3. EXECUTIVE SUMMARY

In 1994, the Sedgwick County Department of Community Health (Health Department) convened a Public Health Summit attended by community health care leaders and local government officials. One of the recommendations at that Summit was that our City and County carry out a community health assessment and, based on that assessment, develop a community health plan. In 1995, the Health Department, in collaboration with the University of Kansas School of Medicine (Department of Preventive Medicine) and Wichita State University (College of Health Professions), obtained a grant from the Kansas Health Foundation to carry out a community health assessment. An Advisory Committee of 40 community health leaders was assembled to assist with the assessment. Five work groups that included Advisory Committee members and other interested individuals were assembled: a health status group, a health perceptions group, a health resources group, an education group, and an evaluation group.

Data collection and analysis were carried out between September 1995 and January 1997. Multiple focus groups and town meetings were held to discuss health issues. One group (Health Status) collected existing data and spent 2-3 months reviewing and categorizing various community health problems. Eventually, they set health priorities for the community, based on magnitude and importance of the problem, as well as data on availability and effectiveness of existing interventions. Another group (Resource Group) surveyed providers and developed a Health Resource Inventory for the community. The Perceptions Group randomly surveyed 1,000 adults with a 175 question phone survey. Using this same Inventory, four low income neighborhoods were also surveyed. The Education Group arranged for media coverage and worked with *The Wichita Eagle* to make community health assessment a potential topic for public journalism.

Early on it was agreed that our health assessment group should embrace both a medical model of caring for individual patients (with illness) AND a public health model that emphasizes the overall health of groups of people. Life expectancy in the United States has increased 30 years since the turn of the century (from 46 years to 76 years). Twenty-five (25) of these years of increased life can be attributed to public health improvements (less crowding, sanitation, clean air/water, immunizations, decreased risk factors, etc.). Individual clinical care, however, has also helped to prolong life and, especially, to improve the quality of life and the functioning of individuals.

Health Care Costs and Outcomes

The United States spends more money (one trillion dollars per year) and a larger percentage of the Gross Domestic Product (15%) on health care than any other country in the world. Despite the money spent, health indicators in the U.S. fall significantly below many other countries in the world. Low birth weight, neonatal mortality, infant mortality, immunization rates, life expectancy, and death rates are worse in the U.S. than in many other developed countries.

Americans have an insatiable appetite for medical care after illness has occurred. A fee-for-service payment system has fed this appetite, but new constraints, such as managed care, are beginning to slow the rate of growth in the health care sector.

Physicians, and other health care providers, perform many medical care interventions that are not of proven benefit and, in fact, do more harm than good. We spend much money on health care that does not lead to improved health. Much expensive health care leads to very small increments in health. On the other hand, many people are not receiving interventions of proven benefit, such as the control of hypertension or cholesterol or medications of proven benefit for heart disease.

Health care costs in Kansas are below the U.S. average. Although no Sedgwick County data is available on total per capita health care costs, we do know that hospital costs (about 1/3 of total costs) in the Wichita Medicare Hospital Referral Area are exactly average. Very high rates of cardiovascular and urological procedures are performed on Medicare patients in the Wichita Hospital Referral Area. These costly procedures are performed by fewer cardiologists and urologists than the U.S. average. Although we do not know whether these costly interventions have improved health, it is disturbing that **heart disease death rates in Kansas are above the national average**.

The percentage of uninsured persons in Sedgwick County is less than the Kansas average and national average. Six percent (6%) of **our adult residents**, however, are continuously uninsured and another 15% were periodically uninsured over the past 12 months. Like elsewhere in the U.S., managed care programs are beginning to expand in an attempt to slow the growth of health care costs. Currently, somewhere between 5-15% of our residents are enrolled in capitated managed care (HMO) plans. This figure is below the national average of 19-27%, but is beginning to grow steadily.

