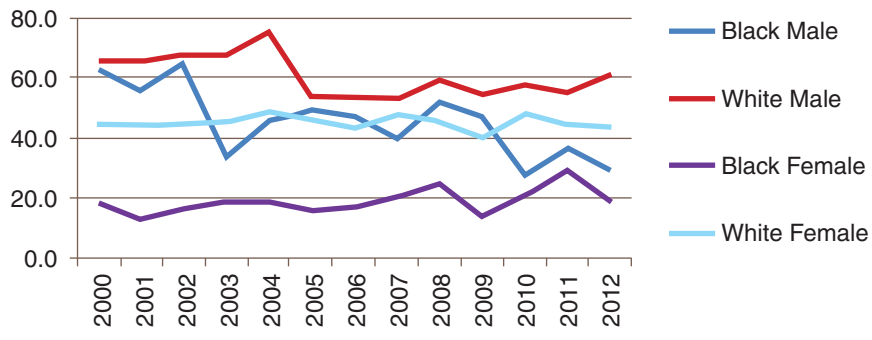
COPD AND ALLIED DISEASE MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



COPD AND ALLIED DISEASE MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



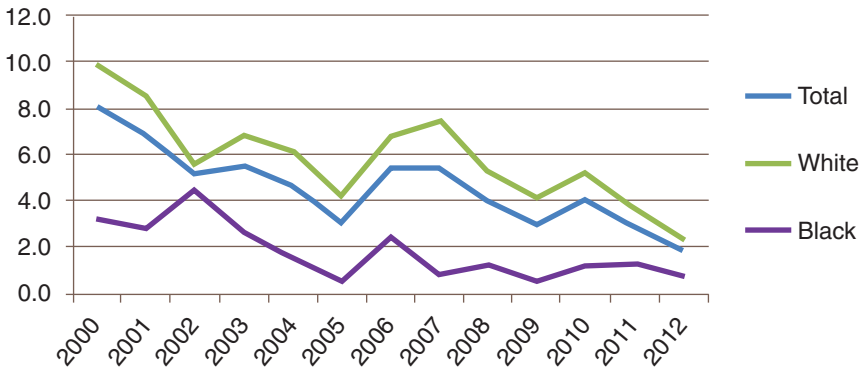
COPD AND ALLIED DISEASE MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



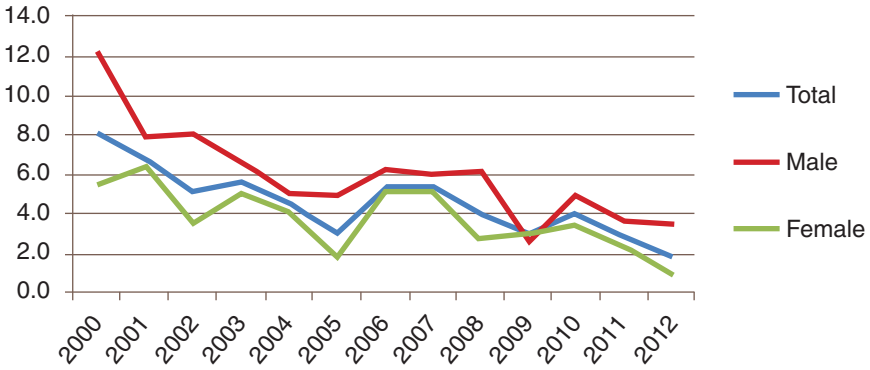
EMPHYSEMA MORTALITY

Emphysema is a destructive lung disease associated with smoking. Jefferson County's emphysema mortality rates decreased by 76.8% from the 2000 rate of 8 per 100,000 population to the 2012 rate of 1.8 per 100,000 population. The declining rates have been most pronounced among white males.

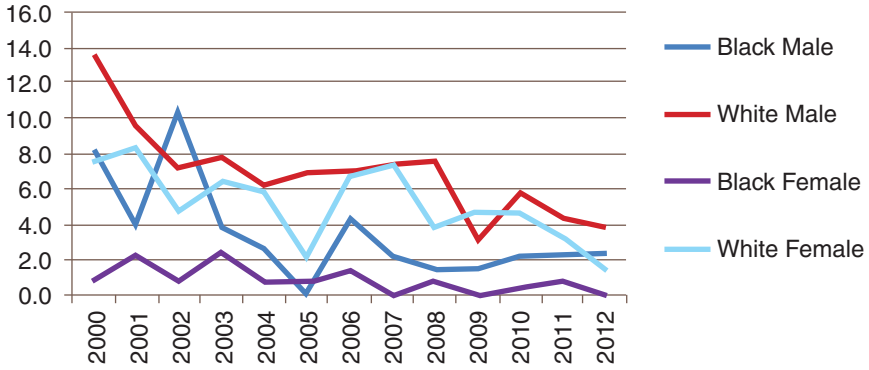
EMPHYSEMA MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



EMPHYSEMA MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



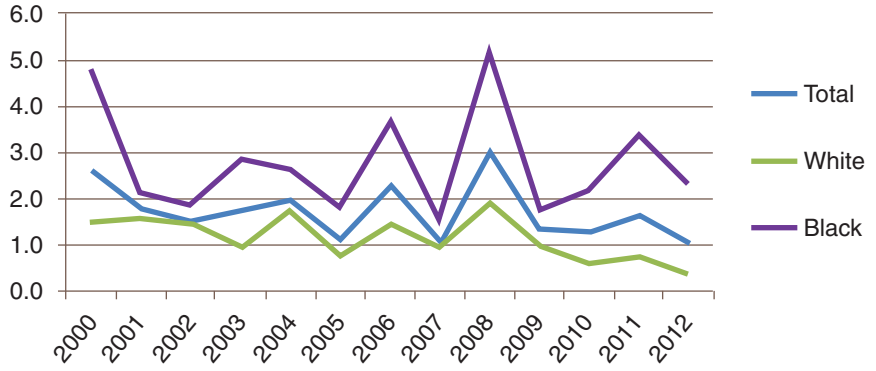
EMPHYSEMA MORTALITY PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



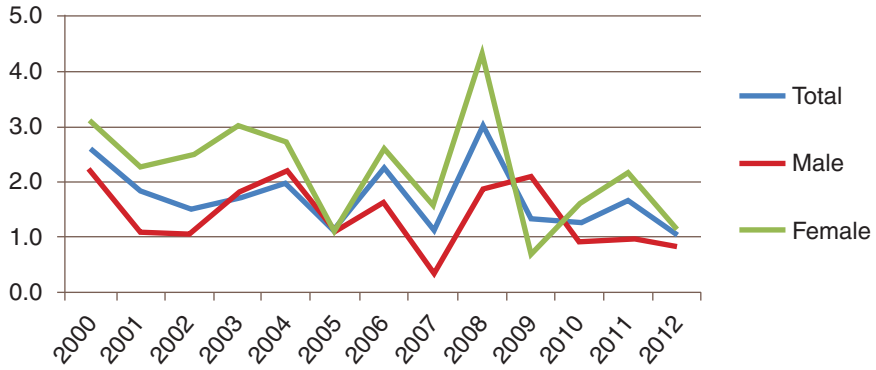
ASTHMA MORTALITY

Asthma is an inflammatory lung disease causing bronchiolar constriction and resulting in breathing difficulties. Overall asthma mortality rates have decreased by 60.8% from the 2000 rate of 2.6 deaths per 100,000 population to the 2012 rate of one death per 100,000 population. The black population suffers from higher asthma mortality rates than the white population. Females suffer from higher asthma mortality rates as compared to males in Jefferson County.

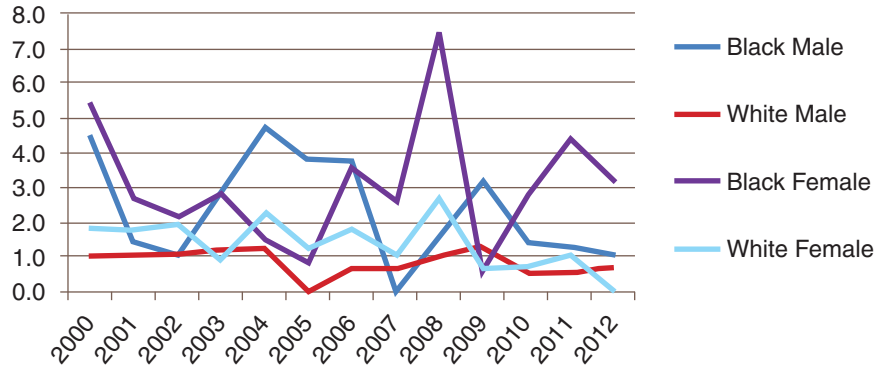
ASTHMA MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



ASTHMA MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



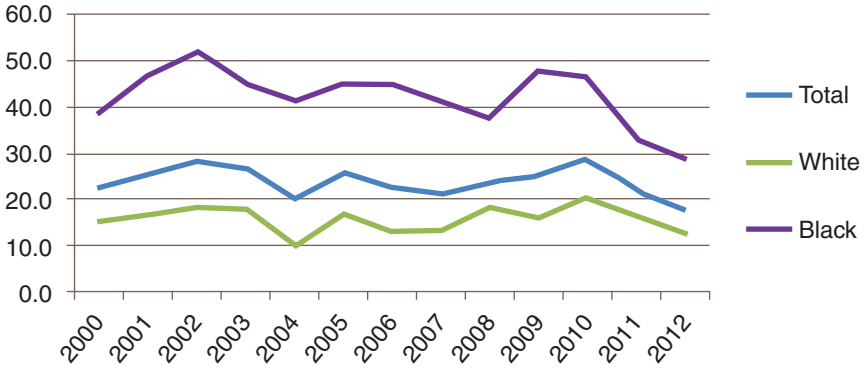
ASTHMA MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



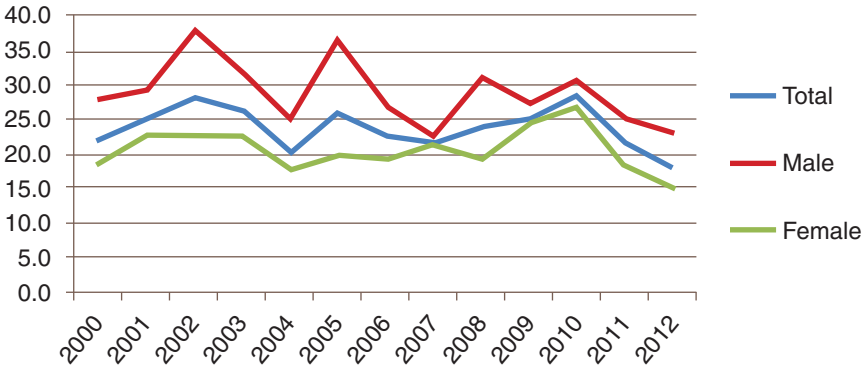
NEPHRITIS MORTALITY

Nephritis is kidney disease caused by inflammation of the kidney and is the ninth leading cause of death in Jefferson County. Overall nephritis mortality rates have declined since 2008. The 2012 nephritis mortality rate of 17.9 per 100,000 population is 18.9% lower than the 2000 rate of 22.1 per 100,000 population. Nephritis mortality rates are higher among the black population and are higher among males. Nephritis mortality rates among black females, black and white males have demonstrated decline, however, the rate among white females has increased.

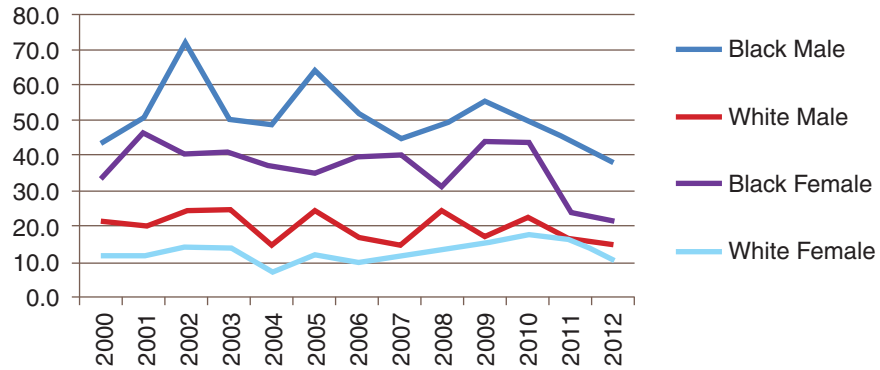
NEPHRITIS MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



NEPHRITIS MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



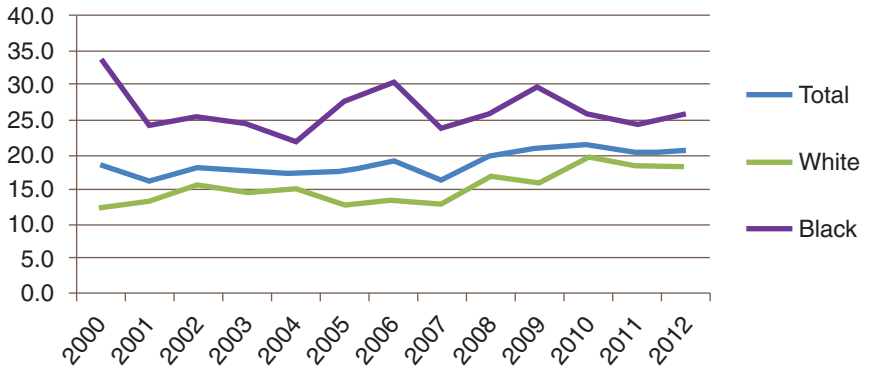
NEPHRITIS MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



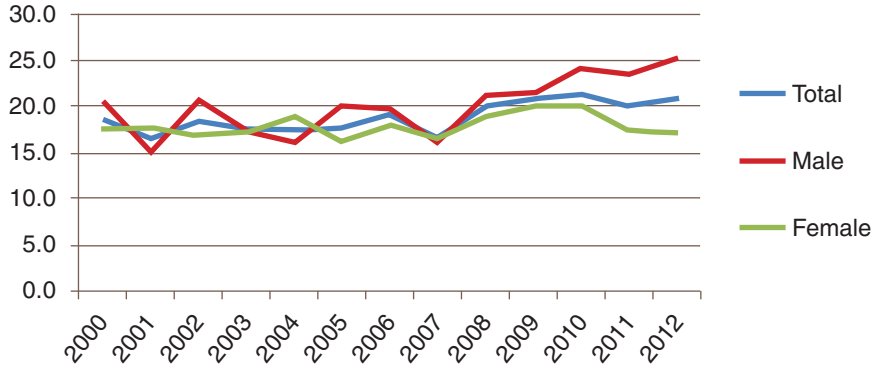
SEPTICEMIA MORTALITY

Septicemia is the result of a bacterial infection that enters the bloodstream and is the seventh leading cause of death in Jefferson County. Overall septicemia mortality has been increasing slightly since 2000. The 2012 rate of septicemia mortality at 20.8 per 100,000 population is 11.5% higher than the 2000 septicemia mortality rate of 18.7 per 100,000 population. While the septicemia mortality rate is higher among the black population, the death rate is increasing more significantly among the white population.

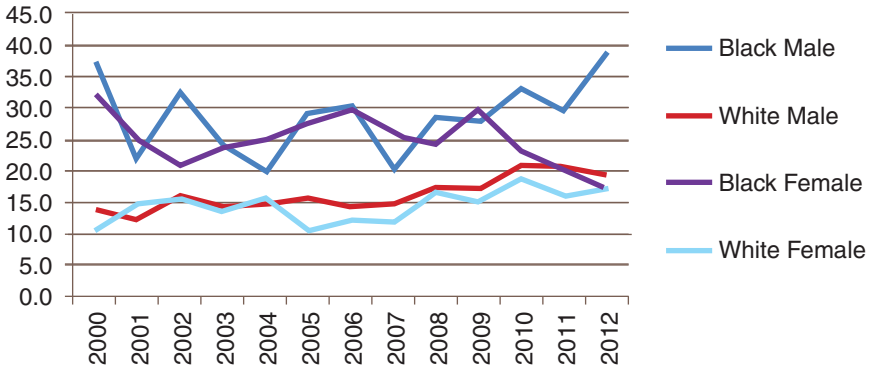
SEPTICEMIA MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



SEPTICEMIA MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



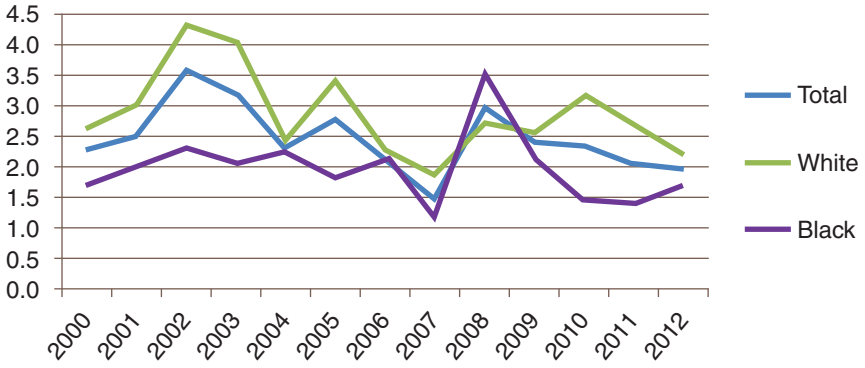
SEPTICEMIA MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



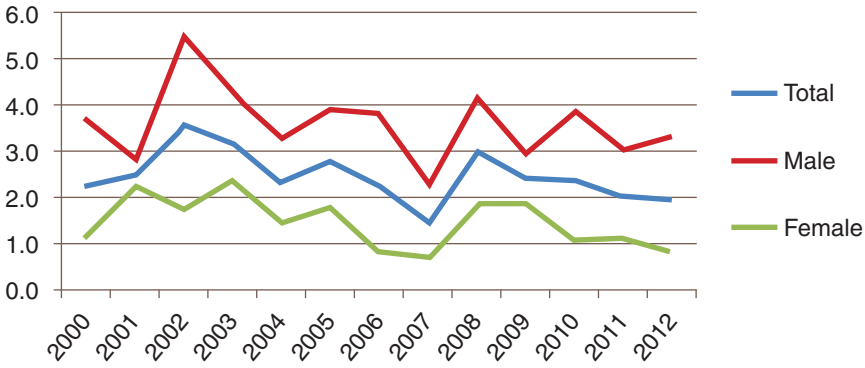
VIRAL HEPATITIS MORTALITY

Viral hepatitis is an inflammation of the liver caused by a viral infection. Overall viral hepatitis mortality rates have fluctuated widely between 2000 and 2008, but have demonstrated a declining trend since 2008. The 2012 viral hepatitis mortality rate of two deaths per 100,000 population is 13.3% lower than the 2000 rate of 2.3 deaths per 100,000 population. The viral hepatitis mortality rate is higher among the white population and is higher among males.

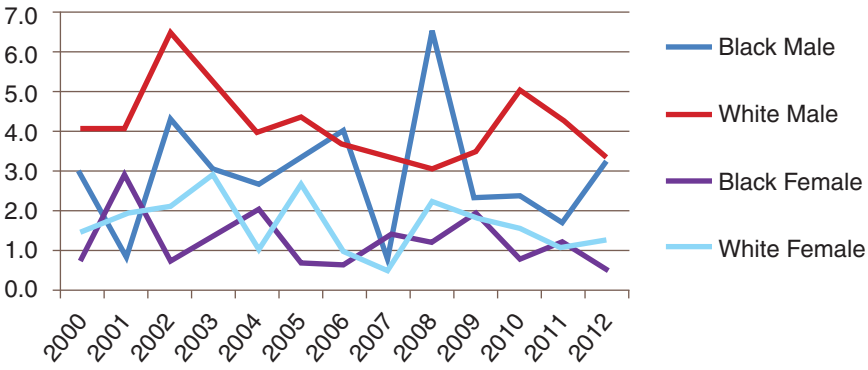
VIRAL HEPATITIS MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE 2000-2012



VIRAL HEPATITIS MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY SEX 2000-2012



VIRAL HEPATITIS MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS BY RACE AND SEX 2000-2012



HOSPITALIZATIONS

The number of hospitalizations among Medicare beneficiaries in Jefferson County is indicative of the prevalence and incidence of certain diseases in the population.

JEFFERSON COUNTY HOSPITALIZATIONS - 2013		
	Medicare Only	65 and older
Asthma	148	222
Cellulitis	313	470
Congestive Heart Failure	146	219
Diabetes	216	324
Gangrene	55	83
Influenza	43	65
Malignant hypertension	32	48
Perforated/bleeding ulcers	56	84
Pneumonia	980	1,470
Pyelonephritis	52	78
Ruptured appendix	37	56

DEATH, ILLNESS AND INJURY FINDINGS

For many causes of death, the Jefferson County's mortality rates have decreased over time. The overall all-cause mortality rate is declining, as are the mortality rates for heart disease, cancer and cerebrovascular disease, the three leading causes of death in Jefferson County. Mortality rates are decreasing among the black and white populations for these leading three causes of death, but are increasing among Jefferson County residents of other races. Among the different types of cancer, mortality rates for lung cancer, colorectal cancer, colon cancer, cervical cancer, prostate cancer, and leukemia have all decreased since 2000. Breast cancer rates have fluctuated widely and liver cancer rates have increased.

Rates of mortality from Alzheimer's Disease, hypertension, stroke, diabetes, HIV, pneumonia and influenza, COPD, emphysema, asthma, nephritis and viral hepatitis all have decreased since 2000.

Septicemia mortality rates have increased in Jefferson County since 2000, as have the death rates for cirrhosis, motor vehicle accidents rates and unintentional injuries.

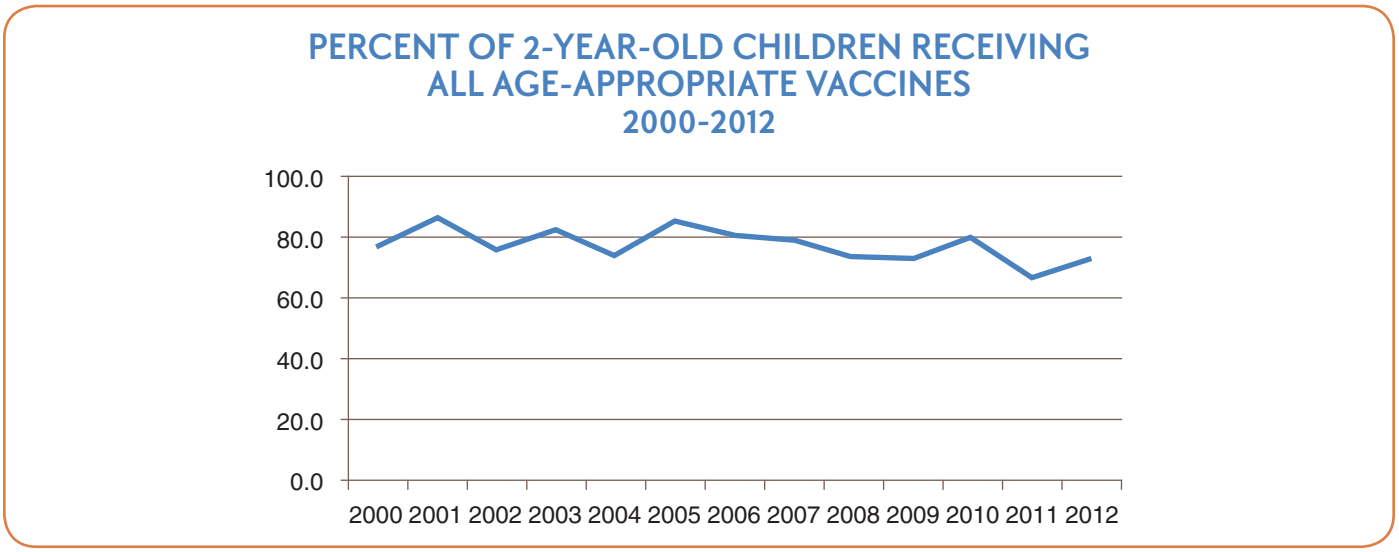
Hospitalization data for Jefferson County residents over 65 indicate that pneumonia is a disease of concern within the population over age 65. With only one year of data, these hospitalization data points will be tracked over time to determine any emerging trends in hospitalization.

COMMUNICABLE DISEASES

Indicators in this category include data related to immunizations, sexually transmitted diseases, Tuberculosis and Hepatitis.

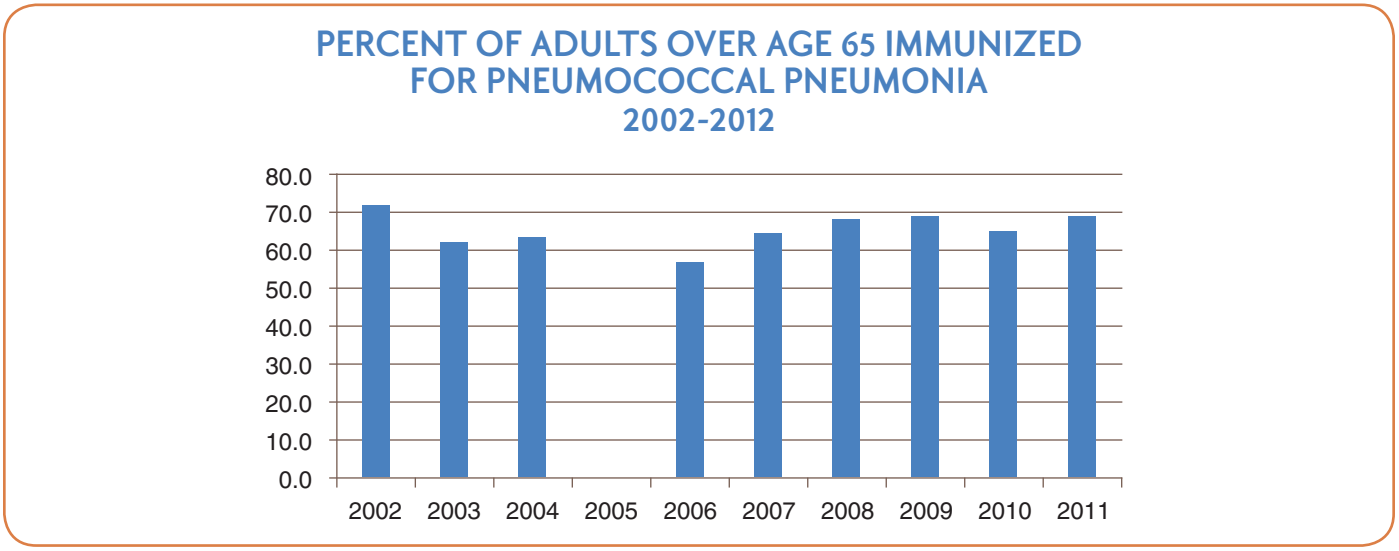
PROPORTION OF TWO YEAR OLD CHILDREN RECEIVING AGE-APPROPRIATE VACCINATIONS

The Advisory Committee on Immunization Practices provides annual guidance on the recommended vaccinations for children and adults. Immunization recommendations for two year old children include vaccinations for Hepatitis B, Rotavirus, Diphtheria, Tetanus and Pertussis, Haemophilus Influenza B, Pneumococcal virus, Polio, Influenza, Varicella, and Hepatitis A. While the variance in the rates of two year old age-appropriate vaccination between 2000 and 2012 is not significant, the percent of children who have received all age-appropriate vaccinations has trended down over time.



PROPORTION OF ADULTS OVER AGE 65 IMMUNIZED FOR PNEUMOCOCCAL PNEUMONIA

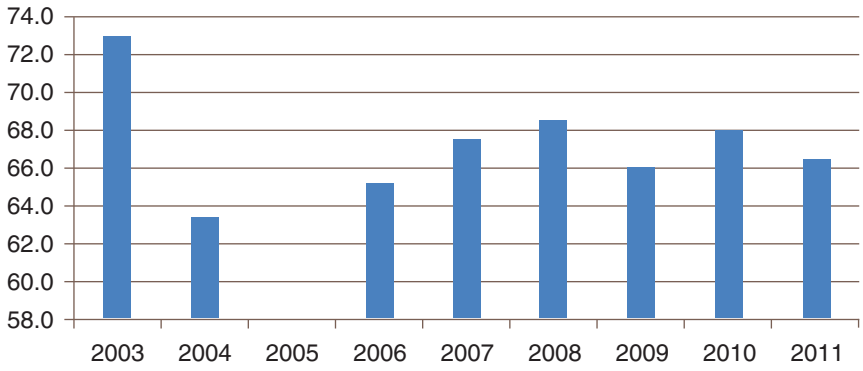
Pneumococcal pneumonia is a bacterial infection that can affect the lungs. This disease especially affects the population over age 65 and can cause death. Immunization is important in preventing pneumococcal infection among this vulnerable population. Rates of pneumococcal pneumonia immunization in Jefferson County remained static at around 70% for the Jefferson County population over age 65. Data were not available for 2005.



PROPORTION OF ADULTS AGE 65 AND OLDER IMMUNIZED FOR INFLUENZA IN THE PAST 12 MONTHS

Influenza is another disease that adversely affects people over age 65 and disproportionately causes illness and death in this population. Between 2003 and 2004, annual influenza immunization rates dropped significantly, but have risen slightly since 2004 and remain around 65% of the population over age 65. Data were not available for 2005.

PERCENT OF ADULTS 65 AND OLDER IMMUNIZED FOR INFLUENZA IN THE PAST 12 MONTHS 2003-2012

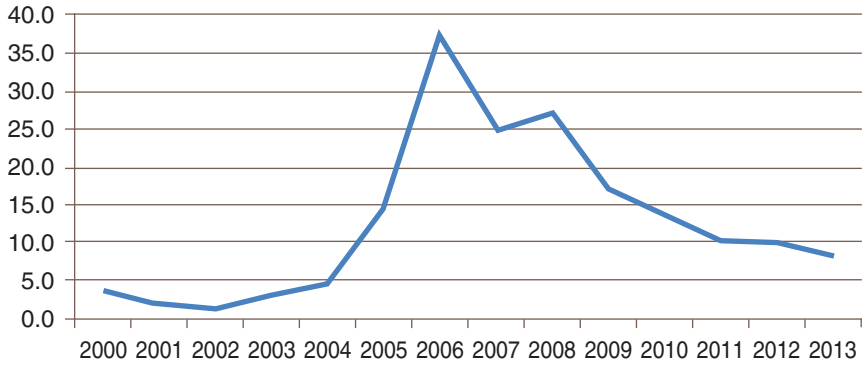


SYPHILIS

Syphilis is a sexually transmitted disease that can cause severe long-term complications if it is not treated correctly or remains untreated. Syphilis infection is reported as primary, secondary or late stage, depending on the stage of illness at diagnosis. Jefferson County syphilis rates remained static from 2000 to 2003. In 2004, there was a dramatic increase in the rates of primary and secondary syphilis infection. Syphilis peaked in 2006 with rates declining since 2006; but the rates for this disease have not returned to the lowest levels observed in 2002.

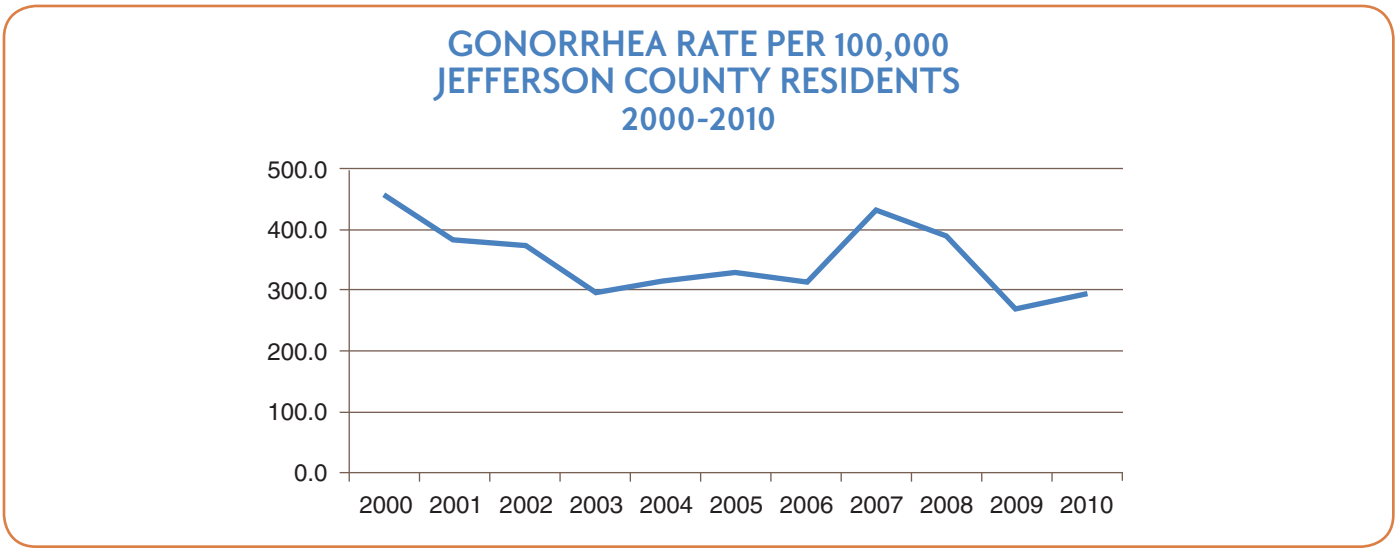
Among Jefferson County males, the 2013 rate of primary and secondary syphilis was 17 per 100,000 population, a rate more than double the Healthy People 2020 goal of 6.7 primary and secondary syphilis infections per 100,000 males. The primary and secondary syphilis rate among females was 0.9 per 100,000 which is lower than the Healthy People 2020 goal of 1.3 per 100,000 females.

PRIMARY AND SECONDARY SYPHILIS RATE PER 100,000 JEFFERSON COUNTY RESIDENTS 2000-2013



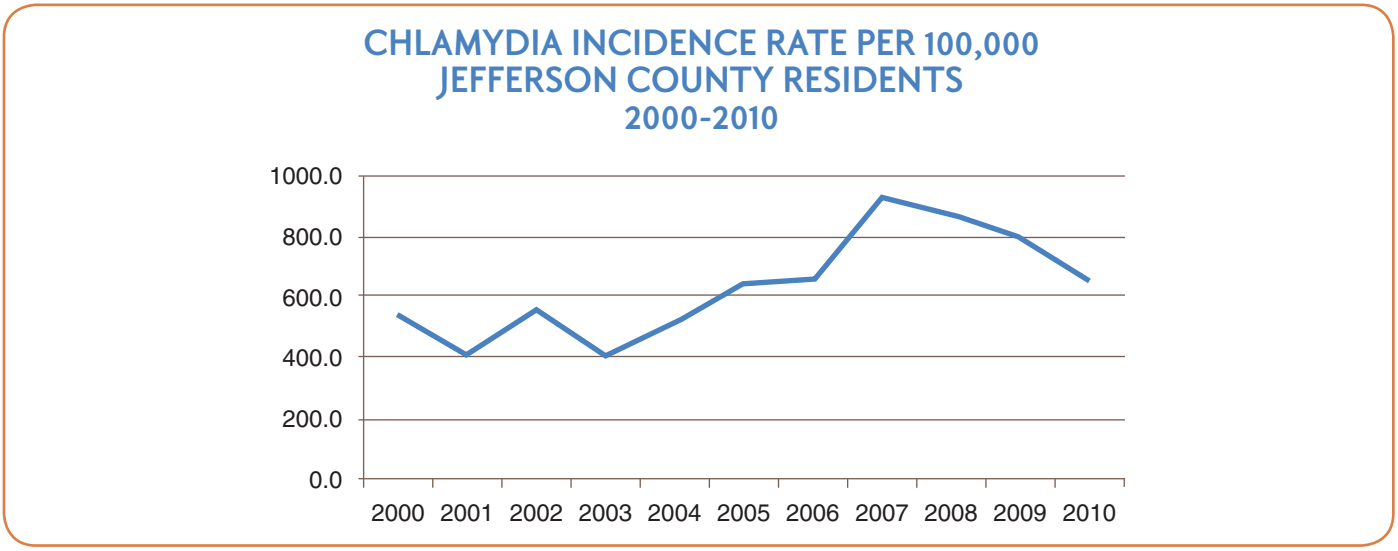
GONORRHEA

Gonorrhea is a sexually transmitted disease that can affect both men and women. Jefferson County Gonorrhea rates have decreased from the 2000 rate of 454 per 100,000 population to the 2013 rate of 259.7 per 100,000 population. Due to reporting inconsistencies, the rates for 2011 and 2012 are not reliable at this time.



CHLAMYDIA

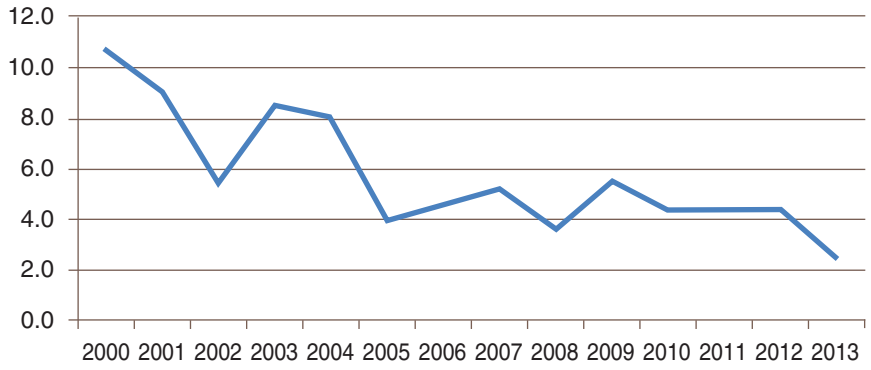
Chlamydia is the most commonly reported sexually transmitted disease in the United States. If left untreated, Chlamydia infection can result in infertility in females. The 2013 Chlamydia rate for Jefferson County was 707.3 per 100,000 population which is 30.5% higher than the 2000 rate of 541.7 per 100,000 population. Due to reporting inconsistencies, the Chlamydia rates for 2011 and 2012 are not reliable at this time.



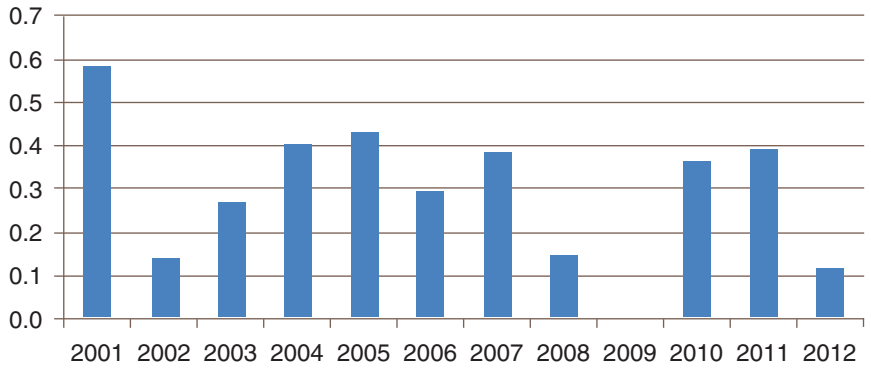
TUBERCULOSIS

Tuberculosis is a bacterial illness that usually affects the lungs, but can affect other parts of the body and may be fatal if left untreated. Tuberculosis incidence in Jefferson County has declined steadily since 2000. The 2013 rate of 2.4 Tuberculosis infections per 100,000 population is 77.6% lower than the 2000 rate of 10.7 per 100,000 population. Although Tuberculosis mortality rates fluctuate from year to year, there is an overall decreasing trend in incidence for this disease.

