Rural Health Plan Update

February, 2009

David Libby, Chairman
Elizabeth Rugg, Executive Director
Teresa Kelly, Special Projects Coordinator

WHO WE ARE

The health councils were created in 1983 by Florida Statute to identify, address and resolve health care issues of local concern. Each health council is a private, non-profit organization governed by a Board of Directors. The Board members are appointed by County Commissioners to represent the concerns of health care consumers, providers and purchasers.

The Health Council of West Central Florida, Inc. (HCWCF) serves Hardee, Highlands, Hillsborough, Manatee and Polk counties. The Council has extensive experience working with for-profit and non-profit agencies, public health organizations, consumers and professionals. Collaboration and cooperation are critical to the success of our mission.

We have three strategic goals: (1) influence the accessibility of health care and social support systems through *comprehensive health planning*; (2) provide *education* about essential community health challenges and solutions; and (3) participate as a collaborative partner to address current and emerging health issues to develop and sustain efficient and cost effective *service delivery* systems.

HEALTH COUNCIL OF WEST CENTRAL FLORIDA, INC.
BOARD OF DIRECTORS

David Acebo, Hillsborough
Dr. Ronald Berezniak, Manatee
Joel Chudnow, Hillsborough
Ray Dielman, Manatee
Jacquelyn Garvin, RN, Hillsborough
David Libby, Polk (Chair)
Carole Mackey, Hillsborough
Ted Wilson, Hillsborough

TO LEARN MORE ABOUT THE HEALTH COUNCIL

Visit our website - www.healthcouncils.org

Or Contact Us:

Health Council of West Central Florida, Inc.
9600 Koger Blvd., Suite 221
St. Petersburg, FL 33702
727-217-7070
727-570-3033 (Fax)

Rural Health Plan Review and Update

The Health Council of West Central Florida conducted a desk review of 29 local health needs assessments. The needs assessments generally utilized the MAPP process, and were carried out over several years ranging from 2004 to 2007. Four counties (Jackson, Jefferson, Taylor and Washington) were not reviewed as information was not attainable.

In addition, an on-line survey was developed to gather information from a variety of key informants to ascertain if new or different issues were identified for rural health that had not been identified in the MAPP processes. The on-line survey was also used to validate the findings across all rural areas of the State of Florida.

The findings of the county needs assessments were compared with the goals and objectives of the 2002 Florida Rural Health Plan for concurrency and outlying themes were identified.

Concurrency among County Needs Assessments and State Plan

All rural counties were designated as medically underserved with particular health professional shortages in primary care, dental health and mental health. This need was addressed in the Rural Health Plan's objectives related to improving quality of care and increasing availability of coordinated systems of care.

Rates of uninsured residents under age 65 in rural counties were higher than the statewide average. The Rural Plan addressed the need for increasing financial access to health services.

Morbidity and mortality rates were higher than statewide rates for several indictors, including motor vehicle crashes, infant mortality, diabetes, Alzheimer's disease, and chronic lower respiratory disease. The Plan acknowledged this issue in the goal related to improving the health status of Florida's rural citizens.

Other chronic diseases such as asthma, heart disease and cancer were included in some local assessments. In addition, risky behaviors, which included teen pregnancy, teen repeat birth rates, substance abuse, sexually transmitted diseases, HIV/AIDS, child abuse and domestic violence, were indicated In many local assessments, but no specific strategies related to these issues were addressed in the State Plan's goals and objectives.

Obesity and nutrition issues were cited in nine of the 29 local plans.

One area that was not specifically noted in most of the local plans was the need for more Emergency Medical Services. Even though mortality data surrounding motor vehicle crashes and other unintentional injuries was acknowledged, it did not

generally result in specific action plans at the local level. The State Plan did address the specific need for increasing the number of EMS personnel, as well as the need to provide on-going training for personnel to assist with retention.

Local assessment findings indicated that many people are satisfied with the care they received, despite having limited options for treatment and experiencing challenges with payment. Dissatisfaction arose with the need for specialty care providers and the distances that must be traveled to obtain care. The State Plan addressed quality of care issues in goals and objectives, but did not include specific strategies related to specialty care.

