



2015 State of Alabama COMMUNITY HEALTH IMPROVEMENT PLAN

A collaborative plan to improve the health of Alabama Citizens 2015-2019



*“The groundwork
of happiness
is health.”*

– Leigh Hunt



Table of Contents

4	Letter from State Health Officer
5	Executive Summary
6	The Alabama Community Health Improvement Plan Process Overview
7	Overall Goal of the Alabama Community Health Improvement Plan
8	The Alabama Community Health Improvement Plan Process
9	The Alabama Community Health Improvement Health Priority Focused Approach
10	Identifying Statewide Partners and Stakeholders for the Alabama Community Health Improvement Plan
11	Concerns and Themes Identified by Stakeholders in the Alabama Community Health Improvement Plan
13	Q-sort: Setting the Three Statewide Health Care Priorities
14	Leading 13 Health Concerns Derived from the Community Health Assessment
16	Setting Alabama Community Health Improvement Plan Goals, Objectives, and Action Plans
17	Collaborative Planning Process: September 2014-June 2015
18	Health Care Priority Plans
21	Priority Concern 1: Access to Health Care
27	Priority Concern 2: Nutrition and Physical Activity
32	Priority Concern 3: Mental Health and Substance Abuse
38	Key Policies, Strategies, and Partners for Achieving the Alabama Community Health Improvement Plan
43	Moving Ahead: Coordination of Efforts
44	Appendix A – Listing of the 13 Leading Health Care Concerns Identified Through Domain 1 Efforts Along With the Proposed Indicators/Measures of Each
51	Appendix B – Alabama Community Health Improvement Stakeholders
53	Acronyms



STATE OF ALABAMA DEPARTMENT OF
PUBLIC HEALTH

Donald E. Williamson, MD
State Health Officer

LETTER FROM THE STATE HEALTH OFFICER

Dear Health Improvement Partners and Citizens of Alabama:

For the past year, it has been a privilege to work collaboratively on the Alabama Community Health Improvement Planning (ACHIP) process. This plan represents the efforts of committed individuals representing health care providers, academia, tribes, non-profit health care organizations, state and local government agencies, professional affiliations, businesses, policy advocates, consumers, funders, and the faith-based community.

The purpose of the ACHIP is to describe how the Alabama Department of Public Health, and the community it serves, can work together to overcome some of Alabama's major health care concerns. The ACHIP issues – access to care, physical activity and nutrition, and mental health and substance abuse – are all issues that impact the health status of Alabamians. It is essential for us to work together, across multiple health care systems, to improve the poor health status and poor health outcomes reflected in our state's health status rankings.

Poverty, education, transportation, and limited access to care are all examples of social determinants which impact health. These determinants, along with risky behaviors such as low fruit and vegetable consumption, low physical activity, drug and alcohol abuse, and high prevalence of smoking, all contribute to the poor health status of many of our citizens.

The ACHIP considers both social determinants of health and personal health behaviors in crafting key priorities, outcomes, and policies outlined in this plan. The ACHIP also provides a structure to connect people, communities, programs, and resources to achieve optimal results.

Together, our efforts to address complex health care concerns will improve the public health system. We look forward to working with you as we strive to promote, protect, and improve the health of all Alabamians.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Williamson", with a long horizontal flourish extending to the right.

Donald E. Williamson, M.D.
State Health Officer

Executive Summary.

Alabama's Community Health Improvement Plan (ACHIP) is a stakeholder driven collaborative framework to inform, mobilize, and empower communities to address three key health care priorities – Access to Care, Nutrition and Physical Activity, and Mental Health and Substance Abuse – through education, new partnerships, and evidence-based interventions.

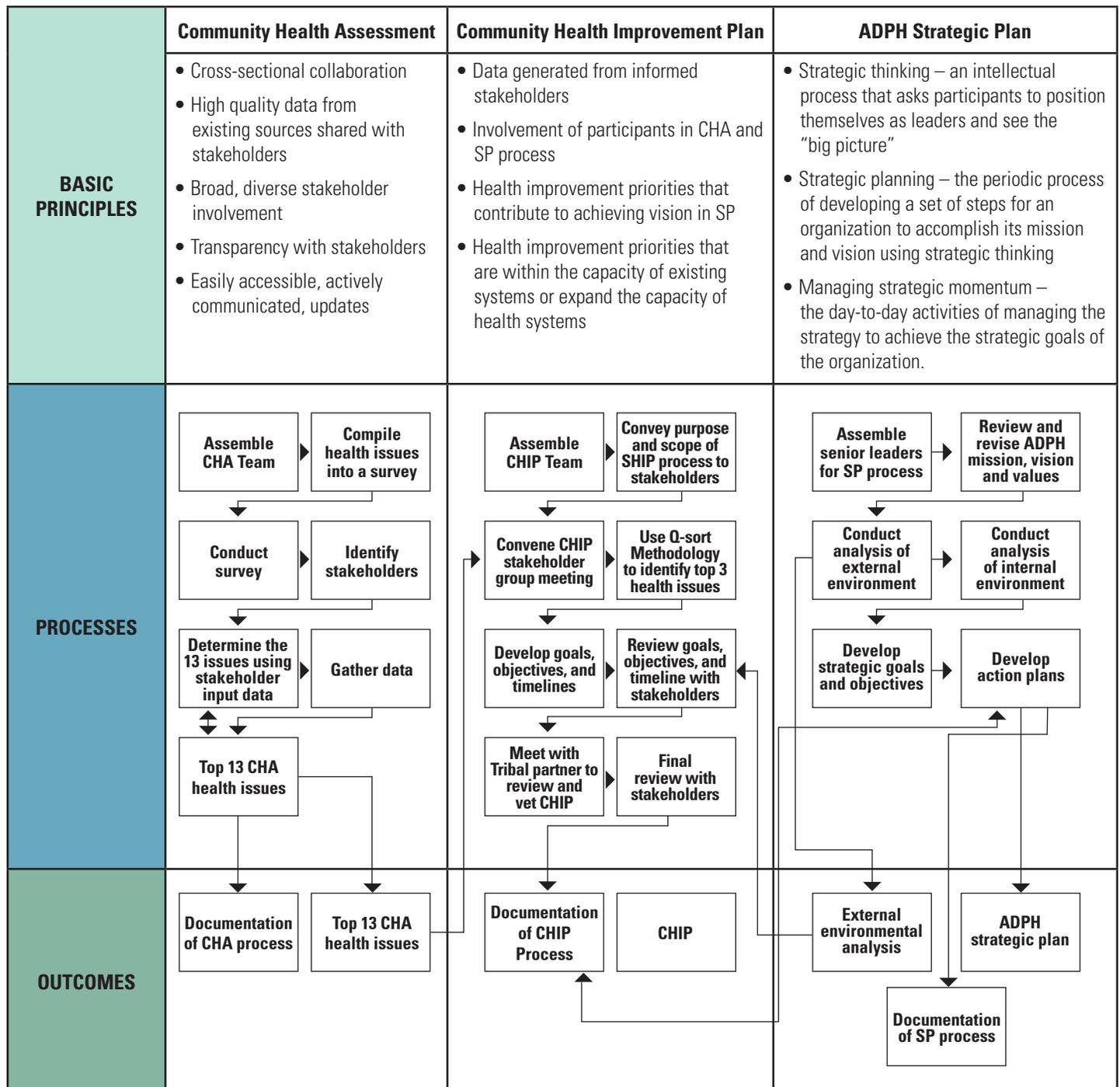
ACHIP activities were guided by the following principles:

- Actions and policies were aligned with community, state, and national public health practices, using *Healthy People 2020* as a model.
- Goals and objectives were built on Alabama's existing assets and resources. For example, instead of creating and implementing a new transportation survey, stakeholders identified other partners and networks that had either completed transportation surveys or were developing transportation surveys. ACHIP members integrated health components into these existing surveys/ plans, and through community networking and shared planning, avoided duplication of resources. Collaborative objectives were developed through stakeholder workgroups and stakeholder partnerships.
- Achievable objectives were developed with measurable outcomes in mind. Several issues were discussed that had no existing tracking or performance measurements available to demonstrate progress toward objectives. Stakeholder workgroups and partnerships developed objectives that could be baselined, measured, and modified. Environmental factors were assessed and certain objectives and activities listed by the ACHIP workgroups were deferred until the impact of the Alabama Medicaid system transformation could be better understood. Consideration was given to targets and baselines in establishing goals and objectives as outlined in the Healthy People 2020 Defining Terms Plan guide.
- Annual review and update of ACHIP by stakeholders was planned in response to the changing health care delivery system in Alabama with the implementation of Regional Care Organizations (RCOs).
- ACHIP stakeholder workgroups focused on health issues that impacted chronic diseases as well as social determinants of health. These issues were population-focused and stakeholder-driven to develop a framework to improve health, realizing health is not only an individual issue but also a community issue.

The ACHIP Plan Process Overview.

The Alabama Department of Public Health (ADPH), ACHIP was developed as a result of a comprehensive statewide Community Health Assessment (CHA); is guided by ADPH’s vision, mission, and values; and is integrated into ADPH’s Strategic Plan. The relationships among the CHA, ACHIP, and Strategic Plan (SP) are shown in Figure 1, as well as the principles, processes, and outcomes for each. Statewide community partners and stakeholders provided extensive input into the CHA (See the ADPH Community Health Assessment documentation for additional detail) and are integral to the accomplishment of the ACHIP.

Figure 1. Alabama Department of Public Health CHA, ACHIP, and SP Principles, Processes, and Outcomes



Overall Goal of the ACHIP.

The World Health Organization defines a healthy community as “one that is safe with affordable housing and accessible transportation systems, work for all who want to work, a healthy and safe environment with a sustainable ecosystem, and offers access to health care services which focus on prevention and staying healthy.”

A healthy community, as described by the U.S. Department of Health and Human Services *Healthy People 2010 Report* is one that continuously creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and to develop to their fullest potential.

The Defining Healthy Communities Project states “A healthy community is where people come together to make their community better for themselves, their family, their friends, their neighbors, and others. A healthy community creates ongoing dialogue, generates leadership opportunities for all, embraces diversity, connects people and resources, fosters a sense of community and shapes its future.”

Drawing upon these definitions, ACHIP views a healthy community as not only characterized by an absence of disease but a complete state of physical, mental, and social well-being.

ADPH Vision, Mission, and Value. (See ADPH SP documentation for additional detail)

ADPH Vision Statement

Assure the health of Alabamians by promoting healthy, safe, prepared, and informed communities.

ADPH Mission Statement

To promote, protect, and improve the health of individuals and communities in Alabama.