TUBERCULOSIS INCIDENCE RATE PER 100,000 JEFFERSON COUNTY RESIDENTS 2000-2013

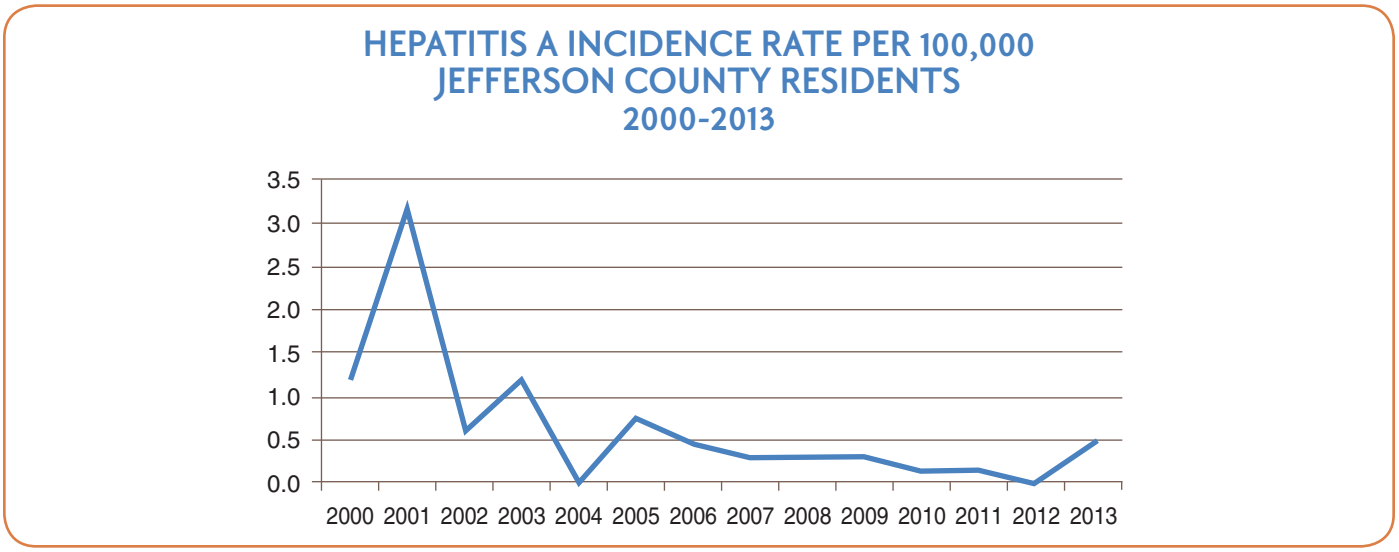


TUBERCULOSIS MORTALITY RATE PER 100,000 JEFFERSON COUNTY RESIDENTS 2001-2012



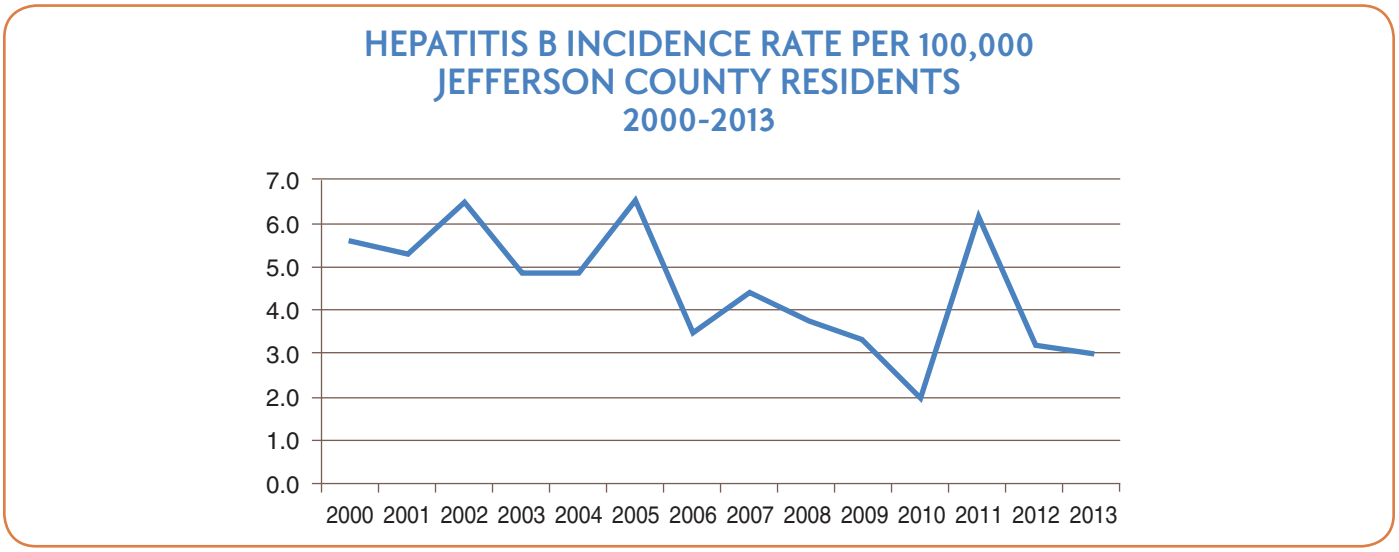
HEPATITIS A

Hepatitis A is a viral disease that affects the liver and produces an infection that does not result in chronic infection or chronic liver disease, but can cause acute liver failure. Hepatitis A incidence rates have decreased in Jefferson County from the 2000 rate of 1.2 per 100,000 population which is 58.3% higher than the 2012 rate of 0.5 per 100,000 population.



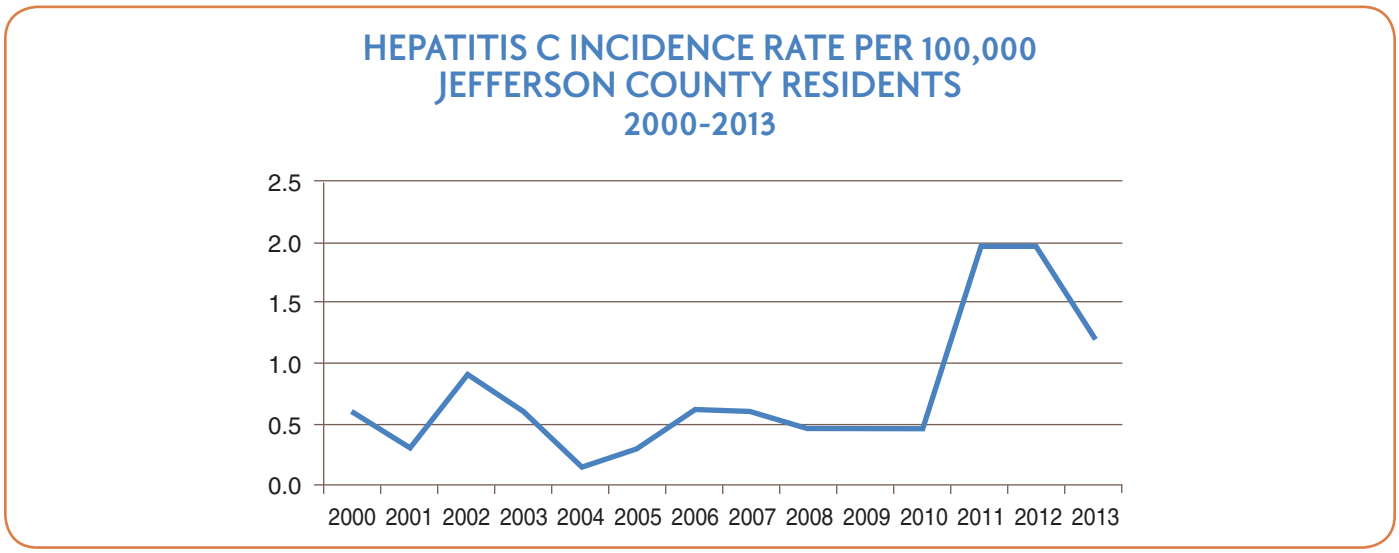
HEPATITIS B

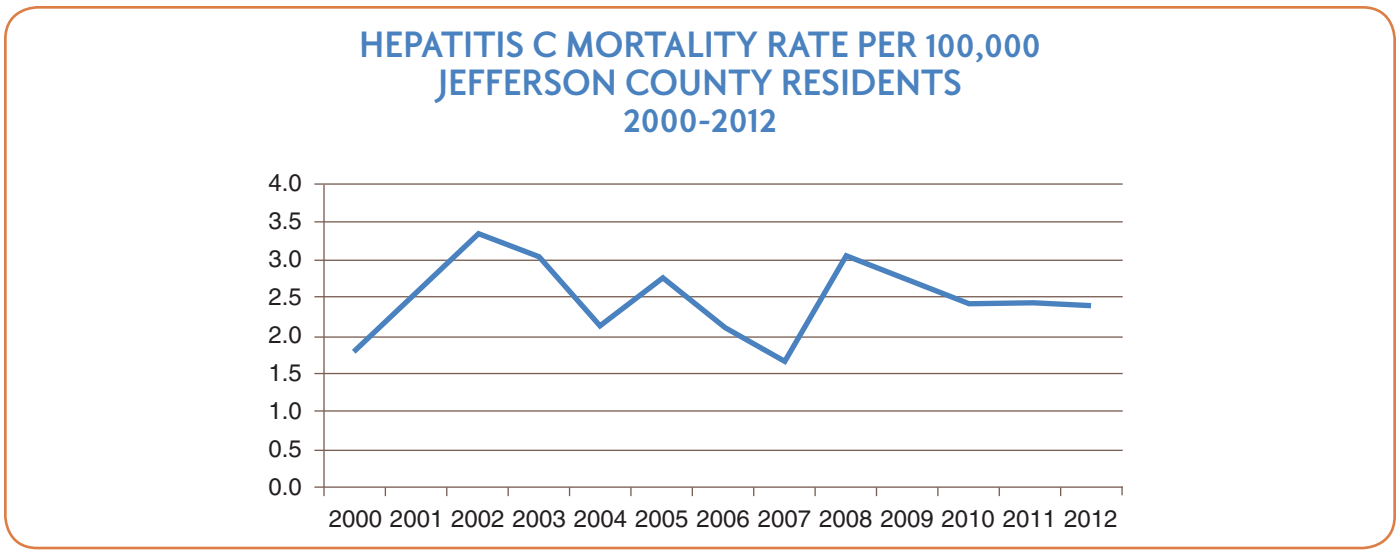
Hepatitis B is a viral disease that affects the liver and can result in a chronic or acute liver infection leading to acute liver failure or death. Hepatitis B incidence rates have decreased by 46.4% from the 2000 rate of 5.6 per 100,000 population to the 2013 rate of 3 per 100,000 population.



HEPATITIS C

Hepatitis C is the most common chronic blood borne infection in the United States. It is most commonly transmitted by exposure to infected blood through blood transfusions or needle sharing and less commonly through sexual contact. Hepatitis C rates in Jefferson County have increased by 100% from 0.6 per 100,000 population in 2000 to 1.2 per 100,000 population in 2012. Hepatitis C mortality rates have fluctuated around 2.5 per 100,000 population from 2010 through 2012.





COMMUNICABLE DISEASE FINDINGS

Immunization rates have declined among children under age two, and for annual influenza vaccination in the elderly population. The percentage of the population age 65 and older receiving a pneumococcal vaccination remains stable. Decreasing immunization rates are an indicator of concern as these indicate higher risk for unimmunized individuals and for the Jefferson County population as a whole for contracting preventable diseases.

While the sexually transmitted diseases rates for Syphilis and Gonorrhea are decreasing, Chlamydia rates are increasing. As Chlamydia and Syphilis rates among males are higher than the Healthy People 2020 goal, increased need for treatment and prevention of sexually transmitted diseases is indicated. Among other communicable diseases, Tuberculosis, Hepatitis A and Hepatitis B rates are decreasing in Jefferson County. The increasing rates of Hepatitis C infection is an undesirable finding, especially due to the strong link between Hepatitis C and liver cancer.

SENTINEL EVENTS

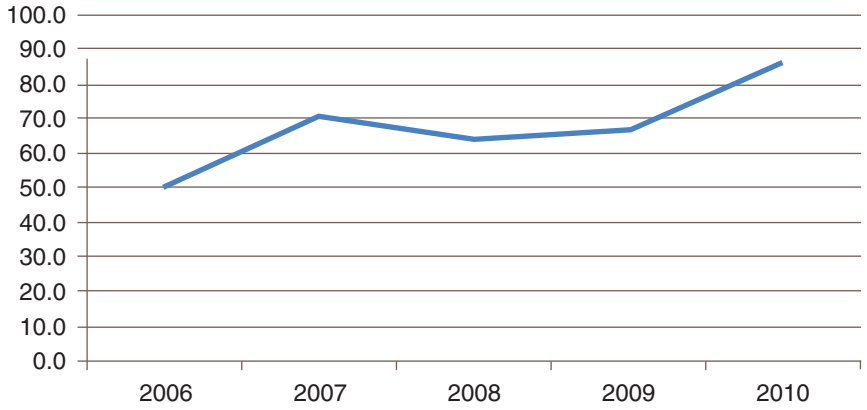
Sentinel events are unanticipated events that may result in death, illness or injury for a particular population. The indicators in this category represent outbreaks of certain communicable diseases and incidence rates for vaccine preventable illnesses.

PERTUSSIS

Pertussis, or whooping cough, is a vaccine preventable and highly contagious disease causing uncontrollable and violent coughing. Pertussis infection rates in Jefferson County have risen by 540% from the 2000 rate of 0.5 per 100,000 population to the 2012 rate of 3.2 per 100,000 population. This increase mirrors the increasing rates of this disease observed across the United States. Jefferson County's rate of 3.2 per 100,000 population is significantly lower than the national rate of 15.4 per 100,000 population. Many of these Pertussis cases could have been prevented with adequate vaccination. The percent of preventable Pertussis infections has risen as well.

PERTUSSIS RATE PER 100,000 JEFFERSON COUNTY RESIDENTS 2000-2012

PERCENT PERTUSSIS INFECTIONS THAT WERE PREVENTABLE 2006-2010



MEASLES

There have been no cases of measles, a vaccine preventable and highly contagious respiratory disease that causes fever, cough, runny nose and a rash over the entire body, in Jefferson County since 2000. Appropriate vaccination coverage with the Measles, Mumps and Rubella vaccine is a likely reason for the lack of Measles cases.

MUMPS

In 2006, Jefferson County reported two cases of mumps. During the following two years, 2007 and 2008, Jefferson County reported one case each of mumps. Mumps is a vaccine preventable and highly contagious disease that causes swelling of the salivary glands and is accompanied by fever, muscle aches, headache, tiredness and loss of appetite. Since 2008, Jefferson County has had no reported cases of mumps which is likely the result of appropriate Measles, Mumps and Rubella vaccination coverage.

RUBELLA

Rubella is a contagious viral disease which is vaccine preventable. Rubella infection in a pregnant woman can cause birth defects such as deafness, cataracts, heart defects, mental retardation and liver and spleen damage. There have been no reported cases of Rubella in Jefferson County since 2000 which is expected with appropriate Measles, Mumps and Rubella vaccination coverage in Jefferson County.

TETANUS

There have been no reported cases of Tetanus in Jefferson County from 2000 to date. Tetanus is a vaccine preventable disease spread through contaminated soil and dust entering the body through breaks in the skin.

LISTERIOSIS

Listeriosis is a disease spread by eating food contaminated with the bacteria Listeria monocytogenes. This disease predominately affects older adults, pregnant women, infants and children and adults with a compromised immune system. During 2008 and 2010, Jefferson County reported one death due to Listeriosis.

DIPHTHERIA

Diphtheria is a vaccine preventable disease that was major cause of illness and death among children prior to the implementation of broad based vaccination practices. From 2000 through the present, there have been no reported cases of Diphtheria in Jefferson County.

LEGIONELLA

Legionella is a bacteria that causes a type of pneumonia and is the result of environmental exposure to the bacteria. Jefferson County reported one death due to Legionella infection during 2004, 2007 and 2008.

VARICELLA

Varicella, also known as chickenpox, is a highly contagious, vaccine preventable disease that causes a blister like rash, itching, tiredness and fever. In 2004, Jefferson County reported two deaths due to Varicella infection. None have been reported since 2004.

MENINGOCOCCUS

Meningococcus refers to any disease caused by the bacteria *Neisseria meningitides*. Infections usually involve swelling of the brain and spinal cord as well as bloodstream infection. Jefferson County reported one death due to Meningococcus during the years 2000, 2003 and 2012.

SENTINEL EVENTS FINDINGS

Due to the infrequent nature of sentinel events, it is difficult to determine if trends exist. The occurrence of a sentinel event could indicate problems with the local public health system or alert health care providers to trends within the community that affect public health. One such trend is declining immunization rates. As immunization rates continue to decline in Jefferson County, death and illness due to vaccine preventable diseases may increase. This increase has been seen in the rates of Pertussis infection in Jefferson County and nationwide. While Jefferson County's rates of Pertussis infection remain lower than the national rate, the increase in incidence remains a concern for the county.

COMMUNITY HEALTH STATUS ASSESSMENT FINDINGS

The following summarize the key desirable and undesirable findings from the assessment of the 144 indicators included in the Community Health Status Assessment for Jefferson County, Alabama.

DESIRABLE FINDINGS:

- Life expectancy has increased from 71.3 years to 72.2 years.
  - The increase in life expectancy was observed across all races and genders, but had a greater increase among blacks and males.
  - This trend shows a closing gap in life expectancy between whites and blacks.
- The percent of pregnant women receiving adequate prenatal care is a strength.
  - In 2012, 81.5% of pregnant women received adequate prenatal care as measured by the Adequacy of Prenatal Care Utilization
  - Index which includes the timing of entry into prenatal care and the number and time of prenatal visits received.
  - Jefferson County exceeds the national Healthy People 2020 goal of 77.6% of all pregnant women receiving adequate prenatal care.
- Homicide rates have decreased by 17% since 2000.
  - A decreasing trend was observed among the white and black populations, as well as among males and females.
- The ratio of population per mental health provider improved from 1,957 people for every mental health provider in 2007-08 to 1,024 people per mental health provider in 2012-13.
- Self-reported smoking rates decreased from 25.7% of the adult population in 2002 to 20% in 2012.

The national Healthy People 2020 goal is 12% of the population reporting smoking, indicating the need for continued efforts to decrease tobacco use.

  - The associated mortalities of lung cancer and emphysema have decreased; however, Chronic Obstructive Pulmonary Disease mortality has remained static since 2000.
- The number of outdoor recreation areas is increasing.
  - In 2012, there were 4.38 miles of on-street bike infrastructure and 12.28 miles of multi-use trails. Currently, the number of on-street bike infrastructure miles has increased to 7.37 miles and 13.38 miles of multi-use trails.
- Both indoor and outdoor air quality improved over time.
  - The percent of residents protected by a tobacco-free public ordinance increased to 76.3% in 2013.
  - The first comprehensive smoke-free public ordinance in Jefferson County passed in 2011 and protected 2.1% of the population. In 2013, 39.1% of the population was protected by comprehensive smoke-free policies.
  - Outdoor air quality improved. The number of noncompliance days for Ozone and 2.5 micron Particulate Matter air pollutants decreased. Both the 2.5 micron Particulate Matter annual and 24-hour national Environmental Protection Agency compliance standards have become more stringent. Even with the more stringent standards, air quality improved with zero days of non-compliance with the 24-hour 2.5 Particulate Matter standard in 2009, 2010 and 2012.
- The infant mortality rate decreased from 12.1 deaths per 1,000 live births in 2000 to 9.6 deaths per 1,000 live births in 2012.
  - This decreasing trend is observed in neonatal and post neonatal mortality and among the black and white populations.
- While heart disease, cancer and stroke remain the three leading causes of death in Jefferson County, mortality rates for these three diseases are decreasing across all gender and race groups.

UNDESIRABLE FINDINGS:

- Poverty and unemployment are social determinants of health which are increasing.
  - In 2012, 18.6% of the total population lived at or below 100% of the Federal Poverty Level for income. Poverty is increasing across all age groups. The US percentage of people with household income less than the Federal Poverty Level was 15.9% in 2012, placing Jefferson County above the national average.
  - Unemployment continues to increase, with 9.3% of the working age population unemployed.

- While the percent of adults over the age of 25 with a high school education has increased, high school graduation rates for public school systems have declined to 79.8% for on-time graduation. Graduation rates vary widely across school systems. Education is an important social determinant of health, and low high school graduation rates threaten the health of residents.

- Obesity rates continue to increase.
  - In 2012, 34.8% of the population self-reported being obese. This represents a 42.6% increase from the 2002 rate of 24.4% self-reporting as obese.

- Hypertension is related to overweight and obesity and is a risk factor for kidney disease, heart disease, diabetes and stroke. Self-reported hypertension rates have increased to 37.9% of Jefferson County's adult population.

- Access to health care is inadequate.
  - Among women, Pap smear screening rates declined from 87% in 2000 to 80.6% of women over age 18 reporting receipt of a Pap smear within the last 3 years.
  - The total percent of the population living below 200% of the Federal Poverty level served by either the Jefferson County Department of Health or a Federally Qualified Health Center has decreased to 19.2%. It is undetermined whether these individuals are receiving care through other clinics, private providers or are not receiving care at all.

- While overall infant mortality rates have improved from 12.1 deaths per 1,000 live births in 2000 to 9.6 deaths per 1,000 live births in 2012, the infant mortality rate continues to be significantly higher than the 2010 national rate of 6.14 per 1,000 live births.
  - The Healthy People 2020 target is 6.6 infant deaths per 1,000 live births.

- Cesarean Section deliveries increased to 32.4% of all deliveries in 2012.
  - This increasing trend is occurring among women in the white and black populations.

- Diabetes mortality and prevalence among the black population and males continues to be an issue.
  - While the mortality rate has been decreasing since 2000, data analysis beginning in 1990 shows that the diabetes 2012 mortality rate among males has risen 17.5%, with black males having the largest rate increase of 19.3%. Diabetes prevalence has increased from 6.5% of the adult population reporting diabetes in 2004 to 12.3% in 2012.

- Septicemia is one of the ten leading causes of death in Jefferson County. Septicemia mortality rates increased 11.2% from 2000 to 2012.

IMPLICATIONS

Through the Community Health Status Assessment a more robust picture of the health status of Jefferson County, Alabama is obtained. Within the analysis of data generated from the 144 indicators, a number of desirable and undesirable findings were revealed. The data from the Community Health Status Assessment were analyzed in relationship to the themes emerging from the other three MAPP Assessments: Community Themes and Strengths, Local Public Health System and Forces of Change. From this evaluation, ten potential overarching strategic issues for Jefferson County were identified. After consideration of the data supporting each of the potential strategic issues, the level of community engagement around the potential issues, current or future availability of resources to address the issues and the measurability of outcomes related to the issue, the Community Matters 20/20 Steering Committee selected five strategic issues to form the foundation for Jefferson County, Alabama's Community Health Improvement Plan.

The selected Strategic Issues are, in rank order:

- **Reduce Health Disparities Associated with Race, Ethnicity and Economic Status**
- **Promote Physical Well-being through Healthy Lifestyles;**
- **Optimize the Built Environment, Transportation System and Safety;**
- **Optimize Healthcare Access, Availability and Utilization, and**
- **Improve Mental Health.**

The local public health system, working together to address these strategic issues, will move Jefferson County forward in its vision to be an inclusive, thriving community of healthy and connected people.

The work of Community Matters 20/20 is supported by the Jefferson County Department of Health

Jefferson County
Department of Health

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II. JEFFERSON COUNTY, ALABAMA'S

COMMUNITY THEMES AND STRENGTHS ASSESSMENT

COMMUNITY MATTERS 20/20

ASSESSMENT, VISIONING AND PLANNING
FOR A HEALTHY JEFFERSON COUNTY

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OVERVIEW OF COMMUNITY MATTERS 20/20

In October 2013, the Jefferson County Department of Health (JCDH) began preparing for the next county-wide community health assessment and strategic planning process. Building on the framework and processes developed during the initial community health assessment and strategic planning process conducted from 2005-2007, JCDH formed a Core Team to begin the planning and design for a comprehensive, community-based assessment and strategic planning initiative utilizing the Mobilizing for Action Through Planning and Partnerships (MAPP) process to be concluded in late 2014. The title for the 2014 assessment and strategic planning process, *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County, AL,* distinguishes the current effort and sets a course for the next anticipated full assessment and strategic planning process; *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County, AL* is led by a steering committee chaired by Jefferson County's Health Officer, Mark E. Wilson, MD, and is composed of fifteen community leaders.

A STRATEGIC APPROACH TO COMMUNITY HEALTH IMPROVEMENT: MAPP

WHAT IS MAPP?

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-wide strategic planning tool for improving community health. Facilitated by the Jefferson County Department of Health, this tool helps the community prioritize public health issues and identify resources for addressing these issues.

BACKGROUND OF COMMUNITY HEALTH ASSESSMENT AND HEALTH STRATEGIC PLANNING USING MAPP IN JEFFERSON COUNTY, ALABAMA

In 2005, the Jefferson County Department of Health (JCDH) led the completion of a comprehensive assessment of the county's public health system utilizing MAPP. After multiple stakeholder meetings and extensive community engagement, JCDH published *Our Community Roadmap to Health,* a document outlining the goals for community health in 2007. JCDH is again initiating this community health strategic planning process to define the community's current and future health-related goals.

HOW MAPP WORKS

The phases of MAPP are shown in the center of Diagram 1, while the four MAPP Assessments, the key content areas driving the process, are shown in the four arrows surrounding the phases.

To initiate the health strategic planning process, lead organizations in the community begin organizing and preparing to implement MAPP (**Organize for Success/Partnership Development**). Community-wide strategic planning requires a high level of commitment from the partners, stakeholders and community residents recruited to participate.

The second phase of MAPP is **Visioning**. A shared vision and common values provide the framework for pursuing long-range community goals. During this phase, the community answers questions such as, *"What would we like our community to look like in ten years?"*

Next, the **four Assessments** are conducted, providing critical insight into challenges and opportunities experienced by the community:

- The **Community Themes and Strengths Assessment** provides a deep understanding of the issues residents believe are important;
- The **Local Public Health System Assessment** offers a comprehensive assessment of how well the local public health system delivers the 10 Essential Public Health Services;
- The **Community Health Status Assessment** identifies priority issues related to community health and quality of life by assessing data about health status, quality of life and risk factors in the community, and
- The **Forces of Change Assessment** focuses on the identification of forces such as legislation, technology and other issues that affect the context in which the community and its public health system operate.

While each of these assessments provides important information independently, taken together, these provide a robust assessment of health and quality of life. A list of challenges and opportunities is generated from each of the four assessments.

The fourth phase of MAPP is to **Identify Strategic Issues**. During this phase, participants identify linkages among the

DIAGRAM 1.

While each of these assessments provides important information independently, taken together, these provide a robust assessment of health and quality of life. A list of challenges and opportunities is generated from each of the four assessments.

The fourth phase of MAPP is to **Identify Strategic Issues**. During this phase, participants identify linkages among the results from the MAPP Assessments to determine the most critical issues to be addressed to enable the community to achieve its vision. After issues have been prioritized, participants **Formulate Goals and Strategies** for addressing each issue.

The sixth and final phase of MAPP is the **Action Cycle**. During this phase, participants plan, implement and evaluate strategies to address the identified strategic issues supporting the shared vision. These activities build upon one another in a continuous and interactive manner to create continued success.

With community input, the following vision statement was endorsed by the Community Matters 20/20 Steering Committee on March 14, 2014 for Jefferson County's health strategic planning process, *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County:*

"JEFFERSON COUNTY ALABAMA IS AN INCLUSIVE, THRIVING COMMUNITY OF HEALTHY AND CONNECTED PEOPLE."

The following description of terms further defines Jefferson County's vision:

Inclusive reflects the purposeful invitation and acceptance of individuals from all backgrounds within the county - social, economic and cultural. No one is left behind.

Thriving describes the growth and flourishing of the community – economically, educationally, socially, culturally and in other dimensions.

Community represents Jefferson County as a whole: its cities, municipalities, unincorporated areas, neighborhoods and their residents.

Healthy reflects the community's experience of physical, mental, social and spiritual well-being.

Connected describes people working together cohesively to support the improvement of the community as a whole.

This vision statement provides the focus, purpose and direction for Jefferson County's health strategic planning process conducted by the community and coordinated by the Jefferson County Department of Health.

Following the adoption of the vision statement, the *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County, AL,* the Steering Committee planned, implemented and evaluated the results from the four MAPP assessments. The remainder of this document provides the Executive Summary and full results from the Community Health Status Assessment.

OVERVIEW OF COMMUNITY THEMES AND STRENGTHS ASSESSMENT AND EXECUTIVE SUMMARY

The Community Themes and Strengths Assessment (CTSA) is one of the four assessments completed as part of *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County.* The CTSA identifies assets in the community and issues, both strengths and weaknesses, important to community members. The following questions are used to identify these assets and issues:

- *What is important to the community?*
- *How is quality of life perceived in the community?*
- *What assets does the community have that can be used to improve the community's health?*

The CTSA Subcommittee developed, implemented and analyzed results from a survey instrument entitled, *Your Opinion Matters!*, and focus groups using a scripted outline. A communication strategy promoted community-wide participation in the survey. *The Your Opinion Matters!* survey *was available in* English and Spanish online and in paper format.

A total of 785 *Your Opinion Matters!* survey (107 paper and 678 online) responses were received. The seven focus groups reached an additional 58 individuals from urban, suburban and rural locations within Jefferson County.

Data from this assessment was analyzed based on its category as quantitative or qualitative. Survey questions with defined answer

choices were considered quantitative. Open ended questions and comments were analyzed along with the focus group transcripts as qualitative data.

The quantitative survey findings indicate that Jefferson County residents perceive the following as strengths and weaknesses of the county:

STRENGTHS

- The availability of parks/outdoor recreation opportunities
- Access to and participation in arts and cultural events
- The availability of public libraries and their resources

WEAKNESSES

- Poor road conditions and lack of repair
- Lack of sidewalks and broken sidewalks
- Unreliable public transportation with limited access and reach
- The presence of litter and graffiti
- The presence of crime, especially violent crimes, burglary and theft
- Inadequate resources for the homeless
- Failing school performance within some school systems
- Increasing substance abuse
- The lack of responsiveness by leaders to the concerns of county residents

The following lists are the perceived strengths, weaknesses and assets garnered through the focus groups and survey comments.

STRENGTHS

- Educational excellence in some school systems
- Revitalization of downtown and other communities bringing new business and industry
- Availability and expansion of parks and recreational spaces
- A general feeling of physical safety
- Beauty of the county

WEAKNESSES

- Lack of access to healthy and affordable foods
- Lack of access to health services for all residents
- Local government's lack of responsiveness to residents
- The impact of crime and violence on families and the community
- Increasing substance abuse
- Lack of physical safety in some communities
- Vacant and run-down properties
- Inadequate school performance in some school systems
- Poor road conditions
- Inadequate public transportation
- Poor air quality
- The prevalence of inequalities in distribution of assets and services, as well as differential treatment of minority populations
- Parks and recreational opportunities are not accessible to all residents
- Waste management services are not available to all residents

- Lack of sidewalks and sidewalk disrepair
- Chronic homelessness and the increase of individuals at risk for homelessness
- Access for rural populations to assets and services

ASSETS

- The presence of church groups in communities
- Local government's ability to solve problems
- Service organizations providing resources to communities
- Neighborhood associations connecting resources to communities
- Health service providers rendering care to vulnerable populations

The qualitative findings illustrate a difference of opinion in regard to the designation of strengths, weaknesses and assets among participants. This difference in categorization was also seen among the quantitative data and is most likely due to the difference in experience of county residents dependent on the area of the county in which they spend the most time. Despite the differences, there was some agreement across the results on significant community strengths, health-related issues and areas for improvement.

The information gathered through the CTSA process will inform the identification of key issues in Jefferson County communities and will lead to an action plan to improve health and quality of life in Jefferson County.

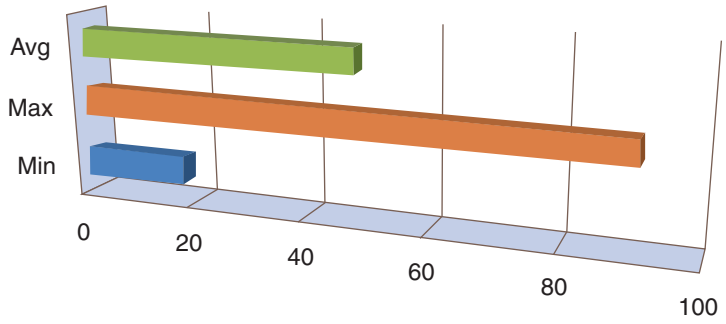
QUANTITATIVE RESULTS

The primary vehicle used to collect quantitative data from the community was the *Your Opinion Matters!* survey. A communication strategy promoted community-wide participation in the survey. The *Your Opinion Matters!* survey was available in English and Spanish at the website of Jefferson County Department of Health from April 7, 2014 through May 31, 2014. Additionally, many community partners shared the survey through business email distribution and via organizational websites. Paper surveys, also available in both languages, were distributed through the Jefferson County Department of Health Centers, community partners, community events, community meetings and informal gatherings. A total of 785 *Your Opinion Matters!* survey (107 paper and 678 online) responses were received, representing more than double the calculated sample size requirement of 384.

The demographic profile of the *Your Opinion Matters!* survey participants is shown in Figures 1- 6. The survey, targeted to adults, had respondents ranging from 18 to 91 years of age. Almost three-quarters (73.2%) of the surveys were completed by females; the percent of female county residents is 52.8%[ii]. Based on race, the survey captured data from a larger percentage of white residents at 67.3% than live in Jefferson County (51.1%[ii]). Black or African Americans, who represent 42.3%[ii] of Jefferson County's population, completed 27.4% of the surveys. Five percent of the survey respondents were individuals of other races, including Asian and American Indian, a percentage slightly higher than the 1.8%[i] of county residents in these race categories. By ethnicity, 4.6% of survey responses were generated from the Hispanic/Latino population which represent 3.9%[ii] of the county's population. The distribution of survey completion by individuals with a college degree or higher was substantially greater at 79.2% compared to 30.7%[ii] of the county with such degrees. Individuals with less than a high school education comprise 11.7%[ii] of the county's population, but represented only 2% of survey responders. The percentage of county residents without health care coverage is 12.4%[ii], whereas 6.1% of survey responders indicated they lacked health insurance. Of note, respondents could choose more than one insurance type on the survey. The profile of the survey respondents must be considered in the evaluation of the generalizability of the data as the demographics are not 100% representative of county residents.

FIGURE 1: AGE OF SURVEY RESPONDENTS

AGE OF SURVEY RESPONDENTS (N=698)



	Min	Max	Avg
Years	18	91	48

[i] Source: US Census Bureau, 2012 American Community Survey (1 yr Estimate)

[ii] Source: Community Health Status Assessment

FIGURE 2: GENDER OF SURVEY RESPONDENTS

GENDER OF SURVEY RESPONDENTS (N=709)

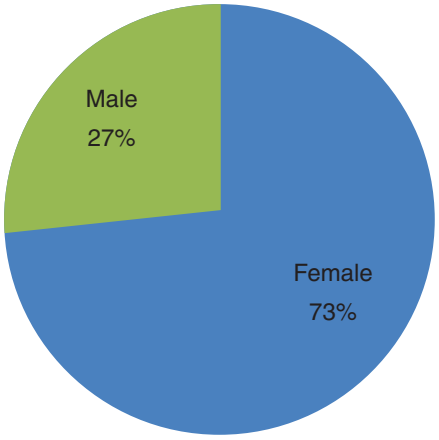


FIGURE 3: RACE OF SURVEY RESPONDENTS

RACE OF SURVEY RESPONDENTS (N=686)

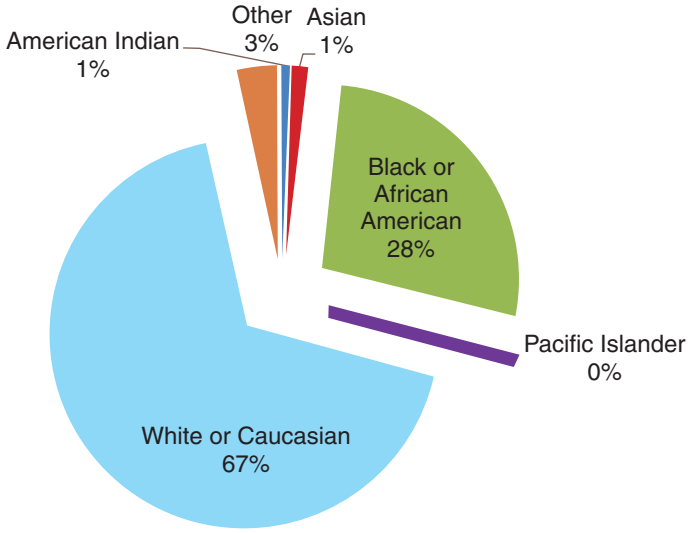


FIGURE 4: ETHNICITY OF SURVEY RESPONDENTS

ETHNICITY OF SURVEY RESPONDENTS (N=653)

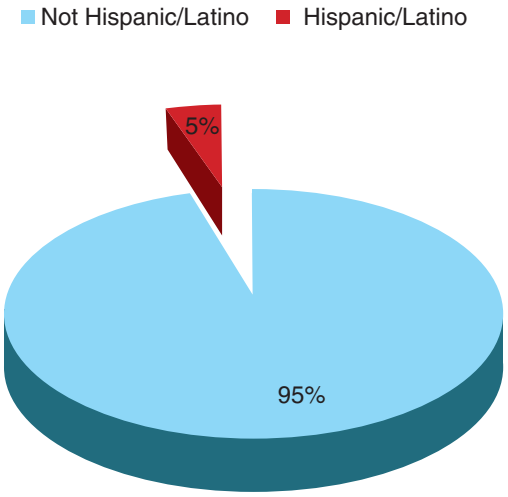


FIGURE 5: EDUCATIONAL ATTAINMENT OF SURVEY RESPONDENTS

EDUCATIONAL ATTAINMENT OF SURVEY RESPONDENTS (N=705)

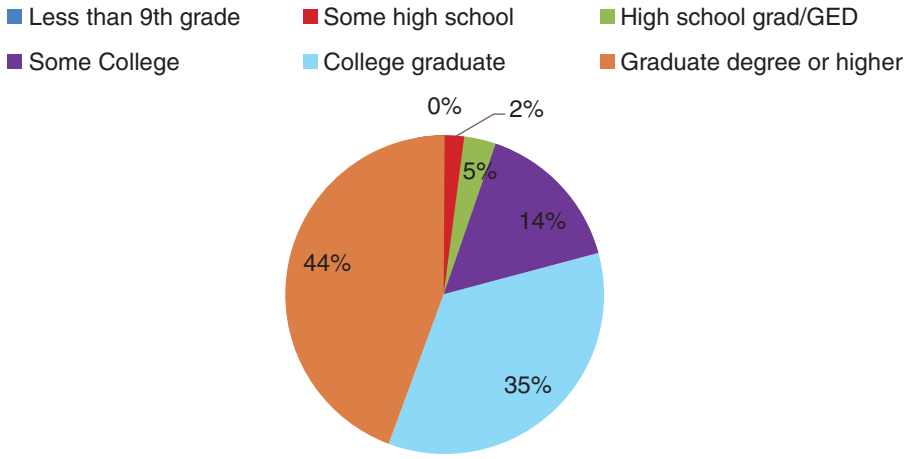
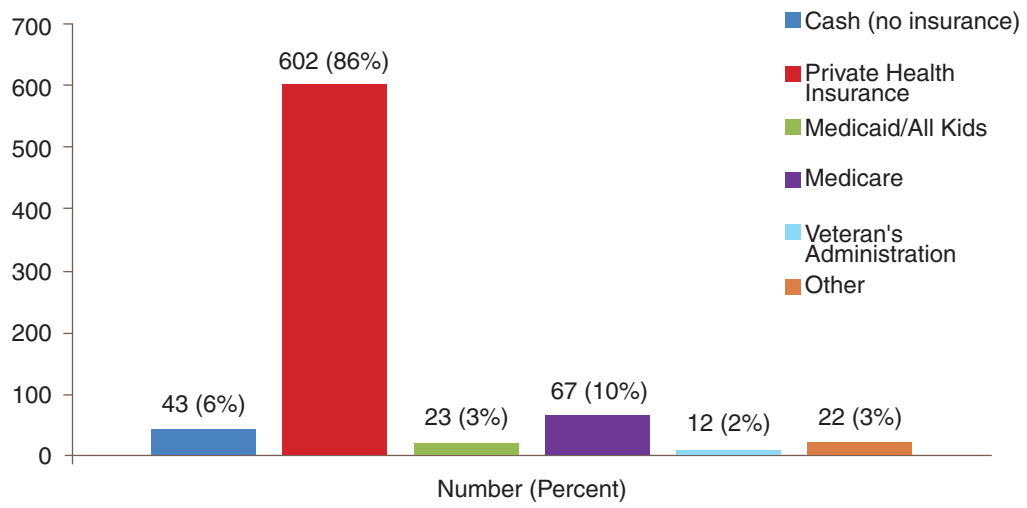


FIGURE 6: INSURANCE STATUS OF SURVEY RESPONDENTS

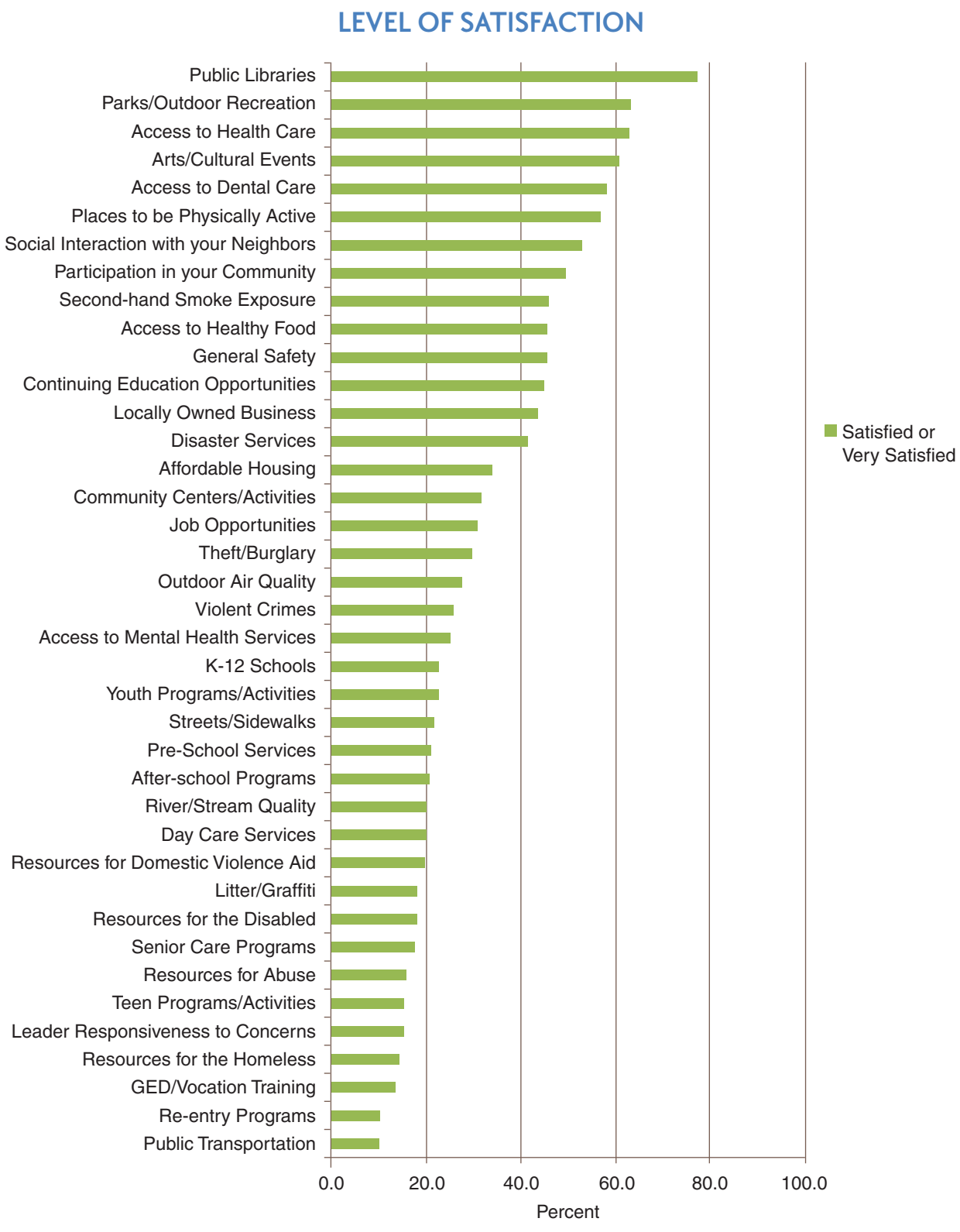


Survey respondents were asked to think about his or her community in Jefferson County and rank their satisfaction on a Likert scale with the current condition or presence of each item. The Likert scale ranged from 1 to 5, 1 represented very dissatisfied, 2 was dissatisfied, 3 was neutral, 4 was satisfied and 5 was very satisfied. Respondents were also asked to rank how important each item was to his or her quality of life. The scale for importance ranged from 1 to 3, 1 represented low importance, 2 was medium importance and 3 was high importance. Quality of life was defined as personal level of satisfaction with the combined conditions (e.g. safety, health and employment) in which one lives. Respondents were instructed that if they were unable to rate an item to leave it blank. The major strengths of the county, based on the survey data, are indicators that had an average score of 4, satisfied, or higher. The major strengths were public libraries, parks/outdoor recreation opportunities and arts and cultural events (see Figure 7).

