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Public Health in Georgia, An Internet Advocacy Tool: A Capstone Project

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**Public Health in Georgia, An Internet Advocacy Tool:
A Capstone Project**

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GEORGIA STATE UNIVERSITY

Public Health in Georgia An Internet Advocacy Tool

Capstone Project

Patricia B. Garcia

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Local Public Health programs are at the frontline of Georgia's struggle to prevent disease, prolong citizens' lives, and promote health. In recent history it has been observed that both Georgia's citizens and state government do not completely understand the breadth of the Public Health system and all its beneficiaries. Unfortunately this lack of comprehension about the scope of Public Health programs has led to a significant decrease in support and funding. This capstone project describes the systematic development of an online educational portal that is a central tool used in the Public Health advocacy campaign in Georgia, "Partner-Up for Public Health". An electronic database of Public Health statistics for all of Georgia's counties (n=159) was created using secondary sources. The database presents data on four primary domains: geographic/population descriptive statistics, broad social determinants of health, health indicators, and health outcomes. Within these domains, there are a total of twenty-one indices. This project is important because it collects and presents Public Health information into one centralized location for easy retrieval and is formatted to deliver content in non-technical jargon. A hallmark of the online portal is that it facilitates the mobilization of information and tools necessary for Georgians to advocate for local Public Health action, programs, funding, and political attention.

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Overview of Public Health

The attempt to define Public Health can be elusive at times and difficult to convey to a non- Public Health practitioner. Public Health has existed since the ancient Roman times but its mission has continued to grow and change as new health discoveries and technologies are being realized. One of the most popular and enduring definitions for Public Health was written by C.E.A. Winslow in 1942. He defined Public Health as "the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals." (1) This definition of health was further expanded by the United Nations' World Health Organization in 1946, when health was described as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."(2)

According to the Association of Schools of Public Health, the field of Public Health is highly varied and encompasses multiple academic disciplines. (3) However, Public Health consists of the following core areas:

- Environmental Health
- Behavioral Science/Health Education
- Maternal and Child Health
- International/Global Health
- Public Health Laboratory Practice
- Health Services Administration/Management
- Biostatistics
- Epidemiology
- Nutrition
- Public Health Policy
- Public Health Practice

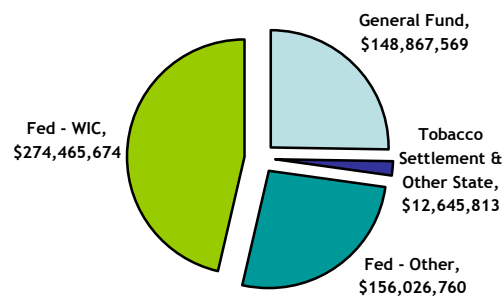
Public Health professionals are classified into specialty fields, including epidemiology, biostatistics, and health services; and such subfields as environmental, social, behavioral, and occupational health. (3)

When comparing Public Health to traditional medical care, both areas are rather different and yet there are several areas of overlap that cause the misunderstanding about the primary mission for Public Health. Public Health can be considered proactive medicine. It concentrates on preventative medicine for a particular group or population level unlike traditional medicine, which is reactive and focuses on individuals once they are already ill. Social justice or health disparities represent the overlap between the two fields. The safety net system of health care in the USA is one of the issues, where the discernment concerning Public Health's primary mission has become vague.

During the National Public Health Week, April 2009, the American Public Health Association led a campaign to educate Public Health practitioners and supporters on how to advocate to their federal legislatures the merits of the Public Health provisions in the economic stimulus bill. (4) They concluded that one of the largest obstacles to overcome was the misconception that Public Health beneficiaries were only people belonging to the lower social economic classes. Their strategy was to develop a program whereby Public Health professionals would tell their Public Health stories and explain how many people from different social and economic classes benefited from their work. In the state of Georgia, the same problem was identified as the major obstacle for garnering support and funding for Public Health. (5)

Georgia Public Health programs are funded by a combination of financing from both federal and state monies. (6) State support comes primarily from either the General Fund, which is money collected from taxes on Georgia residents and businesses, or the Tobacco Settlement. Figure 1 from the Georgia Budget Policy Institute (GBPI) depicts the breakdown of funding sources for Georgia's Public Health Budget for FY2011.

Figure 1. FY2011 Public Health Budget in Georgia



Adapted from Georgia Budget and Policy Institute, Tim Sweeney, Senior Health Analyst, "Overview of Georgia's Public Health Budget and Activities", accessed May 10, 2010, <http://www.togetherwecandobetter.com/ff/SweeneyGBPIReport.pdf>.