HEALTH STATUS AND ITS SOCIAL CONTEXT

Wichita is a typical middle class American city. Tables in this chapter describe its demographic characteristics. Most importantly, our figures document the fact that most citizens are solidly middle class with above average incomes and significant educational achievement. We have a smaller percentage of extremely poor people than the national average, but the percentage of our residents who are extremely wealthy is also below average.

In terms of perceived health, we are also typical of the national average. For instance, 78% of our residents have not had their activities limited by poor physical or mental health in the previous 30 days. Unappreciated by many people is the fact that musculo-skeletal conditions account for the majority of medical problems that limit activity: arthritis 17%; back and neck problems 16%; fractures 10%; and walking problems 10%.

During the previous 12 months, 80% of our residents have seen a physician and 66% a dentist. Seventy-seven percent (77%) receive their medical care from a private physician.

Most people did not find barriers to health care delivery, but 19% of our residents reported that cost had prevented them from obtaining one of the following: emergency room care, dental care, prescription medications, or any other medical care. On a scale of 1 to 5, with 5 representing a major problem, 12% of Sedgwick County residents scored 3 or higher for experiencing financial barriers to care. Confidence in health care providers, however, was high. Eighty-five percent (85%) and 82% of residents had significant confidence in their physician or dentist, and 83% were satisfied or very satisfied with health care services over the previous 12 months.

Although 26% of Sedgwick County adults smoked, almost 4% had quit during the past year and 24% had quit for more than one year. Higher income and more education predicted lower smoking rates. Over one-third (36%) of adults reported being regularly exposed to second-hand smoke. The majority of residents always (62%) used or very often (14%) used automobile seat belts. Using the Quetelet Index (based on height and weight), 31% of residents were classified as obese.

Vulnerable Populations in Sedgwick County

The Uninsured

As mentioned before, 5.7% of the adult population in Sedgwick County were continually uninsured during the prior 12 months, while 14.9% were periodically uninsured. On average, these groups were younger, less educated, and poorer than the insured. About 13% of the insured and uninsured groups reported fair or poor health, and 55% judged their health as excellent or very good. During the previous 30 days, however, the uninsured group included significantly more people with three or more days when their physical health had been poor than the insured group. Mental health was also poorer in the uninsured group, especially the continually uninsured.

In terms of health care utilization, 80% of the insured had seen a physician during the past 12 months while only 60% of the continually uninsured had. A greater difference was seen for dental visits.

About 7% of the insured population was prevented by cost from obtaining health care during the past year compared to 38% for the periodically uninsured, and 58% for the continually uninsured. Organizational barriers to obtaining health care were about twice as great in the continually uninsured compared to the insured. Also, both groups of uninsured were somewhat less satisfied than the insured with the health care they had received.

Vulnerable Populations in Sedgwick County

Four Neighborhoods

About 100 people in each of four neighborhoods were independently surveyed with our questionnaire. The Colvin/Plainview area contained all race and ethnic groups, but predominantly non-Hispanic whites (40%), Asians (31%), and African-Americans (16%). North

Midtown was largely Hispanic (75%). African-Americans predominate in the Northeast/Atwater neighborhood (94%), while Oaklawn included primarily non-Hispanic whites (76%) and African-Americans (14%). All four neighborhoods were poor, with income under $10,000 being the largest category in three of the areas. For the general population, the largest income category was >$50,000. Between 37 and 67% of people in the neighborhoods have not completed high school, compared to 9% in the general population. Interestingly, 73% of the Hispanic North Midtown area were married, compared to only 38% in the African-American Northeast/Atwater area. The other two areas were similar to the general population at 59%.

Residents of all the neighborhoods were in worse health than the general population, as indicated by number of days when mental health was poor, activities were limited due to physical or mental health, and perceived health status. These residents were also much less likely than the general population to have seen a physician, a dentist or other health care provider. On the other hand, when they did seek care, they used the same services as the general population. As expected, many more people in these neighborhoods were uninsured or on Medicaid.