FIGURE 7: QUALITY OF LIFE INDICATORS WITH AN AVERAGE SCORE OF 4 OR HIGHER

In addition to these strengths, the majority of survey respondents were also satisfied with access to health care, dental care and places to be physically active. It is important to note that 94% of respondents, however, had some form of health insurance. Figure 8 shows individual quality of life indicators and the total percentage of respondents who were satisfied or very satisfied with its current condition.

FIGURE 8: LEVEL OF SATISFACTION BY QUALITY OF LIFE INDICATOR



The major weaknesses of the county, based on the survey data, were considered those indicators that had an average score of 2, dissatisfied, or less (see Figure 9) and where among the top concerns highlighted in the question regarding conditions that are a problem for children in the community. The major weaknesses were streets and sidewalks, public transportation, litter and graffiti, responsiveness of leaders to community concerns, violent crime, resources for the homeless, performance of some school systems and substance abuse.

FIGURE 9: QUALITY OF LIFE INDICATORS WITH AN AVERAGE SCORE OF 2 OR LESS

Figure 10 shows individual quality of life indicators and the total percentage of respondents who were dissatisfied or very dissatisfied with its current condition. In addition to the previously named weaknesses, 50% of survey respondents were also dissatisfied with outdoor air quality. Figure 11 shows the combined magnitude of individual quality of life indicators. The percentage level of those very dissatisfied is stacked in combination with the percentage who felt the indicator was very important to quality of life. The issues that rose to the top with a combined percent over 90 were violent crimes, leaders responsive to community concerns, general safety, theft and burglary, outdoor air quality, K-12 schools, access to health care, job opportunities and access to healthy foods. While most respondents ranked access to health care, access to healthy food and general safety high in satisfaction, their absolute importance place them as a key indicator to community health.

FIGURE 10: LEVEL OF DISSATISFACTION BY QUALITY OF LIFE INDICATOR

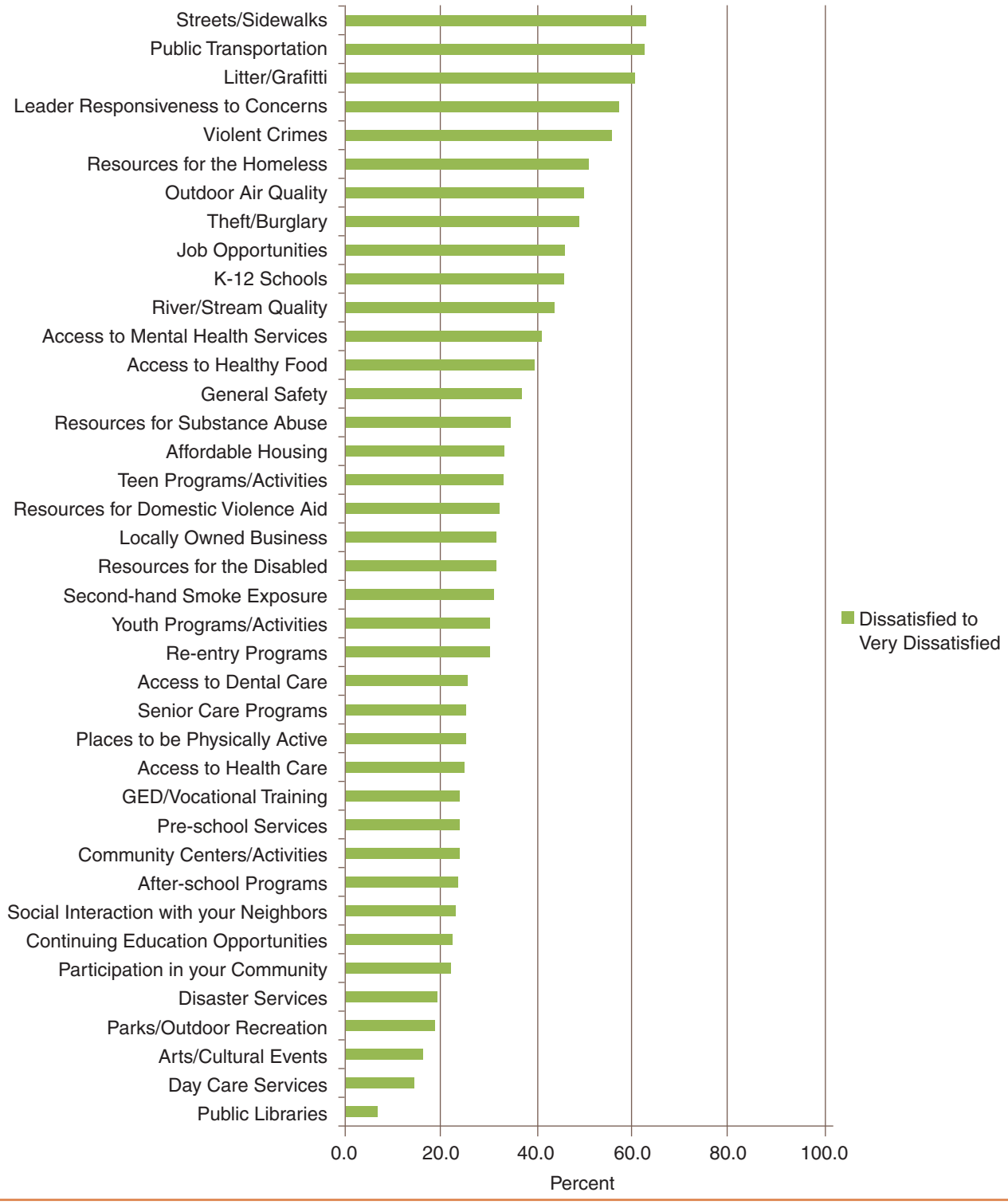
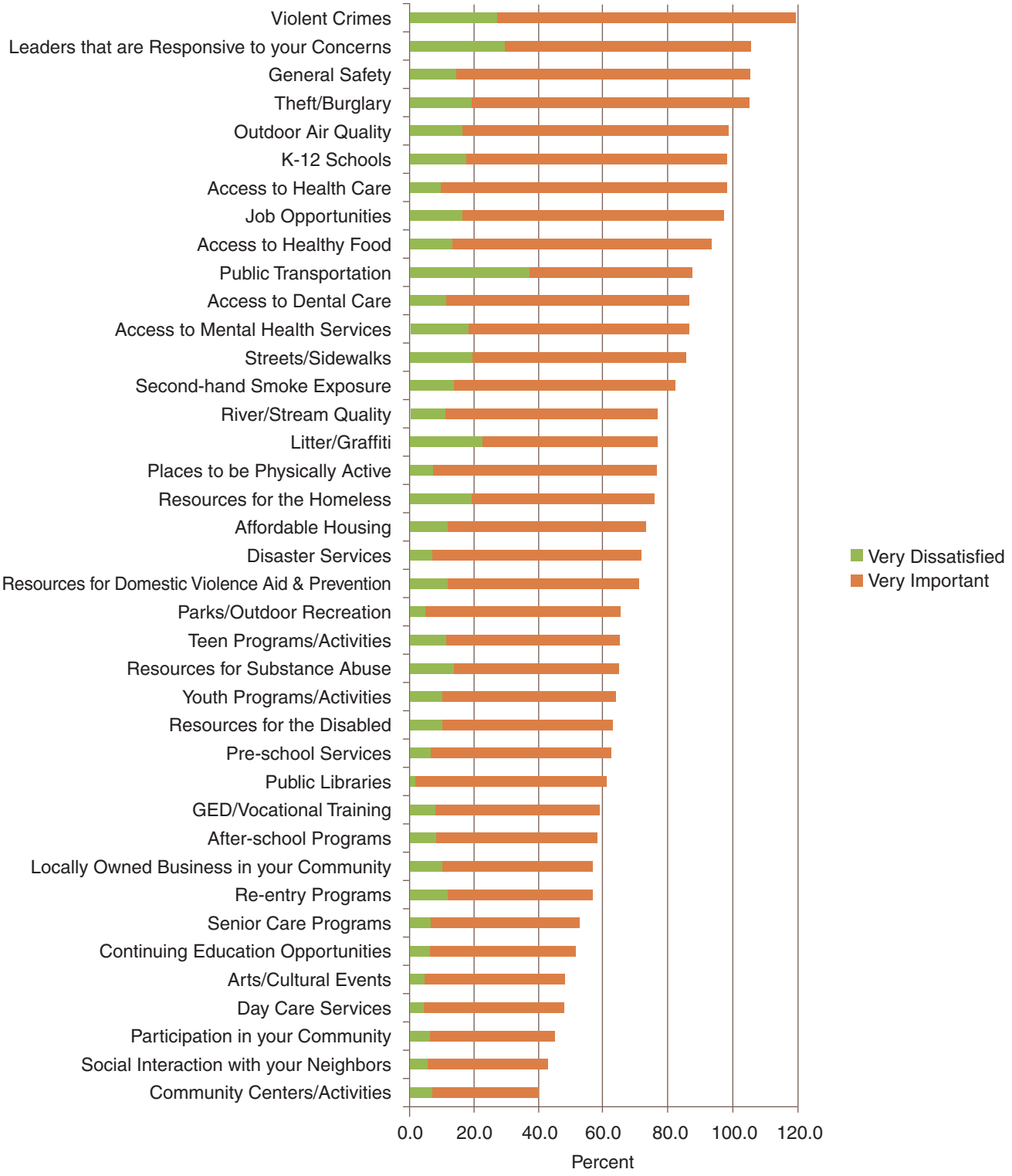


FIGURE 11: LEVEL OF DISSATISFACTION AND IMPORTANCE

VERY DISSATISFIED VS. VERY IMPORTANT



Tables 1 through 4 illustrate the top five indicators by respondent demographics. Table 1 shows the top five quality of life indicators for which the largest percent of respondents were dissatisfied to very dissatisfied by race and ethnicity. Race and ethnicity breakdown is provided for those categories that represented at least five percent of the survey respondents. The percentage of respondents who identified as Black or African American, selected violent crime as an indicator for which they were dissatisfied to very dissatisfied at 71.7%. The percent of respondents dissatisfied to very dissatisfied with litter/graffiti was 70.8%, streets/sidewalks at 67.2%, leaders that are responsive to concerns at 63.2% and job opportunities at 61.9%. The respondents who identified themselves as White or Caucasian were dissatisfied to very dissatisfied with public transportation at 68.8%, streets/sidewalks at 59.2%, litter/graffiti at 58.2%, leaders that are responsive to concerns at 53.9% and outdoor air quality at 50.8%. The respondents who identified themselves as Hispanic or Latino were dissatisfied to very dissatisfied with streets/sidewalks at 73.3%, violent crime at 70.4%, leaders that are responsive to concerns at 65.5%, theft/burglary at 55.2% and litter/graffiti at 50%.

TABLE 1: TOP FIVE INDICATORS WITH WHICH RESPONDENTS WERE DISSATISFIED BY RACE OR ETHNICITY

Black/African-American n=188	White/Caucasian n=462	Hispanic/Latino n=30
Violent Crime	Public Transportation	Streets/Sidewalks
Litter/Graffiti	Streets/Sidewalks	Violent Crime
Streets/Sidewalks	Litter/Graffiti	Leaders that are Responsive to Concerns
Leaders that are Responsive to Concerns	Leaders that are Responsive to Concerns	Theft/Burglary
Job Opportunities	Outdoor Air Quality	Litter/Graffiti

Table 2 shows the top 5 quality of life indicators for which the largest percent of respondents were dissatisfied to very dissatisfied by age. Age categories were constructed using psychologist Erick Erikson's stages of human development with a deviation between young adulthood and the middle adulthood cut off based on U.S. Census Bureau's middle age category start point. Therefore, quality of life indicators are presented for respondents 18 to 35, 36 to 64 and 65 and above. There is large agreement among life stage for which respondents were dissatisfied to very dissatisfied. The one nonconformity was with the age group 65 plus who ranked dissatisfaction with resources for the homeless in its top five instead of leaders that are responsive to concerns.

TABLE 2: TOP FIVE INDICATORS WITH WHICH RESPONDENTS WERE DISSATISFIED BY AGE

18 to 35 years n=171	36 to 64 years n=452	65 years and over n=76
Streets/Sidewalks	Litter/Graffiti	Litter/Graffiti
Public Transportation	Public Transportation	Resources for the Homeless
Leaders that are Responsive to Concerns	Streets/Sidewalks	Violent Crime
Litter/Graffiti	Leaders that are Responsive to Concerns	Streets/Sidewalks
Violent Crime	Violent Crime	Public Transportation

The respondents who reported ages of 18 to 35 were dissatisfied to very dissatisfied with streets/sidewalks at 66.7%, public transportation at 66.7%, leaders that are responsive to concerns at 58.6%, litter/graffiti at 55.9% and violent crime at 54.9%. The respondents who reported ages of 36 to 64 were dissatisfied to very dissatisfied with litter/graffiti at 62.3%, public transportation at 61.1%, streets/sidewalks at 60.5%, leaders that are responsive to concerns at 55.4% and violent crime at 53.5%. The respondents who reported ages of 65 and above were dissatisfied to very dissatisfied with litter/graffiti at 73.0%, resources for the homeless at 72.6%, violent crime at 68.6%, streets/sidewalks at 68.0% and public transportation at 63.5%.

Table 3 shows the top five quality of life indicators for which the largest percent of respondents were dissatisfied to very dissatisfied by gender. There was no statistical difference between the genders on the top five indicators; however, the percentage of

dissatisfaction varied. Females were dissatisfied to very dissatisfied with streets/sidewalks at 66.0%, public transportation at 61.0%, litter/graffiti at 60.7%, violent crime at 56.6% and leaders that are responsive to concerns at 54.5%. Males were dissatisfied to very dissatisfied with public transportation at 67.0%, leaders that are responsive to concerns at 64.6%, litter/graffiti at 63.6%, streets/sidewalks at 55.8% and violent crime at 53.6%.

TABLE 3: TOP FIVE INDICATORS WITH WHICH RESPONDENTS WERE DISSATISFIED BY GENDER

Female n=520	Male n=190
Streets/Sidewalks	Public Transportation
Public Transportation	Leaders that are Responsive to Concerns
Litter/Graffiti	Litter/Graffiti
Violent Crime	Streets/Sidewalks
Leaders that are Responsive to Concerns	Violent Crime

Table 4 shows the top five quality of life indicators for which the largest percent of respondents were dissatisfied to very dissatisfied by educational level attained. The respondents who reported less than a high school education were dissatisfied to very dissatisfied with violent crime at 77.8%, teen programs at 54.5%, litter/graffiti at 53.9%, social interaction with neighbors at 50.0% and parks/outdoor recreation at 50.0%. The respondents who reported a high school education or equivalent were dissatisfied to very dissatisfied with resources for the homeless at 71.9 %, litter/graffiti at 71.4%, violent crime at 70.6%, theft/burglary at 68.6%, and leaders that are responsive to concerns at 61.8%. The respondents who reported at least some college education were dissatisfied to very dissatisfied with public transportation at 64.7%, streets/sidewalks at 63.1%, litter/graffiti at 61.5%, leaders that are responsive to concerns at 57.4% and violent crime at 54.5%.

TABLE 4: TOP FIVE INDICATORS WITH WHICH RESPONDENTS WERE DISSATISFIED BY EDUCATION LEVEL

No High School Diploma/GED n=16	High School Graduate/GED n=35	Some College and Higher n=655
Violent Crime	Resources for the Homeless	Public Transportation
Teen Programs	Litter/Graffiti	Streets/Sidewalks
Litter/Graffiti	Violent Crime	Litter/Graffiti
Social Interaction with Neighbors	Theft/Burglary	Leaders that are Responsive to Concerns
Parks/Outdoor Recreation	Leaders that are Responsive to Concerns	Violent Crime

The survey also included general quality of life statements and questions. Respondents were asked to select a response from a 5-point Likert scale. The first statement, there are support networks in my community for people and their families during times of need, received an average answer selection of 3, a neutral response. Additionally, across the 704 responses for this statement, 43.8% were either satisfied or very satisfied. Figures 12-15 illustrate the difference in response based on reported race or ethnicity, age, gender and educational level attained.

FIGURE 12: THERE ARE SUPPORT NETWORKS IN MY COMMUNITY FOR PEOPLE AND THEIR FAMILIES DURING TIMES OF NEED BY RACE/ETHNICITY

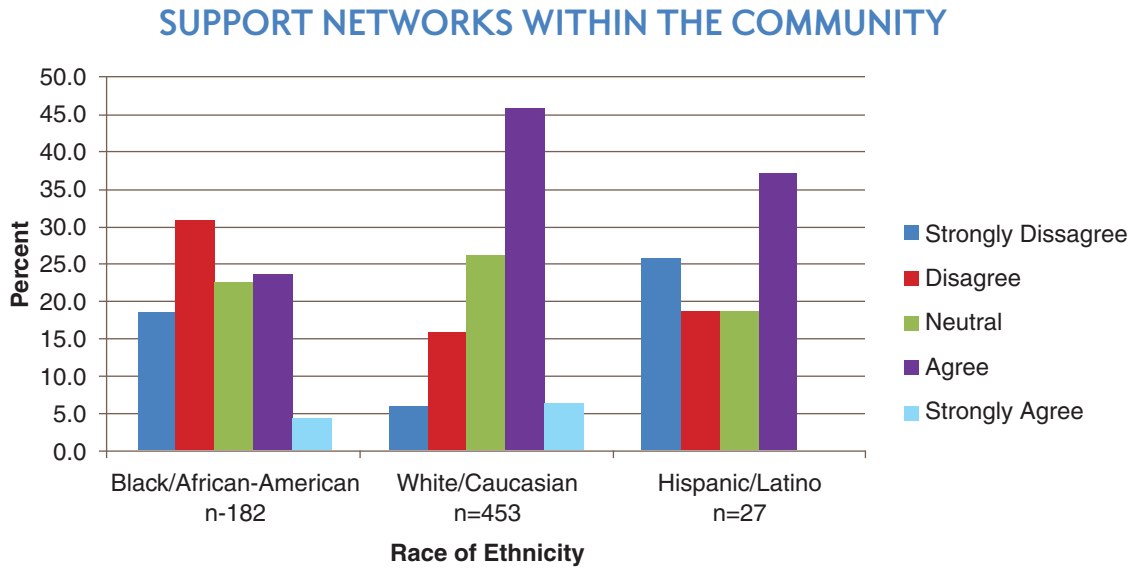


FIGURE 13: THERE ARE SUPPORT NETWORKS IN MY COMMUNITY FOR PEOPLE AND THEIR FAMILIES DURING TIMES OF NEED BY AGE CATEGORY

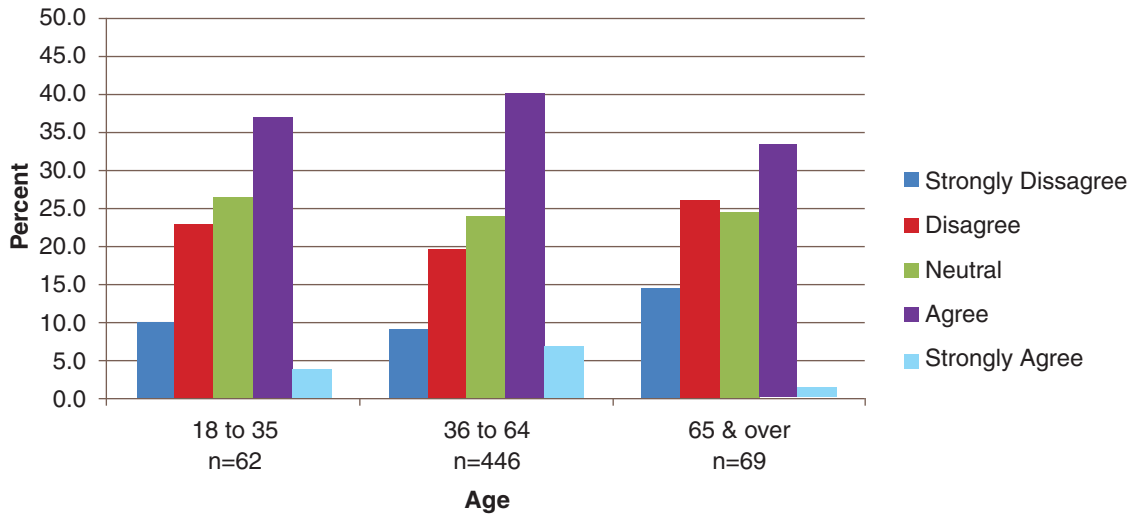


FIGURE 14: THERE ARE SUPPORT NETWORKS IN MY COMMUNITY FOR PEOPLE AND THEIR FAMILIES DURING TIMES OF NEED BY GENDER

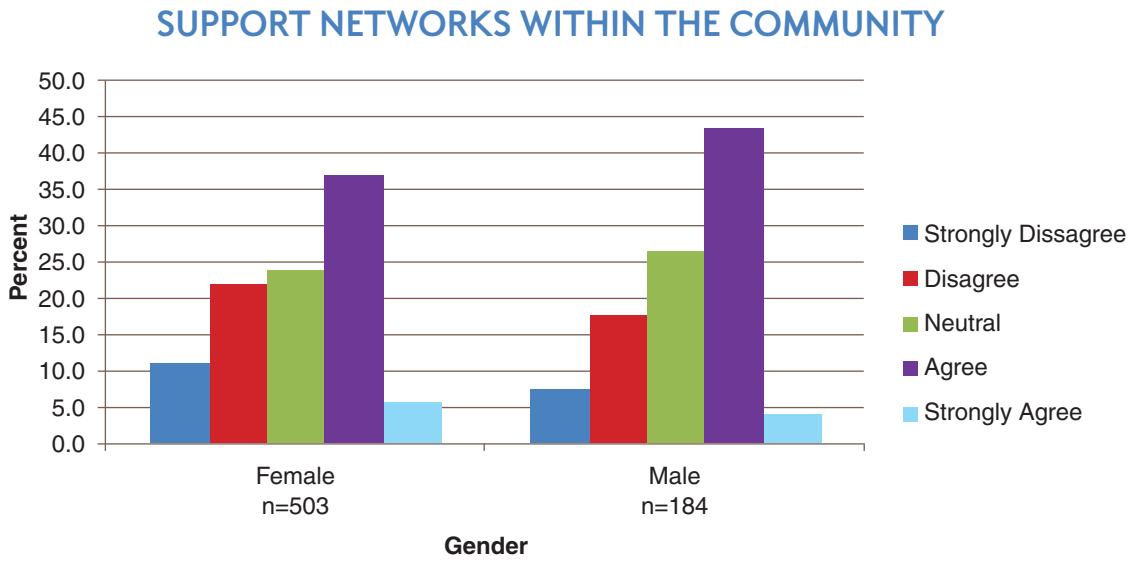
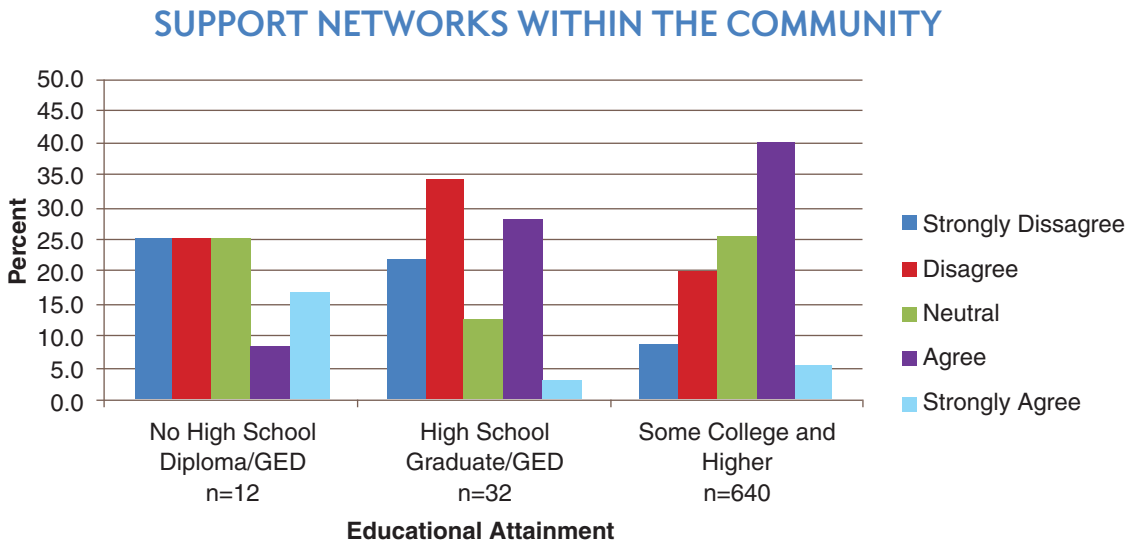


FIGURE 15: THERE ARE SUPPORT NETWORKS IN MY COMMUNITY FOR PEOPLE AND THEIR FAMILIES DURING TIMES OF NEED BY EDUCATION LEVEL



The second question was "how satisfied are you with the quality of life in your community?" The average answer selection was also neutral. Still, across 711 responses, 61.3% were either satisfied or very satisfied. Figures 16-19 illustrate the difference in response based on reported race or ethnicity, age, gender and educational level attained.

FIGURE 16: SATISFACTION WITH THE QUALITY OF LIFE IN YOUR COMMUNITY BY RACE/ETHNICITY

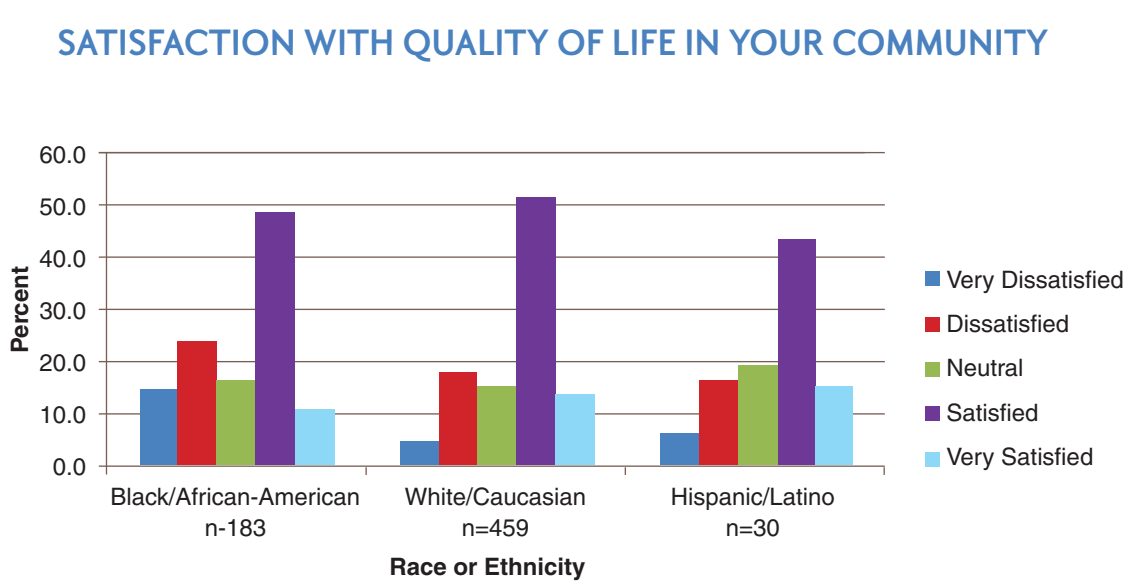


FIGURE 17: SATISFACTION WITH THE QUALITY OF LIFE IN YOUR COMMUNITY BY AGE CATEGORY

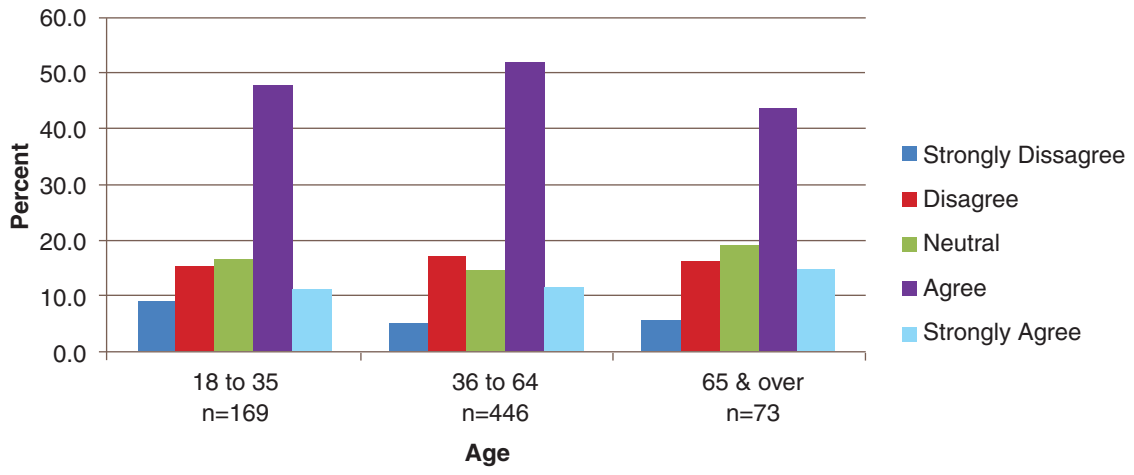


FIGURE 18: SATISFACTION WITH THE QUALITY OF LIFE IN YOUR COMMUNITY BY GENDER

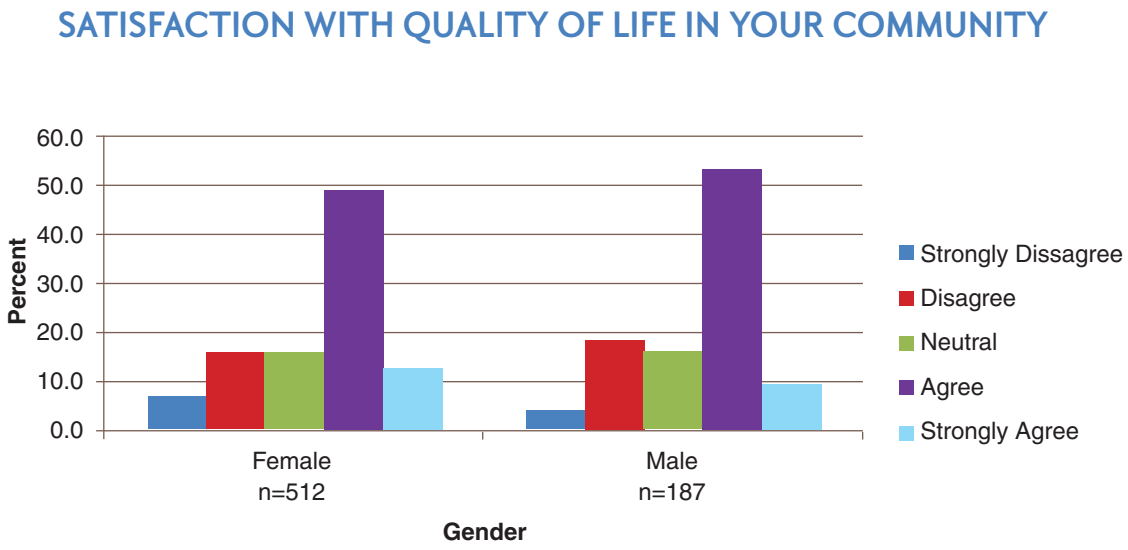
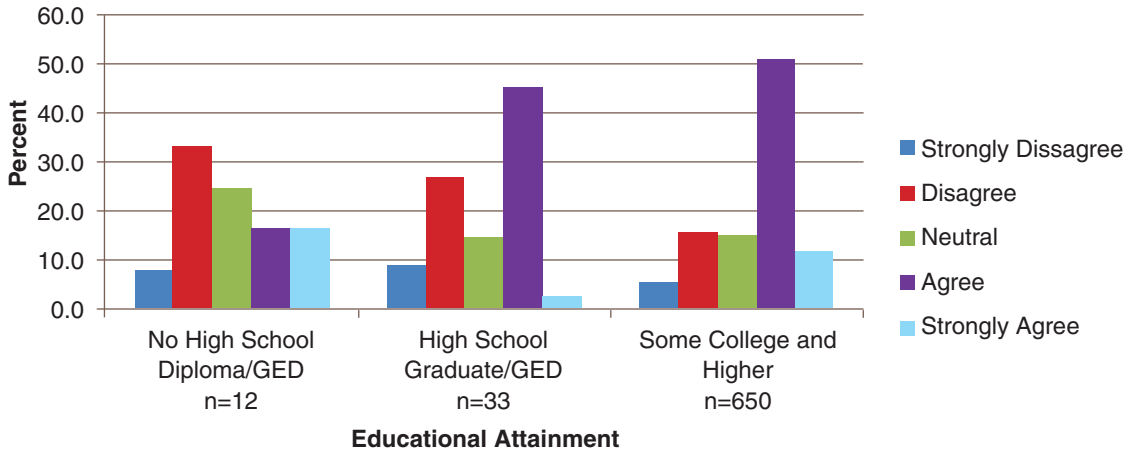


FIGURE 19: SATISFACTION WITH THE QUALITY OF LIFE IN YOUR COMMUNITY BY EDUCATION LEVEL



The third question was "how would you rate your community as a place to raise children?" The average answer selection was neutral, and 54.7 percent were either satisfied or very satisfied. Figures 20-23 illustrate the difference in response based on reported race or ethnicity, age, gender and educational level attained.

FIGURE 20: YOUR COMMUNITY AS A PLACE TO RAISE CHILDREN BY RACE/ETHNICITY

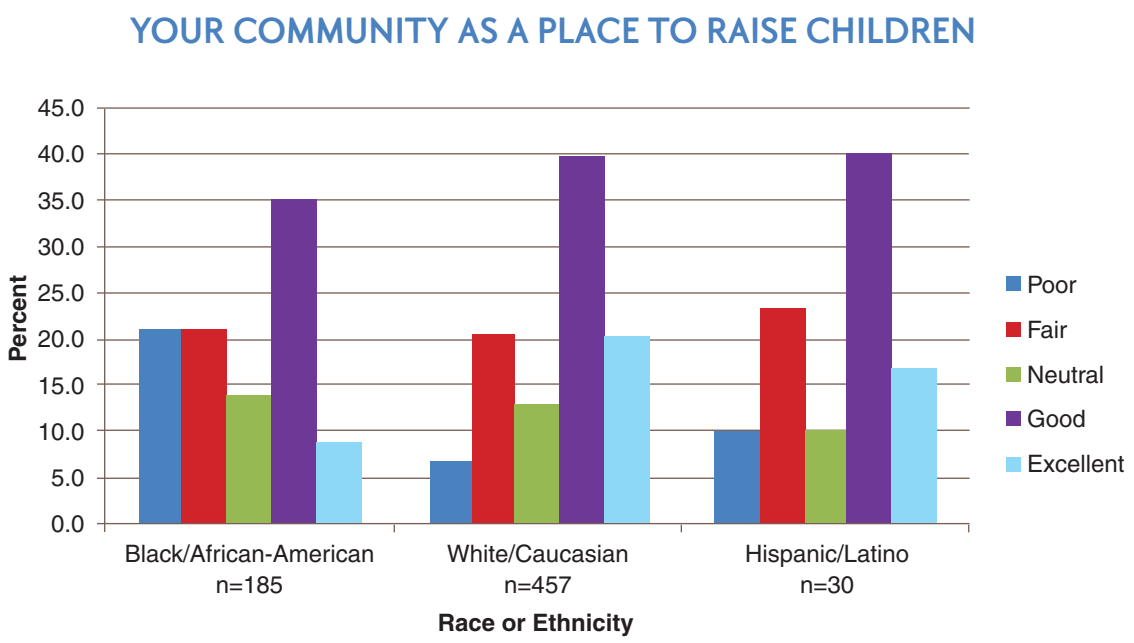


FIGURE 21: YOUR COMMUNITY AS A PLACE TO RAISE CHILDREN BY AGE CATEGORY

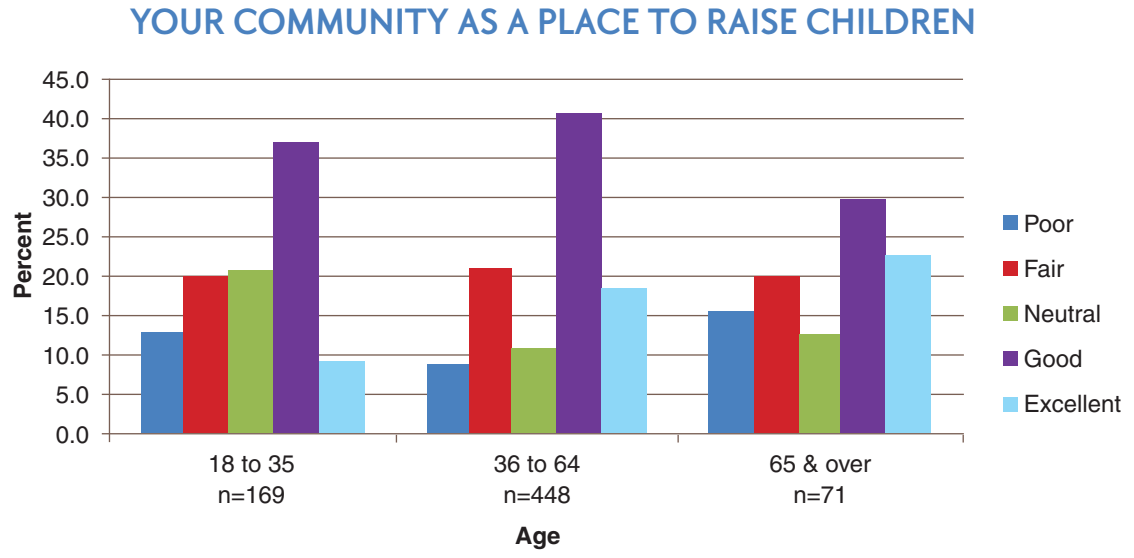


FIGURE 22: YOUR COMMUNITY AS A PLACE TO RAISE CHILDREN BY GENDER

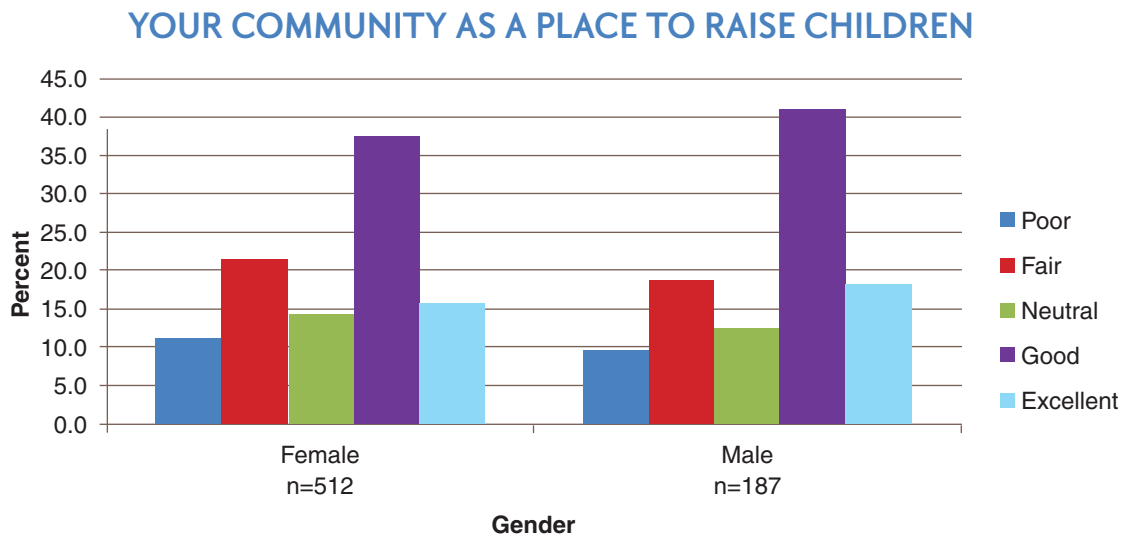
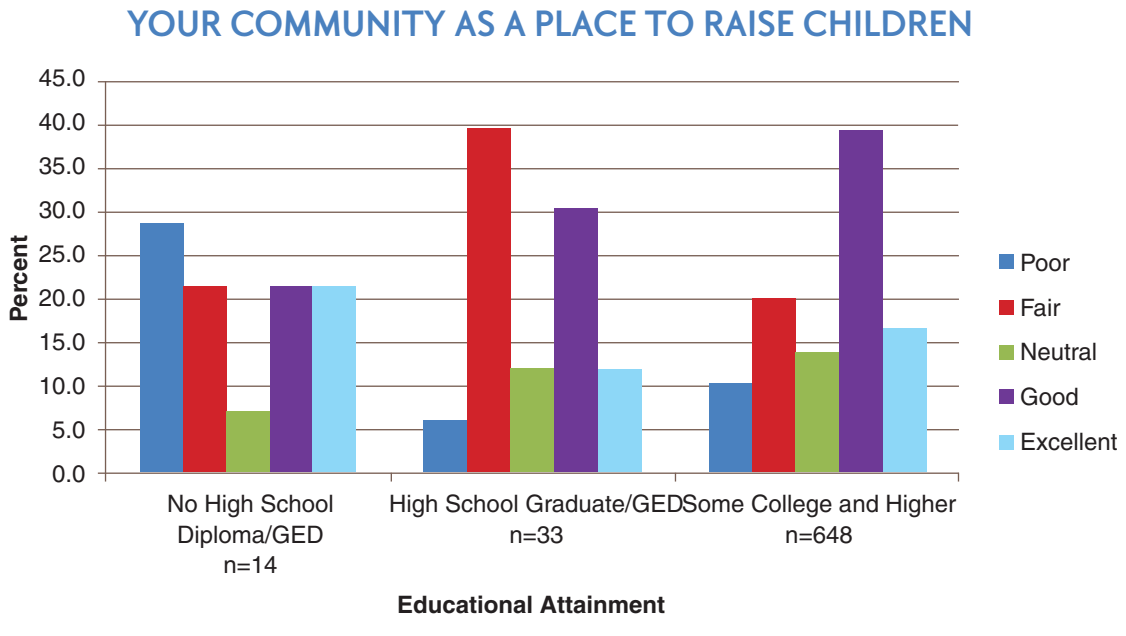


FIGURE 23: YOUR COMMUNITY AS A PLACE TO RAISE CHILDREN BY EDUCATION LEVEL



The fourth question was "how would you rate your community as a place to grow old?" The average answer selection was neutral, and 50.1 percent of respondents were either satisfied or very satisfied. Figures 24-27 illustrates the difference in response based on reported race or ethnicity, age, gender and educational level attained.