The federal government is the largest contributor of funding for Public Health programs in Georgia. According to Trust for America's Health, Georgia government spends approximately \$19.66 per person annually on Public Health, while the median for the other US states is \$28.92. Therefore, Georgia is ranked 38th lowest in the country in state funding for Public Health in FY2008-2009 in per capita spending. (7)

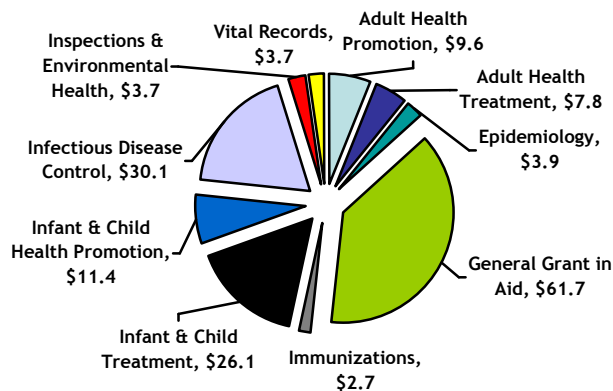
According to Tim Sweeney, the Senior Health Analyst for GBPI, Georgia's Department of Public Health encompasses many programs including:

- Adult & Adolescent Health Promotion
- Adult & Adolescent Essential Health Treatment

- Epidemiology
- Immunizations
- Infant & Child Health Promotion
- Infant & Child Essential Health Treatment
- Infectious Disease Control
- Infections and Environmental Hazard Control
- Public Health Grants to Counties
- Vital Records

Figure 2 from the GBPI displays how much funding goes to each of these Public Health programs in Georgia. (6)

Figure 2. FY 2011 State Public Health Spending in Georgia (General Fund and Tobacco Settlement, \$ in millions)



Adapted from Georgia Budget and Policy Institute, Tim Sweeny, Senior Health Analyst, "Overview of Georgia's Public Health Budget and Activities", accessed May 10, 2010, <http://www.togetherwecandobetter.com/f/SweeneyGBPIReport.pdf>.

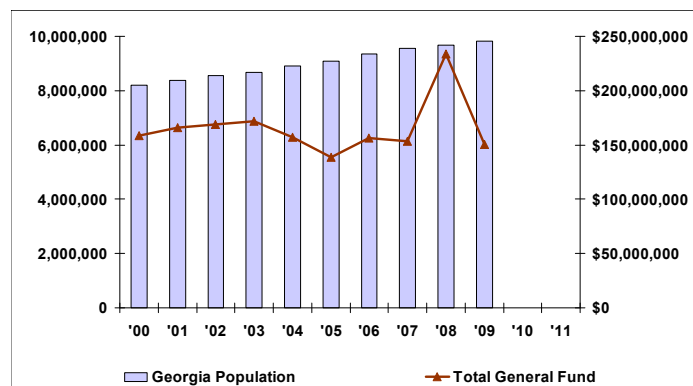
It should be noted that in previous years other programs fell under the Department of Public Health and monies had to be allocated for them from the Department of Public Health's budget. These

programs, which have now been separated from the general Public Health budget and now receive their own monies, include:

- Substance Abuse (moved to mental health in 2009)
- Emergency Preparedness (new division in Department of Community Health)
- Injury Prevention (General Funds eliminated)
- Trauma Center Funding (Trauma Commission now a separate agency attached to Department of Community Health)

Georgia’s funding for Public Health has been experiencing a downward trend since FY 2000, except for 2008 when Trauma Center funding received the allocation of \$58 million. If this Trauma Center Funding, which is no longer in the Department of Public Health, is removed from the analysis, the downward trend is consistent. (6) According to the Georgia Census, the state has experienced approximately a 20% population growth compared to FY 2000. (7) Steady growth of population is expected to continue. Figure 3 from GBPI compares allocation of state general funds with the population growth in Georgia.

Figure 3. General Georgia PH Funding in Relation to Population Growth



Adapted from Georgia Budget and Policy Institute, Tim Sweeny, Senior Health Analyst, “Overview of Georgia’s Public Health Budget and Activities”, accessed May 10, 2010, <http://www.togetherwecandobetter.com/f/SweeneyGBPIReport.pdf>.

If this budget trend continues, the Public Health system in Georgia will be significantly weakened to the point of program failure. The effects of these budgetary cuts have already been noted. According to Partner Up for Public Health, an advocacy campaign for Georgia's Public Health system, there are serious challenges and consequences that call for re-investing in and rebuilding the whole system (8).

Table 1. Georgia Public Health System Challenges and Consequences

During a significant emergency the shortage of Public Health professionals “will lead to mass disruption, unavailability and degradation of care, perhaps leading to panic or civil unrest. In the event of pandemic, the medical system in Georgia will collapse due to unprecedented volume...” as reported by a 2006 Georgia House study committee.

Georgia historically ranks near the bottom of state-by-state rankings of overall health system performance by groups like United Health Foundation and The Commonwealth Fund.