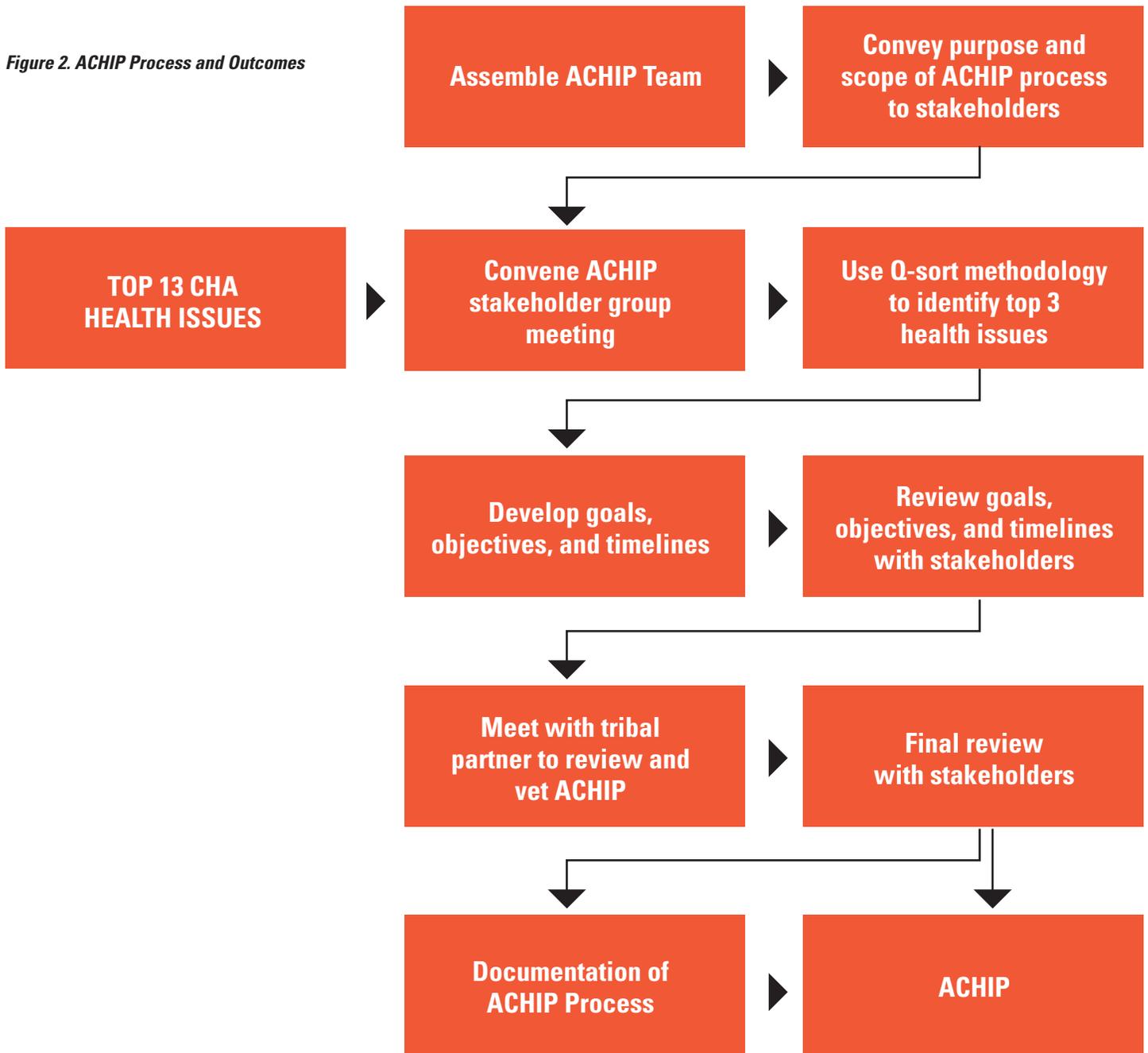
ADPH Core Values

High quality services.
Competent and professional workforce.
Compassionate care.

The ACHIP Process.

The purpose of ACHIP is to provide guidance to ADPH, its partners, and stakeholders to improve the health of Alabama’s citizens. The health of Alabama’s population is considered across programs and across communities.

Figure 2. ACHIP Process and Outcomes



Through the health issued focused approach utilized in developing the CHA, 13 leading health concerns were identified by over 6,500 Alabama citizens and organizations. **(See page 14)**

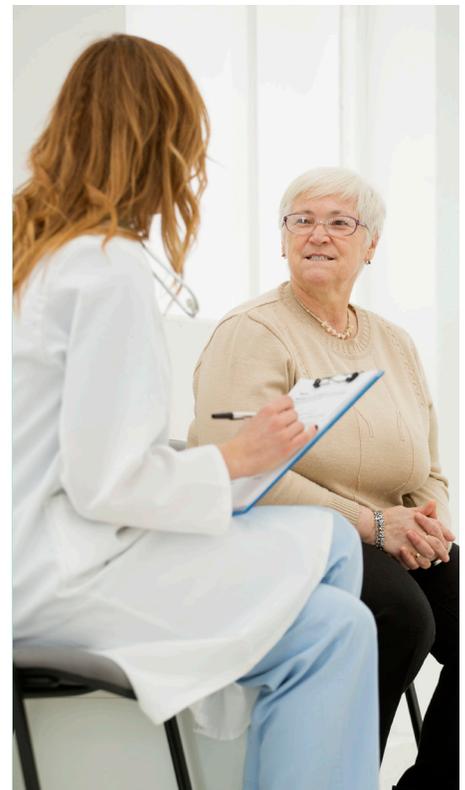
This list of 13 health concerns were presented to the ACHIP partners and stakeholders to determine the three highest-priority health care concerns. The proposed indicators and measures were reviewed as part of the ACHIP stakeholder meeting. **(See Appendix A)**

ACHIP Health Priority Focused Approach.

The ACHIP is a natural extension of the CHA, using information developed in the CHA to identify public health improvement priorities with measurable objectives and defined outcomes. A variety of data sources and analysis methods were used in the CHA both at the state level and the public health area level. A survey was distributed through public health clients, partners, community groups, and other entities to rank their top health care concerns. In addition, public health areas conducted focus groups with their clients and communities to identify areas of concern. Community input opportunities were also incorporated into the ACHIP through targeted meetings with statewide partners such as the Alabama Medicaid Agency (AMA), City Councils of Governments, the Alabama Primary Care Association (PCA), the Alabama Department of Economic and Community Affairs (ADECA), United Way of Central Alabama, Regional Planning Councils (RCO), the Poarch Band of Creek Indians, and the Alabama Department of Mental Health (ADMH).

ADPH, in collaboration with the University of Alabama at Birmingham (UAB) School of Public Health, adopted a Health Priority Focused Approach for the development of a statewide ACHIP. The Health Priority Focused Approach methodology used for the ACHIP and CHA was developed from focused strategic thinking, a methodology presented in *Strategic Management of Health Care Organizations*.¹

A Health Priority Focused Approach is a community member, partner organization, and other stakeholder participative process that focuses on a “hybrid model,” drawing upon features of other methodologies such as Centers for Disease Control and Prevention’s (CDC) Community Health Assessment and Group Evaluation (CHANGE) and Mobilizing for Action through Planning and Partnership (MAPP). The Health Priority Focused Approach focuses on the components, activities, competencies, and capacities of the county, public health area, and state health departments, as well as areas of improvement that guide the community towards population-based strategies that create healthier environments. This “top-down, bottom-up” approach includes state population demographics, state health assets and resources diversity, as well as local health issues and local health resources.



1. The Health Priority Focused Approach is presented in the following book; Ginter, P.M., Duncan, W.J. and Swayne, L.E., *Strategic Management of Health Care Organizations*, 7th ed., San Francisco, California; John Wiley & Sons/Jossey-Bass Publishers, March 2013 (first published in 1992)

Identifying Statewide Partners and Stakeholders for the ACHIP.

The Process for Determining ACHIP Stakeholders: The ADPH ACHIP members initially met to review, brainstorm, and draft a stakeholder list for the collaborative health improvement planning process. The workgroup met on May 23, June 5, June 9, and June 26, 2014, to determine the ACHIP stakeholder list.

Thirteen broad community circles of involvement were defined by ADPH Domain 5 members:

In addition, CHA participants were also included in the ACHIP stakeholder list. Individuals with a variety of interests and leadership positions who could represent multiple community groups/organizations to maximize engagement from the ACHIP participants were sought.

Tribal leader representatives were visited to discuss the ACHIP process and ensure that tribal interests and health care concerns were appropriately represented. The 13 top health care concerns were reviewed with tribal leaders to determine opportunities for collaboration and coordination of resources on November 19, 2014. Tribal representatives to serve on the ACHIP were also identified during this meeting.

Representatives from the CHA and ACHIP also met with the AMA on June 10, 2014, to discuss the CHA and ensure that plans to transform the AMA to RCOs were appropriately represented in stakeholder discussions. Information on plans for the ACHIP were shared with the AMA. Representatives from the RCO Quality Assurance Committee were recommended for inclusion on the ACHIP stakeholder team.

Additional meetings occurred with the PCA on June 23, 2014, and the ADMH on June 24, 2014, to introduce the accreditation process and review findings from the CHA.

Non-traditional partners were contacted by Domain 5 Workgroup members to introduce the ACHIP and identify representatives to participate in the ACHIP Stakeholder Meeting planned for August 20, 2014. Examples of partners contacted include the District Attorney's office, the City Council of Governments, the League of Municipalities, Blue Cross Blue Shield Foundation, and Alabama Power Company. In all, 59 diverse representatives from across Alabama attended the ACHIP Stakeholder Meeting.

(See Appendix B identifying ACHIP stakeholders)

- Providers – primary care, dental, behavioral providers, safety net providers, and health care professional associations
- Policy advocates
- Non-profits and special interest groups
- Business
- Faith
- Youth
- Funders - foundations
- Consumers
- Payors – health insurance industry, Medicaid, Medicare, Children's Health Insurance Program (CHIP).
- Media
- Government – local and state
- Education
- Law enforcement
- Poarch Band of Creek Indians

The list was reviewed by ACHIP members who recommended participants for each listed category.

Issues and Themes Identified by Stakeholders in the ACHIP Process.

The 13 top health care concerns developed through the CHA process and presented to the ACHIP stakeholders included indicators for health improvement and priorities for action that addressed social determinants of health. The ACHIP stakeholders reviewed the CHA indicators during the August 20, 2014 Stakeholder Meeting and discussed priorities for action. Each of the 13 top health care concerns were presented to the ACHIP stakeholder group with information on population demographics, special population health needs, health disparities, and resources.

ACHIP stakeholders recognize that health and well-being are not just about clinical care and health behaviors. Social factors, state policies, health services, individual behaviors, and genetics all play a role in an individual's and a population's health. As the ACHIP stakeholders considered the 13 top health care concerns and their associated contributing factors, several social determinants of health were discussed including poverty, transportation, and health policy.

According to Healthy People 2020:

"It is the interrelationships among these factors that determine individual and population health. Because of this, interventions that target multiple determinants of health are most likely to be effective. Determinants of health reach beyond the boundaries of traditional health care and public health sectors; sectors such as education, housing, transportation, agriculture, and environment can be important allies in improving population health."

The 13 top health care concerns from the CHA, along with information on health care data for each, were presented to the ACHIP stakeholders for review. This CHA data reflected statewide statistics and county rankings developed by ADPH using CDC-provided data, as well as information and data collected on the community level.

For example, even with limited public transportation systems in 11 of the poorest Alabama counties, as much as 16 percent of households in these counties also do not own a personal vehicle. This relative lack of available public transportation systems in Alabama also impacts seniors who are no longer able to drive and must rely on relatives and neighbors for transportation to health care appointments. Transportation gaps were a major concern discussed in the ACHIP Stakeholder Meeting.