FIGURE 24: YOUR COMMUNITY AS A PLACE TO GROW OLD BY RACE/ETHNICITY

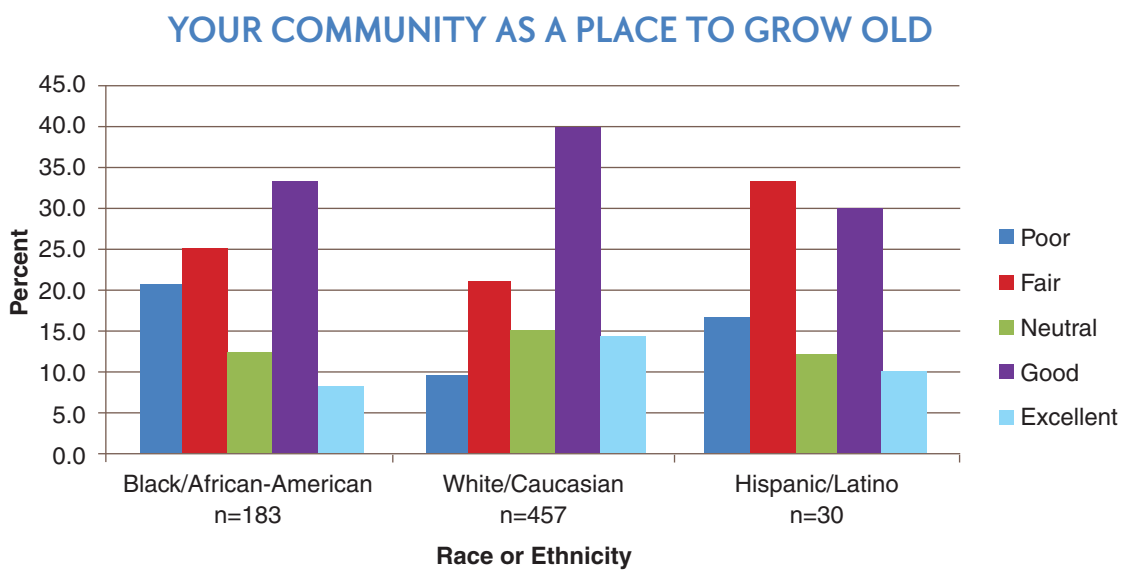


FIGURE 25: YOUR COMMUNITY AS A PLACE TO GROW OLD BY AGE CATEGORY

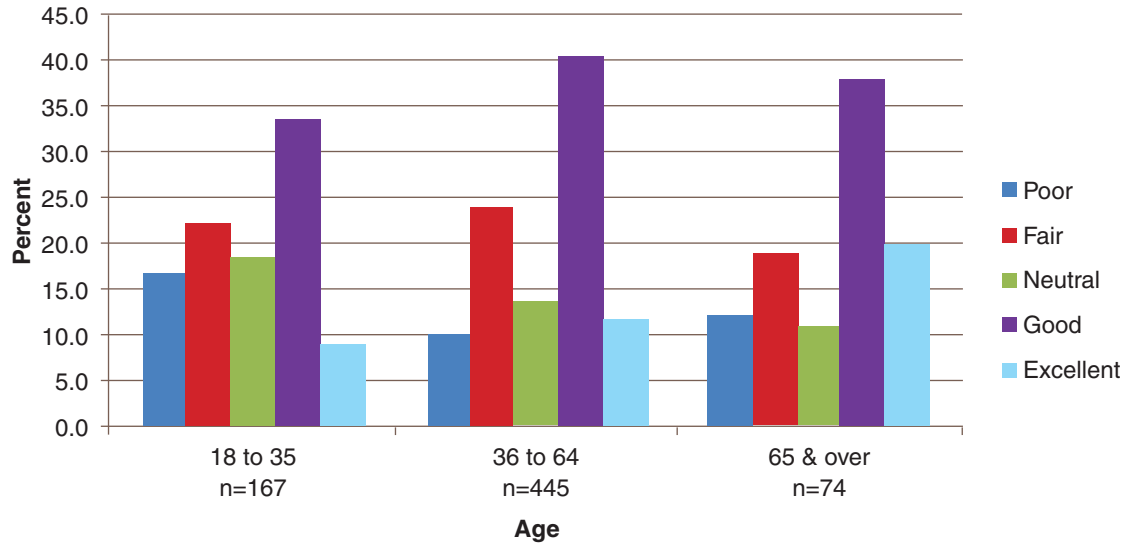


FIGURE 26: YOUR COMMUNITY AS A PLACE TO GROW OLD BY GENDER

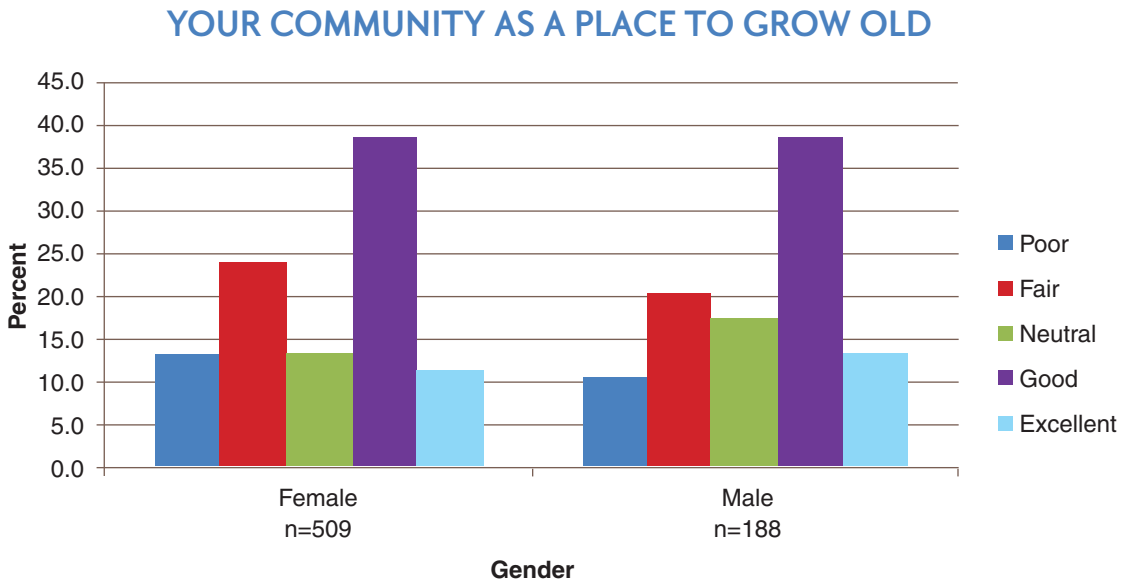
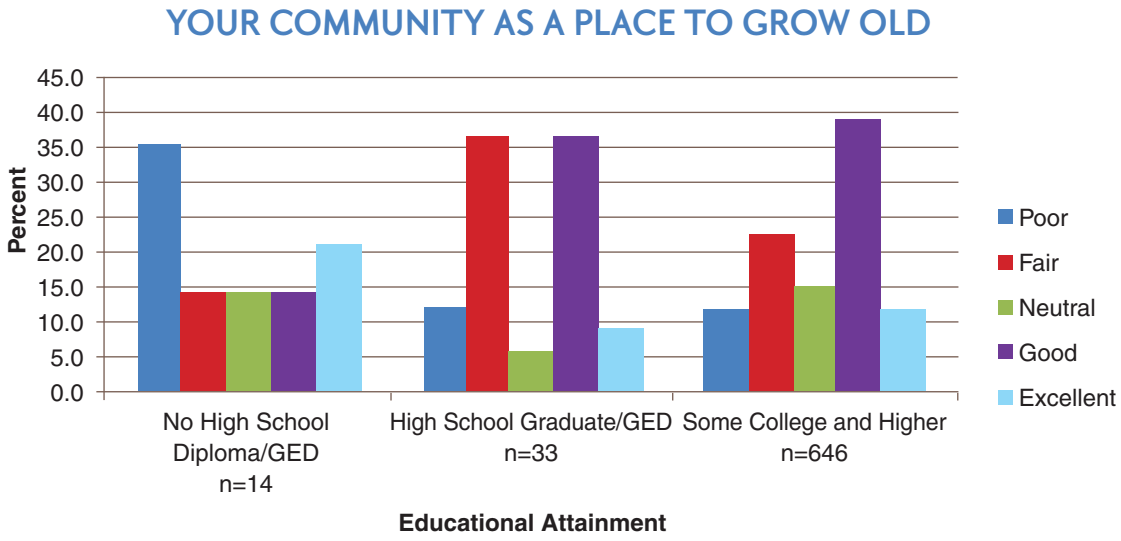


FIGURE 27: YOUR COMMUNITY AS A PLACE TO GROW OLD BY EDUCATION LEVEL



The fifth question was "how would you rate your own personal health?" The average answer selection was satisfied, and 78.2 percent of respondents were either satisfied or very satisfied. Figures 28-31 illustrate the difference in response based on reported race or ethnicity, age, gender and educational level attained.

FIGURE 28: YOUR OWN PERSONAL HEALTH BY RACE/ETHNICITY

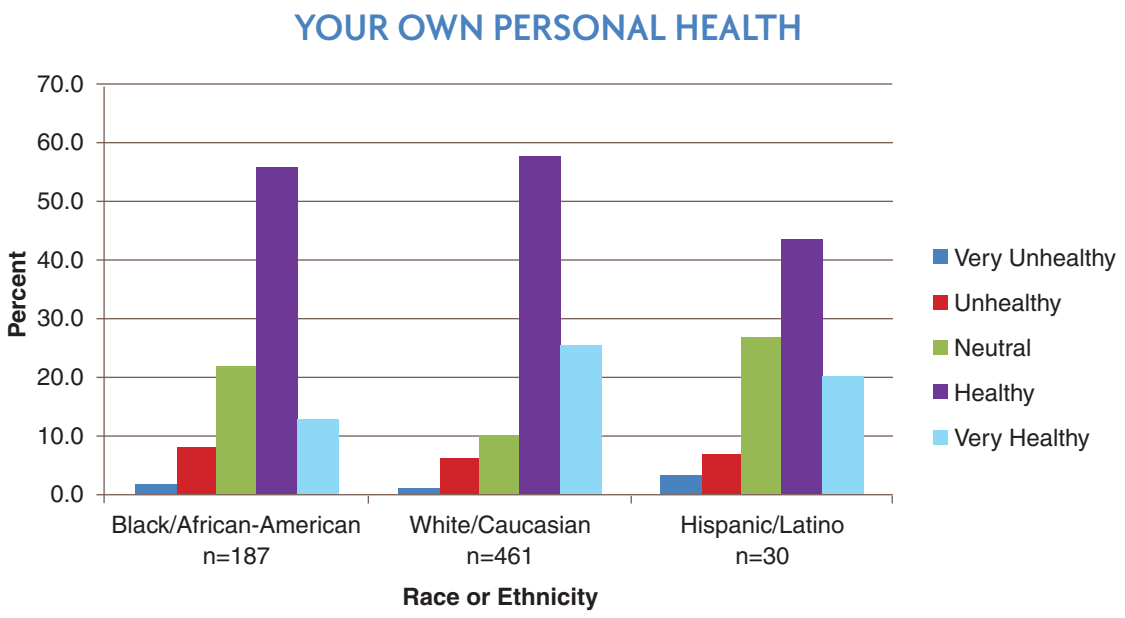


FIGURE 29: YOUR OWN PERSONAL HEALTH BY AGE CATEGORY

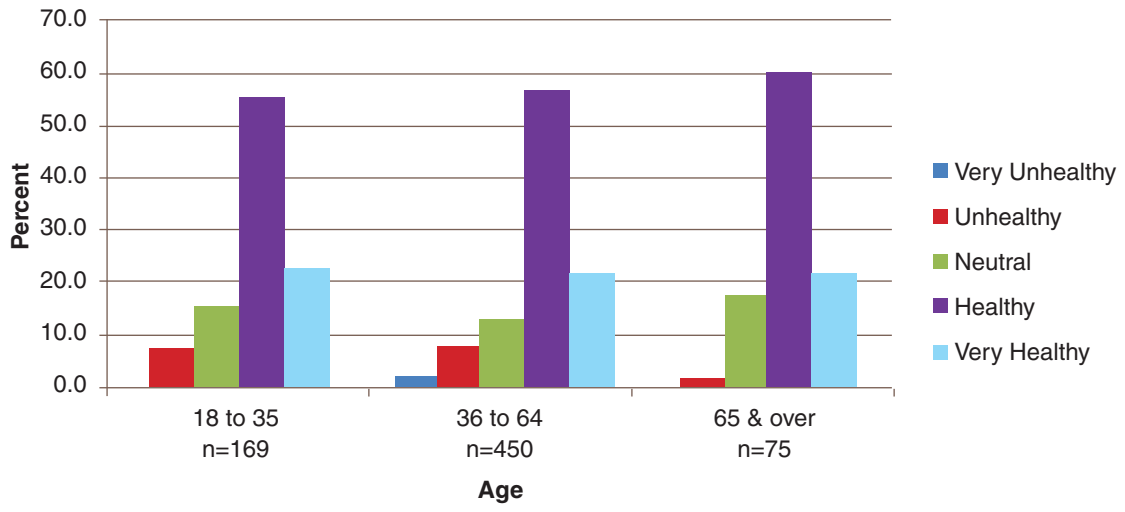


FIGURE 30: YOUR OWN PERSONAL HEALTH BY GENDER

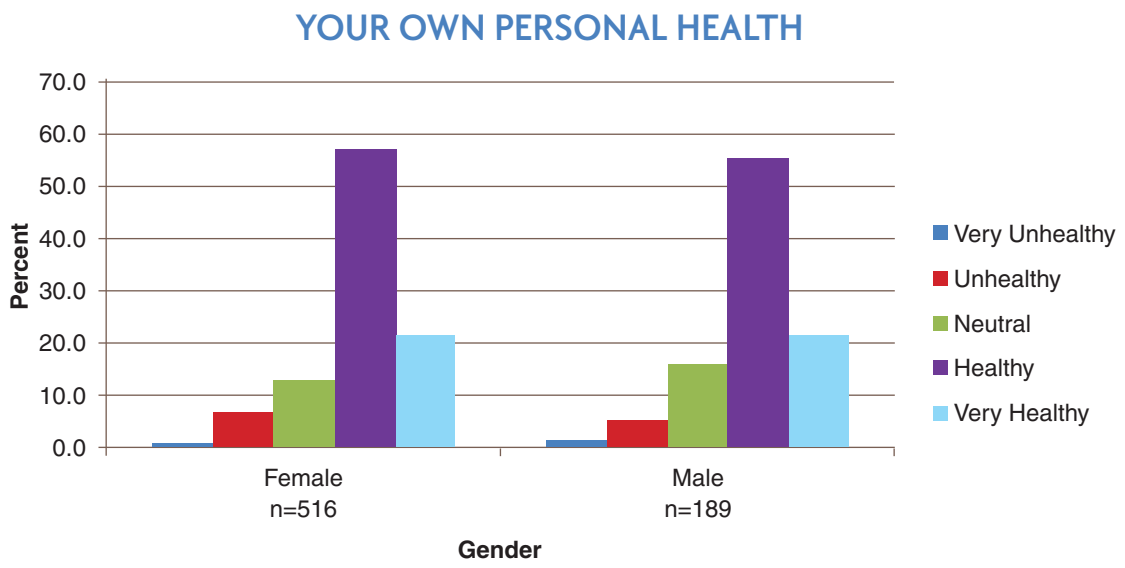
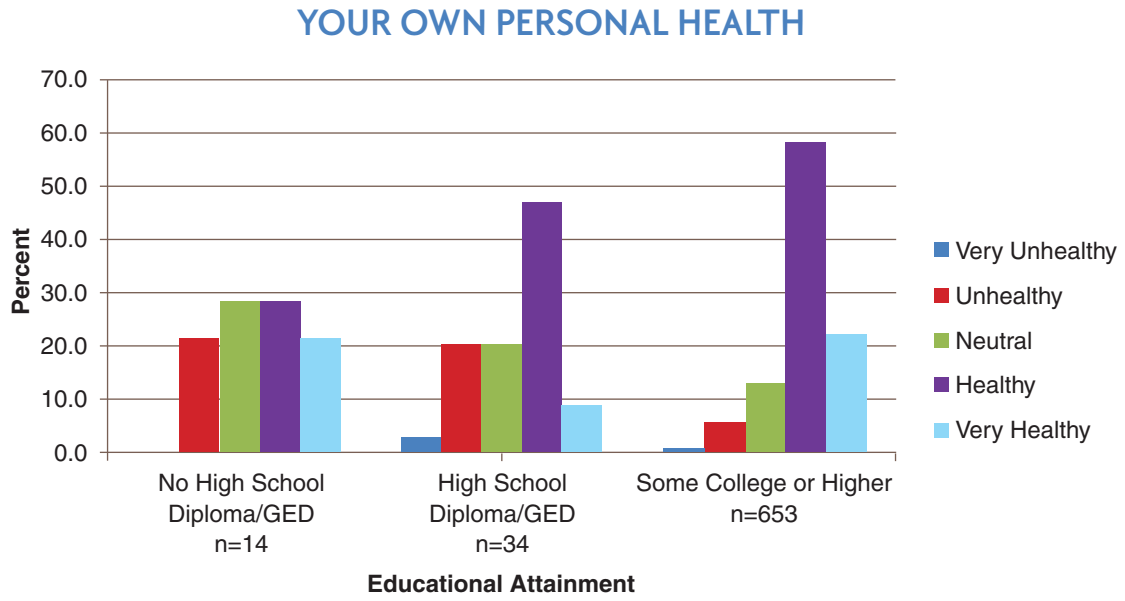


FIGURE 31: YOUR OWN PERSONAL HEALTH BY EDUCATION LEVEL



The sixth statement allowed respondents to select multiple issues perceived as problems for children in the community. Eighty percent of respondents identified obesity as a problem for children. Emotional and/or behavioral problems were indicated by 66%. In addition, drug and/or alcohol abuse was selected by 60%, asthma by 58%, diabetes by 42% and injury by 21%. Respondents also provided additional conditions in a free text field. The top conditions that were most frequently provided via the free text field were lack of quality education, poor parenting (structure or guidance), crime, hunger, poverty, air pollution and allergies.

DISCUSSION

The quantitative data from the survey revealed points of pride for those who live, work, study or play in Jefferson County such as public libraries, arts and cultural events and area parks and outdoor recreation. There were also a number or opportunities cited for improvement in Jefferson County communities. These include streets and sidewalks, public transportation, litter/graffiti, crime, leader's responsiveness to concerns and resources for the homeless.

It is important to note that the top five quality of life indicators in which participants indicated dissatisfaction had a large amount of agreement within demographic categories. However, there were a few variances particularly among race or ethnicity, age category and education level. In addition, the quality of life questions reveal dissimilarity in response most clearly among respondents without a high school diploma or equivalent; however, the sample size for this population was small. This finding does signal that there is a perception that the strengths and weaknesses are not shared equally among county residents.

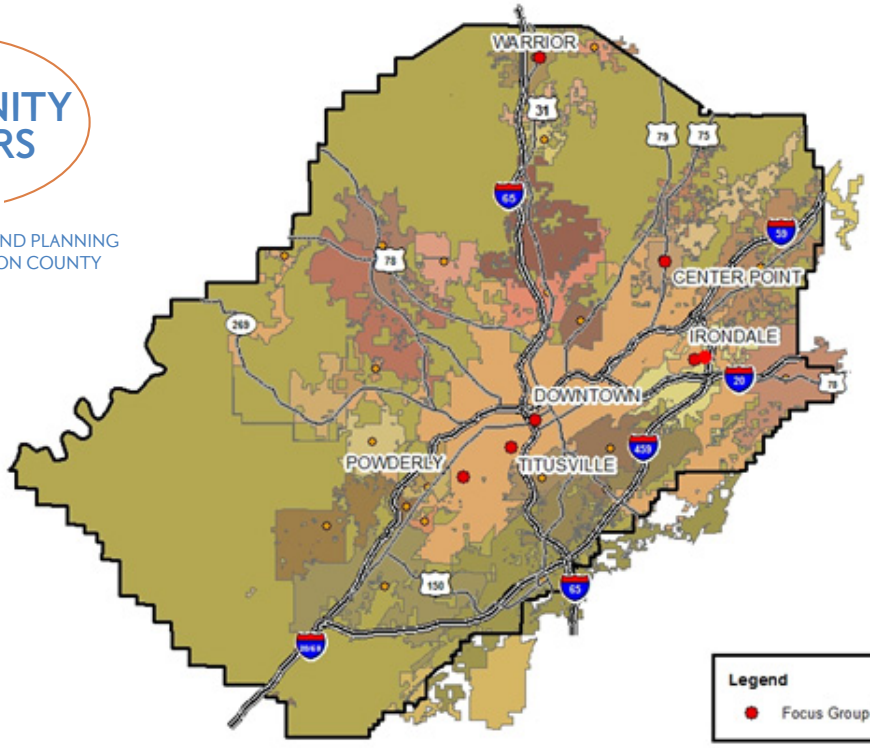
QUALITATIVE RESULTS

As part of the county-wide community health improvement process the, CTSA Sub-committee conducted seven focus groups during the month of May 2014 as the primary vehicle to collect qualitative data from the community. The focus groups were informal, structured sessions where participants were asked to share their thoughts on specific issues introduced by a facilitator. These focus groups were conducted to obtain more detailed information about resident perceptions of quality of life, including the assets, strengths and weaknesses of Jefferson County communities.

The Sub-committee collaborated with community leaders to organize focus groups throughout Jefferson County. Members of the CTSA Sub-committee developed a structured questionnaire for use by a facilitator at focus group sessions. Participants were informed prior to the commencement of the focus group that results would be reported in a way to protect confidentiality. Each focus group was recorded and transcribed to ensure accuracy of information. A note taker attended sessions to record field notes and observations which provided additional descriptive information. The focus groups were conducted in urban (Birmingham – Powderly, Titusville, Downtown), suburban (Center Point, Irondale) and rural (Warrior) locations within the county and included two groups which focused on Spanish-speaking residents and one with the homeless population. Figure 32 shows the locations where focus groups were conducted. In total, 58 individuals provided qualitative data regarding their experience of living in Jefferson County. The demographics of participants are as follows: 74.1% female, 25.9% male; 63.8% Black or African American, 19% White or Caucasian, and 17.2% Hispanic or Latino. The profile of the focus group participants must be considered in the evaluation of the generalizability of the data as the demographics are not 100% representative of county residents.

FIGURE 32: FOCUS GROUP LOCATIONS

COMMUNITY MATTERS 20/20
ASSESSMENT, VISIONING AND PLANNING FOR A HEALTHY JEFFERSON COUNTY

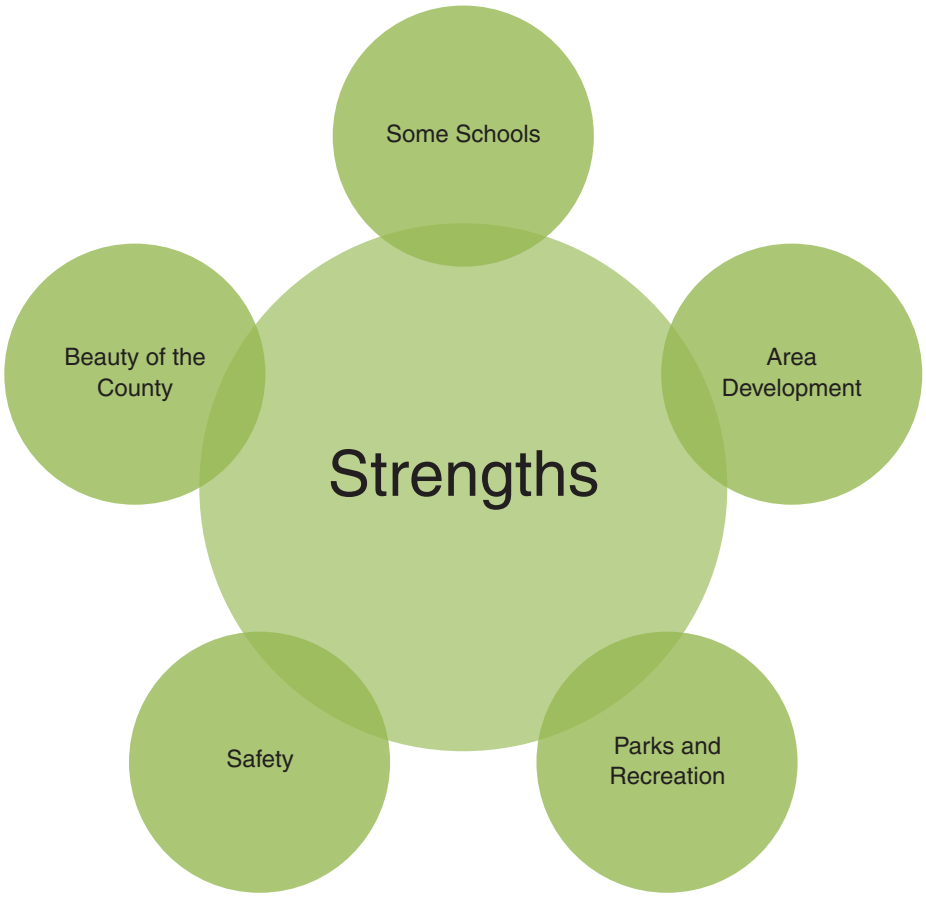


Prepared by Jefferson County Department of Health
Division of Quality Improvement and Decision Support

The procedure for qualitative data analysis included data from the seven focus groups and open-ended comments from the *Your Opinion Matters!* survey. Qualitative analysis was provided by a doctoral level student from the University of Alabama at Birmingham School of Public Health's Health Care Organization and Policy department. The qualitative software package, NVivo 10, was used to code and classify observations into three major themes: assets, strengths and weaknesses. Minor themes were then derived from the groups of similar observations within those major themes. Quotations regarding each theme were compiled and evaluated to identify common themes and variant views. In interpreting this data, please note that a theme was coded as a strength if it was described in a positive manner. A theme was coded as a weakness if it was described in a negative manner. Assets were those themes that participants described as current resources in their community that could be used to improve conditions and the health of the County. There were a total of 46 themes identified in the data. Strengths were associated with 29 of the 46 themes, weaknesses with 45 of the 46 and assets with 25 of the 46 themes. A full table of themes is available in Appendix E.

In the focus group and survey comments themes were referred to as strengths ranging from one to nine times. The themes that were referred to positively at least five times were highlighted and analyzed further (see Figure 33).

FIGURE 33: THEMES INDICATED AS STRENGTHS OF THE COUNTY



Educational excellence in some school systems was mentioned nine times across five focus groups. A Center Point focus group participant stated, "The school structure has improved." An Irondale resident shared, "I also think that [Irondale] has good schools. The school gives the opportunity to the children to participate [in] different programs such as sports [and] music." A Birmingham resident offered the strength and weakness in school systems, "We have good schools. We don't have that many, but I shouldn't say that. But anyway, we have pretty good schools." Some participants also mentioned the caliber of higher education institutions such as "Alabama and Auburn" for attracting businesses to Jefferson County.

Revitalization of Birmingham's downtown and other communities was a theme that was positively recorded in the focus group transcripts six times. This occurred across three focus groups. A resident from Fultondale said, "They throw up a community or home area and here comes the section for your grocery stores, your Walmart, your Target. I mean it's amazing just in the past five to ten years." Another resident shared, "They built Railroad Park up and the ball field. It brought a little bit [of revitalization] into [this area]." Two Birmingham residents thought that, "Birmingham is building up; they are building lofts. They are going to have venues at the bottom of the Smith and Gaston Building," and "I would encourage a new person to move into Jefferson County, the City of Birmingham or any area in Jefferson County because of the conveniences… whether you are young, middle [aged] or elderly because now they're doing condominiums in all the different areas; eastern area, the southwest area for anybody, the young or the elderly. It's more convenient in the last 20 years than it has been."

The availability and expansion of parks and recreational spaces was mentioned five times in survey comments and three focus groups. A Birmingham resident shared, "We have parks, and we have some beautiful parks, and the city is kept up." Another said, "A new park [was] built last year. It's a beautiful park, and it's equipped for children." When asked what was different about their community compared to five years ago a Center Point participant mentioned the addition of parks. A comment from the survey stated the respondent was "very happy about the addition of new green space, parks, walking paths & trails, community urban gardens and bike lanes" but indicated that there is still room for improvement.

A general feeling of physical safety was also mentioned five times in survey comments and four focus groups. An Irondale resident stated that, "[Jefferson County] is a safe county…It is also a good place to work and develop." A Warrior resident stated, "I always feel pretty safe in Warrior," with agreement from the rest of the focus group's participants. A Birmingham resident offered both a strength and weakness sharing, "I would say some of the neighborhoods are nice and safe and some are not." Another Birmingham resident pointed out, "We are a low crime area, but because we are in the southwest area, we get blamed in Riley. There is very little to no crime. You can leave the door opened in Riley if you wanted to, but we have become so accustomed to locking doors and things. We see police patrol."

The beauty of the county was mentioned five times as well. This theme ran across three focus groups. A Birmingham resident said, "…the Magic City is a beautiful place to move and to live." Birmingham residents also commented on the beauty of recently built parks. A Mount Olive resident shared the following statement about his part of county, "It's a beautiful area."

In the focus group and survey comments themes were referred to as weaknesses ranging from one to 22 times. The themes that were referred to negatively at least ten times were highlighted and analyzed further (see Figure 34).

FIGURE 34: THEMES INDICATED AS WEAKNESSES OF THE COUNTY

The issue of access to healthy and affordable food was a theme that was mentioned 22 times across six focus groups and survey comments. A West End resident stated, "I see our neighborhood as a food desert area. And we've got some lots that I could see vegetables growing [on]." A Warrior participant said, "It just makes me mad that we can get a Dunkin Donuts and Taco Bell… but we can't get a vegetable stand. No wonder children have weight issues." Participants also linked the issue of food affordability with poor health outcomes, as noted in these statements: "And diabetes is coming earlier and heart disease because vegetables are so high," and "If I buy these [vegetables], I spend 50 dollars, [so] I'm going to get a TV dinner and spend 10 [dollars]." A Center Point participant shared, "I can always go back to the community with agriculture and getting fresh foods. Someone has to teach people how to use them, if they've never had them before." When a resident was asked what the most important issue was to address, she stated, "I would say health issues with obesity and the food." A few survey comments also highlighted the issue through, "More access to health eating options," "Eliminate food deserts in the Roebuck area," and "A grocery/drugstore downtown would be great."

Health service access was referred to as a weakness 20 times in the data. This was the case across five focus groups and survey comments. A Center Point participant pointed out, "Yes, there is a health care issue. Cooper Green is gone and that, for some people, was a major blow to getting medical treatment, and yes, they are putting up [an] American Family Care Center, this and that. I don't care how sick you get; you better have some insurance or some money. I had an insurance card, and they still wouldn't take my co-pay." A Birmingham resident offered, "The health issue that never seems to come up in the discussions, but it isn't really dealt with at all, is dental." Another Birmingham resident shared that people need to have somewhere to go to receive mental health services, including the homeless population. An Irondale resident shared, "There are persons that do not go to the doctor or decide not to. The main reason or the most important one is the cost of the visit and the medicine, and sometimes the appointments are given way in the future." Survey comments provided the following observations, "Need to improve medical and behavioral health access for [the] indigent," "School age children need more mental health services" and "There needs to be more local infrastructure for adolescent mental health."

Crime and violence was also mentioned as a weakness 20 times. It spanned across four focus groups and survey comments. When a Five Points West resident was asked the number one issue that should be addressed, he or she answered, "Illegal activity in my area. The illegal drug activity definitely." An Irondale resident was concerned about burglaries in her community, "There have been many burglaries. This month alone there have been 20, 30." A Center Point participant stated that "Violence is everywhere" in this community. A survey commenter shared, "Jefferson County has become a less desirable place to live in the 44 years I have lived here. Violence is increasing, and the county and state governments are worthless." Another commenter expressed, "There's so much violence that it's an uphill battle to say the least. Drugs, gangs and too much time on their hands create huge issues for people, especially young people, in our city."

The local government was cited as a weakness 18 times in focus group and survey comments. A Birmingham resident made this observation, "…When they [are] running for office, they put their signs everywhere. They come to your meetings; but, when they get in office, that's the end of it." Residents across the county shared, "Elected officials don't spend time on their off time coming out [to] areas like Pinson and having sessions to listen [to] the residents. This is a big concern for me. Once elected, where are they?" "One of many primary problems is that the leaders do a lousy job of interacting with the citizens. Even worse, failing to explain, to some extent, decisions that personally affect them (i.e. health and financial matters)." "Jefferson County Commissioners have no interest in their constituents. Their only concern is lining their own pockets" and "It is a shame that a city this populated hasn't got more going for it. It must be due to the poor leadership over the years. It is sad that our city has such blight."

Substance abuse was ranked on the list with 18 mentions in three focus groups and survey comments. A Birmingham resident thought that the county needs "more mental health and substance abuse intervention to prevent homelessness." An Irondale resident stated that help is needed for youth that are using drugs. Survey commenters shared, "My community was once a thriving progressing community. In the last 25 years, the rate of drug and alcohol abuse, single parent families and emotional problems has gone up significantly" and "[There are]too many teen suicides in Mountain Brook. Access to drugs and alcohol is too easy for our teens." Another commenter noted "the growing heroin problem" as an issue in the county.

Four focus groups and survey comments cited safety as a concern 16 times. An Irondale resident shared, "There are not many good things we can tell due to the lack of safety right now. There is no safety now. If you are not safe at your own home [then], who would like to live here?" A commenter said, "Safety in my neighborhood has gone from a five, being the best, to a 2.5 in the last 15 years." Another commenter stated, "I think safety is a huge issue in Birmingham. I live in Southside and do not feel comfortable walking around and have had someone attempt to break in before."

Vacant and run-down properties were also mentioned 16 times across four focus groups. A Birmingham resident stated, "The vacant buildings need to be torn down. It looks bad, but we must stay on top of those things. We, as a community, have to work together to get these things done." Another resident said, "Yes, like I said, the abandoned houses. There are so many abandoned houses in the neighborhood, and they are not bad houses. They're not bad, but you can't keep people in them; certain people can't qualify to buy that house because they're asking so much money for it." A Warrior resident stated, "I want to see old unused buildings torn down."

Schools, mainly the poor performance of some school systems, were mentioned 15 times across three focus groups and among survey comments. A Birmingham resident said, "They also need to work on that school board, work on these schools [and] administration. There is a very bad problem with Birmingham school[s], and I'm going to say, [the] Superintendent." A commenter shared, "I live in a wonderful neighborhood. Wish the school system's reputation matched." A few other commenters

shared, "If you improved the schools, you will have more students going to college. The more people going to college, the more likely they are to come back into the neighborhood and in the area and want to start [a] business there, you know. It's where all the money comes from. Get the parent's involved," and "The horrible schools outside of a few unaffordable areas will guarantee that I move after the birth of my first child."

The poor condition of area roads was mentioned 14 times across two focus groups and among survey comments. A Birmingham resident stated, "Basically, all the roads in the city need repairing." Another Birmingham resident shared, "I do know that to me the roads have been neglected, and you see pot holes everywhere. And, I think that's a bad reflection on the city." Survey comments provided additional details, "There are no bike lanes either on the roads, and bus stops are few and far between" and "Fix the pot holes!!!!"

Public transportation as an inadequacy was mentioned 14 times in focus group and survey comments. A Center Point participant shared, "There is no real public transit. For most people, there is not public transit. If you live [in] Downtown, Southside or parts of Homewood, you can ride the bus; that's about it." Survey comments included, "Public transportation is delayed, has few stops and routes, and makes it difficult for people to travel on it," "Better regional transportation is an economic engine that creates jobs and reduces air, soil, and water contamination," "We need transportation options -- better transit (bus rapid transit), bikeshare, bike lanes and [to] leverage existing programs like CommuteSmart" and "[We] need [an] improved public transportation system (rail)."

Issues with air quality were highlighted 13 times in three focus groups and survey comments. A Center Point participant shared, "Of course, with the ozone and the clean air, we are building more buildings for our communities, and that's bringing in more people and more exhaust." A few commenters stated, "The air quality in Jefferson County is poor," "I think it is very important that our county proactively deal with our air problems for the sake of all of our health. I find it appalling that we consistently fail air quality standards and seem content to do so at the cost of all our citizens, especially our poorest" and "Can we stop blaming car emissions and tell the truth: industry and utilities are doing the lion's share of the air and water pollution."