The state's percentage of adults who are obese and the percentage of overweight high school students are among the highest in the U.S. We rank high for the percentage of adults who do smoke – and the percentage of adults who do not exercise regularly.

Georgia has a very high percentage of adults with diabetes and a very high rate of cardiovascular deaths due to heart diseases and strokes.

Georgia is among the worst states in the nation for low birthweight babies, pre-term births, infant mortality and teen birth rate.

The prevalence of infectious diseases like tuberculosis, hepatitis and AIDS in Georgia is one of the nations highest.

Some program reductions are penny wise and pound foolish. Deterioration and elimination of prevention programs ultimately drives up costs to private insurers and the state's Medicaid program when avoidable illnesses or complications occur. That means fewer bread winners, lower tax revenues and more costs passed on to

businesses, employees, families and communities... costs that come back to all of us.

Because of concerns like insurance costs and absenteeism, businesses are reluctant to expand or locate in states or communities with poor health systems. A deteriorating Public Health system hinders economic development in Georgia.

More than 1,000 Public Health positions across the state are vacant... salaries are low and turnover is high... and prevention programs that can pay for themselves have been cut or are in jeopardy.

Adapted from Partner Up for Public Health website, "Challenges and Consequences", accessed May 10, 2010, <http://www.togetherwecandobetter.com/challenges.html>

Advocating Strategies

The University of Washington Health Link website defines advocacy as "to speak up, to plead the case of another, or to champion a cause." Legislative advocacy or lobbying specifically involves influencing public policy through the legislative process. (13) Learning to advocate for a cause can have a steep learning curve and may be daunting at times but, if successful, it may become a very rewarding experience.

If a campaign hopes to succeed, it is required to follow several basic guidelines. The Democracy Center, which works globally to advance social justice through investigation and reporting, training citizens in public advocacy, and leading international citizen campaigns, developed a Democracy Owners' Manual that expounds a combination of policy and advocacy basics. (14) Some of their recommendations include:

- 1) Developing Advocacy Strategy: The most important parts of effective advocacy are effective strategy, clear vision of where you are, where you want to go, and a plausible plan of action to get there.
- 2) Policy Analysis - A Primer: Public policy debates are concerned with two basic questions: What is the problem, and what is the solution? Policy analysis is a step-by-step method for looking at these questions in a deliberate way.
- 3) Effective organization requires a mix of ingredients. Learning how to mix the ingredients together is step one of effective political action. These crucial ingredients include the Organizer, Outreach and Recruitment, Meetings and Decision Making, and Coordination of the Work to be Done.
- 4) Building and Maintaining Advocacy Coalitions
- 5) Media advocacy, like all aspects of public advocacy, must be strategic.
- 6) Effective citizen lobbying involves not only talking with public officials but also building broad coalitions, working with the media, mobilizing grassroots pressure, changing public opinion, undermining your opposition, and much, much more.
- 7) Today, the Internet is one of citizen advocacy's most important tools used for research, public education, organizing, political discussion, and coordination. The Internet's basic tools are emails, websites, list servers, discussion groups, and social media.

If we follow the proposed recommendations from the Democracy Center outlined above, this capstone project can be utilized to assist with recommendations 2, 6, and 7.

As part of the Partner Up for Public Health campaign, the Government Affairs Consultant firm of Mathews and Maxwell was contracted to assist in the education of campaign organizers and

volunteers on how to be effective advocates for Public Health. Please refer to Attachment A for an educational handout developed by Scott Maxwell, professional GA lobbyist that was used in the Partner Up for Public Health Campaign Leadership Academies discussed in previous paragraphs. This leaflet shows what one individual can do to influence legislative decisions, including the budget.

Partner Up for Public Health Campaign

According to the Healthcare Georgia Foundation, Partner Up for Public Health is a statewide advocacy campaign funded by Healthcare Georgia Foundation and designed with the purpose to advance Public Health in Georgia. (9) The campaign was launched in October 2009 as part of a multifaceted effort to rebuild Georgia's Public Health system. At the heart of Healthcare Georgia Foundation's initiative is a grant to Hayslett Group LLC, an Atlanta-based communications firm, to fund a two-year program called Advancing Public Health in Georgia. The goal of the program is to prepare Public Health leaders in Georgia to be more effective advocates on the public policy arena. By using media and other public communications tools to shape the policy environment, it may be possible to begin improving Georgia's Public Health system. In addition, the Foundation awarded Public Health advocacy-related grants to the Georgia Public Health Association, Mathews & Maxwell, Inc., The Carter Center, Inc., and The Schapiro Group, Inc. (9)