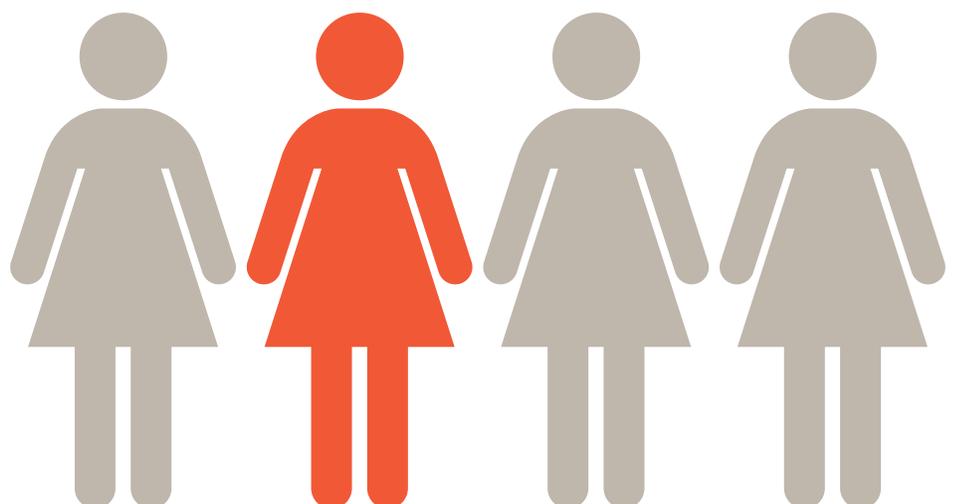
Issues and Themes Identified by Stakeholders in the ACHIP Process. (continued)

Once the top three health care concerns were identified by the ACHIP stakeholders through the Q-sort method, ACHIP workgroups continued to address social determinants of health and consider action items and objectives to address gaps in services, including expansion of telemedicine and broadband access.

Another example of a social determinant of health is poverty, which impacts access to healthy food options and opportunities for safe outdoor recreational activities. Recognizing this, ACHIP stakeholders discussed programs focusing on improving nutrition and increasing physical activity. Since this is also an issue that many community organizations currently seek to address, the stakeholders felt there were a variety of external assets and resources that could be incorporated into the ACHIP process. ACHIP stakeholders addressing nutrition and physical activity included the Alabama Obesity Task Force, VOICES for Alabama's Children (Healthy Food Access program), and the Alabama State Department of Education (ASDE) (school wellness policies, community gardens, and farm-to-table programs).

Poverty also impacts depression and suicide rates.² One of the ACHIP stakeholders representing a District Attorney's office commented on the "hotspots" where people with mental health and substance abuse issues fall through the cracks in the present system. These hotspots include emergency rooms, jails, and probate courts. Integrating mental health treatment and primary care will help improve the early identification of mental health and substance abuse disorders. Improving training for those coming in contact with clients with mental health and substance abuse disorders will also help improve awareness of these issues.

According to the World Health Organization (WHO) 1 in 4 people will be affected by mental or neurological disorders at some point in their lives.



Q-sort: Setting the Three Statewide Health Care Priorities.

Following the presentation and discussion of the top 13 health care concerns identified in the CHA, the ACHIP stakeholders were presented with the Q-sort method by facilitators from the UAB School of Public Health.

The partners and stakeholders agreed that the ACHIP could not effectively address all 13 concerns and make significant progress. Therefore, the partners and stakeholders concluded that the ACHIP should focus on a consensus of the top three concerns based on the following criteria:

- 1) The extent of the need for improvement within the state.
- 2) The likelihood of making a significant difference in the health of the state by implementing the plan.
- 3) The level of anticipated engagement and resources of the partners and stakeholders.

As the stakeholders prioritized these 13 health care concerns, a key component of their discussions was the consideration of available community and organizational assets and resources needed to address each concern. The broad-based stakeholder group identified resources they were aware of as part of their decision-making process.

Leading 13 Health Concerns Derived from the CHA.

Table 1. Top 13 Health Issues Derived from the CHA

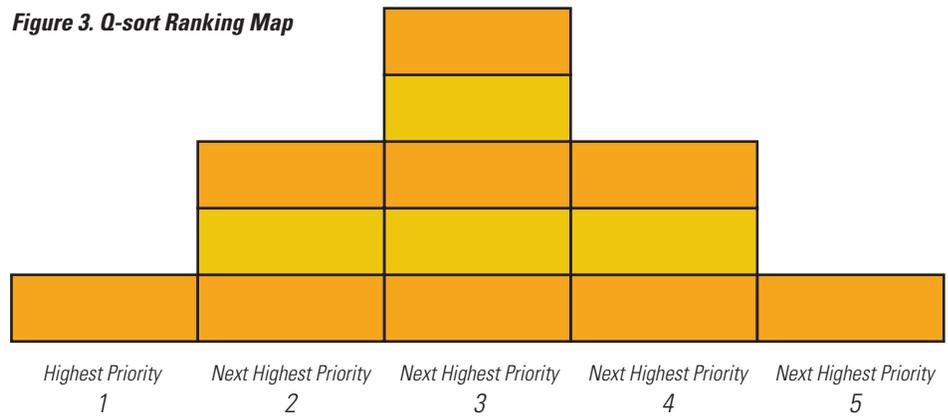
1. Access to Care
2. Mental Health and Substance Abuse
3. Poor Pregnancy Outcomes
4. Nutrition and Physical Activity
5. Cardiovascular Diseases
6. Sexually Transmitted Infections
7. Cancer
8. Child Abuse and Neglect
9. Diabetes
10. Geriatrics
11. Injury and Violence Prevention
12. Oral Health
13. Cigarette Use

Prioritization of the top 13 health concerns was accomplished using the Q-sort methodology.

Q-sort is a formal method of rank-ordering competing issues when all concerns are important and there is considerable subjectivity involved. It allows participants to use their unique expertise, perspectives, and viewpoints in ranking the concerns and forces choices where difference in importance may be quite small.

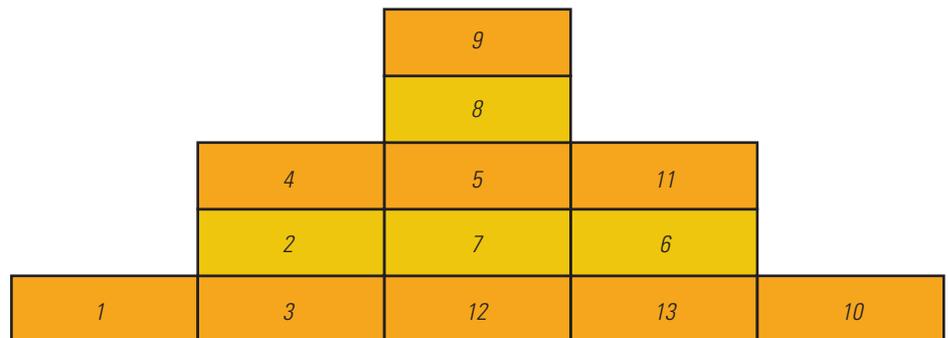
In the Q-sort procedure, each participant was asked to sort the 13 choices (health concerns) into five categories based on their perceived need within the state, the likelihood of making a significant difference in the health of the state, and the anticipated level of engagement and enthusiasm of potential partners and stakeholders. Each category had a limit on the number of health concerns that could be placed into it, as shown in the Q-sort Ranking Map (Figure 3). Each choice was assigned a priority score ranging from 1 to 5, depending on the column in which it was placed. Mean priority scores for each choice were calculated, then summarized by entering the numerical identifier of each health issue in order from lowest score to highest score in the Q-sort Ranking Map.

Figure 3. Q-sort Ranking Map



Participation in the Q-sort process was voluntary. Fifty-one of the 59 partners and stakeholders submitted their rankings of the 13 health issues identified in the CHA, and the resulting rank-order of issues is shown in Figure 4. Table 2 lists the health issues in order by their associated mean priority scores.

Figure 4. Q-sort Ranking Map of Results of the Priority Setting Process



Health Issue	Mean Score
1	1.66
4	2.32
2	2.47
3	2.79
9	2.81
8	2.98
5	3.13
7	3.15
12	3.32
11	3.45
6	3.55
13	3.68
10	3.70

Table 2. Health Issue and Mean Score from Q-sort Procedure

UAB School of Public Health facilitators tabulated the results of the 51 rank-orders of the 13 health care priorities and assigned each a mean priority score. As demonstrated in Figure 4 and Table 2, there was considerable consensus in selecting the three highest-ranked concerns (found in Columns 1 and 2) with mean priority scores ranging from 1.66 to 2.47.

As a result, it was agreed that the following three issues would be the initial health care concerns addressed in the ACHIP:

- Access to Care
- Nutrition and Physical Activity
- Mental Health and Substance Abuse

Setting ACHIP Goals, Objectives, and Action Plans.

Each of the ACHIP partners and stakeholders elected to participate in one of three workgroups corresponding to the top three priority health concerns identified in the Q-sort. These workgroups began developing the goals, objectives, and action plans to address their assigned health issues, and also identified appropriate partners and stakeholders that should be involved in implementing these strategies. Much of this planning was done after the initial Stakeholder Meeting, utilizing a collaborative process involving additional conference calls and meetings with ACHIP workgroup members to further define objectives, timelines, and action items not outlined in preliminary discussions.

In a follow-up ACHIP Stakeholder Meeting on August 27, 2014, the three workgroups set the following goals:

Priority Health Concern: Access to Care

Goal: Measurably improve access to care for all Alabamians by reducing transportation barriers, addressing the shortage of providers, closing insurance coverage gaps, and improving health literacy.

Priority Health Concern: Nutrition and Physical Activity

Goal: Measurably improve nutrition and physical activity education and opportunities for the residents of Alabama through increasing public education awareness, encouragement of healthy lifestyles, and access to healthy food options with the intention of reducing adult and pediatric obesity, increasing vegetable and fruit consumption, and participation in aerobic and muscle strengthening exercise.

Priority Health Concern: Mental Health and Substance Abuse

Goal: Measurably improve mental health and substance abuse within Alabama through 1) enhancing understanding of the prevalence of mental health and substance abuse issues by mapping mental health and substance abuse data and convening relevant stakeholders, and 2) lowering the incidence of suicide and yet-to-be-determined measures of substance abuse.

Collaborative Planning Process: September 2014 – June 2015.

*Just as a pebble
creates a
ripple effect,
collaborations pass
from community
organization
to community
organization and
greatly broaden the
impact of the initial
outreach effort.
ACHIP has
demonstrated that
collective action and
collaboration creates
new opportunities for
improving health.*

– Carolyn Bern

Each ACHIP workgroup (Access to Care, Nutrition and Physical Activity, and Mental Health and Substance Abuse) participated in conference calls to review the goals, objectives, and action plans recommended in the Stakeholder Meeting. Draft plans were adjusted to reflect workgroup member recommendations, and updated plans were sent out to the workgroup for further refinement. Follow-up conference calls, emails, and meetings occurred to address additional plan updates and actions.

Since Alabama has limited resources, ACHIP workgroup members gave consideration to building on existing community and organizational assets and resources. For example, in the Access to Care Workgroup, ADECA, Top of Alabama Regional Council of Governments, and Alabama Arise recommended that ADPH collaborate with the 12 Regional Planning Commission Human Services Coordination Transportation Plans (HSCTP). The HSCTP involves an in-depth review of transportation systems within each region, analyzing the spatial relationships between current service areas and areas of need. Participation in the HSCTP grants each Regional Planning Commission future access to grant fund allocation, while generating concrete goals and objectives aimed at improving transportation services. As a result of fostering a collaborative working relationship between community organizations through the ACHIP Access To Care Workgroup, other sectors of the community have been reached through HSCTP, such as parks and recreation departments, senior centers, and nursing homes. Local health departments have also been brought into regional planning commission HSCTP plans through the involvement of social work directors.