Inequalities, particularly in the distribution of resources and services, were mentioned 13 times in four focus groups and survey comments. When Center Point participants were asked whether Jefferson County was a healthy community, a participant responded, "It's according to where you live. I mean really to answer that question, I hate to say it; that's the way it is." Another participant pointed out the inequalities among areas of Jefferson County based on economic status noting that, "Most of the folks over there in Mountain Brook have the money; they grew up with it, so they've always had the parks; they've had the best schools; they've always had those things most people don't have access to." Survey commenters also shared, "The large number of municipalities within Jefferson County often reflects inequities in the above conditions and responses to them. If you live in Mountain Brook, your conditions would be markedly different than if you live in Pratt City" and "Education, health care, and public safety conditions stand out as glaring inequities across these municipal boundaries." A Mount Olive resident stated, "I would love to see the county administration get the county out of debt to start and then try to disperse money into areas like Warrior, Mount Olive [and] the northern Jefferson County area instead of dumping everything they got into the cities of Birmingham, Hoover [and] Mountain Brook, where the higher dollar people are. There are a lot of county operations going on in the areas, and you don't see them here. And, I'd like to see it be dispersed a little more evenly."

The accessibility of parks and recreation was also mentioned as weaknesses 12 times across two focus groups and among survey comments. An Irondale resident talked of wanting to see more areas for children to play. A Warrior resident observed, "I think that you could bring more to this area if you had more parks, more recreational places for families to go to and have functions and types of things like that." Another Warrior participant spoke of expanding places where the Black Warrior River can be accessed for outdoor recreation. A survey comment reflected, "More places where families can go and be active and safe." Another commenter said, "Jefferson County needs more bike paths and running trails."

Waste management services were highlighted as an issue for some residents. This was a theme across four focus groups and survey comments. An Irondale resident talked about dumping in her neighborhood, "Here in the trailer park, we have a place where people dump garbage or anything. It smells really bad here around the corner." Another resident stated, "They should clean the surrounding areas. There is lots of garbage, lots of it; there are tires, furniture. It is exaggerated." A Birmingham resident shared, "I'd like us to do more recycling. We have no recycling program in our neighborhood at all. And, I'd like for us to be more structured with trying to recycle the paper and the plastic and the cans because I know in one area, one community, there is recycling but not in ours." A survey comment stated, "My area of the county seems to be all but forgotten. The litter is piled up very high because the county doesn't have the funds to provide litter services. The weeds also get so high in the summer that they block driving view. Once again, due to alleged lack of funds nothing is done."

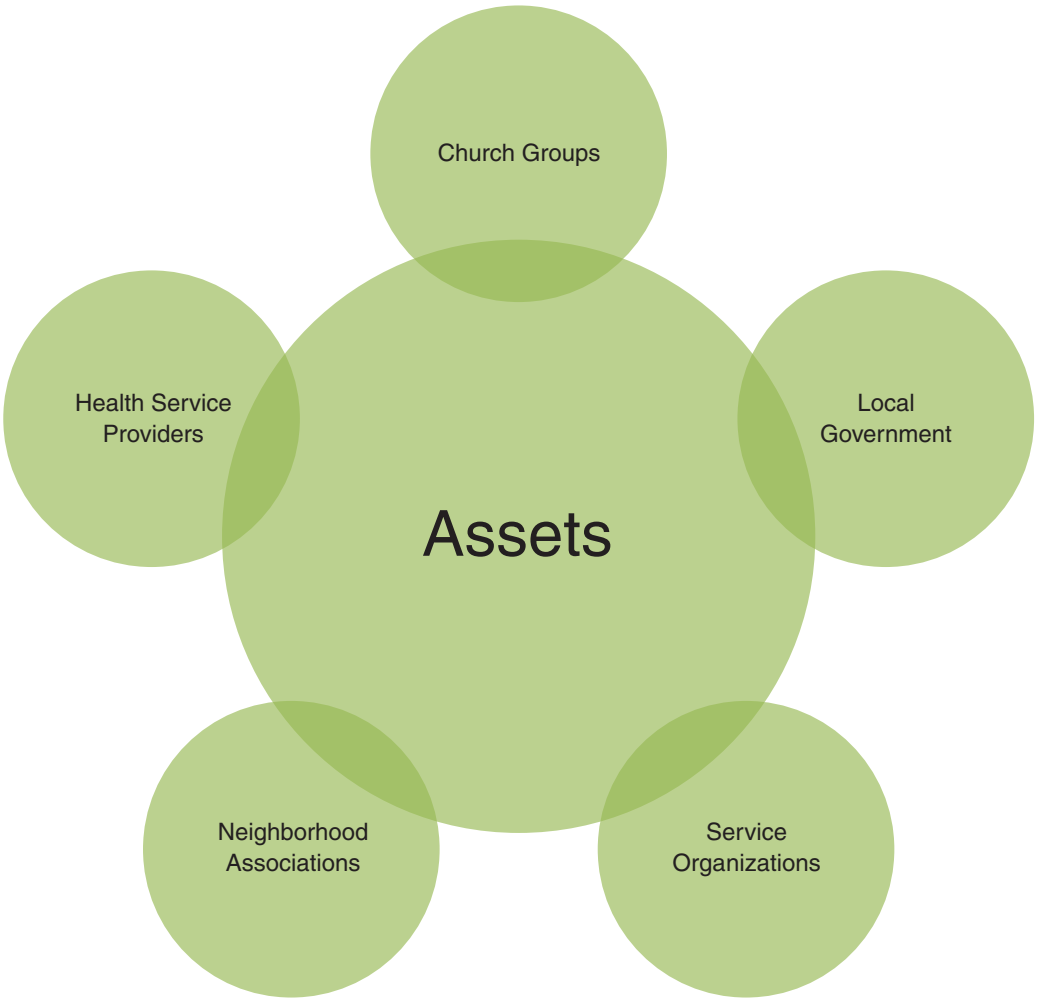
The poor condition of sidewalks was noted 11 times in one focus group and among survey comments. A Birmingham resident stated the need for sidewalks in the area. Survey comments included, "The lack of good sidewalks/footpaths and trails in this area is terrible. I see people walking on the road or through the grass nature strip all the time. It is so hard to walk to the store here; you have to drive everywhere…," "Sidewalks would encourage more physical activity and fellowship with neighbors in my community" and "One of my biggest concerns is the condition of the sidewalks. In my community, they are terrible and very unsafe in some places because of the number of broken, dislodged or generally uneven slabs."

The state of and needs of the homeless population in the county were mentioned 10 times in two focus groups and among survey comments. A Birmingham resident observed, "Yeah, there's a lot of difference here now. This used to be a nice community around here, but a lot of businesses have moved out and more people [are] living on the streets." Another resident stated, "There were so many places and so many churches that would feed the homeless and provide food to the homeless. And the city has just cracked down; and all of a sudden, groups aren't allowed to take the food to the homeless anymore..." In addition, a resident stated, "I think it's been less programs that get to the exact root issues of why drug addiction and alcoholism come up in the homeless community. A lot of programs designed today [are] to give them a crutch or just like a revolving door. It's not getting to the exact nature of why homelessness exists." A survey comment stated, "Commit to the former 10 year plan to end homelessness in Birmingham. Money promised to do so was never directed to this vital need. Housing ends homelessness. With supportive care, housing allows persons to get needed assistance to develop stable and productive lives." An additional comment stated, "Too many local programs/ charities only address immediate needs rather than preventing chronic problems. We need fewer organizations feeding the homeless and more mental health and substance abuse intervention to prevent homelessness. This community rallies around those affected by acts of God while ignoring the acts of mankind that perpetuate our culture of inequality."

Access to resources and services in rural areas was discussed extensively in the Warrior focus group. A Warrior resident stated, "I want to see more places for us to go on a picnic instead of driving to the other side of the county or somewhere like that, more access." Another resident shared, "I agree that we need more recreation areas and more local businesses, not large businesses but local businesses and more restaurant-type places. We have to drive to Gardendale or Fultondale, unless you want to eat the same thing all the time." Another participant observed, "Don't you find that the edges of the county like North Jefferson County… that are right on the cusp, get left out of a lot of things." A Mount Olive resident said, "In the outskirts, these communities, you find people moving closer in to get at these services that everybody should…be sharing…a plan could be figured out, I think, to better serve the outskirts of Jefferson County."

In the focus group and survey comments, themes were referred to as assets ranging from one to 11 times. The themes that were referred to as current assets at least seven times were highlighted and analyzed further (see Figure 35). Some themes identified as assets were also frequently noted as weaknesses by respondents. Themes that had five or six mentions were not included as major assets.

FIGURE 35: THEMES INDICATED AS ASSETS OF THE COUNTY



The presence of church groups as an asset was noted 11 times among three focus groups and among survey comments. A Birmingham resident shared that free dance classes were offered near her at a church; "A lady at the church teaches it. There have been a few young people, but most of them are elderly. And it gets them up and moving. And, on top of that, the class is free. They don't charge for it, and it's at one of the local churches right here in this community." Warrior focus group participants also highlighted church groups that provide service to the community. A survey comment stated, "Partner and provide more support for East Lake United Methodist. They provide many services for residents [in] the eastern Birmingham area."

The charge to local governments to solve problems was mentioned as an asset 10 times in two focus groups. Birmingham residents talked about open meetings where residents are able to share opinions in front of the City Council. Warrior residents expressed satisfaction with Warrior's current city government, "…The government officials that we have here are doing such a better job as far as getting money. Showing us a way to get things and just like ya'll come in trying to help us to pave a better way for the community," "The city officials have been awesome to deal with" and "we've got really good government officials right now."

Service organizations that provide resources to the community were mentioned nine times across six focus groups. A Birmingham resident pointed out an organization, "At the Foundry, they got a school there. They train them, and they leave there, and they get a job and everything." Another Birmingham resident highlighted organizations providing resources to the community, "We got the Firehouse Shelter; they got some programs. You got the Arc [of Jefferson County], Salvation Army, Jimmie Hale Mission, Aletheia House, Pearson House and Fellowship House."

Neighborhood associations were highlighted as an asset in three focus groups. In particular, Birmingham residents talked of neighborhood associations as resources for receiving information and getting involved in community activities. One resident remarked, "…We always get into a situation, and it's always a question of, well, who do we call? A lot of times in our neighborhood we may not know who to call. And with me, I've always started calling my immediate neighborhood association president…" Another shared, "We've had a diverse plan to revitalize our community. We're doing that now, meeting with the three neighborhoods which is our community. And we have about three more plans to do. This is the 20 year plan, and that's what we're working on now."

Health service providers rendering care to vulnerable populations was mentioned seven times in two focus groups and survey comments. A Birmingham resident referenced a free clinic for the homeless. "On Sunday's they have a medical field [team] that come here to provide for the people who are of need, who can't afford to go to a doctor." Other focus group participants and survey commenters mentioned community health centers in various places throughout the county that provide care for uninsured or underinsured families.

DISCUSSION

The qualitative findings illustrate that there is a difference of opinion in regards to the designation of strengths, weaknesses and assets among focus group participants. For instance, schools and safety were both identified as a top strength and weakness. It is noteworthy that the data indicates a vital indicator of quality of life, schools and safety, are not adequate across the county. Local government was identified as a top weakness and asset. This highlights the powerful role government plays in Jefferson County. Government, in its many forms, has the potential to build and reinforce conditions for a thriving county. However, in the majority of assessments, participants point to a lack of responsiveness by government to resident concerns. These discrepancies are most likely due to the difference in experience of county residents dependent on the area of the county in which they spend the most time. Other demographic differences such as race and ethnicity or education level may also explain differing perspectives. Despite the variances, there was agreement across survey and focus group results on major community strengths, assets and areas for improvement. Therefore, addressing the themes from this assessment can improve upon the current status of quality of life and public health in Jefferson County.

IMPLICATIONS

Through the Community Themes and Strengths Assessment, the Sub-committee was able to engage a substantial number of residents who live, work, study, worship or play in Jefferson County to obtain perceptions of their community. This reach included urban, suburban and rural populations. It also included often over looked populations in Jefferson County such as the homeless and those who do not speak English.

The themes identified from the analysis of data from the Community Themes and Strengths Assessment were analyzed in relationship to themes emerging from the other three MAPP Assessments: Community Health Status, Local Public Health System and Forces of Change. From this evaluation, ten potential overarching strategic issues for Jefferson County were identified. After consideration of the data supporting each of the potential strategic issues, the level of community engagement around the potential issues, current or future availability of resources to address the issues and the measurability of outcomes related to the issue, the Community Matters 20/20 Steering Committee selected five strategic issues to form the foundation for Jefferson County, Alabama's Community Health Improvement Plan.

The selected Strategic Issues are, in rank order:

- **Reduce Health Disparities Associated with Race, Ethnicity and Economic Status;**
- **Promote Physical Well-being through Healthy Lifestyles;**
- **Optimize the Built Environment, Transportation System and Safety;**
- **Optimize Healthcare Access, Availability and Utilization, and**
- **Improve Mental Health.**

The local public health system, working together to address these strategic issues, will move Jefferson County forward in its vision to be an inclusive, thriving community of healthy and connected people.

The work of Community Matters 20/20 is supported by the Jefferson County Department of Health

JEFFERSON COUNTY
DEPARTMENT OF HEALTH

ACKNOWLEDGMENTS

The Jefferson County Department of Health expresses appreciation to those who completed the *Your Opinion Matters! Survey* or participated in a focus group. Additionally, gratitude is expressed to the Community Themes and Strengths Sub-Committee for its assistance in the planning, implementation and evaluation of this assessment.

Sub-Committee Members

Nan Baldwin, Birmingham Business Alliance

Alonzo Darrow, Community Advisory Board Birmingham

Jessica Estrada, St. Vincent's Health System

Stan Law, YMCA of Greater Birmingham

Christa Lyle, PEER, Inc.

Wynne Speir, Children's of Alabama

Sheila Tyson, Birmingham City Council

Dr. Nir Menachemi, UAB School of Public Health

Whitney Dan Smith, UAB School of Public Health

Joanice Thompson, UAB Minority Health Research Center

Teneasha Washington, UAB Center for the Study of Community Health

Haskey Bryant, Jefferson County Department of Health

Craig Corwin, Jefferson County Department of Health

Nina Hassell, Jefferson County Department of Health

Rachel Hobgood, Jefferson County Department of Health

Charles Esther Kellum, Jefferson County Department of Health

April Pearce, Jefferson County Department of Health

Devon M. T. Sims, Jefferson County Department of Health

Greg Townsend, Jefferson County Department of Health

APPENDIX A.

YOUR OPINION MATTERS! COMMUNITY HEALTH SURVEY FOR JEFFERSON COUNTY, ALABAMA

Community Themes and Strengths Survey
YOUR OPINION MATTERS!

Please complete this survey whether you live, work, study or play in Jefferson County. You will not be asked to give your name and your answers are anonymous. You can also find a glossary of key terms (indicated by a star*) on the last page of this survey.
This survey is a part of a community needs assessment, visioning and planning process for Jefferson County, Alabama. The word "community" represents Jefferson County as a whole: its cities, municipalities, unincorporated areas, neighborhoods and their residents. This survey will capture your opinions about Jefferson County by highlighting characteristics you may enjoy and areas for improvement in your community. The information you provide will help to focus our improvement efforts in the coming years. We conducted a similar assessment in 2005. The information we gathered helped to identify key issues in Jefferson County communities such as second hand smoke exposure, lack of places to be physically active and limited access to healthy foods. Since then we have seen positive change throughout Jefferson County in these areas and others.
This survey can also be found online at the following website: www.surveymonkey.com/s/Community_Matters
This survey is conducted in collaboration with the many partners that make up the local public health system and is coordinated by the Jefferson County Department of Health.

Thinking about your community in Jefferson County, Alabama rank your satisfaction, how pleased you are, with the current condition or presence of each item listed below and how important it is to your quality of life. Quality of life refers to your personal level of satisfaction with the combined conditions (e.g. safety, health, employment) in which you live. If you cannot rate an item, please leave it blank.

	Satisfaction					Importance		
	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied	Low Importance	Medium Importance	High Importance
Public Service Items								
Streets/ Sidewalks	①	②	③	④	⑤	①	②	③
Public Transportation	①	②	③	④	⑤	①	②	③
Parks/ Outdoor Recreation	①	②	③	④	⑤	①	②	③
Community Centers/ Activities	①	②	③	④	⑤	①	②	③
Arts/ Cultural Events	①	②	③	④	⑤	①	②	③
Environment Items								
Outdoor Air Quality*	①	②	③	④	⑤	①	②	③
River/ Stream Quality*	①	②	③	④	⑤	①	②	③
Litter/ Graffiti	①	②	③	④	⑤	①	②	③
Second-hand Smoke Exposure*	①	②	③	④	⑤	①	②	③

	Satisfaction					Importance		
	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied	Low Importance	Medium Importance	High Importance
Education Items								
Public Libraries	1	2	3	4	5	1	2	3
Day Care Services	1	2	3	4	5	1	2	3
Pre-school Services	1	2	3	4	5	1	2	3
K-12 Schools	1	2	3	4	5	1	2	3
GED/Vocational Training	1	2	3	4	5	1	2	3
Health Items								
Access* to Health Care	1	2	3	4	5	1	2	3
Access to Dental Care	1	2	3	4	5	1	2	3
Access to Mental Health Services	1	2	3	4	5	1	2	3
Access to Healthy Food	1	2	3	4	5	1	2	3
Places to be Physically Active	1	2	3	4	5	1	2	3

	Satisfaction					Importance		
	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied	Low Importance	Medium Importance	High Importance
Crime Items								
General Safety*	1	2	3	4	5	1	2	3
Theft/ Burglary	1	2	3	4	5	1	2	3
Violent Crimes*	1	2	3	4	5	1	2	3
Economic & Community Items								
Job Opportunities	1	2	3	4	5	1	2	3
Continuing Education Opportunities*	1	2	3	4	5	1	2	3
Affordable Housing	1	2	3	4	5	1	2	3
Locally Owned Businesses in your Community	1	2	3	4	5	1	2	3
Social Interaction with your Neighbors	1	2	3	4	5	1	2	3
Participation in your Community	1	2	3	4	5	1	2	3
Leaders that are Responsive to your Concerns	1	2	3	4	5	1	2	3

	Satisfaction					Importance		
	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied	Low Importance	Medium Importance	High Importance
Programs								
Senior Care Programs	1	2	3	4	5	1	2	3
After-school Programs	1	2	3	4	5	1	2	3
Youth Programs/ Activities	1	2	3	4	5	1	2	3
Teen Programs/Activities	1	2	3	4	5	1	2	3
Services								
Resources for the Disabled*	1	2	3	4	5	1	2	3
Resources for the Homeless	1	2	3	4	5	1	2	3
Resources for Domestic Violence* Aid & Prevention	1	2	3	4	5	1	2	3
Re-entry* Programs	1	2	3	4	5	1	2	3
Resources for Substance Abuse* Assistance	1	2	3	4	5	1	2	3
Disaster* Services	1	2	3	4	5	1	2	3

Please rate your level of agreement with the statement below.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
There are support networks in my community for people and their families during times of need (financial, emotional, spiritual, etc.).	1	2	3	4	5

Please answer the following questions using the scale to the right of each question. If you cannot rate an item, please leave it blank.

	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
How satisfied are you with the quality of life in your community? - Quality of life refers to your personal level of satisfaction with the combined conditions (e.g. safety, health, employment) in which you live.	1	2	3	4	5
	Poor	Fair	Neutral	Good	Excellent
How would you rate your community as a place to raise children?	1	2	3	4	5
	Poor	Fair	Neutral	Good	Excellent
How would you rate your community as a place to grow old?	1	2	3	4	5
	Very Unhealthy	Unhealthy	Neutral	Healthy	Very Healthy
How would you rate your own personal health?	1	2	3	4	5

Please answer the following questions to the best of your knowledge.

1. Please select all the conditions that are a problem for children in your community.
   ① Asthma ③ Diabetes ⑤ Emotional/Behavioral Problems ⑦ Other, specify _____
   ② Obesity ④ Injury ⑥ Drug/Alcohol Abuse

2. Please write any additional thoughts or comments you would like to share.

Please provide the following demographic information. This information will not be used to identify you.

1. In what zip code is your home located? _____

2. What is your age? _____

3. What is your gender? ① Female ② Male

4. Which group(s) best represent your race?
   ① American Indian or Alaska Native ④ Native Hawaiian or Pacific Islander
   ② Asian ⑤ White or Caucasian
   ③ Black or African American ⑥ Other, specify _____

5. Are you of Hispanic or Latino origin or descent? ① No ② Yes

6. What is the highest level or education you have completed?
   ① Less than 9th grade ③ High school graduate or GED ⑤ College graduate
   ② Some high school ④ Some college ⑥ Graduate degree or higher

7. How do you pay for health care?
   ① Cash (no insurance) ④ Medicare
   ② Private Health Insurance (e.g. BCBS, VIVA, HMO) ⑤ Veteran's Administration
   ③ Medicaid/ ALL Kids ⑥ Other, specify _____

If you would like to receive a summary of the results please leave your contact information below (optional):

Email _____or Address _____ ___Zip Code_____

THANK YOU FOR YOUR RESPONSE

Please return completed surveys to:

Jefferson County Department of Health
1400 Sixth Ave South
Birmingham, AL 35233

Attn: Community Matters 20/20,
Quality Improvement and Decision Support

GLOSSARY OF KEY TERMS

Access - a way to get near, at, or to something or someone

Continuing education opportunities – after high school learning activities that include: degree credit courses for non-traditional students, non-degree career training, workforce training, personal enrichment courses, etc.

Disabled – physical (seeing, hearing, walking, etc.), mental or emotional condition that limits activity especially in employment or education

Disaster - something (such as a flood, tornado, fire, etc.) that happens suddenly and causes major damage or loss to people

Domestic violence - the act of causing physical or emotional injury to a family or household member by another family or household member

Outdoor air quality – the level of small particles, car exhaust, smoke, road dust, factory emissions, pollen, smog, etc. in the air

Quality of life - Quality of life refers to your personal level of satisfaction with the combined conditions in which you live.

Re-entry - refers to the transition of offenders from prisons or jails back into the community

River/stream quality – the level of trash, chemical waste and agricultural (pesticides, fertilizers, etc.) waste in the waterways

Safety – a place that is free from harm or danger

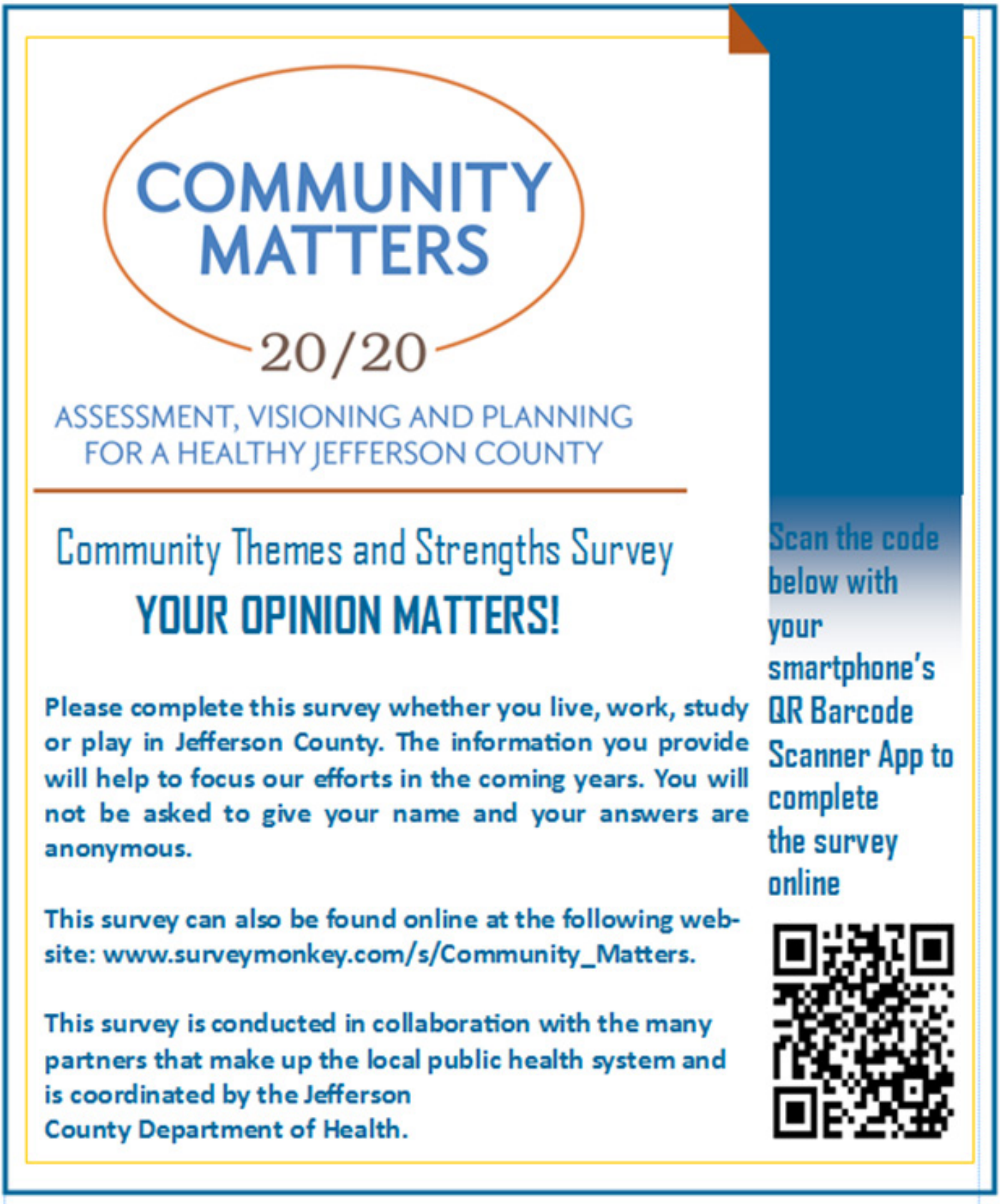
Second-hand smoke exposure - smoke from a cigarette, cigar, etc., that is exhaled or given off by the smoker and is inhaled by persons nearby

Substance abuse – dependence on an illegal or legal drug(s), prescription drug(s) or alcohol in which the user consumes the substance in amounts or with methods that are harmful to themselves or others

Violent crimes - offenses which involve force or threat of force such as murder, forcible rape, robbery, and aggravated assault

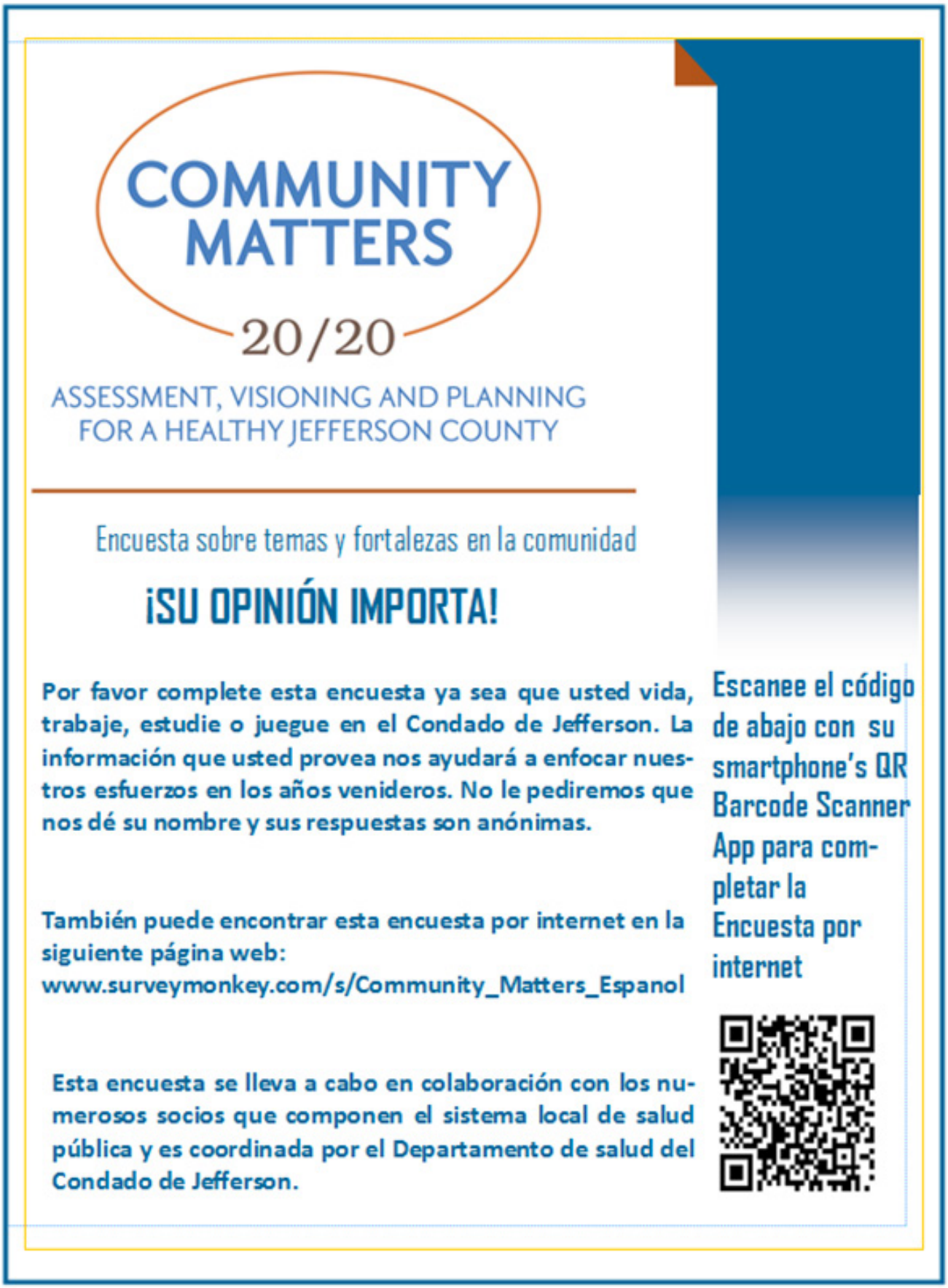
APPENDIX B.

ENGLISH SURVEY FLYER



APPENDIX C.

SPANISH SURVEY FLYER



APPENDIX D.

FOCUS GROUP FACILITATOR GUIDE FOR JEFFERSON COUNTY, ALABAMA

Community Themes and Strengths Focus Group Guide

(8-12 people)

[Inform attendees entering that providing their information on the sign-in sheet is optional]

OPENING

Welcome to the Community Matters 20/20 Community Themes and Strengths Focus Group. My name is _____ and with me today is _____ and _____. Thank you for taking the time to share your opinions about Jefferson County. This focus group is a part of a large community needs assessment, visioning and planning process for Jefferson County, Alabama. We conducted a similar assessment in 2005. The information we gathered helped to identify key issues in Jefferson County communities such as second hand smoke exposure, lack of places to be physically active and limited access to healthy foods. Since then we have seen positive change throughout Jefferson County in these areas and others.

We are here with you today to get your thoughts and experiences as residents of Jefferson County. We want your opinions and there is not a right or wrong answer. The information you share with us will give us insight into some of the concerns and points of pride for Jefferson County community members and direct our efforts in the coming years. We recognize that your time is valuable and this focus group will last about 90 minutes. We appreciate your participation.

CONFIDENTIALITY

Your comments during this focus group session will remain confidential. If you do not feel comfortable using your real name please feel free to use a fake one. We will report summaries of the comments made today but your name will not be attached to the comment. In addition we will not share who was present today. Also, please do not discuss what was said by people here today with others when you leave.

GROUND RULES

Your input is important and we want to make sure we accurately capture what you tell us. Therefore, we would like to take notes and tape record this focus group. After we are finished using the tapes for this focus group they will be destroyed. Is this okay with you? Please remember to speak clearly and do not interrupt when others are speaking. If you cannot hear what I am saying or what someone else is saying, please ask us to speak up. Do you have any questions before we get started?

Introduction (5 min)

Let's go around the room to give everyone the opportunity to introduce themselves and tell us:

1. How long have you lived in Jefferson County?
    - o Probe: If you are new to the area what brought you here?

Changes over Time (15 min)

Think about your community over the past 5 years:

1. Is there anything different about your community now that was not the case 5 years ago?
    - o Probe: Describe how your community has changed over the past 5 years.
    - o Probe: What do you think about these changes? Do you consider them to be good or bad changes?
2. Have people in your community worked on community projects together in the past five years?
    - o Probe: What kind of projects were these?
    - o Probe: How were you involved?
3. Is there anything you want to change about your community in the next 5 years?
    - o Probe: What changes would you make and why?
    - o Probe: How could those changes in your community be achieved?

Strengths and Weaknesses (25 min)

1. If you knew someone was thinking about moving to your community, what would you tell him or her about the area to convince them to move?
    - o Probe: What are some other good things about your community?
2. Are there groups of people involved in community activities?
    - o Probe: What types of groups are involved in these community activities?
    - o Probe: Are people from all age groups (race or ethnicity) involved?
    - o Probe: What would it take to get more people involved in community activities?
3. Are there people in your community that are looked to when things need to be done?
    - o Probe: Who are these people and why do people look to them?
    - o Probe: What groups or organizations exist in the community?
4. Do you believe your community and/or Jefferson County can be improved?
    - o Probe: How could your community/Jefferson County be improved?
    - o Probe: What community groups, individuals or organizations should play a role in the improvement?

Community Health (25 min)

1. Do you consider Jefferson County to be a healthy community?
    - o Probe: What makes it a healthy community or why wouldn't you consider Jefferson County to be a healthy community?
2. Are there health concerns in your community?
    - o Probe: From what health problems do people in your community suffer? (e.g. Heart disease, high blood pressure, depression, asthma, allergies, cancer, sexually transmitted infections)
    - o Probe: Why do these health problems exist?
3. Do people in your community take action if they have health problems?
    - o Probe: Do they seek care?
    - o Probe: Where do they go to receive medical, dental, mental, etc. care?
4. Do you have environmental health concerns?
    - o Probe: Water quality, air quality, food safety, animal control, illegal dumping, etc.

Closing (5 min)

[Briefly summarize main points of discussion]

1. Think about the issues we have talked about today, what issues do you think are the most important for your community to address?
2. Think about the strengths in your community we have talked about today, what do you think is the community's greatest asset?
3. Is there anything else we have not asked about that is important for us to know about your community?

Thank you for your participation! [Reiterate that their thoughts will be summarized to direct the Jefferson County assessment, visioning and planning process.]

APPENDIX E. QUALITATIVE THEME TABLE

	ASSETS	STRENGTHS	WEAKNESSES	TOTAL SCORE (USED FOR SORTING)
Local Government	10	3	18	31
Schools	5	9	15	29
Access to Health Services	3	4	20	27
Food Access	1	3	22	26
Crime and Violence	1	1	20	22
Safety	0	5	16	21
Parks and Recreation	3	5	12	20
Substance Abuse	2	0	18	20
Programs	2	2	15	19
Service Organizations	9	1	8	18
Church Groups	11	1	5	17
Area Development	2	6	9	17
Vacant and Run-Down Properties	0	0	16	16
Health Service Providers	7	2	6	15
Public Safety	6	2	7	15
Public Transportation	1	0	14	15
Roads	0	1	14	15
Air Quality	0	1	13	14
Inequalities	0	1	13	14
Maintenance	0	1	13	14
Waste Maintenance	1	1	11	13
Community Leaders	4	0	8	12
Community Awareness	3	2	7	12
Homeless	0	2	10	12
Businesses	4	3	4	11
Rural Access	1	0	10	11
Sidewalks	0	0	11	11
Neighborhood Association	8	1	1	10
Libraries	5	3	0	8
Community Center	4	0	4	8
Physical Activity	1	2	5	8
Health Education	1	0	7	8
Prevention	0	2	6	8
Animal Control	0	0	8	8
Economy	0	0	8	8
Grants	4	1	2	7
Beauty	0	5	2	7
Unity	0	1	6	7
Water Quality	0	0	7	7
Parent Involvement	0	0	7	7
Other Environmental Safety	0	1	5	6
Public Finance	0	0	6	6
Policy Process	0	0	6	6
Housing	1	0	4	5
Asthma	0	0	5	5
Mental Health	0	0	5	5

III. JEFFERSON COUNTY, ALABAMA'S

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

COMMUNITY MATTERS

20/20

ASSESSMENT, VISIONING AND PLANNING
FOR A HEALTHY JEFFERSON COUNTY

TABLE OF CONTENTS

OVERVIEW OF COMMUNITY MATTERS 20/20

In October 2013, the Jefferson County Department of Health (JCDH) began preparing for the next county-wide community health assessment and strategic planning process. Building on the framework and processes developed during the initial community health assessment and strategic planning process conducted from 2005-2007, JCDH formed a Core Team to begin the planning and design for a comprehensive, community-based assessment and strategic planning initiative utilizing the Mobilizing for Action Through Planning and Partnerships (MAPP) process to be concluded in late 2014. The title for the 2014 assessment and strategic planning process, *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County, AL,* distinguishes the current effort and sets a course for the next anticipated full assessment and strategic planning process; *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County, AL* is led by a steering committee chaired by Jefferson County's Health Officer, Mark E. Wilson, MD, and is composed of fifteen community leaders.

A STRATEGIC APPROACH TO COMMUNITY HEALTH IMPROVEMENT: MAPP

WHAT IS MAPP?

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-wide strategic planning tool for improving community health. Facilitated by the Jefferson County Department of Health, this tool helps the community prioritize public health issues and identify resources for addressing these issues.

BACKGROUND OF COMMUNITY HEALTH ASSESSMENT AND HEALTH STRATEGIC PLANNING USING MAPP IN JEFFERSON COUNTY, ALABAMA

In 2005, the Jefferson County Department of Health (JCDH) led the completion of a comprehensive assessment of the county's public health system utilizing MAPP. After multiple stakeholder meetings and extensive community engagement, JCDH published *Our Community Roadmap to Health,* a document outlining the goals for community health in 2007. JCDH is again initiating this community health strategic planning process to define the community's current and future health-related goals.

HOW MAPP WORKS

The phases of MAPP are shown in the center of Diagram 1, while the four MAPP Assessments, the key content areas driving the process, are shown in the four arrows surrounding the phases.

To initiate the health strategic planning process, lead organizations in the community begin organizing and preparing to implement MAPP (**Organize for Success/Partnership Development**). Community-wide strategic planning requires a high level of commitment from the partners, stakeholders and community residents recruited to participate.

The second phase of MAPP is **Visioning**. A shared vision and common values provide the framework for pursuing long-range community goals. During this phase, the community answers questions such as, *"What would we like our community to look like in ten years?"*

Next, the **four Assessments** are conducted, providing critical insight into challenges and opportunities experienced by the community:

- The **Community Themes and Strengths Assessment** provides a deep understanding of the issues residents believe are important;
- The **Local Public Health System Assessment** offers a comprehensive assessment of how well the local public health system delivers the 10 Essential Public Health Services;
- The **Community Health Status Assessment** identifies priority issues related to community health and quality of life by assessing data about health status, quality of life and risk factors in the community, and
- The **Forces of Change Assessment** focuses on the identification of forces such as legislation, technology and other issues that affect the context in which the community and its public health system operate.

While each of these assessments provides important information independently, taken together, these provide a robust assessment of health and quality of life. A list of challenges and opportunities is generated from each of the four assessments.

The fourth phase of MAPP is to **Identify Strategic Issues**. During this phase, participants identify linkages among the

DIAGRAM 1.

results from the MAPP Assessments to determine the most critical issues to be addressed to enable the community to achieve its vision. After issues have been prioritized, participants **Formulate Goals and Strategies** for addressing each issue.

The sixth and final phase of MAPP is the **Action Cycle**. During this phase, participants plan, implement and evaluate strategies to address the identified strategic issues supporting the shared vision. These activities build upon one another in a continuous and interactive manner to create continued success.

With community input, the following vision statement was endorsed by the Community Matters 20/20 Steering Committee on March 14, 2014 for Jefferson County's health strategic planning process, *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County:*

"JEFFERSON COUNTY ALABAMA IS AN INCLUSIVE, THRIVING COMMUNITY OF HEALTHY AND CONNECTED PEOPLE."

The following description of terms further defines Jefferson County's vision:

Inclusive reflects the purposeful invitation and acceptance of individuals from all backgrounds within the county - social, economic and cultural. No one is left behind.

Thriving describes the growth and flourishing of the community – economically, educationally, socially, culturally and in other dimensions.

Community represents Jefferson County as a whole: its cities, municipalities, unincorporated areas, neighborhoods and their residents.

Healthy reflects the community's experience of physical, mental, social and spiritual well-being.

Connected describes people working together cohesively to support the improvement of the community as a whole.

This vision statement provides the focus, purpose and direction for Jefferson County's health strategic planning process conducted by the community and coordinated by the Jefferson County Department of Health.

Following the adoption of the vision statement, the *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County, AL,* the Steering Committee planned, implemented and evaluated the results from the four MAPP assessments. The remainder of this document provides the Executive Summary and full results from the Community Health Status Assessment.