The initial phase of the campaign consisted of an exploratory phase, where in-depth research of available literature on Public Health systems in Georgia and nationwide was conducted. The review was supplemented with interviews and surveys on Georgia Public Health leaders and policy-makers to help validate suppositions generated from early investigations. Once a better

understanding of the root causes for the decrease in support of Public Health in Georgia was elucidated, initial goals were set. Three objectives were identified as follows:

- 1) Increase funding to the Public Health System in Georgia
- 2) Restore legislative and general public understanding and support of Public Health
- 3) Mobilize and energize the Public Health community / beneficiaries to support and advocate for Public Health in Georgia

Other activities that were accomplished during the initial phase were the development community partnerships, construction of a virtual campaign website, and creation and presentation of “Leadership Academies” to educate participants on how to advocate effectively for Public Health. A total of twenty-one community partnerships were developed, including the Georgia Public Health Association, multiple academic institutions and eight schools of Public Health in Georgia, business community members, and representatives of other professional health organizations. As of June 2010, a total of four Leadership Academies were hosted with 189 attendees and 51 official volunteer pledges for the campaign collected. Attendees included representatives from diverse Public Health settings as well as students and others from the general population. Future Leadership Academies are scheduled specifically for the Atlanta Metro area for August of 2010. Both the Partner Up for Public Health campaign and its preliminary virtual campaign website are scheduled to have a “soft launch” date of July 14th, 2010. The plan is to continue building onto the campaign and its website in calculated incremental steps. As new components are added, updates and press released will be pushed out every 2-4 weeks to maintain a continuous feed of information on the Public Health advocacy campaign.

Project Purpose

The primary purpose of this capstone project was to create a user-friendly database for the use by health professionals as well as by the general public to disseminate health information and advocate for Public Health in Georgia. This information would provide a simple and accurate estimate about the health of Georgia, which could be utilized to promote support for local Public Health programs. Contact information of local government and Public Health officials is shared so that users will know who can be targeted for follow-up action (ie sending letters, emails, and/or phone calls). The database was not meant to be a report card but instead should be used to help identify opportunities for improving the wellbeing of Georgians and direct attention and funding to Public Health concerns. This project was only one of many components that composed the Partner Up for Public Health advocacy campaign.

Project Development

No new statistics were collected in the development of this database. All numbers came from secondary database sources such as open websites presently available to the public. Our goal was to collect pre-existing Public Health data into one centralized location and present it in a format that would be simple to retrieve and easy to comprehend.

Data with two overarching characteristics was chosen. First, the data had to be reported on the county level. Planners were most interested in county level statistics as they were viewed more valuable due to the alignment between Public Health and legislative voting districts. Public Health information was collected in a format that could be easily tailored to inform legislators about their

specific voting areas. Second, the data had to be simple non-scientific statistical information that health professionals and the general public could easily understand and use to support their advocacy efforts. Therefore, any value that might require advanced training to understand was avoided. For example, it is common within the Public Health profession to use YPLL's, Years of Potential Life Lost, which is a measurement for morbidity that the general population is not instinctively comfortable using. Instead, Life Expectancy was selected on the basis that is an easier concept for the general public to understand and apply.

The first step in the development of the database was extensive research. Two types of investigations were performed. First, online and journal searches were conducted to explore types and formats of available Public Health data. Second, an in-depth literature review was conducted to determine types of data to be collected and decide on the presentation of information for the goal of advocacy.

Doing an internet search on the issue of Public Health, researchers can be quickly overwhelmed by the wealth of information available. Public Health, as previously discussed, encompasses multiple facets of health promotion and prevention. At the same time, the Public Health profession has become highly specialized, and its components tend to work separately from each other. This characteristic affected the way how Public Health material is presented on the World Wide Web. Public Health websites are very narrowly-focused and technical. For example, many websites focus only on infectious diseases, environmental concerns, or occupational health, and so on.

There are a few websites that do try to present the "whole" picture of Public Health but they are primarily targeted to reach Public Health professionals with a medical background. Some of the websites that portray the entire Public Health system in a format that can be used to present current

Public Health challenges and strengths in communities, including the University of Wisconsin's County Health Rankings (16), United Health Foundation's American Health Ranking (17), and the Department of Human and Health Service's Community Health Status Indicators (18). The final database was closely modeled to these websites but modified to meet the specific need to present county level data in a simple non-jargon format which can be easily understood and used by a non-health professional audience.

Upon completion of the literature and website review described above, 21 parameters were chosen for the database. An informal email survey was sent to all of Georgia's Public Health District Directors and a small group of Public Health professors from all of Georgia's Public Health Schools. The purpose of the survey was to introduce the project and its goals and to ask for expert review of the statistics and proposed sources of county-level Public Health data for the website. . Unfortunately, the response rate from the academic community was rather low but the author speculates that extenuating circumstance impacted the final number of replies. In particular, the email was sent out on March 11th, and Georgia's Governor announced severe budget cuts to the state university system earlier that month. Consequently, the expert review request was overshadowed by this announcement and likely participants from public universities had immediate concerns regarding possible outcomes of the budget cuts. Besides the initial email, 3 reminder e-mails requesting assistance were sent out during March. A total of 64 individuals were contacted but only 12 responses were received (10 from Public Health District Directors and 2 from the members of academic community).