Residents in the four neighborhoods were much more likely than the general population to perceive barriers to obtaining health care. Cost prevented access to health care in all neighborhoods, but especially in North Midtown (77% had cost barriers compared to 9% in the general population). Except for residents of Oaklawn, persons in the neighborhoods were somewhat less satisfied than the general population with the health care they had received in the past year. The multiple figures in our report highlight other health concerns of residents of these four neighborhoods.

Smoking, and second-hand smoke, rates were higher in these neighborhoods, especially in the Colvin/Plainview area and Oaklawn. Seat belt usage was lower in all neighborhoods except North Midtown. Obesity levels were higher, but not statistically significant.

Perceived Household and Community Problems

The top six household problems for the general population and our four neighborhoods included:

behavioral risk factor problems related to eating and overweight
physical environment problems
organization barriers to obtaining health care (not a priority for Northeast/Atwater or Oaklawn)
financial barriers to obtaining health care
general financial/economic problems
problems with neighborhood crime

Within the neighborhoods, financial barriers and economic problems were highest, while physical environment and organizational barriers to obtaining care were lower. Importantly, also, was the fact that categories had much higher mean scores (more serious/severe problems) in the neighborhoods compared to the general population.

Perceived community problems differed somewhat from perceived household problems:

behavioral risk factor problems related to sexuality and alcohol
behavioral risk factor problems related to eating and overweight
financial barriers to obtaining health care
violence problems
general financial/economic problems
problems with access to services for children and youth

Interestingly, violence was not among the top six in any of the neighborhoods. Instead, these residents were more concerned about access to services.

COMMUNITY HEALTH ISSUES

Health Status

This section of the report deals with the health status of Sedgwick County residents. Existing data from multiple sources has been used to compile this summary. After summarizing various socioeconomic factors in the County, eight (8) areas were investigated further. Within these areas, subtopics were evaluated and rated by our Health Status Work Group. The rating considered the magnitude and importance of each problem, as well as the availability and effectiveness of interventions. The Committee concluded its task by making the following priorities within each of the eight areas:

Morbidity and Mortality

1 - Heart Disease
2 - Stroke
3 - Obstructive Lung Disease
4 - Cancer
5 - Unintentional Injury
6 - Diabetes
7 - Atherosclerosis
8 - Kidney Failure
9 - Pneumonia and Influenza
10 - Suicide

Substance Abuse

1 - Alcohol
2 - Tobacco
3 - Illegal Drugs

Maternal and Child Health

1 - Infant Mortality
2 - Low Birth Weight
3 - Adolescent Pregnancy
4 - Prenatal Care
5 - Breast Feeding

Dental Health

1 - Lack of Dental Education
2 - High Number of Cavities and Gum Disease
3 - Baby Bottle Tooth Decay
4 - Emergency Dental Services for Adults

Unintentional Injury and Violence

1 - Motor Vehicle Accidents
2 - Violent Crime
3 - Unintentional Injury
4 - Homicide
5 - Falls
6 - Suicide

Mental Health

1 - Dually Diagnosed Problems
2 - Mood Disorders
3 - Severe and Persistent Mental Illness
4 - Severely Emotionally Disturbed Children
5 - Out-of-Home Placement of Children
6 - Anxiety Disorders
7 - Attention Deficit Disorder
8 - Suicide

Environmental Health

1 - Groundwater Quality
2 - Surface Water Quality
3 - Communicable Disease
4 - Outdoor Air Quality
5 - Solid Wastes
6 - Hazardous Wastes
7 - Indoor Air Quality

Occupational Health

1 - Occupational Fatalities
2 - Construction Injuries and Fatalities
3 - Improved Data System to Provide County-Specific Occupational Injury Data
4 - Food Products Injuries and Fatalities
5 - Manufacturing Injuries and Fatalities

After the Committee made priorities under each area, they recognized that there were underlying root causes of many of these health care problems. Therefore, instead of attempting to choose priorities among these eight areas, they decided to list common underlying root causes of illness and group them into three areas:

1. Inadequate or Absent Health Insurance

2. Behavioral Risk Factors
    - Diet/Nutrition
    - Exercise
    - Tobacco Use
    - Alcohol Use
    - Illegal Drug Use

3. Socioeconomic Problems Underlying Ill Health
    - Education
    - Jobs/Employment Opportunities/Training
    - Family Dysfunction/Single Parent Families
    - Norms of Responsibility
    - Self-Esteem

In studying populations, it has been observed by Marmot[1] and others[2] that individuals can be grouped according to class, based on job, income or education. Significant differences in health, such as longevity and ability to function, can be rated between these groups. Individuals with higher job classifications, more money or education, systematically have better health. In fact, the differential in health (i.e., life expectancy) between the highest and lowest groups can be

explained by the underlying root causes of illness which our Committee identified. On a national and international basis (hypothesis), differences in medical care (i.e., health insurance coverage) explains maybe 20% of the difference between groups. Behavioral risk factors only explain another 20% of the difference. Of the remaining 60% of unexplained difference, socioeconomic factors, such as the areas we have listed, can explain much. With this hypothesis we are attempting to identify factors that explain differences between groups of individuals, NOT explain differences between populations and ideal. The latter comparison might (?) elevate the importance of genetics, biology, health care, nutrition, and other risk factors. Importantly, however, we need to realize that socioeconomic factors explain a great deal of health. Presumably, by removing or improving these factors, population health can be greatly improved.

Although our Committee chose to highlight Underlying Root Causes of Illness, they did look at our community health problems in a more traditional light. Special problems of concern include:

- Substance Abuse (especially tobacco/alcohol)
- Nutrition and Exercise
- Dental Health
  - Very poor access to services among the poor/uninsured
- Maternal and Child Health
  - Especially infant mortality, low birth weight, and teenage pregnancy

MEDICAL CARE FOR VULNERABLE POPULATIONS IN WICHITA/SEDGWICK COUNTY

Based on being uninsured or having an income less than $10,000 per year, we estimate that roughly 51,000 people in Sedgwick County should be called "vulnerable" either because they lack health insurance or have very low incomes.

Sedgwick County residents who are continually uninsured have low incomes, and less education than the insured. However, over 80% are employed, 42.1% make more than $20,000 per year, and 50% have more than a high school education. Among the periodically uninsured, 82.1% are employed, 68.7% make more than $20,000 per year, and 50% have more than a high school education. As designed, Medicaid covers a population with very low income, little education, and high unemployment.

Uninsured persons see the physician much less than the insured (60% vs 80% see an M.D. at least once/year), but the majority of the time their source of medical care is private M.D.s rather than special clinics for the medically underserved. Compared to persons who have insurance, the uninsured frequently cannot obtain needed health care because of high cost. Fifteen percent (15%) to 50% of these uninsured groups state that cost has prohibited various types of needed health care compared to only 3-8% among the non-Medicaid insured group. It is not surprising then that physical and mental health among the uninsured was significantly worse than among the insured population.

We analyzed special Wichita clinics for the medically underserved. We identified eight (8) special clinics, plus many clinics associated with primary care residency training programs, who see medically underserved (or vulnerable) populations. Furthermore, an analysis of private physicians suggests that 13%, or 100, of them see patients with no money or no health insurance.

Most special clinics for the medically underserved feel that additional clinics are not needed. Existing services are underutilized and each of these clinics could accommodate more patients. As already mentioned, the majority of uninsured patients see private physicians anyway, and among Medicaid patients, 27% attend clinics for the medically underserved but 64% see private M.D.s. In addition to physicians, Sedgwick County also has 334 organizations, agencies or programs that provide health care. Many of these groups serve individuals who are poor or uninsured. One of the largest areas of need, however, is dental care. Fifty percent (50%) of the continuously uninsured and 60% of Medicaid patients are prohibited by cost from seeing a dentist when they feel they need to.