OVERVIEW OF THE LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

The Local Public Health System Assessment (LPHSA) is completed using the National Public Health Performance Standards (Performance Standards) Local Instrument. The Performance Standards Local Instrument measures how well system partners provide public health services using a nationally recognized set of optimal performance standards by answering the following questions:

- *What are the components, activities and capacities of our public health system?*
- *How well are the 10 Essential Public Health Services being provided in our public health system?*

PERFORMANCE STANDARDS BACKGROUND

Under the leadership of the Centers for Disease Control and Prevention and its partner organizations, the Performance Standards were developed and launched in 1997 by national, state and local experts in public health. The Performance Standards describe an optimal level of performance and capacity to which all local public health systems can aspire. The goal of the Performance Standards is to promote continuous improvement by providing benchmarks by which the local public health system can be assessed to help identify areas of strengths, weakness, and short and long-term improvement opportunities. The dialogue that occurs among participants in answering the Performance Standards Local Instrument questions leads to a better understanding of the public health system's functioning and performance and can facilitate informed, effective policy and resource decisions to improve the public health system.

The National Public Health Performance Standard's Performance Measures using the 10 Essential Public Health Services, shown in Figure 2 below, provides the framework for the local instrument by describing the public health activities that should be undertaken in all local public health systems.

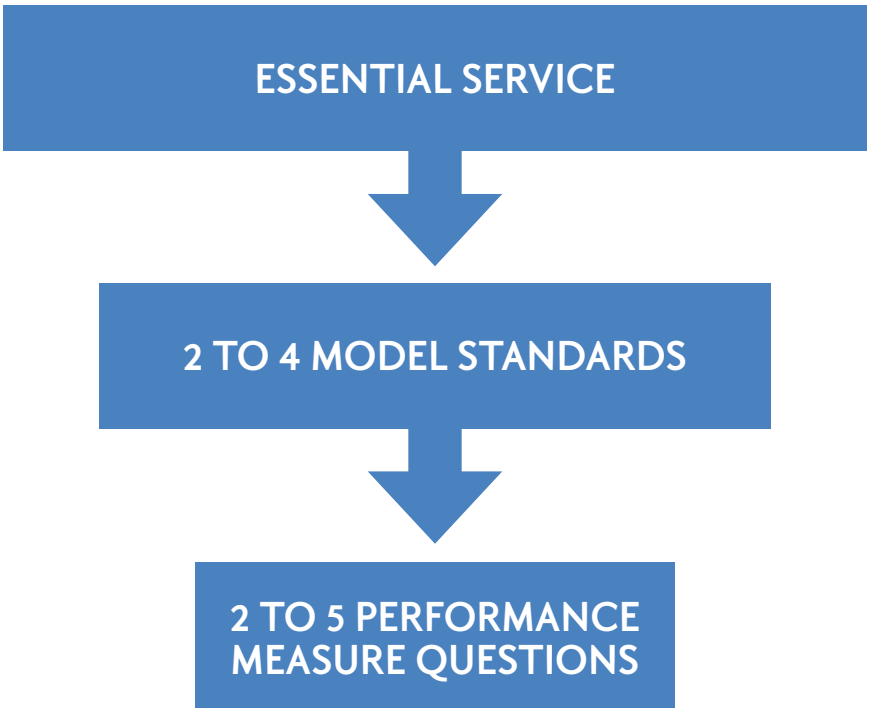
FIGURE 2

THE ESSENTIAL PUBLIC HEALTH SERVICES

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

Within the NPHPS Local Instrument, each essential service includes two to four model standards that describe an optimally performing public health system. Each model standard includes two to five performance measure questions which assess the local public health system's performance (See Figure 3).

FIGURE 3: NPHPS LOCAL INSTRUMENT FORMAT



ASSESSMENT PLANNING

The LPHSA Subcommittee, led by Carolyn Dobbs, MD, PhD, MPH, Jefferson County's Deputy Health Officer, was established to direct the assessment. The Subcommittee represented all segments of the local public health system. Members of this Subcommittee were expected to contribute to the completion of the LPHSA, recruit and train instrument facilitators and recorders and engage potential participants through recruitment, orientation, assessment and follow-up. The LPHSA Subcommittee determined that an all-day retreat would be held. For the assessment process, two facilitators were recruited for each Essential Service breakout session, with the primary facilitator leading the group through the instrument and the secondary facilitator serving as the scribe. Several meetings and conference calls were held to identify and recruit assessment facilitators, note takers and participants for completing the assessment. Orientation sessions were held to prepare recruited facilitators, scribes and note takers.

ASSESSMENT

The Local Public Health System Assessment (LPHSA) was held May 15, 2014 at Canterbury United Methodist Church in Birmingham, Alabama with 114 public health professionals and community members representing both public and private organizations, as well as Jefferson County community representatives. Mark E. Wilson, MD, Jefferson County Health Officer and Community Matters 20/20 Steering Committee Chair, provided an overview of *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County, AL*. Max Michael, MD, Dean of the University of Alabama at Birmingham School of Public Health, provided an overview of the public health system, the 10 Essential Public Health Services and the National Public Health Performance Standards (NPHPS) model standards. Monique Mullins and Lonnie Pressley, LPHSA coordinators, gave a brief logistics presentation.

LPHSA participants were assigned to Essential Service Evaluation Sessions based on the main function(s) of the organization represented and the individual's role within that organization. Trained facilitators in each Essential Service session guided participants through a review of Jefferson County's Local Public Health System activities via the local instrument discussion questions. After a thorough discussion, participants were asked to reach consensus about the level of activity for each performance measure using voting cards with the response options provided in Table 1. Participants voted on the system's level of activity, not the level of activity of their individual organizations. Final scores were determined either by consensus or by averaging the votes.

TABLE 1: PERFORMANCE ASSESSMENT SCORING

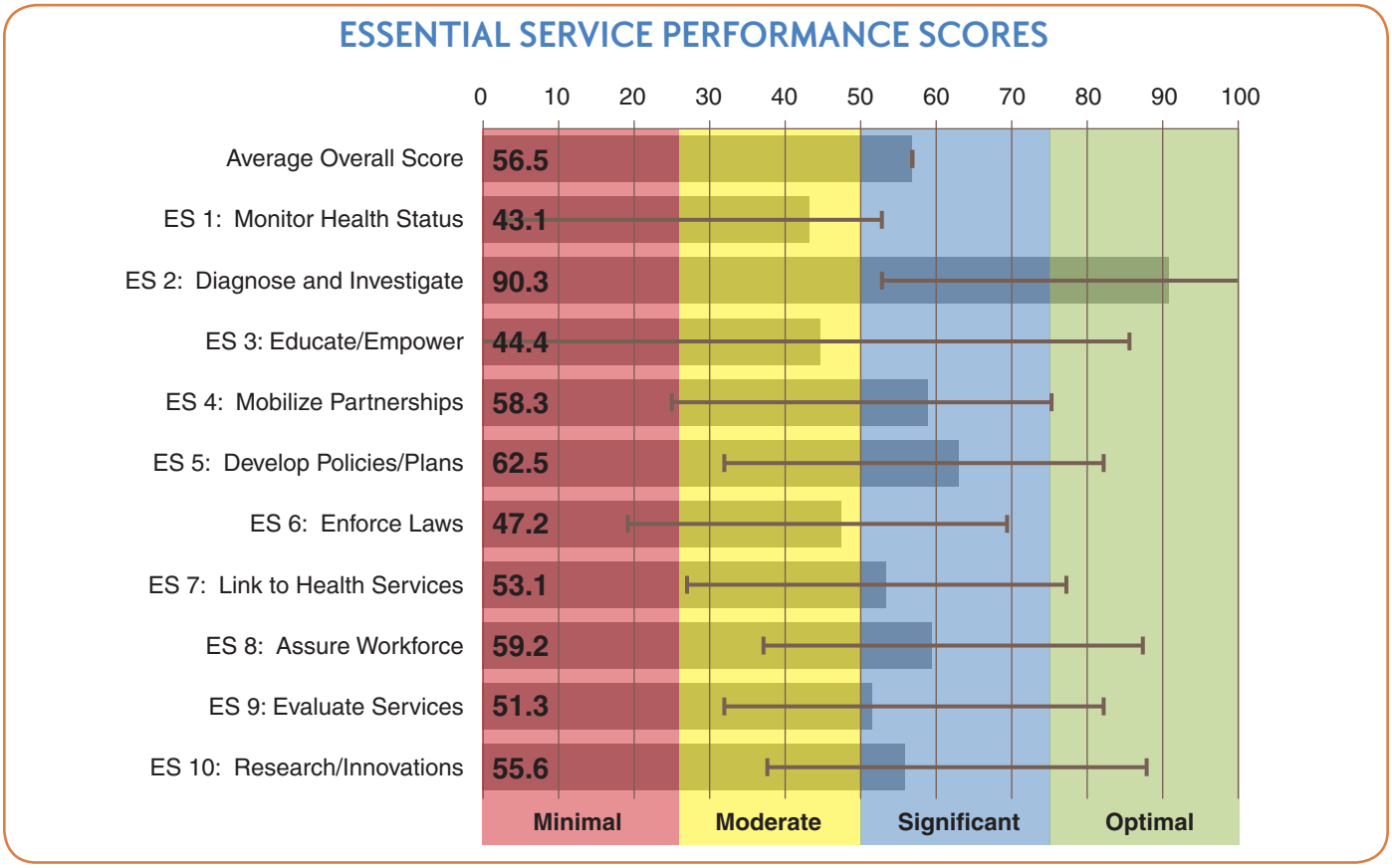
Optimal Activity (76-100%)	Greater than 75% of the activity described within the question is met.
Significant Activity (51-75%)	Greater than 50%, but no more than 75% of the activity described within the question is met.
Moderate Activity (26-50%)	Greater than 25%, but no more than 50% of the activity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

Data collected during the assessment were electronically submitted to the Public Health Foundation for analysis of the quantitative performance measures. A review and interpretation of the notes taken during the Essential Services sessions was analyzed using NVivo 10 qualitative data analysis software. Observations from the notes were coded and classified into four major themes: strengths, weakness, short-term opportunities and long-term opportunities.

EXECUTIVE SUMMARY

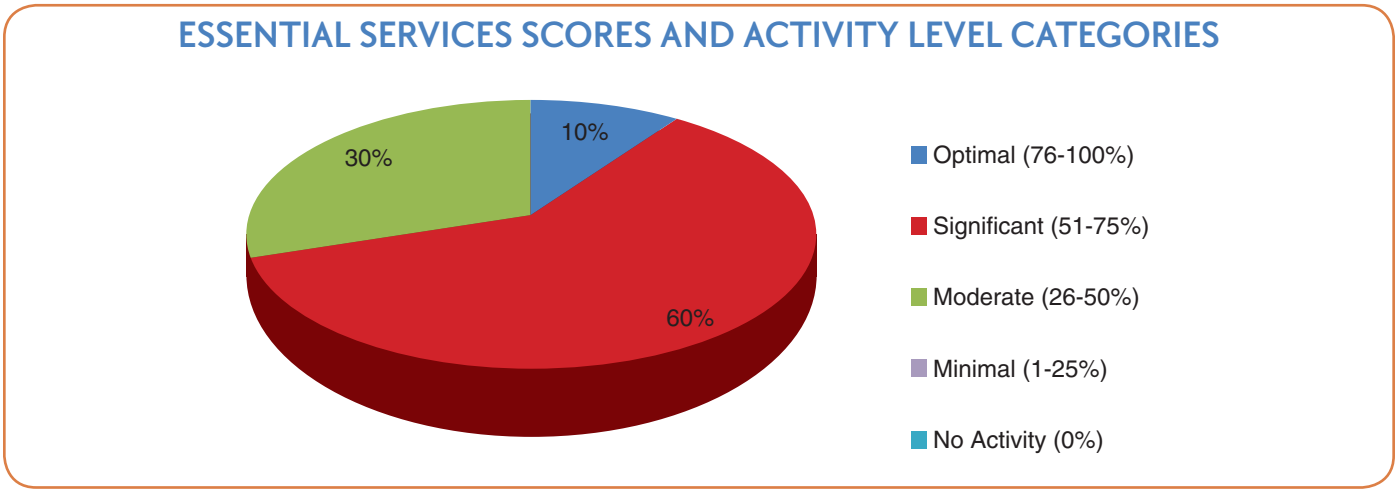
Figure 4 provides a summary of the average overall score and the average score from each Essential Service received on the National Public Health Performance Standards Local Instrument. The average overall score for Jefferson County's Local Public Health System was 56.5, which represents significant activity. Among the Essential Services, Essential Service 2: Diagnose and Investigate Health Problems and Health Hazards in the Community, with a score of 90.3, received the highest activity rating and represents optimal performance. The lowest overall Essential Service score, 43.1, was from Essential Service 1: Monitor Health Status to Identify Community Health Problems and represents moderate performance. Seven of the ten Essential Services were evaluated at the significant activity level (51-75%), while three Essential Services were rated as achieving moderate activity level (26-50%). None of the Essential Services were rated at the minimal (1-25%) or no activity (0%) levels.

FIGURE 4



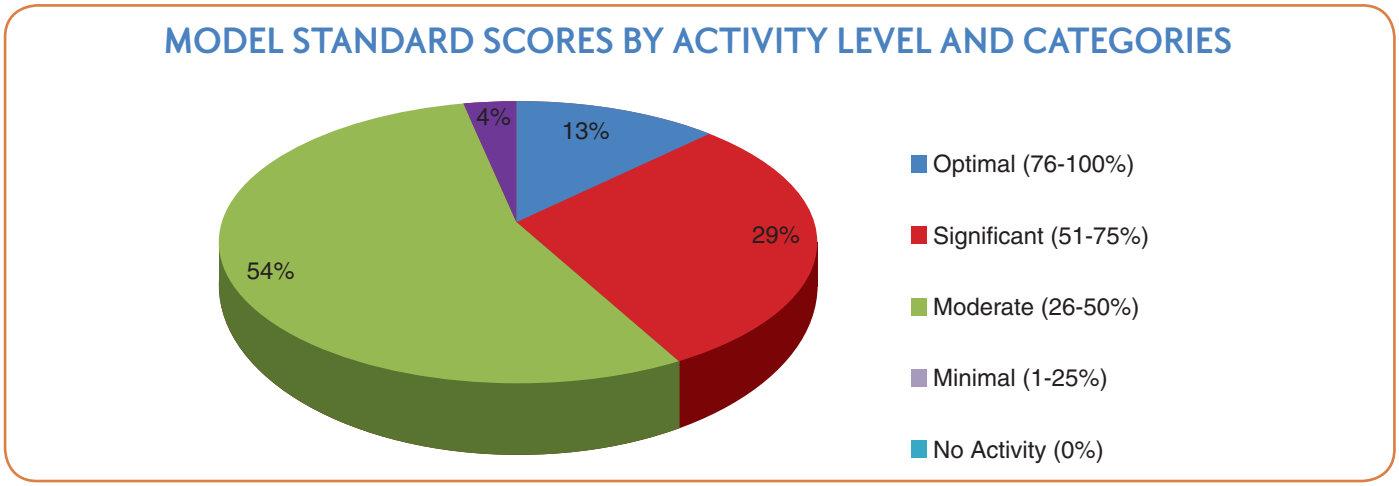
Jefferson County Public Health System's performance in each of the 10 Essential Services fell within the highest three rating categories. Figure 5 provides the percentage of essential services scored within each rating category. None of the essential services were rated within the no activity or minimal categories.

FIGURE 5



Jefferson County Public Health System's performance on each of the thirty model standards scored within the optimal to minimal activity levels (Figure 6). The three model standards which scored 100% were focused on emergency preparedness and public health workforce standards. The model standards with the lowest scores of 33% focused on policy development and the frequency of community health assessments.

FIGURE 6



In addition to the ratings, discussion revealed the following strengths, weaknesses and opportunities for improvement. These are intended to assist the public health system gain enhanced understanding of its collective performance and to strengthen the system.

STRENGTHS

i. The involvement of community organizations in service delivery.

ii. Preparedness plans for public health threats or events within and among organizations.

iii. Community partnership and participation in partnerships by a wide range of organizations and institutions.

WEAKNESSES

i. The general public's lack of awareness about the local public health system, including local needs assessments and resources to meet identified needs.

ii. The tendency of organizations to operate within silos.

iii. Inadequate communication with the general public, as well as across agencies.

SHORT-TERM IMPROVEMENT OPPORTUNITIES

i. Strategic engagement with stakeholders, including community members, to decrease existing fragmentation by improving relationships and trust in the achievement of mutual goals.

ii. Data collection and analysis for evaluating current and future interventions implemented to improve health outcomes and the effectiveness of the local public health system.

LONG-TERM IMPROVEMENT OPPORTUNITIES

i. The development and optimization of community resources.

ii. Purposeful and reasoned strategic communication to build and strengthen partnerships and actively engage the community in strengthening the local public health system.

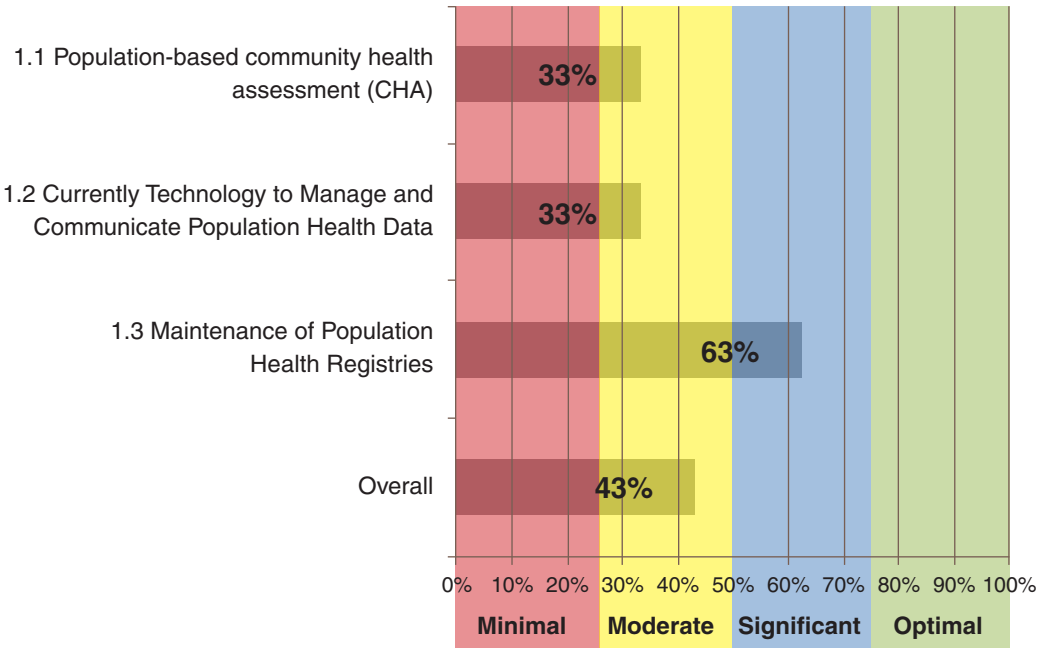
iii. Maintain and continue building community collaborations.

INDIVIDUAL ESSENTIAL SERVICE SCORING

The following graphs and findings are intended to aid Jefferson County public health entities understand their collective performance and strengthen the public health system. For each Essential Service and its corresponding Model Standards, a bar graph depicting an overall score for the Essential Service, as well as the scoring, expressed as a percentage, representing the degree to which the activity described in the Model Standard is conducted, followed by findings from the Essential Service breakout discussion are provided.

FIGURE 7

ESSENTIAL SERVICE 1: MONITOR HEALTH STATUS TO IDENTIFY AND SOLVE COMMUNITY HEALTH PROBLEMS



The overall performance score for Essential Service 1: Monitor Health Status to Identify and Solve Community Health Problems was 43%, indicating moderate activity.

STRENGTHS

i. Availability of public health data.

ii. Hospital data systems, specifically data collection, management and reporting requirements.

WEAKNESSES

i. Lack of communication regarding awareness of health status assessments by the general public.

ii. Community health assessment resource intensiveness, specifically in terms of time, cost and labor.

iii. Lack of integration and consistency of Geographic Information System (GIS) data across locations.

SHORT-TERM IMPROVEMENT OPPORTUNITIES

i. Improved public awareness of local health status assessments and related resources.

ii. A plan for the presentation of health status assessment results to the general public.

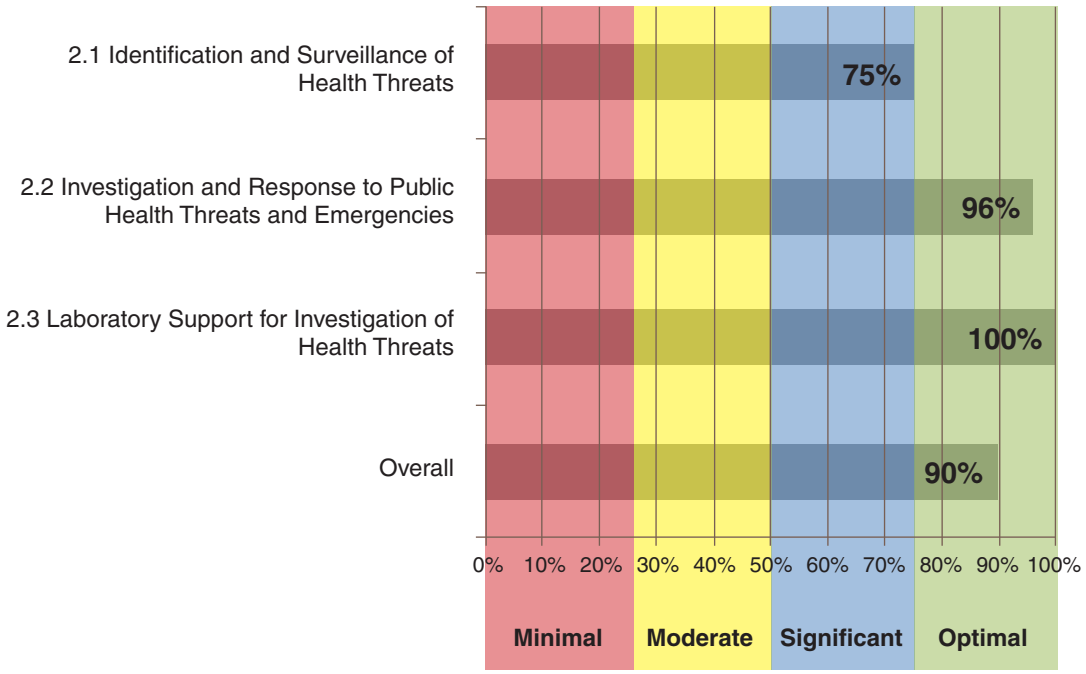
LONG-TERM IMPROVEMENT OPPORTUNITIES

i. Better procedural management of data collected as part of local community health status assessments, including streamlined data entry.

ii. Elimination of gaps in the availability of community health information by improved targeted data collection.

iii. Transition from planning to engaging the community in the community health assessment process.

FIGURE 8



The overall performance score for Essential Service 2: Diagnose and Investigate Health Problems and Health Hazards was 90%, indicating optimal activity.

STRENGTHS

i. Public health preparedness plans have been developed by many organizations. Preparedness planning included standardized procedures during a health threat or other events and the conduction of workforce training in emergency response.

ii. Interagency collaboration in data reporting. Data reporting partnerships between the public health department and community hospitals, providers, labs, schools and long-term care facilities for disease surveillance.

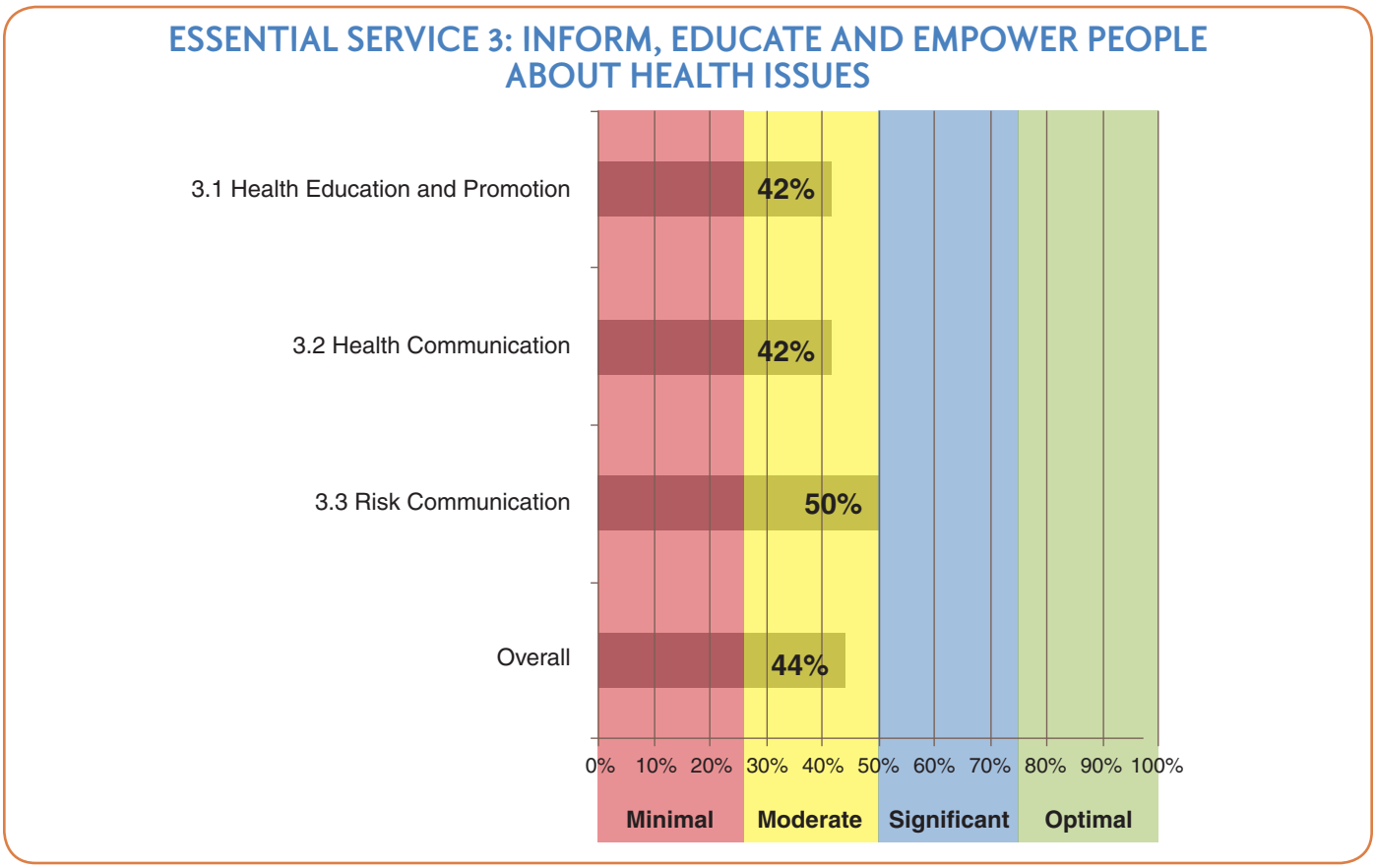
iii. Coordination of emergency response between agencies, such as the Emergency Preparedness Division of the Jefferson County Department of Health, Jefferson County's Emergency Management Agency, local fire departments, faith-based organizations and hospitals.

WEAKNESSES

i. Current surveillance efforts for food borne illnesses are inadequate in Jefferson County and in the state of Alabama compared to other states.

ii. The data indicates some gaps remain in the community's response to emergency events, particularly in terms of personal preparedness planning. Multiple stakeholders pointed to outcomes from recent tornadoes, snow and ice storms as examples of lack of public awareness of preparedness strategies.

FIGURE 9



The overall performance score for Essential Service 3: Inform, Educate and Empower People about Health Issues was 44%, indicating moderate activity.

STRENGTHS

i. Community members highlighted successful health promotion efforts by local public health agencies, including the Jefferson County Department of Health and the YMCA.

ii. Existing media outlets such as webcasts, podcasts, social media, printed materials and phone are important tools in health education and promotion of healthy behavior.

WEAKNESSES

i. Lack of communication with the general community about health and wellness.

ii. Financial restrictions are a barrier to large-scale health promotion efforts.

iii. Poor community understanding of preventive care services.

SHORT-TERM IMPROVEMENT OPPORTUNITIES

i. Creation of strategic communication strategies in which the messages are simple, relatable and delivered in a way that the message effectively reaches its target audience.

ii. Identification of avenues to disseminate information to community groups and community members.

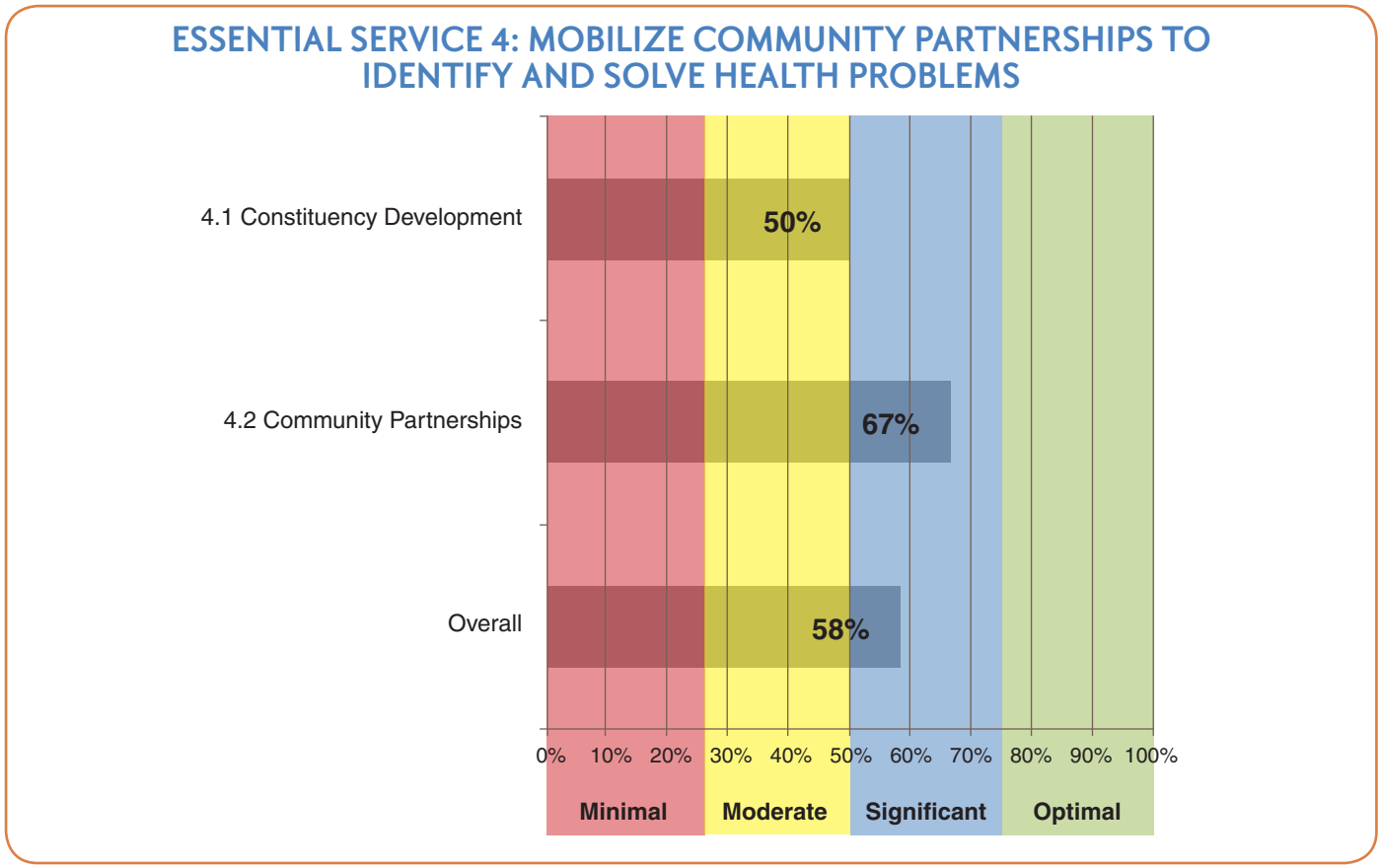
LONG-TERM IMPROVEMENT OPPORTUNITIES

i. Increase community engagement to provide networking opportunities for sharing information, building relationships and forming partnerships for future health promotion efforts.

ii. Schools and community coalitions represent a few of the specific partnerships that may be used for improvement in informing, educating and empowering the community regarding health issues.

iii. Development of tools such as resource maps of services or resource databases.

FIGURE 10



The overall performance score for Essential Service 4: Mobilize Community Partnerships to Identify and Solve Health Problems was 58%, indicating significant activity.

STRENGTHS

i. Existing community partnerships such as the Health Action Partnership and One Great Community have already initiated discussion regarding building a diverse work group to address community health problems. Existing partnerships may provide a model upon which additional partnerships can build.

ii. Increased dialogue by community groups on public health focused health issues.

WEAKNESSES

i. Lack of community engagement is a barrier to involvement in public health activities.

ii. Local public health agencies have a tendency to operate in silos which may make work within the community more difficult.

iii. There is a lack of resource awareness among public health system partners. Specifically, public health partners were unaware of mental health agencies and services.

SHORT-TERM IMPROVEMENT OPPORTUNITIES

i. The development and capitalization of unique opportunities to engage other leaders and community members in collaborative efforts in the short-term.

ii. The creation of partnership goals.

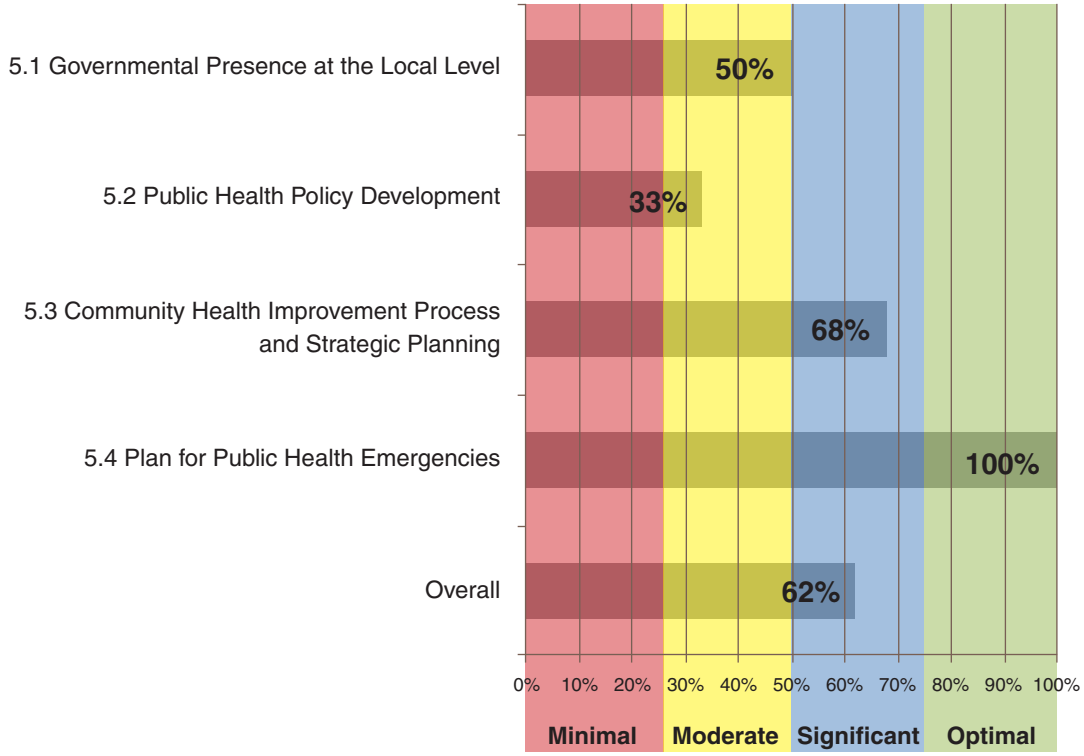
LONG-TERM IMPROVEMENT OPPORTUNITIES

i. The development of shared resources for local agencies.

ii. The evaluation of community health partnerships for effectiveness in achieving intended goals.

FIGURE 11

ESSENTIAL SERVICE 5: DEVELOP POLICIES AND PLANS THAT SUPPORT INDIVIDUAL AND COMMUNITY HEALTH EFFORTS



The overall performance score for Essential Service 5: Develop Policies and Plans that Support Individual and Community Health Efforts was 62%, indicating significant activity.

STRENGTHS

i. Recent health-related policies demonstrate public support of individual and community health.

ii. The availability of public recreation areas.

iii. The ability of community organizations to advocate for the community's needs, alert the appropriate agencies of those needs and their desire to affect change.

WEAKNESSES

i. The policy development, approval and implementation process is incredibly complicated and frustrating to maneuver.

ii. Many stakeholders were previously unaware of their role in the local public health system and of the opportunities available to engage in community improvement efforts.

iii. Community organizations operate in silos and fail to collaborate to achieve broader goals.

SHORT-TERM IMPROVEMENT OPPORTUNITY

i. Increase community awareness of the local public health system. Specifically, community members should know what the local public health system is, what is included in the local public health system and where there are opportunities for community engagement.

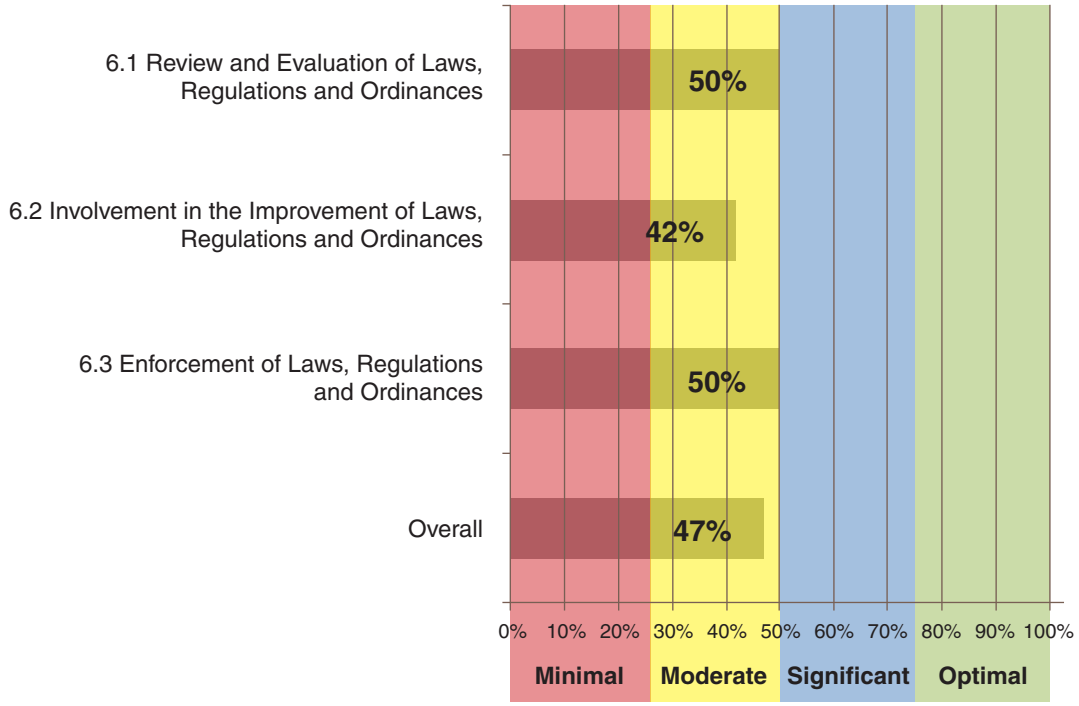
LONG-TERM IMPROVEMENT OPPORTUNITIES

i. Engagement of the community in the policy development process, particularly in influencing and implementing new policies.

ii. Evaluation of the impact of policy implementation on practice, programs and health outcomes.

FIGURE 12

ESSENTIAL SERVICE 6: ENFORCE LAWS AND REGULATIONS THAT PROTECT HEALTH AND ENSURE SAFETY



The overall performance score for Essential Service 6: Enforce Laws and Regulations that Protect Health and Ensure Safety was 47%, indicating moderate activity.

STRENGTHS

i. The enforcement of environmental health and safety policies.

ii. Public health preparedness efforts.

iii. Surveillance of hazardous exposures.

WEAKNESSES

i. The lack of public awareness of existing policies and policy development, approval and implementation processes.

ii. The lack of public communication of new ordinances.

iii. Mental health issues are often ignored.

SHORT-TERM IMPROVEMENT OPPORTUNITY

i. Increase the public's knowledge of governmental agency operations and programmatic functions.