After reviewing literature research findings and information obtained through Public Health websites and analyzing the feedback from the email surveys administered on Georgia Public

Health leaders, the list of health parameters was finalized. These 21 parameters were further subdivided in four categories. Please refer to appendix A, which is the methodology / discussion page of the website that provides the in-depth analysis of each of these individual parameters.

The first is the general or descriptive category developed to help website users visualize the Georgia County. Six parameters included: County Seat, Square Miles, Population, Per Capita Income, and Public Health Budget Information.

Second category represented Social Determinants of Health. According to the World Health Organization's "Solid Facts Report", social determinants are defined as social causes of ill health. (10) We included five parameters to represent these social determinants: Obesity, STDs, Crime, Access to Physicians, and Percentage Medically Uninsured.

Third category covered Health Indicators, which were five parameters selected based on Healthy People 2020 initiative. Healthy People 2020 Health Indicators reflect the major health concerns in the United States at the beginning of the 21st century. (11) This category can be considered a status report, "where are we now", and includes Education, Poverty, Low Birth Weights, Teen Pregnancies, and Unemployment.

The final category is Health Outcomes, which is defined by the National Institute of Health as data that looks beyond the physiological measures of success to examine the effects of the health care process on patients and populations. (12) We reported five parameters to represent health outcomes: Life expectancy, Diabetes, Asthma, Cancer, and Heart Disease.

These parameters were put in an easy format that displayed both comparisons and overall rankings to assist in comprehension and utilization of statistics for advocacy efforts. The comparisons of the data did not include the general descriptive parameters, but the other fifteen health parameters previously described were judged against other individual GA Counties, the GA average plus the US average. The overall uncomplicated ranking system was used to classify each county from best to worst. The ranks for each of the fifteen health parameters were averaged to produce an overall ranking that was then placed in order from the best (#1) to the worst (#159). These comparisons are found in tables in both the Full County and Georgia Reports.

Once the data was collected and organized for the final 21 parameters, a prototype website was created to display the information gathered and our proposed presentation format. A web address to our prototype database was sent to 18 Georgia Public Health Districts Directors asking for assistance in verifying the accuracy of data and requesting comments and suggestions on how to improve the presentation format. We received several responses with many excellent suggestions and recommendations that eventually led to changes in three data sources.

The database concept and proposed format were also presented at the four “Partner Up for Public Health” Leadership Academies. The purpose of this presentation was not only to elicit comments and recommendations but to introduce this tool to potential advocates for the campaign. We had an excellent response to the introduction of the database, and many individuals were excited about the launch of this advocacy tool.

The database is presently being finalized, and one more review will be requested of the Georgia Public Health District directors. Barring any significant errors or concerns, the plan is to launch

the database in early August, 2010. Both a press release and a media campaign blitz are being organized to introduce this tool and promote the Partner Up for Public Health Campaign.

Project Results

The database home page will have an interactive map. When a web user clicks on a county on the map, a pop up window with “snap shot” information is displayed showing county specific data.

Snap shot information will include the county’s overall rank, summary of fifteen parameters that are better or worse than the Georgia and US average. In addition, parameters for each county that ranks in the top 25% of the state will be listed as strengths, while those parameters that rank in the bottom 25% of the state will be listed as challenges. Finally, a budget trend statement or analysis will be presented at the bottom. Links to both the Full County and Georgia Reports will be available in the pop-up window and on the page.

The Full County Report will contain the snapshot information, followed by the six general or descriptive parameters leading to the comparison tables of the fifteen health statistics and a trend analysis of the county Public Health budget. The Full Georgia Report will be a compilation of information for all 159 Georgia counties. Refer to Appendix B for an example of a Full County Report.

Other pages of the county-by-county database portion of the Partner Up for Public Health website include “Methodology”, “Download”, “Get Involved” and multiple parameter comparison sections. The methodology or discussion page includes not only the links to the original data sources but also analyzes each parameter for the reason it is chosen, its meaning, and strengths and weaknesses of using the statistics (Appendix A). All the data presented on the website will be

available to download as an excel database that can be sorted to help the website users organize material according to their needs. In addition, both the Full County and Georgia Reports will be available to download or print in a PDF or MS Word document. One of the anticipated expansions of the website includes the development of single parameter comparison web pages. These pages will include tables showing the rank of each county for each of the 15 specific health parameters. The table data will be organized either by rank number or alphabetized by county name. A color-coded county map ranking quartiles will also be displayed with an option to add legislative district map overlays. Refer to Appendix C for a prototype of this webpage.