Collective action and collaboration continued over a six month period with opportunities for workgroup stakeholders to further refine the final ACHIP. Additional partners were identified on the community level.

ADPH Domain 5 members met to review the plan on April 29, 2015. Final draft plans were redistributed to the Access to Care, Nutrition and Physical Activity, and Mental Health and Substance Abuse ACHIP Workgroups for final recommendations and changes. The resulting plans were finalized, approved, and distributed to the ACHIP stakeholders in June 2015.

Health Care Priority Plans.

The Process for Refining Workgroup Efforts and Ensuring ACHIP Strategies are Feasible and Effective

The ACHIP Stakeholder Group – through stakeholder conference calls, individual conference calls, meetings, and emails – further refined the workplan, objectives, actions, and stakeholders identified during the initial August 20 Stakeholder Meeting. While keeping in mind the overarching goals of the three top priority health care concerns, the stakeholders also considered how measurable milestones would be tracked and quantified. Follow-up conference calls and meetings refined and enhanced the priority health care plans. ADPH reviewed all strategies, objectives, and goals to ensure they would be effective and feasible in the current health care environment.

Three examples of this process are described with Priority Health Concern 3 – Mental Health and Substance Abuse.

Example 1: Integration of primary care and mental health

The August 20, 2014, stakeholder discussion addressing the lack of available mental health and substance abuse data took the majority of time allocated for this workgroup planning. As a result, the Mental Health and Substance Abuse ACHIP Workgroup agreed to participate in follow-up conference calls to further develop the objectives and activities addressing mental health and substance abuse. Face-to-face meetings were not the preferred method of future meetings for this stakeholder group.

In subsequent workgroup conference calls, additional objectives and activities were added to the Mental Health and Substance Abuse Workplan. The workgroup suggested a mental health screening tool for primary care providers. Although this is an evidence-based best practice model for the integration of mental health care in primary care settings, this objective would put additional responsibilities on primary care providers who are already overwhelmed by the transformation of Medicaid, ICD-10 implementation, and Electronic Medical Record (EMR)/meaningful use requirements. A meeting on February 12, 2015 between the ADPH ACHIP co-leader and the executive directors of the Alabama Academy of Family Physicians (AAFP) and the Alabama Chapter of the American Academy of Pediatrics (AL-AAP), occurred to determine if this activity would be realistically achievable in the current health care environment. It was recommended by both association executive directors that this activity not be pursued at this time due to the Medicaid transformation, Affordable Care Act (ACA) implementation, and austere state General Fund Budget. This demonstrated the importance of ADPH staff working with stakeholder groups to ensure that the ACHIP strategies developed by the stakeholders are viable and achievable.

Example 2: Prescription Drug Abuse

The Mental Health and Substance Abuse Workgroup also wanted to focus on prescription drug abuse, which is considered by the CDC to be a public health epidemic. The ADPH houses the Prescription Drug Monitoring Program (PDMP) in the Bureau of Professional and Support Services. The available data on prescription drug usage from the PDMP is restricted by Alabama law and not available to the public or for research purposes. There is no prescription drug abuse data available to serve as a baseline for measuring the impact of prevention activities. The State Pharmacy Director, the PDMP Coordinator, and the Program Manager for Substance Abuse Reporting brainstormed with ACHIP members on available data addressing prescription drug abuse in Alabama. They recommended that ACHIP focus on prescription drug abuse education across professions/specialties, bringing together pharmacy, law enforcement, primary care, social work, nursing, mental health, and community mental health centers to discuss prescription drug management of patients with complex health needs. This strategy could be stated as a measurable objective that could impact this very complex issue. ADPH has video conferencing capabilities in public health area offices across the state and could utilize this resource to provide convenient access to training. This is another example of how ACHIP workgroup strategies had to be assessed by ADPH to ensure feasibility and effectiveness.

Another meeting with the Assistant Medical Director at the Medical Association of the State of Alabama (MASA) on February 11, 2015, addressed further health care provider input on the prescription drug abuse issue in Alabama. MASA also supported the recommendation that ACHIP stakeholders focus on training and education addressing safe use of opioids for providers across specialties.



Example 3: Mental Health and Community Needs for Strategic Action

The ACHIP co-lead participated in a February 4, 2015, mental health and substance abuse brainstorming session for Blount, Jefferson, St. Clair, Shelby, and Walker counties presented by the Community Foundation of Greater Birmingham and the United Way of Central Alabama. This meeting focused on community mental health needs and opportunities for strategic action. Mental health and substance abuse was also a top health priority identified in the Jefferson County Department of Health's CHA. This opportunity for an ACHIP lead to participate in this meeting allowed collaboration between the ACHIP plan and the Jefferson County Department of Health's CHIP plan to occur.

A follow-up conference call with the Community Foundation of Greater Birmingham and the United Way occurred on March 11, 2015, to further explore baseline data around mental health issues. Due to the complexity of the challenges facing the mental health community, the groups decided to explore issues further before creating a community grant program addressing mental health and substance abuse.

Conclusion:

Since the ACHIP Mental Health and Substance Abuse Workgroup cannot currently anticipate how the state of Alabama's 2015 General Fund Budget shortages may impact resources available to implement activities addressing mental health and substance abuse issues, the workgroup is focusing on assets and resources that are already presently available through stakeholder networks. After reviewing strategies, objectives, and activities with additional stakeholders representing clinicians, subject experts, and communities, it was decided that initial ACHIP efforts would focus on achievable and viable strategies supported by environmental realities. The Mental Health and Substance Abuse ACHIP Workgroup will focus on mental health and substance abuse data collection efforts, clinician education with a focus on prescription drug abuse, suicide prevention activities, and smoke free ordinances and policies. Plans to continue networking, meeting, and refining the ACHIP Mental Health and Substance Abuse Plan will continue during the ACHIP implementation.

ACHIP Access to Care Workgroup

Priority Concern 1: Access to Health Care.

Goal 1: Reduce transportation barriers:

Concern 1 Goal 1 Objective 1: ■ **By December 15, 2015, identify organizations that have conducted (in the last three years) or will conduct community transportation surveys.**

Lack of access to primary care services is impacted by the lack of public transportation systems in Alabama. In one of Alabama's poorest counties, 16 percent of all households are without a vehicle. (ADPH) Promising practices that are focusing on transportation to medical appointments include the Care Network of East Alabama, Inc. Between January and March 2013, close to 300 transportation arrangements were made for Medicaid patients resulting in a decrease in missed doctor appointments and improved access to primary care. Several other transportation arrangements exist in rural communities. Examples include the Escambia County WOW van, where the community pays for a private van to take children to doctor appointments.

Performance Measure:

Number of transportation surveys identified and reviewed.

Number of Human Services Coordinated Transportation Planning meetings attended.

Partners and Stakeholders:

Alabama Department of Transportation (ALDOT), Regional Planning Councils, Senior Services, Medical Transit, ALL Kids, Black Belt Foundation, Alabama Rural Health Association (ARHA), Governor's Office of Faith Based Initiatives, Chambers of Commerce, RCOs, and AMA.

Assets and Resources:

City Council of Governments, Regional Planning Councils, Alabama Public Transportation Systems, Governor's Office on Disability, ADECA, HSCTP, ALDOT rural transit assistance program, Alabama Arise, Care Network of East Alabama Inc., Economic Development Association of Alabama (EDAA), faith-based community entities, local service organizations, Medicaid NET Program, American Cancer Society.

Alignment with national state and local goals, objectives, and measures:

Healthy People 2020, Alabama Association of Regional Councils (AARC), and ARHA.

Concern 1 Goal 1 Objective 2: ■ **By March 1, 2016, inventory transportation programs available to Alabamians for health care appointments. Review the HSCTP for the 12 regional planning and development commissions. Identify evidence-based practices that demonstrate success in reducing transportation barriers for health care appointments.**



Performance Measures:

Forty-five percent of Regional Transportation Plans incorporate some type of health care transportation.

Data Source: *Regional Planning and Development Commissions*

Evidence-based practices to reduce transportation barriers to health care are identified and reported to the ACHIP Stakeholder Group for distribution to 20 community partners.

Partners and Stakeholders:

ALDOT, Regional Planning Councils, Senior Services, Medical Transit, ALL Kids, Black Belt Foundation, ARHA, Governor’s Office of Faith Based Initiatives, Chambers of Commerce, RCOs, AMA, Governor’s Office of Disability, and Alabama Disability and Health Program.

Assets and Resources:

Statewide Regional Planning Council’s transportation plans, ALDOT’s rural transit assistance program, Medicaid’s NET Program, KidOne, Regional Transportation Systems, Care Network of East Alabama Inc., Family Resource Centers, and Family Resources Disability Councils.

Alignment with national, state, and local goals, objectives, and measures:

Transportation is a social determinant impacting access to care and mentioned in *Healthy People 2020* “Create social and physical environments that promote good health for all.”

Concern 1 Goal 1 Objective 3: ■ **By December 31, 2017, educate the public on transportation options available at the county level in collaboration with partners. Convene local leaders, health care coalitions, and RCO members to discuss closing transportation service gaps.**

Promote information gathered through HSCTP to regional community health care providers and organizations.

Convene local community groups to address transportation service gaps.

Performance Measure:

By February 1, 2016, ten health care providers and ten community organizations in all 12 regions are provided transportation survey results and available transportation resources.

By June 1, 2016, five community meetings will have occurred addressing health care transportation service gaps.

Partners and Stakeholders:

ADPH, AMA, RCOs, Patient Centered Networks of Alabama (PCNAs), Children’s Policy Councils, Regional Planning Councils, Senior Services, League of Municipalities, County Commissions, and County Extension System.

Assets and Resources:

ALDOT’s Rural Transit Assistance Program, Medicaid’s NET Program, Regional Transportation System, Care Network of East Alabama Inc., Chambers of Commerce, Economic Development Association of Alabama (EDAA), ADECA, ADPH, faith-based community entities, and local service organizations.

Alignment with national, state, and local goals, objectives and measures:

Healthy People 2020 social determinants, Medicaid’s NET Program, West Alabama Transportation Program, Care Network of East Alabama Inc. Transportation Program, and Regional Planning Councils HSCTP.

Goal 2: Increase access to ambulatory primary care.

Concern 1 Goal 2 Objective 1: ■ **By June 1, 2017, decrease the percentage of Alabamians who report having no health insurance coverage from 17.5 percent to 16.5 percent.**

The extent of the need to deliver primary care services to Alabama's underserved populations may be demonstrated by the number of low-income and geographic health professional shortage areas (HPSAs). In Alabama, there are 28 whole-county geographic primary care HPSAs, 25 whole-county low-income HPSAs, 2 counties that are a combination low-income/geographic HPSAs, and 5 partial-county HPSAs. (2014)

Performance Measure:

Number of adults without health care coverage, as measured by the Behavioral Risk Factor Surveillance Survey (BRFSS) and the Census Bureau.

Number of patients enrolling in ACA coverage by county.