PLANNING FOR THE FUTURE

Medical Care Recommendations

Medical care or illness care dominates health care delivery in Wichita/Sedgwick County and the nation. Prevention and public health consume very small proportions of our health care dollar. Furthermore, the United States is one of the few developed countries in the world that does not guarantee health care to all of its citizens. These facts help explain why the U.S. lags behind many other countries in terms of infant health outcomes and life expectancy.

Under our fee-for-service payment system, the cost of health care delivery has grown much faster than other sectors of the economy. The high expense of health care is consuming potential corporate profits. As a result of these realities, there is extreme pressure to control health care costs.

Medical care is very inefficient. Much care is of no proven value and some care even does more harm than good. On the other hand, much medical care does have proven value but fails to reach those who would benefit. In the future, much more attention needs to be devoted to identifying medical care of proven value and applying it to all those who will benefit. Obviously, ineffective and harmful medical care needs to be eliminated.

During the current push for cost control in medical care delivery, it will be easy to eliminate effective care under the guise of cost control. Systems for monitoring and maintaining the highest quality in health care services should become a high priority.

The Uninsured

The uninsured population of Sedgwick County has much poorer health than the insured population. High cost is the major barrier to quality health care. The uninsured population prefers to use the private medical care system as does the insured population. Existing health care facilities for the uninsured and medically underserved can handle many more patients than they currently do. There does not appear to be a need to create more such clinics. Existing clinics can easily be expanded if needed.

The real need is to expand health care insurance to all citizens so they can chose their own health care. We should start by expanding coverage to all children, just like we do for the elderly under Medicare.

Existing Community Health Resources

Wichita/Sedgwick County is blessed with multiple resources to improve health. We have more than an adequate number of well trained health professionals. Our hospitals and outpatient facilities are outstanding. We have a medical school and other health professional training programs. As reviewed in our Guide to Public Health Resources, the City and County have 334 agencies, organizations, and programs designed to improve health or treat illness. We have multiple clinics that treat the medically underserved. Many physicians, dentists, and other health professionals volunteer their time and efforts to those individuals and groups who cannot pay for health care. United Way, foundations, and businesses donate millions of dollars toward the improvement of health.

Despite these tremendous assets, our assessment team did not feel that assets and resources were well coordinated. No overarching plan guides activity and we do little ongoing evaluation or continuous quality improvement. We need to have more accountability for health care outcomes.

Public Health Recommendations

The relatively good circumstances of most Sedgwick County residents with respect to health and health-related problems should not obscure the need of a substantial minority -- poor health status, limited access to medical care, high risk behaviors such as smoking, exposure to environmental hazards, and income and educational levels that make it difficult to provide the foundation for a healthy life for one's self and family. Although there may be numerous means to address the health problems of needy Sedgwick County residents, we suggest that future strategies be guided by three principles. Each involves recognizing and accepting interconnectedness in some way:

1. **Recognize the Interconnectedness of All People in the County**.

The well-being of the whole depends on the well-being of all its parts. This orientation can be justified in purely monetary terms. For example, we know that the larger the group of people in a community who require medical care and cannot pay for it, the greater will be the cost to the community as a whole because those uncompensated medical care costs must be shifted in some way to those who can pay. Also, the more violence in a community, the greater the cost for medical care as well as law enforcement and incarceration, costs that will affect all residents through taxation and higher medical costs. There is also an intangible effect on each individual of the well-being of all other individuals in the community.

Implications for Action: **Community-wide Support**.

Solutions may be targeted to a demographic group, such as the elderly or the young people, or to a geographic region, such as one of the four neighborhoods that were studied for this report, but they should have the support - both tangible and intangible - of the community as a whole. Community-wide support for solutions to the problems of the needy will increase the probability of their success by bringing more resources to bear. They depend on an ongoing commitment to a **civic culture**.

2. **Recognize the Interconnectedness of Individual Problems With the Community Environment**.