Future Directions

The creation of the county-by-county health parameter database's initial design is complete. However, the goal from the onset was to develop and release different components of the database in premeditated, incremental stages. The database described above is scheduled to be available for general use in August, 2010, and the next release is set for September, 2010 when the Geographic Information System maps (refer to Appendix C) are to be posted on the website.

Other educational products for the use by advocates and legislators will need to be developed. Statistics collected for the database serve as the foundation for further analysis and the source for public relations/educational materials. Because of the database's organization pattern, information should be easy to personalize for a specific target audience, whether that would be a particular legislator or a civic group in a county. Not only should the end products be designed but templates for emails, letters, briefs, point papers, pamphlets, and posters should be developed to ease the personalization of these documents to meet the needs of end users.

Use of the newly created Partner Up for Public Health campaign's collaborations, especially the academic allies, should be maximized. Students can play a significant role as advocates for a grassroots movement; their ability to "think outside of the box" should be maximized. The creation of novel approaches for delivering our messages should keep our campaign vibrant and relevant to the general public. In addition, their comfort in using modern technology and electronic social media will be invaluable.

A central point of contact for student activities within this campaign should be appointed. This individual should reach out to the Public Health schools and invite other health and legal professionals in Medical, Nursing, Law, Environmental, and other disciplines to collaborate. Most schools have professional student organizations, and the student coordinator may easily contact them to start developing a network of student volunteers. Information exchange should become easy within such a network. Successes and failures from different activities organized by these different schools could be shared and built upon.

Academic partners could be rallied to assist in the development of educational or public relations materials. Professors could make class assignments or projects that may be useful for the campaign. Policy briefs or point papers on Public Health topics could be written by students and submitted for campaign use. Such papers could be further edited or used as starting points for the development of a final product. Student blogs, podcasts, and other creative mediums could be developed as well. Ideas for content may include:

1. Hot topics – what is the general media talking about today?
2. Before / Now – what did something look like before we had "x" Public Health measure?

3. What's your Public Health story? How have Public Health interventions benefited you throughout your lifetime?
4. Public Health Heroes (podcasts) - Interview or do an investigation about a Public Health professional or a specific job.
5. What if Public Health was not doing its job? What would happen if suddenly one specific Public Health program, initiative, policy, or service was no longer available?
6. Public Health is not "health care for the poor" or just a "safety net" provider. How does Public Health benefit different people from all socioeconomic classes?

Furthermore, a scientific advisory board or database should be created. Either a faculty point of contact or a student could coordinate this effort. Professors from our partner schools would be listed with their contact information, including their research interest and any past Public Health experience. The organization of this database should be well planned to ensure easy retrieval of requested information. Also, the design should be sustainable and feature easy-to-update entries.

A cadre of student "Capital Ambassadors" could be created. This cadre would be available to assist our grassroots advocates or county leaders visiting the state capital. The ambassadors could schedule a tour or a short meeting with their legislators. This cadre would also develop phone scripts, emails, or letter drafts either general in format or specific for whatever Public Health policy or issue is "hot" at the capital. They would also keep current a Public Health legislative "update" website. This web page could be used to locate current Public Health issues, policies or upcoming bills and their status and progress through the state system.

The creation of the Partner Up for Public Health website is just the first step in the establishment of a virtual grassroots campaign headquarters. The design and maintenance of social media should include an organizational Facebook page, Twitter account / messages, electronic newsletters, emails, etc. Website could host a bulletin board to post Public Health messages and stories or consider an editor-based blog. Our partners and student organizations could arrange “think tanks” on how to advance our agendas. We are only limited by our imagination.

Conclusion

Lack of understanding by both Georgia’s citizens and state government concerning Public Health’s mission and its all-embracing pool of beneficiaries has led to the decrease in support and funding in the last decade. Georgia’s Public Health system has been weakened, and cracks in the foundation of our state’s health are beginning to show. If the present trend with funding continues, program or even system failure is eminent. We cannot afford to wait for failure to start advocating for change. Public Health is not just concerned with the quality of life but life itself.

Public Health failures have cost Georgia millions of dollars and have led to loss of the lives of its citizens. Take last year’s Peanut Corporation of America’s peanut butter fiasco which caused 691 people to be sickened, of which 50% were children, and 9 people died. The economic consequences were huge with an extensive recall affecting 3,913 products from 361 companies. The Kellogg’s corporation reported losing about 65-70 million dollars, and financial costs from this single incident were estimated over one billion. (15)

The Public Health system and its workers are the unsung heroes of Georgia’s health system. Unfortunately, they are noticed and appreciated only when failures occur. However, Public Health

is working to protect Georgia's citizens every day. Public Health has repeatedly and consistently improved the health of Georgians and saved many lives. However, the system cannot be sustained for a long time with limited resources. Therefore, if Georgia does not respond by increasing support for the Public Health system, other failures with frightening consequences are inevitable. As the Partner Up for Public Health campaign slogan states,

“TOGETHER WE CAN DO BETTER” WE MUST!