Data Source: Alabama Arise

Partners and Stakeholders:

Blue Cross Blue Shield of Alabama (BCBS), ARHA, Alabama Arise, Alabama's Best Campaign, Alabama Hospital Association (AlaHa), Family Resource Councils, Office of Faith Based Initiatives, VOICES for Alabama's Children, and Primary Care Association (PCA).

Assets and Resources:

Patient Navigators, ACA Outreach grantees, free clinics, and the medical community.

Alignment with national, state, and local goals, objectives and measures:

Healthy People 2020, and the Health and Human Services Action Plan to Reduce Racial and Ethnic Health Disparities.



Concern 1 Goal 2 Objective 2: ■ **Increase the number of primary care pipeline activities for underrepresented populations throughout the state in collaboration with the Area Health Education Center (AHEC) and the rural medical scholars programs.**

Performance Measures:

Assess the number of pipeline programs targeting underrepresented populations in the state in collaboration with AHEC and rural medical scholars programs.

Increase the number of pipeline programs presented at the middle school, high school, and community college level encouraging interest in primary care professions in rural and underserved areas.

Data Sources: AHEC, Rural Medical Scholars Programs

Partners and Stakeholders:

AHEC Program, Primary Care Residency Programs, Board of Medical Scholarship Awards, Rural Medicine Programs, ASDE, Health Occupations Students Association, Rural Coalitions, Envision 2020, AAFP, AL-AAP, MASA, ARHA, ADECA, Alabama Postsecondary Education, PCA, GEAR UP, AlaHa, and Alabama Cooperative Extension System.

Assets and Resources:

Rural Scholars Programs, AHEC, Family Medicine Councils, Schools of Medicine, Envision 2020, Alabama State Nurses Association, and residency programs.

Alignment with national, state, and local goals, objectives, and measures:

Healthy People 2020, AHEC, and Envision 2020.



Concern 1 Goal 2 Objective 3: ■ **Increase the utilization of telemedicine in rural and underserved areas. Collaborate with partners to expand the use of telemedicine in rural and underserved areas.**

Performance Measures:

By May 1, 2015, identify, orient, and train appropriate county health department staff on telemedicine equipment, clinic protocol, and cultural sensitivity at six pilot sites across the state.

By February 28, 2016, increase the number of public health sites housing telemedicine equipment for primary care provider use by 10 percent.

By February 28, 2016, meet with 15 community organizations/partners interested in using telemedicine sites in ADPH county health departments to improve access to care. Add five additional programs utilizing telemedicine equipment in ADPH county health departments by June 1, 2016.

Data Source: ADPH

Partners and Stakeholders:

Medical AIDS Outreach, Rural Development Office, Alabama Partnership for Telehealth, ADPH, AHEC, MASA, AL-AAP, AAFP, and Governor's Health Improvement Task Force.

Assets and Resources:

Alabama Council of Governments, Alabama League of Municipalities, BCBS, AMA, United Healthcare, PCA, mental health centers, Rural Health Clinics, Governor's Health Improvement Task Force.

Alignment with national, state, and local goals, objectives, and measures:

Healthy People 2020 and American Telemedicine Association (ATA).



ACHIP Nutrition and Physical Activity Workgroup

Priority Concern 2: Nutrition and Physical Activity.

Goal 1: Increase physical activity.

Concern 2 Goal 1 Objective 1: ■ **By November 30, 2016, work with the Alabama Obesity Task Force to support and expand the Get Moving Campaign, a public awareness campaign to encourage Alabamians to increase their physical activity.**

Performance Measures:

Track the number of communities engaged in Get Moving Alabama Campaign – ADPH, Alabama Obesity Task Force.

Adults who meet physical activity guidelines - BRFSS

Partners and Stakeholders:

Obesity Task Force, BCBS, ADPH, VOICES for Alabama's Children, AL-AAP, Scale Back Alabama, ASDE, Department of Veterans Affairs, Alabama Department of Senior Services, Governor's Office of Faith Based Initiatives, Family Resource Centers, PCA, Alabama Extension System, Poarch Band of Creek Indians, Chamber of Commerce, and City Council of Governments.

Assets and Resources:

Alabama Obesity Task Force, Get Moving Campaign, RCOs, ADPH, and evidenced-based community programs.

Alignment with national, state, and local goals, objectives, and measures:

Healthy People 2020 and Alabama Obesity Task Force State Plan.

Improve (decrease/reduce) the prevalence of obesity in Alabama's adults and youth through nutrition and physical activity strategies that support healthy lifestyles, and initiatives that improve healthy food access.

Alabama's high obesity rates are a concern impacting all races (32.4 percent) but are particularly high in the African American population (41.3 percent). Alabama's population is ranked in the top eight most obese states in the nation. Obesity is the second leading cause of preventable death in the United States.

(Kaiser)

Concern 2 Goal 1 Objective 2: ■ **Increase participation statewide in Scale Back Alabama annually.**

Adoption of policies and expansion of evidence-based strategies that encourage physical activity in child care facilities, worksites, and schools and that increase access to healthy and affordable foods are needed to combat the growing obesity problem.

Example:

- Alabama Healthy Vending Machine Program
- Scale Back Alabama

Performance Measures:

Track number of sites, type of sites, and number of participating counties engaged in Scale Back Alabama campaign annually.

Data Source: *ADPH, Alabama Obesity Task Force*

Track how many sites register and how many sites complete the Scale Back Alabama Campaign annually.

Data Source: *ADPH, Alabama Obesity Task Force.*

Partners and Stakeholders:

All ACHIP stakeholders.

Assets and Resources: Scale Back Alabama, Silver-Hair Legislature, AL-AAP, ASDE, Obesity Task Force, VOICES for Alabama’s Children, League of Municipalities, Regional Council of Governments, AAFP, EDAA, Chambers of Commerce, Business Council of Alabama, AlaHa, and the Poarch Band of Creek Indians.

Alignment with national, state, and local goals, objectives, and measures:

Healthy People 2020, CDC, Winnable Battles, National Prevention Strategy, and Alabama Obesity Task Force State Plan.



Goal 2: Improve access to healthy foods.

Concern 2 Goal 2 Objective 1: ■ **Increase the number of school systems where wellness policies are updated and address healthy food access from zero to 12 school systems by November 2016.**

Performance Measure:

Number of school systems where wellness policies are updated and healthy food access is addressed.

Data Source: WellSAT CDC

Vegetable consumption less than once daily –BRFSS.

Fruit consumption less than once daily – BRFSS.

Partners and Stakeholders:

ASDE, ADPH, and SNAP Ed Program.

Assets and Resources:

Alabama Obesity Task Force, VOICES for Alabama’s Children, AL-AAP, Alabama Arise, ASDE, and Alabama Cooperative Extension System (ACES).

Alignment with national, state, and local goals, objectives, and measures:

Healthy People 2020, Alabama Obesity Task Force State Plan, ACES and CDC.



Concern 2 Goal 2 Objective 2: **■ By August 2017, increase the number of school districts participating in farm-to-school Programs by 10 percent.**

Performance Measures:

Number of additional farm-to-table programs started in Alabama’s 136 school districts since 2012.

Data Source: *Alabama Obesity Task Force*

Partners and Stakeholders:

ASDE, Department of Agriculture and Industries, ADPH, and Alabama Obesity Task Force.

Assets and Resources:

Alabama Farmers Federation, EAT South, food banks, Alabama Outdoor Classroom, and ASDE.

Alignment with national, state, and local goals, objectives, and measures :

Healthy People 2020 and Alabama Obesity Task Force State Plan.



Concern 2 Goal 2 Objective 3: ■ **By October 2016, increase the number of sites that are offering healthy foods and beverages served in public/private facilities, organizations, and worksites.**



Performance Measures:

Increase number of work sites implementing nutrition standards in vending machines by 10 percent.

Data Source: ADPH

Partners and Stakeholders:

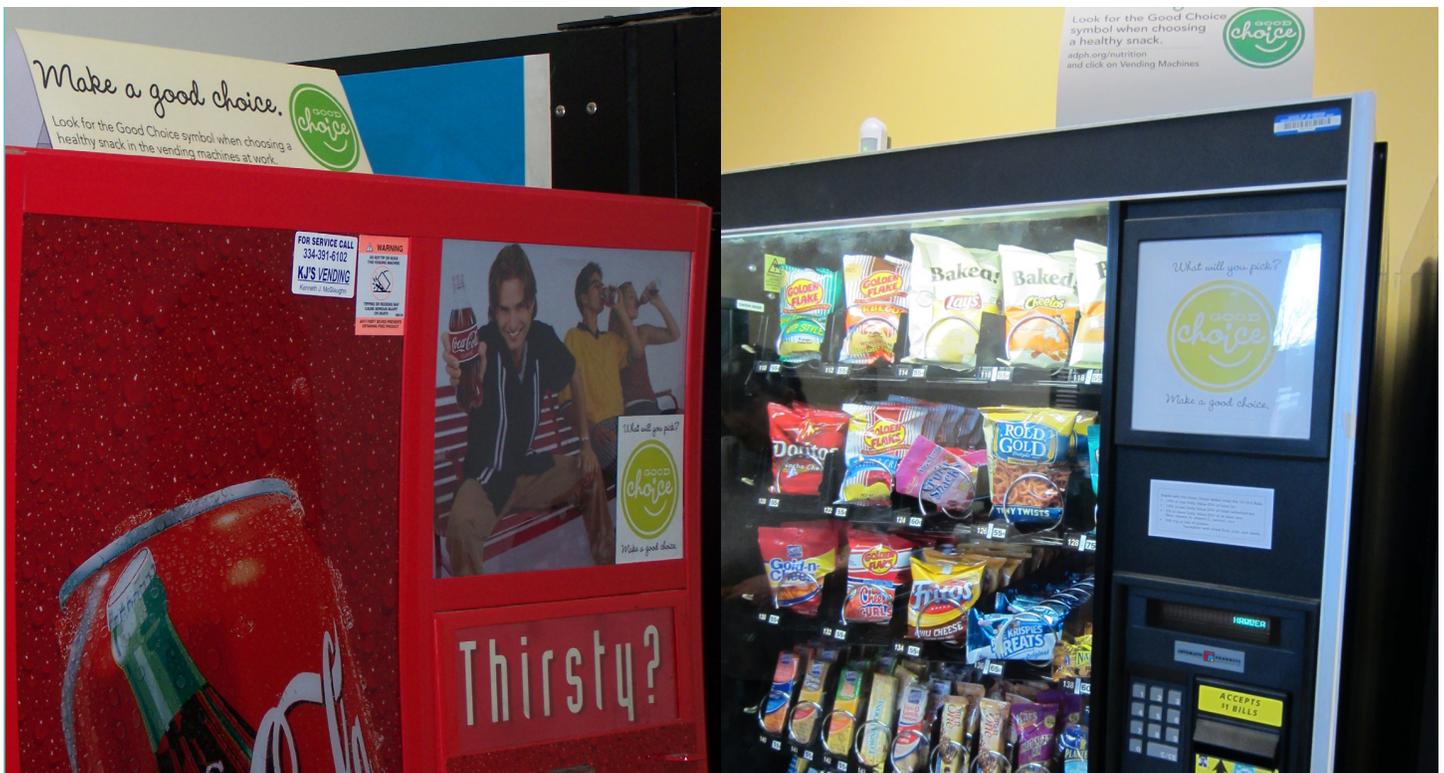
ADPH, Alabama Obesity Task Force, ASDE, Alabama Regional Council of Governments, AlaHa, Chamber of Commerce, and VOICES for Alabama’s Children.