LONG-TERM IMPROVEMENT OPPORTUNITIES

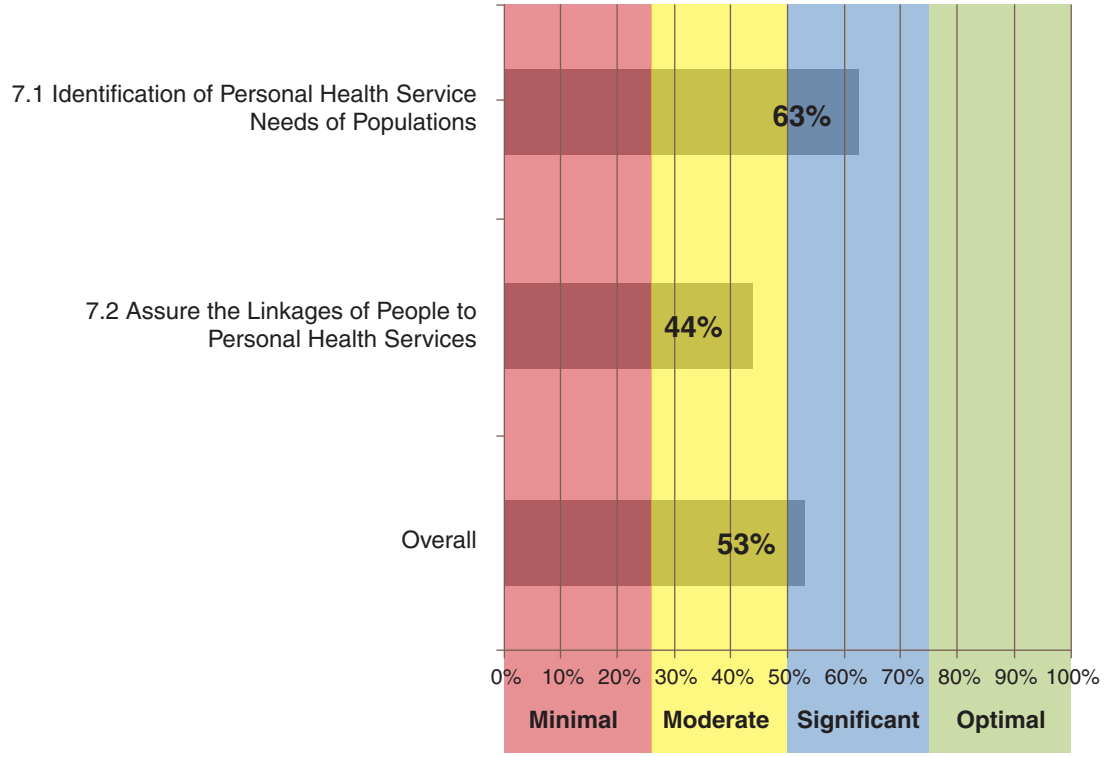
i. Enhance coordination across different levels of government: local, state, federal and interagency.

ii. Improve strategic communication between agencies and at the different levels of government.

iii. Evaluate enforcement of laws and regulations protecting health and ensuring safety.

FIGURE 13

ESSENTIAL SERVICE 7: LINK PEOPLE TO NEEDED PERSONAL HEALTH SERVICES AND ASSURE THE PROVISION OF HEALTHCARE WHEN OTHERWISE UNAVAILABLE



The overall performance score for Essential Service 7: Link People to Needed Personal Health Services and Assure the Provision of Healthcare When Otherwise Unavailable was 53%, indicating significant activity.

STRENGTHS

i. A number of community organizations currently collaborate in increasing access and linkage to services (e.g., United Way, Project Homeless Connect, Jefferson County Department of Health's Mobile Dental Program, United Cerebral Palsy, etc.).

ii. Some populations experiencing barriers in accessing personal health services have been identified.

WEAKNESSES

i. Gaps in healthcare access exist secondary to lack of or inadequate insurance, poor care coordination and challenging system navigation.

ii. Lack of transportation.

iii. Inadequate service coordination and the tendency of public health organizations to operate in silos.

SHORT-TERM IMPROVEMENT OPPORTUNITIES

i. Improved care coordination and referrals with defined system roles.

ii. Identification of qualitative data to evaluate linkages to health services.

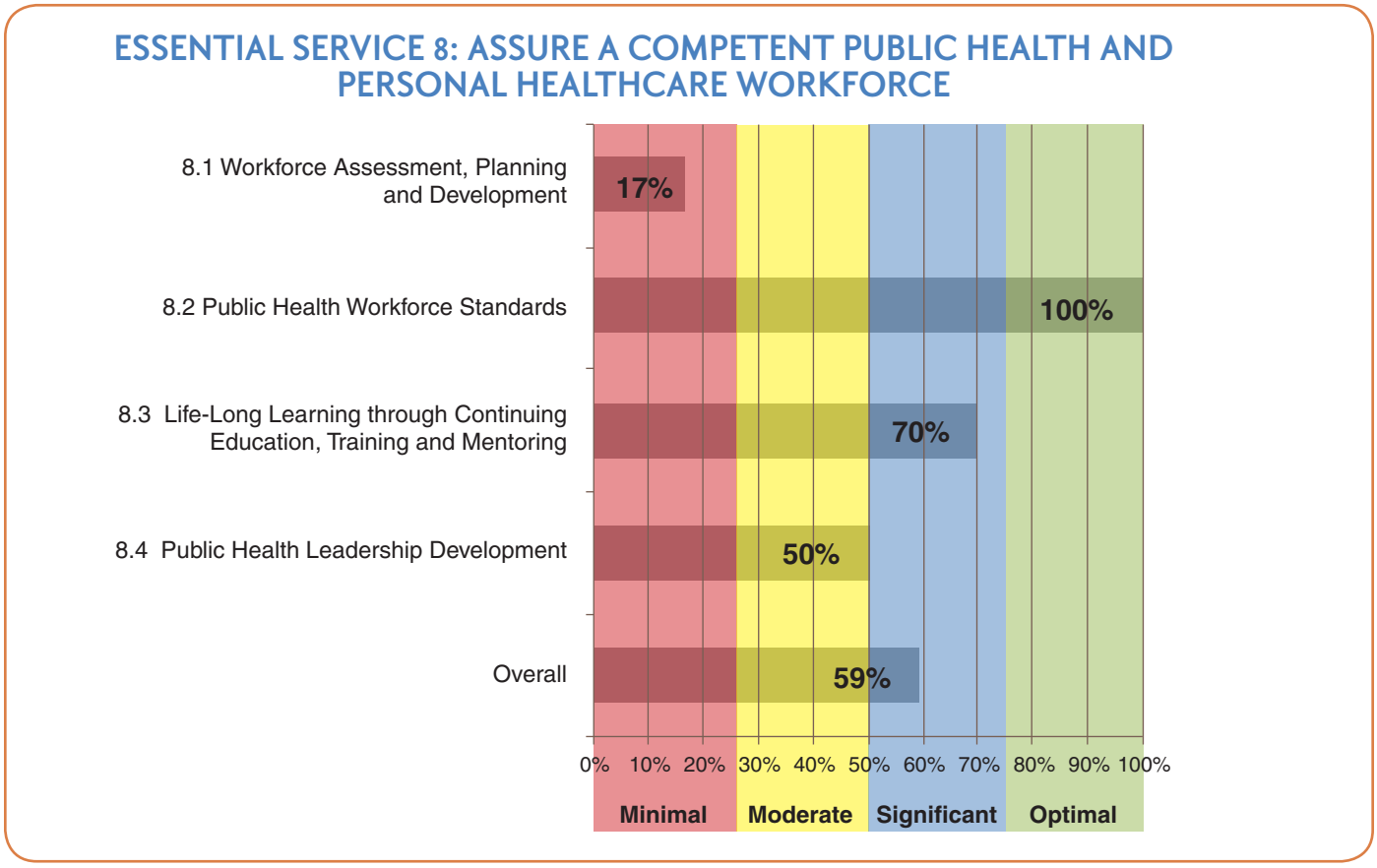
LONG-TERM IMPROVEMENT OPPORTUNITIES

i. Increase the availability of public health service providers and community health workers (e.g., nurse practitioners and interpreters).

ii. Enhance inter-agency coordination in facilitating access and linkage to services long-term.

iii. Develop coordinated and centrally located reference resources for health services.

FIGURE 14



The overall performance score for Essential Service 8: Assure a Competent Public Health and Personal Healthcare Workforce was 59%, indicating significant activity.

STRENGTHS

i. Existing workforce development programs are creating opportunities for entry into health-related professions.

ii. Work-based training programs support on-the-job skills development or higher education.

iii. Partnerships exist between local hospitals, health care agencies and academic institutions for training students.

WEAKNESSES

i. There are barriers to entry into the health care workforce such as job and salary prospects, strict educational requirements, the cost of education and lack of tuition reimbursement.

ii. There is a lack of standardized qualifications and competency requirements for community health worker positions such as medical interpreters.

iii. Competition between healthcare education organizations serves as a weakness because academic and hospital systems are reluctant to share their curricula.

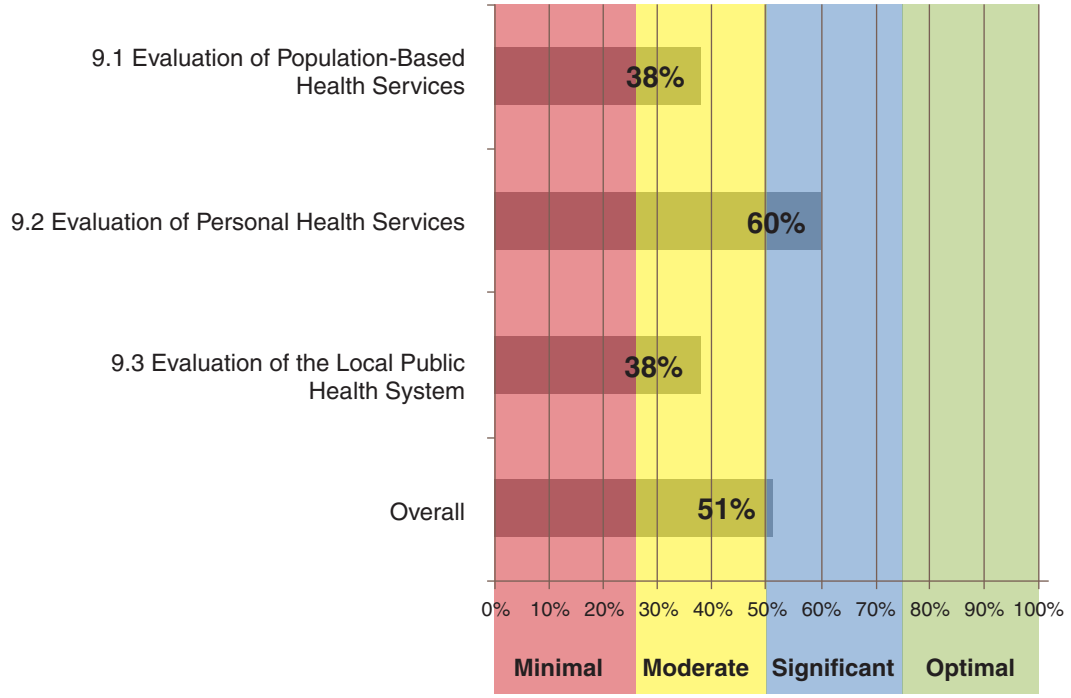
LONG-TERM IMPROVEMENT OPPORTUNITIES

i. Enhanced workforce training; specifically, provide higher education opportunities for public health professionals and cultural competency training for providers.

ii. Creation of strategies for healthcare provider retention.

FIGURE 15

ESSENTIAL SERVICE 9: EVALUATE EFFECTIVENESS, ACCESSIBILITY AND QUALITY OF PERSONAL AND POPULATION-BASED HEALTH SERVICES



The overall performance score for Essential Service 9: Evaluate Effectiveness, Accessibility and Quality of Personal and Population-Based Health Services was 51%, indicating significant activity.

STRENGTHS

i. Data availability for assessment and evaluation of services.

ii. Health information technology providing quick and comprehensive access to patient health information.

WEAKNESSES

i. Inadequate availability and access to mental health and disability services.

ii. Lack of interoperability among and between data systems.

SHORT-TERM IMPROVEMENT OPPORTUNITY

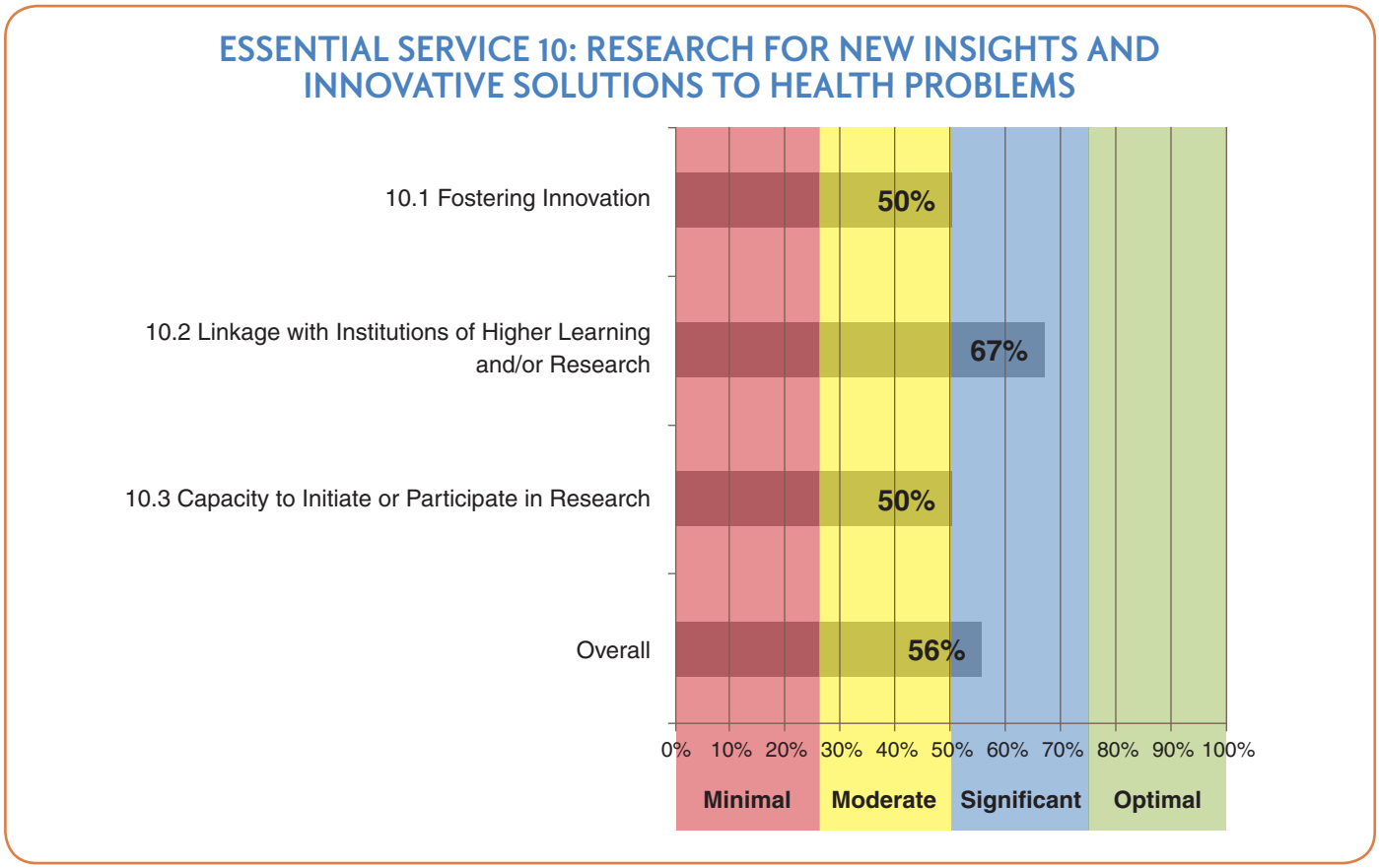
i. Identify the interfaces within the public health system infrastructure where communication of data is inadequate and implement a corrective action plan.

LONG-TERM IMPROVEMENT OPPORTUNITIES

i. Improvement of data system interoperability.

ii. Implementation of continuous evaluation of personal and population-based health services with process and system redesign resulting from evaluation.

FIGURE 16



The overall performance score for Essential Service 10: Research for New Insights and Innovative Solutions to Health Problems was 56%, indicating significant activity.

STRENGTHS

i. Partnerships between the Jefferson County Department of Health and UAB clinical and non-clinical research teams.
ii. The local public health system's ability to engage the community in identifying problems and creating solutions.
iii. The translation of clinical research into practice, legislation and health care savings.

WEAKNESSES

i. Lack of funding which limits the development and implementation of innovative ideas and solutions.
ii. Poor information dissemination regarding research opportunities and the outcomes from conducted research to the community.

LONG-TERM IMPROVEMENT OPPORTUNITIES

i. Improve the dissemination of health-related research.
ii. Increase community collaboration in innovation and research to resolve health issues.
iii. Outcome and impact evaluation to determine the most efficient and effective use of resources, including innovations.
iv. Identification of the most effective strategies for Community-based Participatory Research (CBPR).

PRIORITIZATION RESULTS

The Local Public Health System Assessment (LPHSA) Subcommittee completed a prioritization assessment for each Model Standard which did not reference scores or rank ordering of the Model Standard. Scoring was completed using a scale of one to ten, where ten represented the highest priority.

The prioritization was categorized into four quadrants as shown in Table 2. The Model Standards in quadrant I are high priority activities scoring low in respect to performance. These activities are important to the local public health system and need increased attention to improve performance. It is important to note that the Model Standards within quadrant II are also high priority activities; however, these activities are high performing and should be maintained. Quadrant III indicates the Model Standard activities with high or moderate performance, but lower priority. Based on reasonable performance but low prioritization, the local public health system may consider shifting resources to higher priority activities. Quadrant IV denotes activities that could be improved, but are of low priority and may not need attention at this time.

The Model Standards provide an outline of the essential activities in which all effective public health systems should be engaged. The lowest priority rating given to any of the Model Standards was seven, which represents a high priority. Some essential public health activities, however, are more critical than others given finite resources. The prioritization assessment provided a starting point for discussion among public health system partners regarding the optimal utilization and leveraging of limited resources.

The LPHSA Subcommittee identified the need to increase performance among several high priority areas including enforcement of public health laws, health communication and community health assessments (quadrant I). Enforcement of public health laws protects the health and well-being of communities. LPHSA participants identified the need for improving the policy and permitting process to ensure the equitable enforcement of public health laws. A coordinated approach for educating community members and sharing limited resources for health education and public health messaging was an identified need. The opportunity to increase awareness by public health system partners and community members regarding accessing health registries and actively participating in community health assessments was discussed.

Although community partnerships, evaluation and research are located within quadrant III, LPHS partners indicated the intent to maintain current efforts to support continuing public health work. While Jefferson County's public health system scored in the significant activity and moderate-high priority levels for these areas, partners stressed the continued need for community partnerships to leverage resources and sustain successes. Evaluation and research serve to measure the effectiveness of current efforts and explore innovative solutions to health problems, respectively. Given the unique environment in which Jefferson County's Local Public Health System exists, minimal external resources were indicated as requirements to sustain and build on many of the public health activities within quadrant III.

TABLE 2: MODEL STANDARDS BY PERFORMANCE SCORE AND PRIORITY RATING

Model Standard	Performance Score (%)	Priority Rating
Quadrant I: High Priority/ Low Performance		
8.4 Leadership Development	50	9
6.3 Enforce Laws	50	9
3.3 Risk Communication	50	9
3.2 Health Communication	42	9
3.1 Health Education/Promotion	42	9
1.2 Current Technology	33	9
1.1 Community Health Assessment	33	9
Quadrant II: High Priority/ High Performance		
8.2 Workforce Standards	100	9
5.4 Emergency Plan	100	10
2.3 Laboratories	100	9
2.2 Emergency Response	96	9
2.1 Identification/Surveillance	75	9

Quadrant III: Low Priority/ Moderate to High Performance		
10.2 Academic Linkages	67	8
9.2 Evaluation of Personal Health	60	7
8.3 Continuing Education	70	8
7.1 Personal Health Services Needs	63	8
5.3 CHIP/Strategic Planning	67	8
4.2 Community Partnerships	67	8
1.3 Registries	63	8
Quadrant IV: Low Priority/ Moderate to Low Performance		
10.3 Research Capacity	50	8
10.1 Foster Innovation	50	8
9.3 Evaluation of LPHS	38	8
9.1 Evaluation of Population Health	56	8
8.1 Workforce Assessment	17	8
7.2 Assure Linkages	44	8
6.2 Improve Laws	42	8
6.1 Review Laws	50	8
5.2 Policy Development	33	8
5.1 Governmental Presence	50	8
4.1 Constituency Development	50	8

QUALITATIVE COMPARISON

During October 27-28, 2005, the Jefferson County Department of Health (JCDH) coordinated a completion of the Local Public Health System Assessment using the second version of the National Public Health Performance Standards (NPHPS) Local Instrument. Nine years later, on May 15, 2014, JCDH coordinated another assessment of the local public health system, this time using the updated version three of the NPHPS Local Instrument. Between the iterations of the Local Instrument, the number of Model Standards and tool components were modified. While the quantitative scores from the NPHPS Local Instrument cannot be compared between the two assessments, the qualitative data gathered from the Essential Service sessions can be compared. In 2005, discussion notes from the Essential Services sessions were analyzed to identify strengths, weaknesses and recommendations, while the 2014 discussion notes were analyzed to identify strengths, weaknesses, short-term improvement ideas and long-term improvement opportunities.

Some of the public health system weaknesses identified in 2005 were identified as strengths in 2014, while some of the weaknesses identified in 2005 remain weaknesses in 2014.

2005 WEAKNESSES IDENTIFIED AS STRENGTHS IN 2014:

- The 2005 assessment identified a low compliance rate by physicians in reporting reportable diseases. In 2014, data reporting partnerships between the health department and community hospitals, providers, labs, schools and long-term care facilities for disease surveillance was a strength (Essential Service 2).
- In 2005, community partnerships for identifying and reducing health issues were either not established or in the early stages of formation. Several strong partnerships with a track record of coordination and success in addressing community health problems was a 2014 assessment finding (Essential Service 4).
- The need for opportunities to encourage young individuals to enter the public health workforce was identified in the 2005 assessment. The 2014 assessment revealed that workforce development programs have encouraged the entry into health-related professions (Essential Service 3).

2005 WEAKNESSES THAT REMAIN WEAKNESSES IN 2014:

- The need for coordinated health communication tailored for targeted audiences (Essential Service 3).
- While some policies and plans have successfully engaged the general public, the need for active involvement by the general public throughout the policy and planning processes remains an opportunity (Essential Service 5).

LPHSA participants were asked during the 2005 and 2014 assessments to draft potential strategies for improving Essential Service delivery. A number of the recommendations received in 2005 were echoed in 2014, indicating that gaps in service delivery continue. One recommendation made in 2005 was successful implemented.

2005 RECOMMENDATIONS THAT REMAIN IMPROVEMENT OPPORTUNITIES IN 2014:

- Streamlining of data entry and management processes (Essential Service 1).
- Strategic and coordinated health messaging tailored for different audiences and a central database of available resources (Essential Service 3).
- Enhanced community engagement in public health work (Essential Service 4).
- Community engagement in the policy development, approval and implementation processes (Essential Service 5).
- Availability of an adequate transportation system, mental health resources and a requirement for formal certification for medical interpreters (Essential Service 7).
- Implementation of system-wide, coordinated workforce development opportunities for public health leaders (Essential Service 8).

2005 RECOMMENDATION IMPLEMENTED BY JEFFERSON COUNTY PUBLIC HEALTH SYSTEM:

- Since 2005, several organizations have and continue to collaborate in policy development and approval for large public health impact. Several organizations and partnerships now include faith-institutions and managed care organizations in community health work (Essential Service 5).

CONCLUSION AND STRATEGIC ISSUES

This report provides an assessment and evaluation of Jefferson County's Local Public Health System based upon the 10 Essential Services of Public Health.

The themes identified from the analysis of data from the Local Public Health Assessment were analyzed in relationship to themes emerging from the other three MAPP Assessments: Community Health Status, Community Themes and Strengths and the Forces of Change. From this evaluation, ten potential overarching strategic issues were identified. After consideration of the data supporting each of the potential strategic issues, the level of community engagement around the potential issues, current or future availability of resources to address the issues and the measurability of outcomes related to the issue, the Community Matters 20/20 Steering Committee selected five strategic issues to form the foundation for Jefferson County, Alabama's Community Health Improvement Plan.

The selected Strategic Issues are, in rank order:

- **Reduce Health Disparities Associated with Race, Ethnicity and Economic Status;**
- **Promote Physical Well-being through Healthy Lifestyles;**
- **Optimize the Built Environment, Transportation System and Safety;**
- **Optimize Healthcare Access, Availability and Utilization, and**
- **Improve Mental Health.**

The local public health system and the community, working together to address these strategic issues, will move Jefferson County forward in its vision to be an inclusive, thriving community of healthy and connected people.

ACKNOWLEDGEMENTS:

The Jefferson County Department of Health (JCDH) would like to express appreciation to 114 individuals who participated in the May 15, 2014 Jefferson County Local Public Health Assessment and to the following individuals for their dedication in the planning, implementing and evaluating the assessment.

LOCAL PUBLIC HEALTH SYSTEM SUBCOMMITTEE:

Bruce Braden, *Jefferson County Department of Health*

Joyce E. Brooks, *Birmingham Jefferson County Transit Authority*

Julie Cobb, *Jefferson County Department of Health*

Carolyn Dobbs, MD, PhD, MPH, *Jefferson County Department of Health, Spokesperson*

Warren Callaway, *Community Member*

Gus Heard-Hughes, *Community Foundation of Greater Birmingham*

Alisha Hill, *Jefferson County Department of Health*

Lisle Hites, PhD, *UAB School of Public Health*

Beth Johns, *UAB School of Public Health*

Sonja Lewis, *Jefferson County Department of Health*

Bryn Manzella, *Jefferson County Department of Health*

Roger McCullough, *Alabama Business Leadership Employment Network*

Stephanie Millsap, *Jefferson County Department of Health*

Monique Mullins, *Jefferson County Department of Health, Coordinator*

Lee Pearce, *Alabama Quality Assurance Foundation*

Lonnie Pressley, *Jefferson County Department of Health, Coordinator*

Nick Sims, *Safe Routes to School of Central Alabama*

LAKESHORE FOUNDATION EMPLOYEE:

Luke Hanson

UAB SCHOOL OF PUBLIC HEALTH FACULTY AND STAFF:

Susie Davies, PhD

Michelle Fanucchi, PhD

Matt Fifolt, PhD

Robin Lanzi, PhD

Max Michael, MD

Lisa McCormick, DrPH

Nir Menachemi, PhD

Whitney Dan Smith

Jessica Wakelee

Regina Waller

Teneasha Washington

JEFFERSON COUNTY DEPARTMENT OF HEALTH EMPLOYEES:

Bridget Adams

Stephanie Ayers-Millsap

Bruce Braden

Kim Cason

Julie Cobb

Jannese Covington

Dan Foster

Michele Gowens

Chris Granger

Wanda Heard

Bill Latture

Dolores Johnson

Cathy Jones

Sonja Lewis

Lori McManus

Pamela Oliver

Melissa Potts

Devon Sims

Jonika Smith

Carlos Torres-Sanchez

Greg Townsend

Elisabeth Welty

Mark Wilson, MD

The work of Community Matters 20/20 is supported by the Jefferson County Department of Health.

JEFFERSON COUNTY
DEPARTMENT OF HEALTH

IV. JEFFERSON COUNTY, ALABAMA'S

FORCES OF CHANGE ASSESSMENT

COMMUNITY MATTERS 20/20

ASSESSMENT, VISIONING AND PLANNING
FOR A HEALTHY JEFFERSON COUNTY

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OVERVIEW OF COMMUNITY MATTERS 20/20

In October 2013, the Jefferson County Department of Health (JCDH) began preparing for the next county-wide community health assessment and strategic planning process. Building on the framework and processes developed during the initial community health assessment and strategic planning process conducted from 2005-2007, JCDH formed a Core Team to begin the planning and design for a comprehensive, community-based assessment and strategic planning initiative utilizing the Mobilizing for Action Through Planning and Partnerships (MAPP) process to be concluded in late 2014. The title for the 2014 assessment and strategic planning process, *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County, AL,* distinguishes the current effort and sets a course for the next anticipated full assessment and strategic planning process; *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County, AL* is led by a steering committee chaired by Jefferson County's Health Officer, Mark E. Wilson, MD, and is composed of fifteen community leaders.

A STRATEGIC APPROACH TO COMMUNITY HEALTH IMPROVEMENT: MAPP

WHAT IS MAPP?

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-wide strategic planning tool for improving community health. Facilitated by the Jefferson County Department of Health, this tool helps the community prioritize public health issues and identify resources for addressing these issues.

BACKGROUND OF COMMUNITY HEALTH ASSESSMENT AND HEALTH STRATEGIC PLANNING USING MAPP IN JEFFERSON COUNTY, ALABAMA

In 2005, the Jefferson County Department of Health (JCDH) led the completion of a comprehensive assessment of the county's public health system utilizing MAPP. After multiple stakeholder meetings and extensive community engagement, JCDH published *Our Community Roadmap to Health,* a document outlining the goals for community health in 2007. JCDH is again initiating this community health strategic planning process to define the community's current and future health-related goals.

HOW MAPP WORKS

The phases of MAPP are shown in the center of Diagram 1, while the four MAPP Assessments, the key content areas driving the process, are shown in the four arrows surrounding the phases.

To initiate the health strategic planning process, lead organizations in the community begin organizing and preparing to implement MAPP (**Organize for Success/Partnership Development**). Community-wide strategic planning requires a high level of commitment from the partners, stakeholders and community residents recruited to participate.

The second phase of MAPP is **Visioning**. A shared vision and common values provide the framework for pursuing long-range community goals. During this phase, the community answers questions such as, *"What would we like our community to look like in ten years?"*

Next, the **four Assessments** are conducted, providing critical insight into challenges and opportunities experienced by the community:

- The **Community Themes and Strengths Assessment** provides a deep understanding of the issues residents believe are important;
- The **Local Public Health System Assessment** offers a comprehensive assessment of how well the local public health system delivers the 10 Essential Public Health Services;
- The **Community Health Status Assessment** identifies priority issues related to community health and quality of life by assessing data about health status, quality of life and risk factors in the community, and
- The **Forces of Change Assessment** focuses on the identification of forces such as legislation, technology and other issues that affect the context in which the community and its public health system operate.

While each of these assessments provides important information independently, taken together, these provide a robust assessment of health and quality of life. A list of challenges and opportunities is generated from each of the four assessments.

The fourth phase of MAPP is to **Identify Strategic Issues**. During this phase, participants identify linkages among the

DIAGRAM 1.

The fourth phase of MAPP is to **Identify Strategic Issues**. During this phase, participants identify linkages among the results from the MAPP Assessments to determine the most critical issues to be addressed to enable the community to achieve its vision. After issues have been prioritized, participants **Formulate Goals and Strategies** for addressing each issue.

The sixth and final phase of MAPP is the **Action Cycle**. During this phase, participants plan, implement and evaluate strategies to address the identified strategic issues supporting the shared vision. These activities build upon one another in a continuous and interactive manner to create continued success.

With community input, the following vision statement was endorsed by the Community Matters 20/20 Steering Committee on March 14, 2014 for Jefferson County's health strategic planning process, *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County:*

"JEFFERSON COUNTY ALABAMA IS AN INCLUSIVE, THRIVING COMMUNITY OF HEALTHY AND CONNECTED PEOPLE."

The following description of terms further defines Jefferson County's vision:

Inclusive reflects the purposeful invitation and acceptance of individuals from all backgrounds within the county - social, economic and cultural. No one is left behind.

Thriving describes the growth and flourishing of the community – economically, educationally, socially, culturally and in other dimensions.

Community represents Jefferson County as a whole: its cities, municipalities, unincorporated areas, neighborhoods and their residents.

Healthy reflects the community's experience of physical, mental, social and spiritual well-being.

Connected describes people working together cohesively to support the improvement of the community as a whole.

This vision statement provides the focus, purpose and direction for Jefferson County's health strategic planning process conducted by the community and coordinated by the Jefferson County Department of Health.

Following the adoption of the vision statement, the *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County, AL,* the Steering Committee planned, implemented and evaluated the results from the four MAPP assessments. The remainder of this document provides the Executive Summary and full results from the Community Health Status Assessment.

OVERVIEW OF THE FORCES OF CHANGE ASSESSMENT

The Forces of Change Assessment is one of the four assessments completed as part of the community health strategic planning process for Jefferson County called *Community Matters 20/20: Assessment, Visioning and Planning for a Healthy Jefferson County.*

The Forces of Change Assessment (FOCA) identifies trends, factors and events that are occurring or will occur that affect the community or the local public health system. During the FOCA, participants answered the following questions:

- *What is occurring or might occur that affects the health of our community or the local public health system?*
- *What threats or opportunities are generated by these occurrences?*

While it may not seem obvious at first, the broader environment is constantly impacting communities and the local public health system. State and federal legislation, rapid technological advances, changes in the organization of health care services, shifts in economic forces and the changing of family structures and gender roles are examples of forces of change. These forces are important because they affect, either directly or indirectly, health and quality of life in the community and the effectiveness of the local public health system that serves the community. During this assessment, participants engaged in brainstorming sessions to identify forces, which could be:

- **Trends:** Patterns over time, such as migration in and out of a community or growing disillusionment with government;
- **Factors:** Discrete elements such as a community's large ethnic population, an urban setting or its proximity to a major waterway, or
- **Events:** One-time occurrences such as a hospital closure, natural disaster or the passage of new legislation.

For the FOCA, a five member subcommittee[1] implemented the process for assessing the forces of change that are affecting or have the potential to affect the public health system or the community. Two brainstorming sessions with five separate groups were completed at different times and locations covering a vast portion of the county. Community leaders, policymakers and long term residents were among participants that shared experiences and knowledge from their respective areas of expertise. Participants in the FOCA included representatives from the fields of education, technology, faith, social service, private business and many others. The resulting data was collected[2], compiled and analyzed[3] to reveal a number of prevalent occurrences cited repeatedly and independently across separate brainstorming groups. Emergence of these themes reinforced the understanding that the forces cited are striking, tangible and recognized as real opportunities and/or threats to the public health system and to Jefferson County as a whole. While the data presented in this summary were gathered directly from the brainstorming sessions, the opinions and ideas presented in this document do not necessarily represent the position of the agencies sponsoring the *Community Matters 20/20* assessment process or that of the individuals involved in its collection, analysis and delivery.

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[1] Appendix I: Subcommittee Members and Participant Affiliations

[2] Appendix II: Brainstorming Session Comments

[3] Appendix III: Compilation of Brainstorming Session Results

OPPORTUNITIES:

- **Smoking regulations and protection of clean air** in public places resulting from community mobilization and legislation are positively impacting health and health outcomes across the county.
- **The University of Alabama at Birmingham**, including its hospitals and associated specialty centers, is a driver for medical care, clinical research and health resource innovation. This community asset is pivotal to the county's public health system.
- **Faith-based organizations** provide strong social and economic support to the region and are emerging with a broader role in access to health care and medical services.
- **Local and regional philanthropic agencies** and their investments support the public health system and residents of the community in fueling new initiatives and supporting ongoing efforts.
- **Models of community organizing, self-reliance, empowerment and engagement** are emerging successfully and need to be expanded to strengthen communities.
- **The trend of urban renewal** is a strong force driving development and growth in Birmingham and surrounding communities. Building on these successes will promote further development.
- **Advances in the national and local conversation** about wellness, prevention, healthy/active lifestyles, physical activity, obesity, climate change and other issues are promoting and enhancing local efforts. Funding sources are serving to drive investments to increase equity and decrease disparities.
- **Expansion of roles and maximization of healthcare professionals** like nurse practitioners in treating and prescribing is helping increase healthcare access and service availability.

SIMULTANEOUS OPPORTUNITIES AND THREATS:

- **Use and prevalence of technology** helps processes and amplifies the potential for communication but also **displaces individuals** from the workforce and impedes face-to-face contact.
- **The increase in diversity** due to demographic changes such as immigration and cross cultural interactions is an asset to the county's cultural wealth. The new demographic reality **requires increased resources**, namely, economic investment, increased workforce training and developing local capacity to fulfill the needs of diverse populations., The increase in the county's diversity has brought these underlying issues front and center, as evidenced by the passing and later judicial intervention of Alabama's Immigration Law (HB-56). **Built environment growth and infrastructure development** including parks, trails, walkable communities, bike lanes, urban gardens and use of sustainable resources make our county a better place to live but **require continued investment stretching already thin budgets** and unstable revenues to maintain smart growth initiatives.
- **Medicaid expansion is needed** and is expected to translate into more widespread reach of services and programs for minorities and underserved populations suffering the burden of health disparities. The **potential increase in expenses** if Medicaid expansion occurs may impact funding sources and resources available for other programs in the long term.
- Changes in the historically stigmatized **public image of mental health** and increased awareness and services are impacting health outcomes positively. Promotion and availability of mental health services are moving to the forefront but still lack momentum and broad support. Prioritization of **mental health services is still in its infancy** and demands dedication of more resources and funding to increase and expand efforts. This need for funding threatens the acknowledgment and feasibility of mental health resource expansion.
- **Struggling educational systems and poor academic outcomes** erode human capital as an asset and threaten the intellectual growth and development of the county's children. More investment in education, including increased funding, additional teachers and equipment, etc., are needed. Pooling of these resources will build economies of scales to leverage improvements across the

board. **Current efforts to create and fund improved education** such as specialized academies and charter schools advanced achievement programs and the incorporation of best practices may translate into improved graduation rates and academic progress.

- **The Affordable Health Care Act is increasing access to healthcare** services and will continue to impact residents. The long term impact and potential consequences of its implementation **represent unknown factors** that many people fear could threaten their personal financial stability and the county's economic health.
- **The existing public transit infrastructure is inadequate** and requires further development and additional funding to survive. Mass Transportation improvement and **new investments** like the expansion of Birmingham-Jefferson County Transit Authority routes are paving the way for a much needed comprehensive transportation system that can improve quality of life for Jefferson County residents.

THREATS:

- **Fragmentation** within the county, including municipalities, cities, school systems, groups, communities and socio-economic classes create barriers that curtail opportunities and increase disparities. These divisions polarize issues and people and result in wasted opportunities to build on economies of scale. Matching funds from local agencies and government are shrinking, and funding sources consequentially are being lost.
- **Racial and ethnic divide** and its historical context and legacy are a source of distrust and keep people from working together. Cultural conflict continuously threatens relationships, improved living conditions, conflict resolution and healing opportunities. De-facto segregation hinders and stifles growth and development.
- **"Isms"**, the notion that some individuals or groups are better than others for a variety of reasons, including classism, racism, sexism and ableism, increase disparities and result in missed opportunities.
- **The current political realities of the county**, including dysfunctional politics, are counterproductive and result in poor leadership that erodes trust from constituencies. Failures in both governance and legislative action create division and stall development and growth.
- **Inadequate healthcare access and coverage**, including preventive and specialty care services, negatively impact health outcomes and increase health disparities. The closure of Cooper Green Mercy Hospital (the only County-owned and operated hospital serving the poor and uninsured), gaps in healthcare services, insufficient mental health care, inadequate HIV prevention and care and the loss of primary care physicians and clinics resulting from relocation to more competitive markets drive up costs, create unequal access and increase health disparities.
- Societal challenges including **generational poverty, teen pregnancy, an aging population, crime, violence and increasing incarceration rates** negatively impact families. These issues disrupt family units, threaten the well-being of residents, destabilize communities and affect the health of current and future generations.
- **Illicit drug use and substance abuse**, including prescription drug misuse, threatens the well-being of individuals and increases violent crime and risky behaviors. The recent wave marijuana legalization by other states may create confusion about the dangers and hazards associated with substance abuse.
- **Natural disasters, climate change, man-made environmental changes and the impact of human pollution on nature** threaten the well-being of our community. Tornado outbreaks, flooding, fires and air and land pollution in residential communities increase the risk for disease and the need for emergency preparedness which strain financial resources for normal operations.

IMPLICATIONS

The themes identified from the analysis of data from the Forces of Change Assessment were analyzed in relationship to themes emerging from the other three MAPP Assessments: Community Health Status, Community Themes and Strengths and the Local Public Health System. From this evaluation, ten potential overarching strategic issues for Jefferson County were identified. After consideration of the data supporting each of the potential strategic issues, the level of community engagement around the potential issues, current or future availability of resources to address the issues and the measurability of outcomes related to the issue, the Community Matters 20/20 Steering Committee selected five strategic issues to form the foundation for Jefferson County, Alabama's Community Health Improvement Plan.

The selected Strategic Issues are, in rank order:

- **Reduce Health Disparities Associated with Race, Ethnicity and Economic Status;**
- **Promote Physical Well-being through Healthy Lifestyles;**
- **Optimize the Built Environment, Transportation System and Safety;**
- **Optimize Healthcare Access, Availability and Utilization, and**
- **Improve Mental Health.**

The local public health system, working together to address these strategic issues, will move Jefferson County forward in its vision to be an inclusive, thriving community of healthy and connected people.