References

1. Winslow C.E.A. “The Untilled Fields of Public Health,” *Science*, 1920; 51: 23.
2. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
3. Association of Schools of Public Health. What is Public Health. Available at <http://www.whatispublichealth.org/about/index.html>, Accessed May 12, 2010.
4. American Public Health Association, National Public Health Week, Available at <http://nphw.blogspot.com/2009/02/putting-face-on-public-health.html>, Accessed May 12, 2010.
5. Georgia Health Policy Center. ”Finding the Voice of Public Health”. Georgia State University. Available at <http://aysps.gsu.edu/ghpc/2162.html>, Accessed May 12, 2010.
6. Sweeney T. “Overview of Georgia’s Public Health Budget and Activities.” Recent Publications. Georgia Budget and Policy Institute. Available at www.gbpi.org/documents/20090113.pdf , Accessed May 12, 2010.
7. Sweeney T. “Overview of Georgia’s Public Health Budget and Activities”. Partner Up for Public Health. Available at <http://www.togetherwecandobetter.com/f/SweeneyGBPIReport.pdf> , Accessed May 10, 2010.
8. Partner Up for Public Health. “Consequences and Challenges”. Available at www.togetherwecandobetter.html , Accessed May 12, 2010.

9. Healthcare Georgia Foundation. "Advancing Public Health in Georgia". Available at www.healthcaregeorgia.org/news-and-information/grant-details.cfm/ng_id/54437ADA-3048-7C59-1987E07B9878A91D , Accessed May 12, 2010.
10. Wilkinson R. & Marmot M. "The Solid Facts: Social Determinants of Health". World Health Organization. 2003. Available at www.euro.who.int/_data/assets/pdf_file/0005/98438/e81384.pdf, Accessed May 12, 2010.
11. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. "Healthy People 2020: the road ahead". Available at <http://www.healthypeople.gov/hp2020/default.asp>, Accessed May 12, 2010
12. Academy Health Organization. "Health Outcomes Core Library Project". Advancing Research Policy and Practice, documents. Available at www.nlm.nih.gov/nichsr/corelib/houtcomes.pdf, Accessed May 12, 2010.
13. University of Washington. "How to Sheets: Legislative Advocacy". Health Links. Available at <http://healthlinks.washington.edu/howto/legislative/>, Accessed June 20, 2010.
14. The Democracy Center. "Citizen Action Series". Advocacy Resources. Available at www.democracyctr.org , Accessed June 20,2010.
15. U.S. Department of Human and Health Services. Food and Drug Administration. "FDA's Investigation of Peanut Corporation of America". Available at <http://www.fda.gov/Safety/Recalls/MajorProductRecalls/Peanut/FDA%E2%80%99sInvestigation/default.htm>, Accessed November 15, 2009.
16. Robert Wood Johnson's Foundation. County Health Rankings. Available at <http://www.countyhealthrankings.org/>, Accessed May 10, 2010.
17. America's Health Foundation. America's Health Ranking. Available at <http://www.americashealthrankings.org/>, Accessed May 10, 2010.
18. U.S. Department of Human and Health Services. Community Health Status Indicators. Available at <http://communityhealth.hhs.gov/homepage.aspx?j=1> , Accessed May 10, 2010.

Appendix A:

Nine Out of Ten Essentials For Influencing Legislative Decisions *(Including the budget!)*

1) Yes, YOU can change things! Yes, you **CAN** change things!

No Capitol lobbyist can influence the thinking of an elected official nearly as much as a respected constituent from “back home.”

2) Wash, Rinse, Repeat.

The education of elected officials is an on-going process. With few exceptions, your legislator probably doesn’t understand the full scope of what Public Health does, how it works, or how it’s funded. Tell them the basics; tell them the specifics, **REPEAT** . . . often.

3) Go LOCAL, not Loco.

Every interest group at the Capitol is asking for money. It can get crazy up there. More than 3,000 bills and resolutions are introduced in an average two-year term. Tell you legislators **WHY** your issue or budget item is important to **THEIR CONSTITUENTS**. Use local names and faces with your examples.

4) Out of Sight? Out of Your Mind!

Stay in touch with your legislators. Do they have your email, office number, cell phone?

5) Help Your Legislator Help You.