Assets and Resources:

United States Department of Agriculture (USDA) Food and Nutrition Division and Healthy Hunger Free Kid Act of 2010.

Alignment with national, state, and local goals, objectives, and measures:

Healthy People 2020, Alabama Obesity Task Force State Plan, Heart and Voices, USDA, and Healthy Hunger Free Kid Act of 2010.



ACHIP Mental Health and Substance Abuse Workgroup

Priority Concern 3: Mental Health and Substance Abuse.

Goal 1: Strengthen infrastructure for mental health promotion and substance abuse prevention.

Concern 3 Goal 1 Objective 1: ■ **By December 31, 2015, identify and disseminate mental health and substance abuse indicators that are collected by state agencies.**

Information on mental health and substance abuse is being collected by various state agencies and community organizations. Strengthening the infrastructure for sharing mental health and substance abuse data and resources will help stakeholders identify service area gaps and establish baseline targets needed to monitor evidence-based interventions. Alabama practitioners, community leaders, and citizens gain a better understanding of the prevalence of mental health and substance abuse disorders when data and resources are shared, accessible, and publicized.

Performance Measures:

Available mental health and substance abuse data will be identified across state agencies.

Mental health and substance abuse indicator data is available and accessible for researchers, practitioners, communities, and citizens to use for establishing baseline targets needed to monitor evidence-based interventions for promoting mental health and managing/preventing substance abuse.

Partners and Stakeholders:

ADMH, Alabama Department of Human Resources, Alabama Department of Senior Services, Children's Trust Fund, Alabama Council of Community Mental Health Boards, Alabama Department of Corrections, ASDE, Alabama Administrative Office of the Courts, Alabama Department of Public Safety, U.S Department of Justice, and Drug Enforcement Administration (DEA) in Montgomery.

Assets and Resources:

ADPH Epidemiologists, Medicaid/RCO Mental Health/Behavioral and Chemical Dependency Quality Indicators, ARHA, ALL Kids, BCBS, community mental health centers, university researchers, Alabama Arise, and VOICES for Alabama's Children.

Alignment with national, state, and local goals, objectives, and measures:

Healthy People 2020, *Envision 2020*, *Healthy Minds Network*, and RCOs.

Concern 3 Goal 1 Objective 2: ■ **By December 31, 2016, collaborate with practitioners, university researchers, and community leaders to develop and disseminate a compendium of evidence-based interventions and policies that promote mental health and prevent substance abuse.**

Performance Measure:

Number of publications disseminated in Alabama.

Partners and Stakeholders:

ADMH, Envision 2020, AlaHa, Medicaid/RCOs, Alabama Council of Community Mental Health Boards, and Alabama research institutions.

Assets and Resources:

Community Mental Health Boards, RCOs, research institutions, ADMH, and ADPH.

Alignment with national, state, and local goals, objectives, and measures:

Healthy People 2020, Healthy Minds Network, and RCOs.



Goal 2: Strengthen training and technical assistance of primary care providers and community leaders in behavioral health promotion and behavioral health disorder prevention.

Concern 3 Goal 2 Objective 1: ■ **By December 31, 2017, develop training programs targeting primary care residents and medical students on evidence-based substance abuse and mental health disorder screening tools that can be effectively integrated into primary care settings.**

Since the mind and body are inseparable, the integration of mental health and primary care is of vital importance to the issues of wellness and prevention. Research has demonstrated that there is a high comorbidity of depression with other chronic health conditions. Alabama has the sixth highest rate of depression in the United States.

Performance Measures:

Number of training sessions offered and number of clinicians participating.

Pre and post survey measuring knowledge and attitudes toward integrating substance abuse and mental health screening tools in primary care settings for prospective primary care physicians

Partners and Stakeholders:

AL-AAP, MASA, AAFP, community mental health centers, ADMH, AMA/RCOs, AlaHa, Health Systems, Veterans Administration (VA), Poarch Band of Creek Indians, and residency programs,

Assets and Resources:

District medical societies, Alabama Public Health Areas, RCO, PCA, rural hospitals, rural health clinics, VA, and Poarch Band of Creek Indians.

Alignment with national, state, and local goals, objectives, and measures:

Healthy People 2020, World Health Organization, Healthy Minds Network, and VA.

Concern 3 Goal 2 Objective 2: ■ **Collaborate with the chronic disease community/programs to provide cross-systems training and quality improvement coordination. Provide information on evidence-based demonstration projects integrating mental health and primary care. Support integration of mental health and substance abuse training with primary care clinicians including topics addressing prescription drug abuse.**

Performance Measures:

Number of satellite trainings offered.

Number of primary care providers and community leaders participating.

Partners and Stakeholders:

Primary care training programs, rural primary care providers and hospitals, AlaHa, ADMH, AMA, RCOs, Alabama Chapter American College of Emergency Physicians, United States Department of Justice, Alabama State Board of Pharmacy, mid-level providers, social workers, and AHEC.

Assets and Resources:

Alabama Public Health Training Network, Office of Primary Care and Rural Health, ARHA, AL-AAP, AAFP, MASA. Alabama State Nurses Association (ASNA), chronic disease programs, Alabama School of Alcohol and Other Drug Studies (ASADs), AHEC, and community mental health centers.

Alignment with national, state, and local goals, objectives, and measures:

Healthy People 2020, World Health Organization, National Alliance of the Mentally Ill, VA, and Health Resources Services Administration (HRSA).



Goal 3: Reduce the prevalence of individuals with or at risk of substance abuse or mental illness.

Concern 3 Goal 3 Objective 1: ■ **Disseminate suicide prevention information to a broad range of organizations and programs with a role in supporting suicide prevention activities.**

Performance Measure:

Alabama Suicide Prevention and Resources Coalition (ASPARC) and number of gatekeeper trainers.

Partners and Stakeholders:

ASPARC, ADPH, Governor's Office of Faith-Based and Community Initiatives, AHEC, Family Resource Centers, PCA, ADMH, and community mental health centers.

Assets and Resources:

ASPARC, ADPH, Department of Senior Services, Alabama Council of Community Mental Health Boards, AMA/RCOs, and ADMH.

Alignment with national, state, and local goals, objectives, and measures:

Healthy People 2020, ASPARC, National Institute of Mental Health, and Alabama Veterans Network for Service Members, Veterans, and Their Families (Alavetnet).



Concern 3 Goal 3 Objective 2: ■ **Expand the number of Alabama municipalities that protect residents from second-hand smoke by prohibiting the use of tobacco products and nicotine delivery systems in workplaces.**

Performance Measure:

Increase the number of Alabama municipalities that have passed comprehensive ordinances providing second-hand smoke protections for workers and families from 27 to 30 by March 2017.

Partners and Stakeholders:

Alabama League of Municipalities, Alabama Regional Council of Governments, leadership groups, ADPH, The Coalition for a Tobacco Free Alabama, and Alabama Task Force for Tobacco Prevention and Control.

Assets and Resources:

ADPH Tobacco Control Program, Silver-Hair Legislature, AMA, RCOs, VOICES for Alabama's Children, AAFP, AL-AAP, and AlaHa.

Alignment with national, state, and local goals, objectives, and measures:

CDC National Tobacco Control Program, *Healthy People 2020*, Institute of Medicine, and World Health Organization.



KEY POLICIES, STRATEGIES, AND PARTNERS FOR ACHIEVING THE ACHIP.

PRIORITY ISSUE

1

Access to Care.

Lack of Transportation:

The CHA identified households with no vehicles as one of the indicators impacting access to health care. The ACHIP stakeholders felt that transportation barriers were one of the major *Healthy People 2020* social and physical determinants of health that impacts rural, elderly, and poor populations in Alabama.

Faith-based entities have expressed that volunteer drivers are often concerned regarding liability issues. Insurance policies to protect church vans or volunteer automobiles can be expensive.

Policy Approach:

Review volunteer transportation liability laws in Alabama and work with ACHIP advocacy organizations (VOICES, ARHA, Alabama Arise, PCA, RCOs, etc.) the Governor's Office, and communities on developing volunteer driver liability laws that support volunteers providing transportation to health care appointments.

Lack of Transportation:

Linkages to transportation planning opportunities in rural and underserved communities are critical for creating strategies to overcome barriers to health care access. ADECA, Alabama Arise, and the Alabama Councils of City Governments identified opportunities, as part of the ACHIP process, to develop regional strategies addressing the lack of transportation for patients seeking health care.

Policy Approach:

Integrate access to health appointments in the HSCTP developed by the 12 Regional Planning and Development Commissions.

PRIORITY ISSUE

1

Access to Care. (continued)

Telemedicine:

According to the American Telemedicine Association, telemedicine can bridge the gap in geographic health disparities and provide comparable services to those of in-person care. Although it is surrounded by states with telemedicine parity laws, Alabama has not been successful in passing a similar law.

Policy Approach:

State-regulated payers should provide reimbursement for health care services delivered through telemedicine to the same extent as health care services provided in person. The lack of reimbursement through private insurance carriers is a tremendous challenge to implementing telemedicine in Alabama. ACHIP stakeholders will work to support parity legislation.

Increase the Pipeline of Primary Care Providers:

Provide income tax incentives for primary care providers who participate in clinical rotations to students in a state medical or osteopathic medical program, physician assistant program, an advanced practice nurse program.

Policy Approach:

The ARHA, in collaboration with MASA and the ASNA, introduced a policy to provide income tax credits for physicians, physician assistants, and nurse practitioners who provide clinical rotations without compensation to students enrolled in state medical programs.

PRIORITY ISSUE

2

Nutrition and Physical Activity.

Access to Healthy Food Options:

Access to healthy foods is another social determinant of health impacting families living in poverty and families without transportation. The USDA reports that more than one million Alabamians live in areas designated as food deserts where access to healthy and affordable food options are not readily available.

Policy Approach:

VOICES for Alabama's Children advocates for legislation to secure state funding for implementation of a statewide Healthy Food Financing Initiative. Healthy Food Financing is a policy initiative that helps put healthy foods in underserved communities by providing economic incentives to healthy food retailers to locate in such areas.

Quality Physical Education:

The Quality Physical Education in Alabama Initiative is a joint effort of ADPH, Nutrition and Physical Activity Division (NPA), and the ASDE, Curriculum and Instruction Division, that continues to assist with training of school personnel and integration of students with disabilities into daily physical education classes.

Policy Approach:

The ASDE and Nutrition and Physical Activity continue to work on policy recommendations for the State that focus on quality physical education and healthy weight initiatives.

PRIORITY ISSUE

3

Tobacco use is the single most preventable cause of disease, disability, and death in the United States.

– Healthy People 2020

Mental Health and Substance Abuse.

Substance Abuse: Tobacco:

A study by *The Journal of the American Medical Association* reported that 44.3 percent of all cigarettes in America are consumed by individuals who live with mental illness and/or substance abuse disorders, making persons living with mental illness about twice as likely to smoke as other persons. Tobacco use is the leading cause of preventable death in the United States and in Alabama. People with serious mental illness treated in the public health system die 25 years earlier than those without mental illness according to a 2006 article in *Preventing Chronic Disease*.