Overall, the goals and objectives outlined in the Rural Health Plan were validated at the county level.

On-line Survey

In conjunction with the Rural Health Plan work group convened by the Office of Rural Health, the Health Council developed and conducted an on-line survey of key informants to assess current perceptions of health related needs in rural areas. Members of the work group were asked to identify individuals in their geographic region and invite them to participate in the survey.

Summary of Findings Rural Health Survey

The survey asked respondents to rate the top five unmet needs related to health in their service areas. One hundred and five (105) respondents rated at least one priority.

The percentage of respondents from each county is indicated in Table 1. More than one answer was permitted and some respondents also commented on rural portions of non-rural counties. Highlands, Hardee, DeSoto, Putnam and Nassau counties had the largest percent of participants responding.

Table 1 - County Represented

County	% respondents
Baker	3.8
Bradford	9.5
Calhoun	1
Columbia	5.7
DeSoto	**13.3**
Dixie	3.8
Franklin	1
Gadsen	3.8
Gilchrist	2.9
Glades	4.8
Gulf	1
Hamilton	3.8
Hardee	**18.1**
Hendry	6.7
Highlands	**22.9**
Holmes	1
Jefferson	0
Jackson	1.9
LaFayette	2.9
Levy	3.8
Liberty	1
Madison	1.9
Monroe	1
Nassau	**11.4**
Okeechobee	2.9
Putnam	**13.3**
Sumter	2.9
Suwanee	4.8
Taylor	1.9
Union	8.6
Wakulla	1.9
Walton	1.9
Washington	1
Polk*	2.9
Palm Beach*	1
Alachua*	1.9
Clay*	1
Flagler*	1
St. Lucie*	1
Martin*	1
Manatee*	1
Statewide	1

Respondents were asked to identify their area of expertise. Again, more than one response was permitted. Table 2 indicates percent responding by area of expertise.

Table 2 - Area of Expertise

Area of Expertise	% respondents
Public Health	32.4
Medical Professional	26.7
Health/Safety education	25.7
Maternal and Child Health	21.0
HIV/STD Services	17.1
County Govt.	17.1
Other	17.0
Dental	16.2
Hospital Administration	14.3
Children/Families	14.3
Environmental Health	14.3
EMS Provider	13.3
Health Planning	13.3
Community Health Center	11.4
Social Services	9.5
Rural Health Clinic	9.5
Free Clinic	8.6
Mental health	7.6
Religious Organization	7.6
Information and Referral	7.6
Elderly Services	6.7
Consumer	5.7
Hospice	5.7
School Board/Education	4.8
Home health	4.8
City of Town Govt.	4.8
Pharmacy	4.8
Funder of Services	3.8
Substance Abuse	2.9
Disability Services	2.9
Health Insurance	2.9
Nutrition/meal provider	1.9
Long term care	1.9
Cooperative extension	1.0

Overall Rankings of Rural Health Unmet Needs

Overall rankings were achieved by weighting responses in each question from 1st through 5th greatest need. Weighted responses by topic were added together and then ranked from highest to lowest. Seven topics are included due to the relatively close scores of numbers 5, 6 and 7.

1. Primary Care
2. Specialty Care
3. Chronic Disease Management
4. Dental
5. Chronic Disease Prevention
6. Mental Health
7. Prescription Medications

Reasons for Unmet Needs

Respondents were asked to identify up to five reasons why a need was unmet. Table 3 indicates results by topic.

Table 3 - Reasons for Unmet Needs by Topic

	Primary Care	Specialty Care	Chronic Management	Dental	Chronic Prevention	Mental Health	Medications
Lack of Payment Sources	**X**	**X**	**X**	**X**	**X**	x	**X**
Lack of Transportation	X	x	x			x	x
Lack of resources for uninsured	X	x	x	x	x	**X**	
Inadequate public funding	x						x
Distance to Care						x	
Lack of Locally Available care	x		x	x	x	x	x
Inability to afford co-payments		x		x			x
Lifestyle Choices			x	x	x		
Lack of Compliance by Patient		x			x		

*__Bold X__ indicates most commonly cited reason

As was indicated in the State Plan, financial access was the most commonly cited reason for unmet needs across all topics. Responses related to financial access included lack of payment sources, lack of resources for the uninsured, inadequate public funding, and inability to afford co-payments.