APPENDIX I:

SUBCOMMITTEE MEMBERS AND PARTICIPANT AFFILIATIONS

FORCES OF CHANGE ASSESSMENT SUBCOMMITTEE MEMBERS

Nan Priest, St. Vincent's Health System

Tracy Hipps, Christian Service Mission

Sara Newell, United Way of Central Alabama

Justin Smith, Jefferson County

Carlos J. Torres-Sánchez, Jefferson County Department of Health

BRAINSTORMING PARTICIPANTS' AFFILIATION ROSTER:

	Organization/Affiliation
1	Christian Service Mission
2	Community Foundation Greater Birmingham
3	Hunter Street Baptist Church
4	Public Health Network
5	United Way of Central Alabama
6	Alabama Public Television
7	Graymont Neighborhood Association
8	City of Birmingham
9	University of Alabama at Birmingham
10	AIDS Alabama
11	Childcare Resources
12	Moton Leeds Holistic Health Center
13	Leeds/Moody Community Presbyterian Church
14	Children's Aid Society
15	The Bethesda Life Center
16	Urban Hope Community Church
17	Baptist Health System
18	American Red Cross
19	St. Vincent's Health System
20	Jefferson County Department of Health
21	Addiction Prevention Coalition
22	Holy Family Cristo Rey High School
23	Hoover City Schools
24	Birmingham Mayor's Office
25	Bessemer City Schools
26	Greater Shiloh Baptist Church
27	Birmingham Dream Center

APPENDIX II:

BRAINSTORMING SESSION COMMENTS

Summarized responses provided by participants during the group discussions at the two Brainstorming Sessions are displayed below. The **bolded** responses denote perceived opportunities; *italicized* text represents threats, while non-bolded and non-italicized wording indicates a simultaneous opportunity and strength.

BRAINSTORMING SESSION INPUT GROUP 1:

QUESTION 1: WHAT HAS OCCURRED RECENTLY THAT MAY AFFECT OUR LOCAL PUBLIC HEALTH SYSTEM OR THE COMMUNITY?

- **Walkability to downtown Birmingham**
- **Air quality improvement**
- **No-smoking laws**
- **New medicines and treatments**
- **Increase in transportation**
- **Increase in parks and walking trails**
- **Revitalization of Birmingham's downtown**
- Increase in technology
- Change of address
- Mobility/Population shift "in and out" (Jefferson County losing population)
- *More street drugs*
- *Misuse of prescription drugs*
- *Natural disasters*
- *Politics*
- *Closing of Cooper Green Mercy Hospital*
- *Aging of the population*
- *Increase in poverty*
- *Decrease in access to healthcare*
- *Young parents/teen pregnancy*
- *Unemployment*
- *Crime*
- *Recession*
- *Breakdown of the family structure*
- *Loss of business headquarters from Birmingham*
- *Lack of education*
- *Distrust of healthcare systems*

QUESTION 2: WHAT MAY OCCUR IN THE FUTURE?

- **Digital, portable medical history**
- **Changing methods of communication**
- **Better transportation systems**
- **Better educational outcomes**
- **Enhanced science, technology, engineering and math knowledge**
- **Decrease in prevalence of cancers**
- **Increase in autism spectrum diagnoses**
- **Decrease in diabetes**
- **Decrease in heart disease**
- **Eradication of tobacco use**
- **Improved access for the differently-able**
- **More cooking at home**
- **Fewer food deserts**
- **Arrival of grocery stores in downtown Birmingham**
- **More sidewalks**
- **Improvements in air quality**
- **Increased emphasis on gardens and locally produced foods**
- New treatments but at higher cost
- Increased access to technology
- Increase of virtual medical information and diagnosis
- *Natural disasters*
- *Loss of business headquarters*
- *Medical system bankruptcy*
- *Widening of health disparities driven by socioeconomic status*
- *New diseases and pandemics*

QUESTION 3: ARE THERE ANY TRENDS OCCURRING THAT WILL HAVE AN IMPACT? DESCRIBE THE TRENDS.

- **Reduction of obesity rates (at least leveling off)**
- **More access to technology/cellular devices**
- **More green spaces**
- **"No-Smoking" ordinances**
- **Car pooling**
- **Walking school buses**
- **Increased survival rates**
- Changes in family composition and definition
- More telecommuting
- *More freeways*
- *Decrease in face- to- face personal interactions*
- *Increased vision problems (and other problems related to use of electronic devices)*
- *Movement against inoculations (vaccinations)*
- *Reduction in social intelligence*
- *Increase in Vitamin D deficiency*

QUESTION 4: WHAT FORCES ARE OCCURRING LOCALLY? REGIONALLY? NATIONALLY? GLOBALLY?

- Migration of African Americans from north to south
- Increased integration of demographic categories
- Influence of new, often global, businesses
- Shift in population – growth in percentage of people of color
- Increased awareness of health behaviors
- Increased nutritional information on menus
- Increased mass transit
- Population growth
- Changing sense of national identities
- Increase in "mega" city growth
- *Brain-drain*
- *Increased polarization on basis of politics, religion and other factors*
- *Increased distrust of politicians/authorities*
- *Widening health economic disparities*

QUESTION 5: WHAT CHARACTERISTICS OF OUR JURISDICTION OR STATE MAY POSE AN OPPORTUNITY OR A THREAT?

- **Rich natural resources**
- **Room for new leaders**
- **Fresh water**
- **Business growth**
- **Integration of the University of Alabama's medical and educational work to address community needs**
- **Enhanced educational resources**
- **UAB system as basis for shared medical information**
- Increased home schooling
- *Unethical leaders*
- *Outdated state Constitution*
- *High dependence on public assistance*
- *Climate may be a barrier to exercise*
- *Failing educational systems*
- *Environmental pollution*
- *Decreased fitness standards*

QUESTION 6: WHAT MAY OCCUR OR HAS OCCURRED THAT MAY POSE A BARRIER TO ACHIEVING THE SHARED VISION?

- *Poor educational outcomes*
- *Disparity in access to higher education*
- *Legacy of segregation*
- *Cultural components of eating/diet/food choices*
- *Social life organized around eating*
- *Social life not organized around physical activity*
- *Fragmentation–separate cities and school systems makes organization more difficult*
- *Disconnection between groups of all types*
- *Cultural "blinders"*
- *Lack of mass transit*
- *Urban sprawl*
- *Lack of opportunities to come together*

BRAINSTORMING SESSION INPUT GROUP 2:

QUESTION 1: WHAT HAS OCCURRED RECENTLY THAT MAY AFFECT OUR LOCAL PUBLIC HEALTH SYSTEM OR THE COMMUNITY?

- **Railroad Park District development**
- **Broadened scope of services provided by nurse practitioners and their enhanced prescriptive authority**
- **Expansion of healthcare services to include mental health**
- **Increased access to counseling**
- **Broader health insurance availability**
- Advances in technology have caused decrease in opportunities for people
- *Lack of health insurance*
- *Lack of employment*
- *Tornadoes from "April's Fury"*
- *Cooper Green Mercy Hospital's closing*
- *Lack of infrastructure*
- *Flooding*
- *Ice storm*
- *Insufficient elder and pediatric care*
- *Explosion due to gas leak*
- *Last doctor is leaving Leeds*
- *Lack of transportation to and from healthcare facilities*
- *Home fires*
- *Regional Care Organizations/State legislation (healthcare)*
- *Lack of Medicaid expansion*
- *Closing of schools*
- *Lack of funding for road repair*
- *Business closings*
- *Lack of mass transportation*
- *Crime*
- *Consolidation of hospital services and the potential for additional service closure*
- *Lack of spiritual health*

QUESTION 2: WHAT MAY OCCUR IN THE FUTURE?

- **Churches playing a role in providing healthcare for the community**
- **Economic growth and community development**
- **Senior citizens needing to learn more about technology**
- **Urban renewal**
- *Economic Disparities*
- *Closing of neighborhood schools taking away academic and athletic talent*
- *Teen pregnancy*
- *Cultural conflicts*
- *Revitalization of Carraway Hospital*
- *Demographic shifts*

QUESTION 3: ARE THERE ANY TRENDS OCCURRING THAT WILL HAVE AN IMPACT? DESCRIBE THE TRENDS.

- **Renovation of housing communities**
- **More trade schools**
- **Increase in gun control**
- **Shift of consciousness about health in schools**
- *Efforts are too localized (city governments and organizations need to be more comprehensive)*
- *Creation of more local education systems -the resources are spread thin*
- *Low health literacy*
- *Lack of community identity*
- *Law is driving health policy*
- *Increase in the digital divide*
- *Low morale*
- *Worsening chronic health conditions*

QUESTION 4: WHAT FORCES ARE OCCURRING LOCALLY? REGIONALLY? NATIONALLY? GLOBALLY?

- **Affordable Care Act**
- **Increased funding for specialty academies**
- **Education for young people should be increased (science and math)**
- **Technology innovations that impact homes 24 hours a day**
- **Adequacy of income, if not minimum wage**
- **Creation of a standard on poverty**
- **Increase in the number of doctors in training**
- **Reduction in obesity rates**
- **Adult medication issues among children**
- **Use of ICD-10 coding across the globe**
- **Need for a health bill of rights for prevention and wellness**
- **Gun control**
- **Same sex marriages**
- **Forcing collaboration among healthcare providers and agencies**
- *Lack of compassion for others*
- *Polarization of parties*
- *Global economy, inducing slave labor overseas*
- *Increase in incarceration (for-profit prisons)*
- *Military power is not adequate to defend the country*
- *Increase of "isms" and de-facto segregation*
- *Ignoring communities in need*
- *Manipulation of the country's currency*
- *Business losses*

QUESTION 5: WHAT CHARACTERISTICS OF OUR JURISDICTION OR STATE MAY POSE AN OPPORTUNITY OR A THREAT?

- **UAB**
- **Creation of strategic planning**
- **Strong community of faith**
- **The potential impact of philanthropy**
- **Revitalization of the Pratt City Community and Village Creek after flooding**
- **Technology innovation and Health Information Technology development**
- **Jobs and growth in manufacturing jobs**
- **Development of trail systems and pocket parks**
- *Regionalism*
- *Urban decline/rural poverty, income divide, de-facto segregation, growth of suburbs, suburban sprawl*
- *No confidence in Jefferson County's leadership*
- *Not having autonomy*
- *Unable to conduct business (upgraded technology is needed for attaining license plates)*
- *Poor financing (businesses are closing)*
- *Zoning policies (Jim Crow/Black Laws)*
- *Lack of funding will cause consolidation of services (fire/police)*
- *Low level of education threatens development*
- *Dysfunctional local governmental structure*

QUESTION 6: WHAT MAY OCCUR OR HAS OCCURRED THAT MAY POSE A BARRIER TO ACHIEVING THE SHARED VISION?

- *Lack of recognition and healing from Jefferson County's racial history and the indifference of transplants to it.*
- *Divide between the "have and have nots"*
- *Lack of knowledge of things that will help citizens strive for more*
- *Lack of personal affiliation (silos)*
- *Racisms and other "isms"*
- *Wasted opportunities to build economies of scale*
- *Crime*
- *Too much taxation*
- *Lack of transparency*
- *Clanism (families, churches, social groups)*
- *Lack of finding what we have in common*
- *Selfishness (hoarding information)*
- *Lack of mass transportation*
- *Disconnect between rural and urban parts of the city*
- *Post -manufacturing era jobs that do not provide an adequate wage*
- *"Good old boy" system*
- *Unwillingness to deal with causes of the immigration problems, avoidance of demographic change*

BRAINSTORMING SESSION INPUT GROUP 3:

QUESTION 1: WHAT HAS OCCURRED RECENTLY THAT MAY AFFECT OUR LOCAL PUBLIC HEALTH SYSTEM OR THE COMMUNITY?

- **The need for Medicaid Expansion**
- **Revitalization of Birmingham's downtown area**
- **Tobacco-Free legislation**
- **HIV testing in emergency rooms**
- Health insurance changes
- *Passing Alabama's Immigration Law*
- *Closure of clinics with the Affordable Care Act given as a reason for closure*
- *Policy changes for the undocumented/underserved*
- *Legislative non-action*
- *Closure of Cooper Green Mercy Hospital*

QUESTION 2: WHAT MAY OCCUR IN THE FUTURE?

- **More screening to identify the need for early intervention in children**
- **Continuity in helping people learn to navigate the system**
- **College age residents may see more care**
- Aging of the population resulting in changes in needs
- *Fewer people will seek treatment*
- *Higher out of pocket cost for healthcare resulting in residents deterring visits*
- *Need more mental health/drug prevention programs*
- *Need for bilingual providers/staff*
- *Increased in HIV cases in the 15 to 24 age group*
- *Less doctors leading to concern for access to healthcare*
- *Migration in and out of the state*
- *Continued high pregnancy rates*

QUESTION 3: ARE THERE ANY TRENDS OCCURRING THAT WILL HAVE AN IMPACT? DESCRIBE THE TRENDS.

- **State Pre-K program's success**
- **Use of alternative medicine**
- **Screenings and prevention service coverage under the Affordable Care Act**
- **Healthcare awareness due to political dialogue**
- **Increase in health education**
- 90,000 new covered lives in Alabama Marketplace Exchange (increase in healthcare capacity)
- Impact of Information Technology (IT) on healthcare, especially social media
- Faith-based support leads to need for talk about real sexual issues
- *Increase in HIV, Sexually Transmitted Diseases and pregnancies*
- *Increase in Homeless, Lesbian, Gay, Bisexual and Transgender populations and questioning youth*
- *Fostering of homeless youth that age out (Age 21)*
- *Political uncertainty*
- *Increase in infectious diseases*

QUESTION 4: WHAT FORCES ARE OCCURRING LOCALLY? REGIONALLY? NATIONALLY? GLOBALLY?

- **Food movement/nutrition**
- **"Let's Move" initiative**
- **Philanthropic foundations' emphasis on obesity and exercise**
- **National conversation about "what is family?"**
- **Economic realignment based on health trends like CVS not selling cigarettes**
- **Increased regulation on imports**
- Medicaid expansion
- Migrant Farm Workers – regulatory impact
- Vaccination trends for the HPV vaccine and the anti-vaccination trend
- *Undocumented individuals without access to coverage*
- *Political unrest and trade agreements*

QUESTION 5: WHAT CHARACTERISTICS OF OUR JURISDICTION OR STATE MAY POSE AN OPPORTUNITY OR A THREAT?

- **Storms leading to community reinvestment**
- **State Pre-K/Early intervention as a positive influence that can expand**
- **Sex education is limited, although the law allows it**
- **Philanthropic/giving community**
- **Preparation of the state's infrastructure for national disasters**
- *Aversion to compromise*
- *Municipality silos*
- *Immigrants that will not seek/ask for help due to fear*
- *The poor that will not seek help*
- *Alabama's State Constitution*

QUESTION 6: WHAT MAY OCCUR OR HAS OCCURRED THAT MAY POSE A BARRIER TO ACHIEVING THE SHARED VISION?

- **Acceptance of diversity**
- **Resources like 211 from United Way and 311 for the City of Birmingham**
- Immigration reform
- *Government*
- *Lack of collaboration and continued silos*
- *Cooper Green Mercy Hospital patients not having the right care at the right place and time*
- *Flow of money*
- *Fragmented transportation, medical home and service navigation systems require redesign*
- *Affordable Care Act is creating confusion and preventing access*

BRAINSTORMING SESSION INPUT GROUP 4:

QUESTION 1: WHAT HAS OCCURRED RECENTLY THAT MAY AFFECT OUR LOCAL PUBLIC HEALTH SYSTEM OR THE COMMUNITY?

- **Mandated wellness curricula in schools**
- **City's IBM Innovation Award**
- **Red Rock Trail System**
- **Faith-based groups involved in health issues**
- **Smoke-Free policies**
- **Jefferson County's exiting bankruptcy**
- **Birmingham Department of Youth Services' comprehensive programs**
- **Church involvement in low income areas**
- Affordable Care Act
- Legislative impact
- *Increase in heroin use*
- *Closure of Cooper Green Mercy Hospital*
- *Weak economy leading to job losses*
- *Lack of access to mental health*
- *Legalization of marijuana – public perception and availability*

QUESTION 2: WHAT MAY OCCUR IN THE FUTURE?

- **Increased focus on mental health intervention at an early age**
- **Increased access to neighborhood health services**
- **Social and health strategies to replace law enforcement intervention**
- **Increased utilization of prevention/wellness resources**
- **Revitalization of Birmingham's downtown**
- **Increased emphasis on physical activity and the development of trails and parks**
- **Urban renewal – "filling in doughnut holes"**
- **Increased recognition of the link between poverty and health**
- **Health/Social services in community centers**
- **Increased knowledge and ownership by citizens of community health**
- **Ecumenical covenants to promote justice and health**
- *Shortage of primary care physicians*
- *Increase in drug use and AIDS and limited access to treatment*

QUESTION 3: ARE THERE ANY TRENDS OCCURRING THAT WILL HAVE AN IMPACT? DESCRIBE THE TRENDS.

- **Leveling off of childhood obesity rates**
- Mobile food trucks
- Frustration with national and county government
- Minority children becoming the majority
- Social media's impact
- *Drug distribution routes and outcomes*
- *Immigrants' inability to access care*
- *Long term unemployment's impact on diet and access to care*
- *Growing gap between "techies" and technology*
- *Decrease in food stamp programs creates food insecurity*

QUESTION 4: WHAT FORCES ARE OCCURRING LOCALLY? REGIONALLY? NATIONALLY? GLOBALLY?

- **Philanthropic foundations' focus on outcomes**
- **Force of engagement of faith-based resources**
- **Increased appreciation of different cultures**
- **Drug policy changes**
- Education's shift from the perceived mentality of test taking to developing critical thinking skills
- Change in healthcare reimbursement
- *Decreasing world economy*
- *Social media masking the reality of social needs and conditions*
- *Increase in prison populations leading to demographic trends*
- *Diminishing ability for verbal communication*
- *Affluence counters living simply and simply living*

QUESTION 5: WHAT CHARACTERISTICS OF OUR JURISDICTION OR STATE MAY POSE AN OPPORTUNITY OR A THREAT?

- **Coalitions leading to new work**
- **Diversity**
- **Corporate economic development**
- **Federal Marketplace/Exchange**
- Religiosity in Alabama
- Revitalization of Birmingham's downtown, but not of other areas
- *Redistricting*
- *Geographic size*
- *Inadequate Transportation*
- *Territorial non-profit organizations (17,000 registered in Alabama)*
- *Lack of access to grocery stores and health facilities*
- *Inequity of education with many independent systems*
- *Greater divide socio-economically*
- *Jefferson County's I-20/59 corridor's usage in human and drug trafficking*
- *Disappearance of the Town Hall*
- *No Medicaid expansion*

QUESTION 6: WHAT MAY OCCUR OR HAS OCCURRED THAT MAY POSE A BARRIER TO ACHIEVING THE SHARED VISION?

- *Socio-economic divide*
- *Geographic sprawl*
- *Competition for limited dollars*
- *Continued educational disparity*
- *Lack of experience in achieving goals*
- *Disconnect between having a resource rich, strong medical hub and poor health outcomes*
- *Food deserts and lack of access to healthy food*

BRAINSTORMING SESSION INPUT GROUP 5:

QUESTION 1: WHAT HAS OCCURRED RECENTLY THAT MAY AFFECT OUR LOCAL PUBLIC HEALTH SYSTEM OR THE COMMUNITY?

- **Influx of Latino and Spanish-speaking populations and the lack of preparedness by the public health system for these populations (lack of interpreters and other language services)**
- **Trend toward wellness and health in the city (walking trails, etc.)**
- **Growth of the international population; Jefferson County is the third fastest growing international population in the nation**
- **Strong United Way and Community Foundation Women's Fund**
- **Very giving community**
- **Birmingham Jefferson County Transit System's expanded routes including more hospitals and clinics**
- *Closing of Cooper Green Mercy Hospital and urgent care model*
- *Dependence on food services*
- *Jefferson County's bankruptcy*
- *Primary care doctors reaching capacity for accepting or choosing not to accept Medicaid and Medicare patients*
- *Health care reform, yet no Medicaid expansion*
- *Birmingham City School consolidation and state level changes affecting local education systems*
- *People dying in the county*
- *Exacerbated racial disparities*

QUESTION 2: WHAT MAY OCCUR IN THE FUTURE?

- **Increase in diversity due to economic opportunities coming to the area**
- **Better measurement and evaluation of progress/ success**
- **Increased technology usage in education, for example**
- **Policy changes in healthcare and new opportunities for public heath's role**
- **Local policy changes –focus on implementing and sustaining change in the built environment**
- **Business/employee promotion of health and wellness to keep healthcare cost down**
- *Technology will create an environment that modifies the process of engagement*
- *Aging of the population*
- *Lack of readiness/resources to help with the aging population*
- *Climate change*
- *Lack of young people's understanding why health is important*
- *Economy will get worse before it gets better (hours cut for employees)*

QUESTION 3: ARE THERE ANY TRENDS OCCURRING THAT WILL HAVE AN IMPACT? DESCRIBE THE TRENDS.

- **Wellness trend in getting people more active**
- **Cultural melting within the community, and the community speaking for itself**
- **Tobacco-free environments and the changing of social norms**
- **Growing faith-based and community leadership around health**
- **Going back to creating a sense of community, community empowerment and being "my brother's keeper"**
- **Receipt of healthcare from mid-level professionals such as nurse practitioners and physician assistants rather than physicians**
- **Rise in foster care families**
- **Organizations beginning to address issues besides healthcare, organizing at the community level and speaking on their own behalf**
- *Generational poverty is not changing*
- *Pull from rural to city center*
- *Food supply is a problem with genetically modified foods*
- *Increase in chronic diseases and disabilities*
- *Child obesity trends are unclear*
- *Increasing cost of higher education*
- *Increase of attention deficit diagnosis and the lack of effective treatment*

QUESTION 4: WHAT FORCES ARE OCCURRING LOCALLY? REGIONALLY? NATIONALLY? GLOBALLY?

- **National public health model leading to policy changes in Prevention Research Centers (PRCs) for connecting resources in the community that impact community engagement**
- **Increase in national funders in the south, are we positioned well?**
- **The US President's stance on health issues has elicited conversation in every aspect**
- **Conversation around the US President is creating more dialogue among citizens**
- **The conversation has changed; for example, the dialogue around environmental change**
- **Patients' sharing experiences online positively affecting the care received locally**
- **Public and private funders looking for ways they can help without grant funds**
- **Conversation about obesity has increased**
- **Change in the social network of the country**
- **Growing use of technology for communication**
- **Media providing instant information**
- *Legalization of marijuana*
- *Trickle-down effect of political conversation may affect county negatively*
- *Lack of funding for programs and research in the southern region*
- *Natural disasters and inadequate disaster preparedness and response*
- *Alabama's Governor is perceived by some not to care about poor or unhealthy people*
- *Difficulty in attaining matching funds because local funds are not available*

QUESTION 5: WHAT CHARACTERISTICS OF OUR JURISDICTION OR STATE MAY POSE AN OPPORTUNITY OR A THREAT?

- **Birmingham is the most philanthropic city in the country**
- **Increase in faith-based and for-profit collaborations**
- **Resource clearing houses**
- **Healthcare reform's continued evolution**
- **Rural and urban understanding of and partnership around health**
- *Lack of adequate education and educational systems locally and state-wide*
- *People feeling they cannot depend on public transit*
- *Lack of trust in local and state government*
- *Inadequate nutrition in school systems*
- *Lack of community self-investment*
- *Lack of healthy nutrition in the prison system*
- *The fragmented non-profit system with entities competing for resources and sometimes duplicating efforts*
- *Lack of leadership to bring groups together*
- *History of racism*
- *Not preparing for future natural disasters*
- *Programs not penetrating targeted communities; there is a need to be intentional with public health and design measurable plans*
- *Increase in chronic illnesses and behavioral issues*

QUESTION 6: WHAT MAY OCCUR OR HAS OCCURRED THAT MAY POSE A BARRIER TO ACHIEVING THE SHARED VISION?

- *Lack of educational achievement*
- *Food desert issues that need to be addressed*
- *Lack of positive feedback. What's right about individuals should be celebrated*
- *Alabama's Immigration Act's impact on the economy and education*
- *Mindset and makeup of the state government*
- *Lack of shared communities*
- *Unequal distribution of resources between urban and rural areas*
- *Segmentation of education systems based on income*
- *Privatization of the country's governance and capitalist forces controlling government*
- *History of industrial pollution*

APPENDIX III:

COMPILATION OF BRAINSTORMING SESSION RESULTS

Identified forces of change, including strengths, weaknesses and issues and events defined as both strengths and weaknesses are provided in the tables below. **Bolded** items indicate the item as a perceived strength, items in *italics* represent weaknesses and the non-bolded, non-italicized item represent items concurrently identified as a strength and weakness.

STRENGTHS:

- **Air quality improvement**
- **"Walkability" to downtown Birmingham**
- **"No smoking" laws**
- **New medicines and treatments**
- **Increase in transportation**
- **Increase in parks and walking trails**
- **Revitalization of Birmingham's downtown**
- **Digital, portable medical history**
- **Changing methods of communication**
- **Better transportation systems**
- **Better educational outcomes**
- **Enhanced Science, Technology, Engineering and Math (STEM) knowledge**
- **Decreased prevalence of cancers**
- **Increase in autism spectrum diagnoses**
- **Decrease in diabetes**
- **Decrease in heart disease**
- **Eradication of tobacco use**
- **Improved access for the differently-able**
- **More cooking at home**
- **Fewer food deserts**
- **Arrival of grocery stores in downtown Birmingham**
- **More sidewalks**
- **Improvements in air quality**
- **Increased emphasis on gardens and locally produced foods**
- **Reduction of obesity rates (at least leveling off of rates)**
- **More access to technology/cellular devices**
- **More green spaces**
- **"No Smoking" ordinances**
- **Carpooling**
- **Walking school buses**
- **Increased survival rates**
- **Migration of African Americans from north to south**
- **Increased integration of demographic categories**
- **Influence of new, often global, businesses**
- **Shift in population – growth of the percentage of people of color**
- **Increased awareness of health behaviors**
- **Increased nutritional information on menus**
- **Increased mass transit**
- **Population growth**
- **Sense of national identities changing**
- **Rich natural resources**
- **Room for new leaders**
- **Fresh water**
- **Business growth**
- **Integration of the University of Alabama's medical and educational work to address community needs**
- **Enhanced educational resources**
- **UAB's system as basis for shared medical information**
- **Railroad Park District development**
- **Broadened scope of services provided by Nurse Practitioners and their enhanced prescriptive authority**
- **Expansion of healthcare services to include mental health**
- **Increased access to counseling**
- **Broader health insurance coverage**
- **Churches playing a role in community healthcare provision**
- **Economic growth and community development**
- **Senior Citizens needing to learn more about technology**
- **Urban renewal**
- **Renovation of housing communities**
- **More trade schools**

- Increased gun control
- Shift of consciousness about health in schools
- Affordable Care Act
- Increased funding for specialty academies
- Education for young people should be increased (science and math)
- Technology innovations that impact homes 24 hours a day
- Adequacy of income, if not minimum wage
- Creation of a standard on poverty policy
- Increase in the number of doctors being trained
- Reduction in obesity rates
- Adult medication issues among children
- Use of ICD-10 coding across the globe
- Need for a health bill of rights for prevention and wellness
- Gun control
- Same sex marriages
- Forcing collaboration among healthcare providers and agencies
- UAB
- Creation of strategic planning
- Strong community of faith
- Potential for the impact of philanthropy
- Revitalization of the Pratt City community and Village Creek after flooding
- Technology innovation and health information technology development
- Jobs and growth in manufacturing jobs
- Development of trail systems and pocket parks
- Need for Medicaid expansion
- Revitalization of Birmingham's downtown
- Tobacco-Free Legislation
- HIV testing in Emergency Rooms
- More screening for the need for early intervention in children
- Continuity in helping people learn to navigate the system
- College- aged persons may see more care
- Alabama's Pre-K program's success
- Use of alternative medicine
- Screenings and prevention service coverage under the Affordable Care Act
- Healthcare awareness due to political dialogue
- Increase in health education
- Food movement/nutrition
- "Let's Move" initiative
- Philanthropic foundations' emphasis on obesity and exercise
- National conversation about "what is family?"
- Economic realignment based on health trends like CVS not selling cigarettes
- Increased regulation on imports
- Storms leading to community reinvestment
- Alabama's Pre-K/Early Intervention as a positive influence that can expand
- Sex education is limited, although the law allows it
- Philanthropic/giving community
- Prepare the state infrastructure for national disasters
- Acceptance of diversity
- Resources like 211 from United Way and 311 for the City of Birmingham
- Mandated wellness curricula in schools
- Birmingham's IBM Innovation Award
- Red Rock Ridge and Valley Trail System
- Faith-based groups' involvement in health issues
- Smoke-Free policies
- Jefferson County's exiting bankruptcy
- Birmingham Department of Youth Services' comprehensive programs
- Church involvement in low income areas
- Increased focus on mental health and early age intervention
- Increased access to neighborhood health services
- Social and health strategies to replace law enforcement intervention
- Increased utilization of prevention/wellness resources
- Revitalization of Birmingham's downtown
- Increased emphasis on physical activity and the development of trails and parks
- Urban renewal – "filling in doughnut holes"
- Increased recognition of the link between poverty and health
- Health/Social services in community centers
- Increased knowledge and ownership by residents of community health
- Ecumenical covenants to promote justice and health
- Leveling off of childhood obesity rates
- Philanthropic foundations' focus on outcomes

- **Force of engagement of faith-based resources**
- **Increased appreciation of different cultures**
- **Coalitions leading to new work**
- **Diversity**
- **Corporate economic development**
- **Federal Marketplace/Exchange**
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- **Very giving community**
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- **Increase in diversity due to economic opportunities coming to the area**
- **Better measurement and evaluation of progress/success**
- **Increased use of technology in education, for example**
- **Policy changes in healthcare present new opportunities for public heath**
- **Local policy changes and the focus on implementing and sustaining change in the built environment**
- **Business/employers promoting health and wellness to keep healthcare cost down**
- **Wellness trend of getting people more active**
- **Cultural melting within the community and the community speaking for itself**
- **Tobacco-free environments are changing social norms**
- **Growing faith leadership around health**
- **Going back to creating a sense of community, community empowerment and being "my brother's keeper"**
- **Healthcare provided by mid-level professionals such as nurse practitioners and physician's assistants**
- **Rise in foster care families**
- **Organizations beginning to address issues beside healthcare, organizing at the community level and speaking on their own behalf**
- **National public health model leading to policy changes in Prevention Research Centers (PRCs) to connect resources in the community that impact community engagement**
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- **Growing use of technology for communication**
- **Media providing instant information**
- **Birmingham is the most philanthropic city in the country**
- **Increase in faith-based and for-profit collaborations**
- **Resource clearing houses**
- **Healthcare reforms continued evolution**
- **Rural and urban understanding and partnership around health**

SIMULTANEOUS STRENGTHS AND WEAKNESSES:

- Increase in technology
- Change of address
- Mobility/Population shift "in and out"
- New treatments but at higher costs
- Increased access to technology
- Increase in virtual medical information and diagnosis
- Changes in family composition and definition
- More telecommuting
- Increase in "mega" city growth
- Increased home schooling
- Advances in technology
- Health insurance changes
- The aging of the population is resulting in changing needs
- 90,000 covered through the Alabama Marketplace Exchange (increase in healthcare capacity)
- Impact of Information Technology (IT) on healthcare, especially social media

- Influx of Latino and Spanish-speaking populations and the lack of preparedness by the public health system (lack of interpreters and other language services)
- Medicaid expansion
- Faith-based support leading need to talk about real sexual issues impacting the community
- Migrant Farm Workers and regulatory impact
- Vaccination trends for the HPV vaccine
- Immigration reform
- Affordable Care Act
- Legislative impact
- Mobile food trucks
- Frustration with the Federal and local government
- Minority children becoming the majority
- Social media's impact on drug policy changes
- Education's shift in mentality from test taking to developing critical thinking skills
- Significant change in healthcare reimbursement
- Alabama's religiosity
- Revitalization of Birmingham's downtown, but not of other areas
- Technology will create an environment that modifies the process of engagement

WEAKNESSES:

- *More street drugs*
- *Misuse of prescription drugs*
- *Natural disasters*
- *Politics*
- *Closing of Cooper Green Mercy Hospital*
- *Aging of the population*
- *Increase in poverty*
- *Decrease in healthcare access*
- *Young parents/teen pregnancy*
- *Unemployment*
- *Crime*
- *Recession*
- *Breakdown of the family structure*
- *Loss of business headquarters from Birmingham*
- *Lack of education*
- *Natural disasters*
- *Lack of educational achievement*
- *Lack of positive feedback; what's right about individuals should be celebrated*
- *Food deserts*
- *Widening of health disparities driven by socioeconomic status*
- *New diseases and pandemics*
- *More freeways*
- *Decrease in face-to-face personal interactions*
- *Increased vision problems (and other problems related to use of electronic devices)*
- *Movement against inoculations (vaccinations)*
- *Reduction in social intelligence*
- *Increase in Vitamin D deficiency*
- *Ice storm*
- *Insufficient elder and pediatric care*
- *Explosion due to gas leak*
- *Last doctor leaving Leeds*
- *Lack of transportation to and from healthcare facilities*
- *Home fires*
- *Regional Care Organizations/State legislation (healthcare)*
- *Lack of Medicaid expansion*
- *School closure*
- *Lack of funding for road repair*
- *Business closures*
- *Lack of mass transportation*
- *Crime*
- *Consolidation of hospital services and the potential to close other services*
- *Lack of spiritual health*
- *Brain-drain*
- *Increased polarization on the basis of politics, religion and other factors*
- *Increased distrust of politicians and authorities*
- *Widening health economic disparities*
- *Unethical leaders*
- *Outdated Alabama Constitution*
- *High dependence on public assistance*
- *Climate may be a barrier to exercise*
- *Failing educational systems*
- *Environmental pollution*
- *Decreased fitness standards*
- *Poor educational outcomes*
- *Disparity in access to higher education*

- *Legacy of segregation*
- *Cultural components of eating/diet/food choices*
- *Social life organized around eating*
- *Dependence on food services*
- *Social life not organized around physical activity*
- *The fragmentation between cities and school systems makes it more difficult to organize*
- *Disconnection between groups of all types*
- *Cultural "blinders"*
- *Lack of mass transit*
- *Urban sprawl*
- *Lack of opportunities to come together*
- *Lack of health insurance*
- *Lack of employment*
- *Tornados from "April's Fury"*
- *Cooper Green Mercy Hospital's closing*
- *Lack of infrastructure*
- *Flooding*
- *Economic disparities*
- *Closing of neighborhood schools is taking away academic and athletic talent*
- *Teen pregnancy*
- *Cultural conflicts*
- *Revitalization of Carraway Hospital*
- *Demographic shifts*
- *Efforts are too localized (city governments and organizations need to be more comprehensive)*
- *Creation of more local education systems where resources are spread thin*
- *Low health literacy*
- *Lack of community identity*
- *Law is driving health policy*
- *Increase in the digital divide*
- *Low morale*
- *Worsening chronic health conditions*
- *Lack of compassion for others*
- *Polarization of parties*
- *Global economy inducing slave labor overseas*
- *Increase in incarceration (for-profit prisons)*
- *Military power is inadequate to defend the country*
- *Focus outward*
- *Increase of "isms" and de-facto segregation*
- *Ignoring communities in need*
- *Manipulation of the country's currency*
- *Business losses from regionalism*
- *Urban decline/rural poverty*
- *Income divide*
- *De-facto segregation*
- *Growth of suburbs and suburban sprawl*
- *No confidence in Jefferson County's leadership (Bankruptcy)*
- *Not having autonomy*
- *Unable to conduct business (upgraded technology is needed for attaining license plates)*
- *Poor financing resulting in business closure*
- *Zoning policies (Jim Crow/Black Laws)*
- *Lack of funding will cause consolidation of services (fire/police)*
- *Low level of education is a threat to development*
- *Dysfunctional local government structure*
- *Lack of recognition and healing from racial history and the indifference of transplants to it*
- *Divide between the "have and have nots"*
- *Lack of knowledge of things that will help citizens strive for more*
- *Lack of personal affiliation (silos)*
- *Racisms and other "isms"*
- *Wasted opportunities to build economies of scale*
- *Crime*
- *Too much taxation*
- *Lack of transparency*
- *Clanism (families, churches, social groups)*
- *Lack of finding what we have in common*
- *Selfishness (hoarding information)*
- *Lack of mass transportation*
- *Disconnect between rural and urban parts of the city*
- *Post-manufacturing era jobs that do not provide an adequate wage*
- *"Good old boy" system*
- *Unwillingness to deal with the causes of the immigration problems, avoidance of demographic change and the passage of Alabama's Immigration Act*
- *Closure of clinics with the Affordable Care Act given as a reason for the closure*
- *Policy changes for the undocumented/underserved*
- *Legislative non-action*
- *Closure of Cooper Green Mercy Hospital*
- *Higher out of pocket cost is deterring healthcare visits*
- *Need more mental health/drug prevention programs*
- *Need for bilingual providers/staff*

- *Increase in HIV cases in the 15 to 24 year old age group*
- *Fewer doctors leading to concern for access to healthcare*
- *Migration in and out of Alabama*
- *Continued high pregnancy rates*
- *Increase in HIV, Sexually Transmitted Diseases and pregnancies*
- *Increase in the Homeless, Lesbian, Gay, Bisexual and Transgender populations and questioning youth*
- *Fostering of homeless youth that age out (age 21)*
- *Political uncertainty*
- *Increase in infectious disease*
- *Undocumented residents without access to coverage*
- *Political unrest and trade agreements*
- *Aversion to compromise*
- *Municipality silos*
- *Immigrants that will not seek/ask for help due to fear*
- *The poor that will not seek help*
- *Alabama's Constitution and government*
- *Lack of collaboration and continued silos*
- *Cooper Green Mercy Hospital patients not having the right care at the right place and at the right time*
- *Flow of money*
- *The fragmented transportation, medical home and navigation systems require redesign*
- *The Affordable Care Act is creating confusion and preventing access*
- *Increase in heroin use*
- *Closure of Cooper Green Mercy Hospital*
- *Weak economy leading to job losses*
- *Lack of access to mental health*
- *Legalization of marijuana, public perception and availability*
- *Shortage of primary care physicians*
- *Increase in drug use and AIDS, limited access to treatment, drug distribution routes and the outcomes of these on the community*
- *Immigrants' inability to access care*
- *Long term unemployment's impact on diet and access to care*
- *Growing gap between "techies" and technology*
- *The decrease in food stamp programs creates food insecurity*
- *Declining world economy*
- *Social media masks the reality of social needs and conditions*
- *Increase in prison populations is leading to demographic trends*
- *Losing ability for verbal communication*
- *Affluence counters living simply and simply living*
- *Redistricting*
- *Geographic size*
- *Transportation is inadequate*
- *Territorial non-profit organizations (17,000 registered in the state)*
- *Lack of access to grocery stores and health facilities*
- *Inequity of education with many independent systems*
- *Greater divide socio-economically*
- *Use of Jefferson County's I-20/59 corridor for human trafficking and drug trafficking*
- *Disappearance of Town Hall*
- *Lack of Medicaid expansion*
- *Socio-economic divide*
- *Geographic sprawl*
- *Competition for limited dollars*
- *Continued educational disparity*
- *Lack of experience in achieving goals*
- *Disconnect between having a resource rich, strong medical hub and poor health outcomes*
- *Food deserts and lack of access to healthy food*
- *Closing of Cooper Green Mercy Hospital and urgent care model*
- *Jefferson County's bankruptcy*
- *Primary care doctors reaching capacity for accepting or choosing not to accept Medicaid and Medicare patients*
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- *Generational poverty is not changing*
- *Pull from rural to city center*

- *The food supply is a problem with genetically modified foods*
- *Increase in chronic diseases and disabilities*
- *Childhood obesity rate trends are unclear*
- *Increasing cost of higher education*
- *Increase of attention deficit diagnoses and inadequate treatment options*
- *Legalization of marijuana*
- *Trickle-down effect of political conversation may affect the county negatively*
- *Lack of funding for programs and research in the Southern region*
- *Natural disasters and inadequate disaster preparedness and response*
- *Alabama's Governor is perceived by some not to care about the poor or unhealthy people*
- *Difficulty in attaining matching funds because local funds are not available*
- *Lack of adequate education and educational systems locally and throughout the state*
- *People feeling they cannot depend on public transit*
- *Lack of trust in local and state government*
- *Inadequate nutrition in school systems*
- *Lack of the community investing in itself*
- *Inadequate healthy nutrition in the prison system*
- *Fragmented non-profit systems competing for resources and sometimes duplicating efforts*
- *Lack of leadership to bring groups together*
- *History of racism*
- *Not preparing for future natural disasters*
- *Programs not penetrating targeted communities; there is a need to be intentional with public health and design measurable plans*
- *Increase in chronic illnesses and behavioral issues*
- *Alabama's Immigration Act's impact on the economy and education*
- *Mindset and makeup of Alabama's government*
- *Lack of shared communities*
- *Unequal distribution of resources between urban and rural areas*
- *Educational system segmentation based on income*
- *Privatization of the country's governance and capitalist forces controlling government*
- *History of industrial pollution*

The work of Community Matters 20/20 is supported by the Jefferson County Department of Health

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