The Community Preventive Services Task Force recommends smoke-free policies to reduce secondhand smoke exposure and tobacco use on the basis of strong evidence of effectiveness. Evidence is considered strong based on results from studies that demonstrated the effectiveness of smoke-free policies in the following:

- Reducing exposure to secondhand smoke
- Reducing the prevalence of tobacco use
- Increasing the number of tobacco users who quit
- Reducing the initiation of tobacco use among young people
- Reducing tobacco-related morbidity and mortality, including acute cardiovascular events

Economic evidence indicates that smoke-free policies can reduce health care costs substantially. In addition, the evidence suggests that smoke-free policies do not have an adverse economic impact on businesses, including bars and restaurants. For these reasons, the (name of Stakeholder group on Mental Health Priority area) chose to address smoke-free policy at the municipal level.

Policy Approach:

Alabama has received national awards in two of the past five years for efforts to protect citizens from secondhand smoke exposure, so the workgroup would build upon that infrastructure to advocate for additional smoke-free ordinances that cover all workplaces, including restaurants and bars. The ADPH Tobacco Policy Tracking System can be used to monitor progress toward this goal.

Individuals and Organizations that have Accepted Responsibility for Implementing Strategies:

The Coalition for a Tobacco Free Alabama; local tobacco control coalitions; the American Cancer Society, Cancer Action Network; the American Lung Association; the American Heart Association; the ASNA; the American College of Cardiology, Alabama Chapter; AL-AAP; Voices for Alabama's Children; and ADPH.

Other Policy Issues:

Due to current Alabama health care challenges, the Governor established the Health Care Improvement Task Force, a 39-member panel, charged with addressing the serious barriers to health care access in Alabama. The health care environment is transforming while state budgets are substantially shrinking.

With reduced funding, Alabama will be relying on innovative and collaborative ways to share resources, develop policy, and avoid duplication of efforts while working to address this issue.

The ACHIP stakeholders anticipate additional policy recommendations resulting from the work of the Governor's Health Care Improvement Task Force.

Tracking Progress and Demonstrating Results for the ACHIP Strategies:

The continual engagement of ACHIP stakeholders will occur through quarterly conference calls and annual meetings to update the ACHIP. ADPH will coordinate and host the conference calls and annual meetings.

In addition, the ACHIP goals, objectives, and performance measures will be added to the ADPH Performance Dashboard for tracking. The Performance Dashboard is a web-based application used to track organizational performance in support of ADPH's overall performance management system. Through the ADPH Performance Dashboard, ACHIP data may be updated regularly and progress reports may be generated for distribution to ACHIP stakeholders. ADPH will be responsible for collecting the performance measurement data from other ACHIP organizations and partners. Other tracking resources will include the Medicaid RCO Performance Measures, the policy updates and policy tracking updates from VOICES for Alabama's Children, ARHA, and Alabama Arise advocacy organizations, and data from the Alabama Obesity Task Force.

Moving Ahead: Coordination of Efforts.

“Coordination and identification of resources and programs in Alabama is challenging. An inventory of efforts focusing on health care access would be helpful.”

– Member of the Governor’s Health Care Improvement Task Force, 5/20/15 meeting.

A strategic approach focusing on community-agency linkages was a major theme for the goals, objectives, and performance measures developed by ACHIP stakeholders to address the three priority health care concerns of Alabamians.

The ACHIP focus on access to care, nutrition and physical activity, and mental health and substance abuse is consistent in the advocacy agendas and health care task force agendas of Alabama stakeholders. The challenge lies in linking these efforts to enhance outcomes, avoid duplication of efforts, and allocate resources most effectively.

In order to more effectively link efforts, an initial strategic approach of the ACHIP is to collect and disseminate data, including health disparity data, to inform stakeholders and identify evidence-based best practices for better management of health care access and chronic disease.

For example, Goal 1, Objective 1 and Objective 2, focusing on access to care and reduction of transportation barriers to health care, is being addressed through the Human Services Coordinated Transportation Plans and the Regional Planning Commissions and ALDOT. Working with regional planners across the state to address transportation from a public health perspective has increased the opportunity for transportation resources to support access to health care.

The outlined goals, objectives, and strategies of the ACHIP represent a framework for collaboration and coordination on the local, regional, and state level around priority health issues. No single organization can effectively address them alone. When reviewing this plan, consider developing new partnerships with ACHIP to help improve the health of all Alabamians.

APPENDIX A

Listing of the 13 Leading Health Care Concerns Identified Through Domain 1 Efforts Along With the Proposed Indicators/Measures of Each.

1.	Access to Care
	Percent Uninsured Population Under age 65 (Census Bureau – available down to county level)
	633,845 Alabamians were without health insurance in 2012. This is 15.8 percent of the entire population under age 65. This percentage was 15.7 in 2006. Alabama had the twenty-fourth highest percent uninsured persons under age 65 among all states in 2012. The national percentage was 15.4 in 2012.
	Percent Population Experiencing a Lack of Primary Care Service and Living in Primary Care Health Professional Shortage Areas (ADPH, Office of Primary Care and Rural Health – available down to the county level)
	There are an estimated 1,764,000 Alabamians experiencing a lack of adequate primary care service in Alabama in 2014. This accounts for approximately 36.4 percent of Alabama’s entire population. Only five Alabama counties are not currently entirely or partially classified as Primary Care Health Professional Shortage Areas.
2.	Mental Health and Substance Abuse
	Intentional Self Harm (Suicide) Mortality Rate (Center for Health Statistics – available down to the county level)
	2,037 Alabamians were suicide victims during 2010-2012. The age-adjusted mortality rate was 13.8 deaths per 100,000 standardized population. This rate was 12.0 during 2000-2002.
	Alabama had the twenty-second highest rate (13.4) among all states in 2008-2010.
	The national rate was 11.8 in 2008-2010.
	Percent Adult Population Ever Told That They Have Depression (BRFSS – available down to the PHA level) In 2012, 21.9 percent of adult Alabamians had ever been told that they have depression. Alabama had the sixth highest prevalence of depression among states. The national percentage was 18.0 in 2012.

3.	Poor Pregnancy Outcomes
	Infant Mortality Rate (Center for Health Statistics – available down to the county level)
	1,522 Alabama infants lost their lives during 2010-2012. The infant mortality rate was 8.6 deaths per 1,000 live births. This rate was 9.3 during 2000-2002. Alabama had the second highest rate among all states in 2010. The national rate was 6.1 in 2010.
	Low Weight Birth Rate (Center for Health Statistics – available down to the county level)
	5,866 Alabama resident babies were born of low birth weight (under 2,500 grams or 5 pounds and 8 ounces) in 2012. This accounted for 10.1 percent of all births to residents. This percentage was 9.9 percent in 2002. Alabama had the third highest percentage among all states in 2011. The national percentage was 8.1 percent in 2011.
4.	Nutrition and Physical Activity
	Percent Adult Obesity (BRFSS and County Health Rankings & Roadmaps– available down to the county level) In 2012, 33.0 percent of adult Alabamians were obese. Alabama had the fifth highest percentage of obesity among states. The national percentage was 27.6 in 2012.
	Vegetable consumption less than once daily (BRFSS - available down to the PHA level)
	In 2011, 24.3 percent of adult Alabamians consumed vegetables less than one time daily. Alabama had the twentieth highest percentage in the nation. The national percentage was 22.5 in 2011. Fruit consumption less than once daily (BRFSS – available down to PHA level)
	In 2011, 43.8 percent of adult Alabamians consumed fruit less than one time daily. Alabama had the eighth highest percentage among states. The national percentage was 37.7 in 2011.
	Participated in enough Aerobic and Muscle Strengthening exercises to meet guidelines - adults (BRFSS – available down to the PHA level) In 2011, 15.0 percent of adult Alabamians participated in enough aerobic and muscle strengthening exercises to meet guidelines. Alabama had the fourth lowest percentage among states. The national percentage was 21.0 in 2011.

5.	Cardiovascular Diseases
	Heart Diseases Mortality Rate (Center for Health Statistics – available down to the county level)
	35,919 Alabamians died from heart diseases during 2010-2012. The age-adjusted mortality rate was 228.9 deaths per 100,000 standardized population. This rate was 294.4 during 2000-2002. Alabama had the third highest rate (239.0) among all states in 2008-2010. The national rate was 184.6 in 2008-2010.
	Cerebrovascular Diseases (Stroke) Mortality Rate (Center for Health Statistics – available down to the county level)
	7,759 Alabamians died from cerebrovascular diseases or stroke during 2010-2012. The age-adjusted mortality rate was 49.8 deaths per 100,000 standardized population. This rate was 69.8 during 2000-2002. Alabama had the highest rate (54.4) among all states in 2008-2010. The national rate was 40.2 in 2008-2010.
	Adults who have had their blood cholesterol checked and have been told it was high (BRFSS – available down to the PHA level)
	In 2011, 42.0 percent of adult Alabamians had their blood cholesterol checked and had been told it was high. Alabama had the second highest percentage among states. The national percentage was 38.4 in 2011.
6.	Sexually Transmitted Infections
	Sexually transmitted cases reported (STD Division – available down to the county level)
	38,624 Alabamians were diagnosed with sexually transmitted diseases (chlamydia, gonorrhea, and syphilis) during 2013. The infection rate was 799.05 per 100,000 population. This rate was 540.93 during 2003. In 2012, Alabama had the: Third highest chlamydia infection rate (637.6) among all states. Third highest gonorrhea infection rate (193.0) among all states. Fifteenth highest primary and secondary syphilis infection rate (4.5) among all states. Fourteenth highest early latent syphilis infection rate (4.9) among all states. Fifteenth highest late and late latent syphilis infection rate (5.2) among all states. Fourteenth highest congenital syphilis infection rate (6.4) among all states.
	The national infection rate in 2012 was: 456.7 for chlamydia. 107.5 for gonorrhea. 5.0 for primary and secondary syphilis 4.7 for early latent syphilis. 6.2 for late and late latent syphilis. 7.8 for congenital syphilis.

	New HIV Cases (HIV/AIDS Division – available down to the county level)
	661 Alabamians were newly diagnosed with HIV during 2012. The infection rate was 13.8 per 100,000 population. This rate fluctuated between 13.8 and 14.9 during 2008-2012. Alabama had the twelfth highest new infection rate among all states in 2011. The national new infection rate was 15.8 in 2011.
7.	Cancer
	Cancer Mortality Rate (Center for Health Statistics – available down to the county level)
	30,673 Alabamians died from cancer during 2010-2012. The age-adjusted mortality rate was 187.3 deaths per 100,000 standardized population. This rate was 212.2 during 2000-2002. Alabama had the seventh highest rate (195.1) among all states in 2008-2010. The national rate was 174.2 in 2008-2010.
	Colorectal Cancer Incidence (Statewide Tumor Registry – available down to the county level)
	24,384 Alabamians were diagnosed with colorectal cancer during the years 2002-2011. The age-adjusted incidence rate was 48.2 per 100,000 standardized population. This rate was 48.8 during 1996-2000. Alabama had the twelfth highest rate (47.9) among all states in 2006-2010. The national rate was 44.7 in 2006-2010.
	Female Breast Cancer Incidence (Statewide Tumor Registry – available down to the county level)
	32,127 Alabama females were diagnosed with breast cancer during the years 2002-2011. The age-adjusted incidence rate was 117.0 per 100,000 standardized population. This rate was 116.0 during 1996-2000. Alabama had the thirty-sixth highest rate (119.4) among all states in 2006-2010. The national rate was 122.2 in 2006-2010.
	Lung Cancer Incidence Rate (Statewide Tumor Registry – available down to the county level)
	38,593 Alabamians were diagnosed with lung cancer during the years 2002-2011. The age-adjusted incidence rate was 75.1 per 100,000 standardized population. This rate was 73.2 during 1996-2000. Alabama had the tenth highest rate (75.2) among all states in 2006-2010. The national rate was 65.7 in 2006-2010.