Often, individual solutions are not as successful as **community solutions that change environments**. Smoking is one example of this precept. To decrease smoking, we may focus on individuals - educating them about the dangers of smoking and offering programs to help them stop smoking. At the same time, however, we have changed the environment in such a way that it encourages and supports non-smoking among individuals by limiting the public places where people can smoke, limiting the smoking advertisements to which people are exposed, and discouraging use through taxation of tobacco products and enforcement of laws restricting youth from purchasing tobacco.

Implications for Action: **Community development to change the environment that fosters poor health**.

The health status in other industrialized countries (OECD 1996)[3] is often far better than our own in terms of life expectancies and other population health indicators. Countries with better health outcomes than our own have public policies that address the causes of poor health on a system-wide basis. These findings support the view that community-wide efforts to improve health are both valuable and necessary for improvement.

3. **Recognize the Interconnectedness of Health Status With a Number of Underlying Causes of Poor Health**.

Limited access to medical care, high risk behaviors, such as smoking and sedentary lifestyle, exposure to environmental hazards, and socioeconomic status have been found to be highly linked, with socioeconomic status being the prime mover. Adequate income and high education appear to provide the best foundation for leading a healthy life. People of high socioeconomic status are the most likely to be in good health and the least likely to be uninsured and to engage in risky behaviors, such as smoking, sedentary lifestyle, and alcohol or drug abuse. The findings of this report related to the vulnerable populations affirm this interrelatedness.

Implications for Action: **Community development that addresses the problems of education, income, and employment**.

A community-wide approach is more important now than ever. If we accept socioeconomic status as a major underlying cause of poor health, we must be concerned with the increasing division in our communities along socioeconomic lines. In the U.S., we have always assumed a great deal of mobility among socioeconomic groups. Yet the distance between groups in income, education, skills, and resources is becoming greater and, as a result, the ability of individuals to achieve upward mobility is decreasing. This is not just a problem of minorities, as in the past, but of the white population as well. Moreover, their are trends which suggest that the distances will grow ever larger and more intractable without community-wide efforts. These trends concern births to single mothers, decreasing funding and commitment to public education, and public resources which promoted a civic culture.

Specific CHAP Recommendations

We have now completed the assessment component of our CHAP project. The next steps are to develop and implement a comprehensive and detailed community health plan. To do this we must accomplish three important tasks:

1. Disseminate and discuss this assessment report with all community groups who can contribute to health improvement. Most importantly, we must go to the neighborhoods most in need of health improvement. Individuals and organizations in the neighborhoods must lead any health improvement process that will be successful. We will also talk with other groups whose efforts and resources can contribute to community-wide health improvement. Specifically, we will approach city, county, and state government, the Chamber of Commerce, United Way, the school system, hospitals, health care payers, health provider groups and the 334 agencies, organizations, and programs listed in our Health Resources Guide. These groups will provide the specific plans, person-power and resources to accomplish community health improvement.

2. Generate a new funding base for community-wide health improvement projects and neighborhood specific projects. We will approach health care institutions, health care payers, foundations and large businesses for financial resources to accomplish our goals.

3. Finally, we must develop a health assessment and consultation group who will develop outcome-based data systems to evaluate our progress at improving community health. They will also be available to consult with local groups on specific data needs related to various health improvement projects.

The following general recommendations are divided into medical care recommendations and public health recommendations:

Medical Care Recommendations

1. The effectiveness of health care interventions must be judged by valid and reliable outcome measures (morbidity, mortality, quality of life and satisfaction). The Wichita Sedgwick County health care community must develop an outcome based health care evaluation system with effective incentives to eliminate ineffective and inefficient medical care.

2. Simultaneously, the Wichita Sedgwick County health care community must develop mechanisms so that health care interventions of truly proven value reach all of those in our community who can benefit from them. (Responsible groups: health care community, provide organizations in concert with health care facilities and payers).

3. Financial mechanisms must be found so that cost savings that accrue from more efficient and effective health care interventions can be channeled into caring for individuals without health care insurance, especially children in our county.