Geographic isolation was indicated in response to lack of transportation, distance to care and lack of locally available care.

Lifestyle choices and lack of compliance by patients was identified as reasons for unmet need specifically for chronic disease management and prevention, dental care and specialty care.

Specialty Care

Specialty care was ranked as the second greatest unmet need overall. Respondents were asked to identify up to five specialists most in need. Table 4 indicates specialists most needed.

Table 4 - Specialists Most Needed

Specialty	% Response
Psychiatry	60.0
Cardiology	54.1
Endocrinology	48.2
Orthopedics	43.5
Obstetrics	35.3
Neurology	30.6
Dermatology	25.9
Oncology	21.2
Trauma Surgery	18.8
Ophthalmology	7.1
Immunology	7.1
Physical/Occupational Therapy	7.1
Don't Know/Not Applicable	5.9
Radiology	3.5

"Other" responses included: Hematology, Pulmonology, Gastroenterology, other rehab specialists, pain management, and general surgery

Data Comparisons

Public Health Officials, Medical Professionals, and Health/Safety education professionals were the most common types of respondents; however, data was analyzed a variety of ways including: grouping similar respondents and assessing each group of responders individually to determine if certain areas of expertise led to different assessments of unmet needs. While most individual groups and groupings reflected the same basic priorities as the overall rankings (although some shifts in ranking order occurred), some atypical rankings were noted.

The most atypical responses came from EMS providers, consumers, Rural Health Clinics, and a combination of community/rural and free clinics. Caution should be used in interpreting this data due to small sample sizes, inherent biases based on

populations served, and work performed. In addition, respondents from these categories may also have indicated more than one area of expertise.

EMS providers (n = 14) rated the top unmet needs as follows:

1. Emergency Medical Services
2. Chronic Disease Management
3. Primary Care
4. Medications
5. Specialty Care

Consumers (n=6) rated the top unmet needs as follows:

1. Basic Needs (shelter, food, clothing)
2. Primary Care
3. Substance Abuse treatment
4. HIV/AIDS services
5. No single issue ranked 5th

Rural Health Clinics (n =10) rated the top unmet needs as follows:

1. Mental Health
2. Dental
3. Chronic Disease Management
4. Emergency Medical Services
5. No single issue ranked 5th

Combined community/rural/free clinic responses (n = 25) resulted in the following rankings:

1. Mental Health
2. Dental (tie)
2. Chronic Disease Management (tie)
4. Primary Care
5. Maternal and Child Care

PEACH Process

Members of the Rural Health Plan Advisory Committee were invited to participate in the PEACH (Popular Empirical Assessment of Community Health) process. Using data gathered from the desk review, on-line survey and existing goals and objectives of the Office of Rural Health, a 5 x 5 grid was constructed focusing on the types of activities needed and the unmet needs impacted by those activities. Members of the Advisory Committee received the following instructions and definitions to complete the PEACH process.

PEACH Exercise (Instructions)

The mandated purpose of the Florida Office of Rural Health is to foster the provision of health care services in rural areas, and serve as a catalyst for improved rural health services.

In order to assist the Office of Rural Health in prioritizing their areas of focus, you are being asked to participate in the PEACH (Popular Empirical Assessment for Community Health) process.

Please keep in mind that activities conducted by the Office of Rural Health generally have statewide impact, and in some cases may take the form of advocating for funding or policy change, but not necessarily providing funding or having control over policy.

Please print out the grid and note your allocations in the appropriate locations and return by fax to Teresa Kelly at (727) 570-3033

Office of Rural Health PEACH Grid

	ACTIVITIES NEEDED				
UNMET NEED IMPACTED	New Resource Development	Capacity Development	Infrastructure Improvement	Manpower Development & Retention	Consumer Education
Accessibility					
Affordability					
Availability					
Quality					
Prevention					

PLEASE USE **ALL** OF YOUR $100 IN THE PERMITTED DENOMINATIONS.