	Prostate Cancer Incidence Rate (Statewide Tumor Registry – available down to the county level)
	35,480 Alabama males were diagnosed with prostate cancer during the years 2002-2011. The age-adjusted incidence rate was 154.1 per 100,000 standardized population. This rate was 129.0 during 1996-2000, but prostate cancer was known to be under-reported during this time. Alabama had the eleventh highest rate (158.4) among all states in 2006-2010. The national rate was 146.6 in 2006-2010.
8.	Child Abuse/Neglect
	Child (age 17 and younger) Abuse and Neglect Reports Completed – (available from the Alabama Department of Human Resources down to the county level)
	There were 20,599 reports completed involving 28,385 children during Fiscal Year 2012 (October 2011 through September 2012) This rate of child abuse and neglect was 25.2 per 1,000 population aged 17 years or less. The national rate was 28.4 during this same time period.
9.	Diabetes
	Diabetes-Related Mortality (any mention of diabetes on the death certificate) (Center for Health Statistics – available down to the county level)
	11,309 Alabamians died from diabetes-related causes during 2010-2012. The age-adjusted mortality rate was 70.6 deaths per 100,000 standardized population. This rate was 79.6 during 2000-2002. Alabama had the eighteenth highest rate (76.8) among all states in 2008-2010. The national rate was 71.6 in 2008-2010.
	Percent of adults ever told by a doctor that they have diabetes (BRFSS – available down to the PHA level)
	In 2012, 12.2 percent of adult Alabamians had ever been told by a doctor that they have diabetes. Alabama had the third highest percentage among states. The national percentage was 9.7 in 2012.
10.	Geriatrics
	Projected percentage increase in elderly population (Census Bureau – available down to the county level)
	Alabama’s elderly population (age 65+) is projected to increase from 657,792 to 1,199,853 between 2010 and 2040. This is an increase of 82.4 percent. The national elderly population (age 65+) is projected to increase from 40,267,984 to 79,719,000 between 2010 and 2040. This is an increase of 98.0 percent.

	Increase the proportion of females aged 65 years and older who are up to date on a core set of clinical preventive services (BRFSS – available down to the PHA level)
	In 2012, 33.3 percent of female Alabamians aged 65 years or more were up to date on a core set of clinical preventive services. The national percentage was 30.9 in 2012.
	Increase the proportion of males aged 65 years and older who are up to date on a core set of clinical preventive services (BRFSS – available down to the PHA level)
	In 2012, 36.5 percent of male Alabamians aged 65 years or more were up to date on a core set of clinical preventive services. The national percentage was 34.1 in 2012.
	Adult (age 18+) Abuse and Neglect Reports Completed – (available from the Alabama Department of Human Resources down to the county level)
	There were 6,145 reports completed involving 6,399 adults during Fiscal Year 2013 (October 2012 through September 2013) This rate of adult abuse and neglect was 17.0 per 10,000 population aged 18 years or more.
11.	Injury and Violence Prevention
	Homicide Mortality Rate (Center for Health Statistics – available down to the county level)
	1,173 Alabamians died from homicide during 2010-2012. The age-adjusted mortality rate was 8.3 deaths per 100,000 standardized population. This rate was 9.6 during 2000-2002. Alabama had the third highest rate (9.0) among all states in 2008-2010. The national rate was 5.6 in 2008-2010.
	Accidental Poisoning Mortality Rate (Center for Health Statistics – available down to the county level)
	1,481 Alabamians died from accidental poisoning during 2010-2012. The age-adjusted mortality rate was 10.6 deaths per 100,000 standardized population. This rate was 4.3 during 2000-2002. Alabama had the twentieth highest rate (11.6) among all states in 2008-2010. The national rate was 10.4 in 2008-2010.
	Motor Vehicle Accident Mortality Rate (Center for Health Statistics – available down to the county level)
	2,661 Alabamians died from motor vehicle accidents during 2010-2012. The age-adjusted mortality rate was 18.4 deaths per 100,000 standardized population. This rate was 23.9 during 2000-2002. Alabama had the fifth highest rate (20.5) among all states in 2008-2010. The national rate was 11.9 in 2008-2010.

12.	Oral Health
	Ratio of Population to Dentists (Board of Dental Examiners – available down to the county level)
	There are 2,138 licensed dentists actively practicing in Alabama during 2014. This is approximately 4.4 dentists per 10,000 population. There were approximately 4.7 dentists per 10,000 population in the nation in 2012.
	Visited the dentist or dental clinic within the past year for any reason (BRFSS – available down to the PHA level)
	In 2012, 58.0 percent of adult Alabamians had visited the dentist or dental clinic within the past year for any reason. Alabama had the fifth lowest percentage among states. The national percentage was 64.9 in 2012.
13.	Cigarette Use
	Adult cigarette smoking (BRFSS and County Health Rankings & Roadmaps– available down to the county level)
	In 2012, 23.8 percent of adult Alabamians were cigarette smokers. Alabama had the ninth highest percentage among states. The national percentage was 19.6 in 2012.
	Adolescent cigarette smoking in the past 30 days (Youth Risk Behavior Survey – available down to the state level)
	In 2011, 22.9 percent of Alabama high school students had smoked cigarettes within the past 30 days. Alabama had the third highest percentage among states. The national percentage was 18.1 in 2012.

Appendix B

Alabama Community Health Improvement Stakeholders.

Matt Allison

American Cancer Society

Jim Alford, MD

Medical Association State of Alabama

Jeff Arrington

Alabama Association of
Family Practitioners

Doris Ball

Alabama Department of
Human Resources

Audrey Barron

Alabama State Department
of Education

Diane Beeson

Coalition for a Tobacco Free Alabama

Emily Benson

Blue Cross Blue Shield
Caring Foundation

Carolyn Bern

Office of Primary Care and
Rural Health

Lynn Beshear

Envision 2020

Rosemary Blackmon

Alabama Hospital Association

Shirley Brown

Blue Cross Blue Shield of Alabama

Eboni Bryant

Alabama Obesity Task Force

Erica Butler

Alabama State Department
of Education

Jim Carnes

Alabama Arise

Lisa Castaldo

Serve Alabama, Governor's Office

Linda Cater

Alabama Community College System

Art Clawson

Area Health Education Center

Linnea Conely

Auburn University Outreach

Valerie Cochran

ADPH Nursing Department

Conan Davis, DMD

Community Dean, UAB Dental School

John Deamer

Black Belt Community Foundation

Kristen Dial

Alabama State Department
of Education

Jamey Durham

Bureau of Professional and
Support Services

Mike Easterwood

Economic and Community
Development Institute,
Auburn University
Alabama Communities of Excellence

Ricky Elliott

Public Health Administrator,
Public Health Areas 7 and 9

Warner Floyd

Consumer
Alabama Silver Hair Legislature

Seth Gowan

District Attorney's Office, Montgomery

Jessica Hales

Alabama Department of
Mental Health

Carol Heier

Public Health Accreditation

Matt Holdbrooks

Kid One Transport

Ken Hollingsworth

Alabama Department of Economic and
Community Affairs

Michael Jackson

Alabama State Obesity Task Force

Catina James

Alabama Department of
Mental Health

Michele Jones

Alabama Department of Public Health
Administration

Wanda Langley

Alabama State Department
of Education

Appendix B

Alabama Community Health Improvement Stakeholders. (continued)

Linda Lee

Alabama Chapter, American Academy of Pediatricians

Stan Long

Cherokee Tribe of NE Alabama

Sallye Longshore

Children's Trust Fund of Alabama

Arlene Mack

Poarch Creek Band of Indians

Robin Mackey

Alabama Network of Family Resource Centers

Rhonda Mann

VOICES for Alabama's Children

Arlene Morris

Alabama State Nurses Association

Drew Nelson

Alabama Medicaid Agency

Tracy Plummer

Children's Trust Fund of Alabama

Denise Pope

Public Health Area 7

Dale Quinney

Alabama Rural Health Association

Robin Rawls

Alabama Medicaid Agency/Regional Care Organizations

Nancy Robertson

Top of Alabama Regional Council of Governments

Khris Robinson

Primary Care Association

Mayor Howard Rubenstein, MD

Alabama League of Municipalities

Arrol Sheehan

Media

Julia Sosa

Office of Minority Health,
Alabama Department of Public Health

Ron Sparks

Alabama Rural Development Office

Yvonne Thomas

Alabama Cooperative Extension Service and Leadership
Autauga County

Jennifer Ventress

Alabama State Department of Education

Randall Weaver, MD

Veterans Administration

Collie Wells

Alabama State Department of Education
Career and Technical Education

Dave White

Governor's Health Policy Advisor
Governor's Office

Tammie Yeldell

Maternal and Child Health Services Program

John Zeigler

Alabama State Nurses Association

Acronyms.

Acronym	Meaning	Acronym	Meaning
ADPH	Alabama Department of Public Health	BRFSS	Behavioral Risk Factor Surveillance
AAFP	Alabama Academy of Family Physicians	CHA	Community Health Assessment
ACA	Affordable Care Act	CDC	Centers for Disease Control and Prevention
ACES	Alabama Cooperative Extension System	CHANGE	Community Health Assessment and Group Evaluation
AL-AAP	Alabama Chapter of the American Academy of Pediatrics	EDAA	Economic Development Association of Alabama
Ala-Ha	Alabama Hospital Association	EMR	Electronic Medical Record
ACHIP	Alabama Community Health Improvement Plan	HRSA	Health Resources Services Administration
ADECA	Alabama Department of Economic and Community Affairs	HSCTP	Human Services Coordination Transportation Plans
ADPH	Alabama Department of Public Health	MAPP	Mobilizing for Action through Planning and Partnership
ADMH	Alabama Department of Mental Health	MASA	Medical Association of the State of Alabama
AHEC	Area Health Education Center	PCA	Alabama Primary Care Association
ALDOT	Alabama Department of Transportation	PCNA	Patient Centered Networks of Alabama
ASAD	Alabama School of Alcohol and Other Drug Studies	PDMP	Prescription Drug Monitoring Program
AMA	Alabama Medicaid Agency	RCO	Regional Care Organization
ASDE	Alabama State Department of Education	SP	Strategic Plan
ASNA	Alabama State Nurses Association	UAB	University of Alabama Birmingham
ASPARC	Alabama Suicide Prevention and Resources Coalition	USDA	United States Department of Agriculture
BCBS	Blue Cross Blue Shield of Alabama	VA	Veterans Administration

Acknowledgement of funding source:

This project was supported by funds made available from the Centers for Disease Control and Prevention, Office for State, Tribal, Local, and Territorial Support, under grant number 5U58CD001273-03 - Revised and 5U58CD001273-04 - Revised.

Disclaimer:

The contents of this article are those of the authors and do not necessarily represent the official position of or endorsement by the Centers for Disease Control and Prevention.