4. Presently, new financial and organizational systems (such as managed care) designed to control escalating health care costs are eliminating medical care of proven value, as well as inefficient and ineffective care. We must develop quality assurance systems so that the present emphasis on cost control does not eliminate or jeopardize health care interventions of proven value.

5. Develop a comprehensive, community-wide health care plan to guide our activities. This plan should cover medical care for citizens with ill health but must also include public health for all of our citizens. Presently, illness care systems are not coordinated with public health systems and adequate mechanisms for accurately tracking the overall health of our community are not in place.

6. The United States is the only developed country in the World that does not assure access to health care for all its citizens. It must become a priority for Wichita Sedgwick County to develop health care access for all of its citizens. To achieve this objective:

a. our first priority must be to ensure health care for all of our children.
b. Medicaid must be expanded and organized so that insurance coverage is significantly expanded to citizens who presently do not have insurance. Medicaid managed care is an important organizational model that should be expanded in Sedgwick County.
c. our citizens and governmental officials must work at the State and Federal levels in order to expand health care access to all of our citizens, especially our children. At the state level a pool of funds should be created in order to cover indigent citizens and those employees (and their families) of small companies that have no coverage.

7. Most of our health care dollar has gone to the illness care system even though the other determinants of health (personal health behavior, social relationships, individual financial status and physical environment) are just as important to an entire community's health. As stated above we must eliminate the unnecessary expenses in our illness care system. In terms of medically underserved populations in Sedgwick County we must resist the temptation to divert resources to the creation of additional illness care services but instead improve the use of our existing health care resources and focus on the improvement of other determinants of health such as personal behavior, new jobs, better education and improvement in other "root" causes of ill health.

Public Health Recommendations

1. Develop a community health care information system that allows for the evaluation of population-based health initiatives in Sedgwick County. This is necessary to determine what works, to document improvements resulting from community health projects, and to guide future strategies to improve health. Data collection must be timely, routine, and designed to measure appropriate, population-based outcomes. It should support areas of community-wide interest such as drug and alcohol abuse.

2. Develop community initiatives that will address the socioeconomic facts that contribute to poor health. These should be community development projects that strengthen communities through creation of desirable jobs, full employment, housing improvement, quality education, and other quality of life improvements. These initiatives should be linked to existing efforts and those being development by the city, local hospitals, and other county organizations including the neighborhood initiatives and the current city efforts to improve the quality and efficiency of services delivered to neighborhoods.

3. Develop initiatives to reduce the prevalence of smoking, obesity, sedentary lifestyle, drug and alcohol abuse, and other behavioral risk factors. Focus on community-wide changes that will encourage and support individual change. Link these efforts to other community initiatives (see Recommendation 2). Monitor the success of efforts to improve health behaviors through the health care information system that is developed (see Recommendation 1).

4. Develop an organization that would provide consultation and support to community development projects. Follow the model of the California Public Health Foundation which provides technical assistant to meet grant and contract objectives, personnel services including payroll and benefits, and evaluation capabilities.

5. Institute mechanisms to coordinate the efforts of the 334 agencies, organizations and programs presently expending resources to improve community health.

    1. Detailed assessment of services provided by agencies.
    2. Match similar services.
    3. Divide into workable size groups based on provision of similar services.
    4. Provide information to providers.
    5. Facilitate interaction by group of providers.
    6. Assist providers to identify needed services and method of delivery of services based on findings of CHAP.
    7. Facilitate problem solving among providers to use available resources to best meet identified needs.

6. Through elimination of duplicate efforts, expand services into areas of unmet need with great physiological importance, such as dental care for the medically underserved and Medicaid recipients.

    Elimination of duplication will be natural outcome of above process. In fact, can be an incentive to participate in that process.

    Decision making process (vision, strengths, barriers, magnitude, consequences and feasibility) can be used by involved providers and consumers to decide which additional services are appropriate and how they can be delivered.

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