- One $50 bill
- One $20 bill
- Two $10 bills
- One $5 bill
- Five $1 bills

Activities Needed

The activities have been defined in broad terms below. Some concepts may cross over into more than one area of focus, but you are asked to use the terms as defined for purposes of this exercise. These are not exhaustive lists of the types of activities that could be considered but are based upon previous activities undertaken by the Office and findings from the recent key informant survey.

New Resources: Relates to development of new clinics (such as FQHC and Rural Health Clinics); development of new volunteer-based providers; development of sources to pay for care; implementation of community-based systems of care and networks.

Capacity Development: Includes planning for community-based systems of care; activities to improve the planning, administrative and financial management capabilities of administrators and Boards; efforts to identify and coordinate with programs and agencies that promote a healthy community approach; efforts to identify health issues and priorities and implement solutions at the local level; provide or support activities that improve the quality of care; activities that contribute to sustainable organizations and networks; improvements in cultural/linguistic competencies among providers.

Infrastructure Improvements: Relates to providing funding for capital improvements, service expansion and technology upgrades, such as electronic health information systems.

Manpower Development/Retention: Includes activities such as the recruitment of providers to rural areas; training of new providers; and ongoing professional development and training.

Consumer Education: Includes activities that improve consumer knowledge of where and how to obtain services; lifestyle choices that contribute to disease and injury; importance of screenings and immunizations; how to communicate with providers; overcoming fear and stigma.

Unmet Need Impacted

Reasons for unmet needs were explored in the key informant survey and are being used as a cross reference to identify relationships between the activities you feel are important and the unmet needs you feel will be impacted by those activities. For purposes of this exercise please use the general descriptions listed below.

Accessibility: Includes location, transportation, hours of operation, wait times for appointments
Affordability: Cost of care, availability of insurance, cost of insurance, cost of co-pays/deductibles, availability of public funding for care

Availability: Related to the existence of services/providers (Are there any?)

Quality: Related to patient outcomes, management/administration efficiencies

Prevention: Service/activities related to the prevention of illness/injury

AN EXAMPLE: You believe that Quality of Care is the most critical issue facing rural communities. You also believe that Quality Care can be influenced most effectively by the Office of Rural Health through Capacity Development, so you place your $50 bill in the row titled Quality under the column titled Capacity Development. You may place additional bills in the same space to indicate the level of importance you place on this activity *OR* you can distribute bills across other spaces to highlight your interest in pursuing other activities to address unmet needs.

A sample of a completed PEACH chart appears below:

	ACTIVITIES NEEDED				
UNMET NEED IMPACTED	New Resource Development	Capacity Development	Infrastructure Improvement	Manpower Development & Retention	Consumer Education
Accessibility	$1	$ 5			
Affordability	$1 $1				
Availability	$20			$10	
Quality		$50	$1 $1		
Prevention					$10

Results of PEACH Process

Nine committee members participated in the PEACH process. Table 5 reflects the results of the PEACH process.

Table 5 - PEACH Results

	ACTIVITIES NEEDED					
UNMET NEED IMPACTED	New Resource Development	Capacity Development	Infrastructure Improvement	Manpower Development & Retention	Consumer Education	Total
Accessibility	131	116	42	51	9	**349**
Affordability	13	102	10	5	1	136
Availability	35	30	70	42	8	185
Quality	1	61	25	22	2	111
Prevention	5	28	1	0	90	124
TOTAL	**185**	**337**	**148**	**120**	**110**	**900**

PEACH respondents identified ***capacity development*** as the primary area of activity for the Office of Rural Health. ***New resource development*** was the activity area ranked second by PEACH respondents.

PEACH respondents identified ***accessibility of care*** as the unmet need most impacted. ***Availability of care*** was the unmet need ranked second by PEACH respondents.

In essence, as the Office of Rural Health prioritizes its work, activities that fall into these categories are thought to have the greatest impact in improving accessibility and access to care.