If you expect your legislator to battle for your cause, arm him or her with plenty of ammunition. Provide **data, facts, illustrations** . . . bullet points are usually best. Statewide and/or local data is appropriate for this purpose. Comparisons to neighboring states can be useful. Remember, rank and file legislators rarely have professional staff members.

6) Be Persuasive . . . in a genial, professional way.

Legislators react to threats about the same way the rest of us do. (Remember, you want them to return your calls.)

7) Make Your Legislator Look Good.

Look for mutually beneficial circumstances to give your legislator positive publicity and exposure. Benefit Public Health at the same time.

8) Take the Initiative.

Don’t sit back and wait to be contacted or approached. Make it happen. **Be proactive.**

9) Become the Go-To RESOURCE for Your Legislators on Public Health issues. Your goal should be that whenever a Public Health issue comes up in Atlanta, your elected officials think, “I’d better call _____ and see how this would impact my folks back home.”

Adapted from [Mathews & Maxwell, Inc. Government Affairs Consultants](#) Handout

Attachment B: Partner Up for Public Health Source / Methodology page (draft /in development)

Sources

	Source	Link
General Information		
County Seat	Georgia Statistics System	http://www.georgiastats.uga.edu/guide.html
Population Census Estimate July 1, 2008	Georgia Statistics System	http://www.georgiastats.uga.edu/guide.html
Area Total Sq Miles	Georgia Statistics System	http://www.georgiastats.uga.edu/guide.html
Per Capita Income 2007	Georgia Statistics System	http://www.georgiastats.uga.edu/guide.html
Social Determinants		
Educational Attainment: % of High School Graduates or Higher 2007	Georgia Statistics System	http://www.georgiastats.uga.edu/guide.html
Below Poverty, Percentage of Persons, 2008 Model Based Estimate	Georgia Statistics System	http://www.georgiastats.uga.edu/guide.html
Total Index Crime Rate per 100,000, 2008	Georgia Statistics System	http://www.georgiastats.uga.edu/guide.html
Unemployment Rate, 2008	Georgia Statistics System	http://www.georgiastats.uga.edu/guide.html
Health Indicators		
Percentage of Obese Adults in GA	Georgia Department of Community Health	http://health.state.ga.us/epi/cdiee/index.asp
All STDs, Total Rate per 100,000, 2008	Georgia Statistics System	http://www.georgiastats.uga.edu/guide.html
Low Weight Births, Total Rate per 100 Live Births, 2007	Georgia Statistics System	http://www.georgiastats.uga.edu/guide.html
Percentage Uninsured <65 Years of Age, All Income Levels, 2006	Georgia Statistics System	http://www.georgiastats.uga.edu/guide.html
Number of Persons per Physician, 2006	Georgia Statistics System	http://www.georgiastats.uga.edu/guide.html
2008 Teen Birth Rate per 1000 population	OASIS	http://oasis.state.ga.us/index.asp
Health Outcomes		
Average Life Expectancy	Community Health Status Indicator	http://www.communityhealth.hhs.gov/homepage.aspx?i=1
Age Adjusted Percent Estimate of Diagnosed Diabetes	Centers for Disease Control and Prevention: Diabetes Data & Trends	http://apps.nccd.cdc.gov/DDT_STRS2/NationalDiabetesPrevalenceEstimates.aspx
Asthma Hospitalization Age Adjusted Rates, 2007	Asthma in Georgia 2007 Report	http://health.state.ga.us/epi/cdiee/asthma.asp
Age Adjusted Death Rate, Major Cardio Vascular Disease, 2007	OASIS	http://oasis.state.ga.us/index.asp
Age Adjusted Death Rate, Cancer, 2007	OASIS	http://oasis.state.ga.us/index.asp

(Continued)

Methodology

In the development of this database no new statistics were collected. All numbers are from secondary database sources that are open websites presently available to the public. Our goal was to collect pre-existing Public Health data into one centralized location and present it in a format that would not only be simple to retrieve but also easy to comprehend.

Data was chosen that had two overarching characteristics. First the data had to be presented at the county level. We believe that county level statistics would be more valuable because of the differences between Public Health districts and legislative voting districts. We wanted Public Health information that could be easily tailored to inform legislators about their specific voting areas. Second characteristic that was required for the parameter to be included in our database was that it was a simple non-jargon statistic that not only health professionals but also the general public could easily understand and use for help in their advocacy efforts. Therefore we tried to avoid any value that might require any advanced training to understand. For example it is common within the Public Health profession to use YPLL's, Years of Potential Life Lost, which is a measurement for morbidity that the general population would not instinctively be comfortable using. Instead we chose to use Life Expectancy that we believe is easier to understand and apply.

A total of twenty-one parameters were chosen to present in these website. These parameters were further subdivided into four categories, General Information, Social Determinants, Health Indicators and Health Outcomes. Please refer below for an in depth discussion for each of these categories and individual parameters.

General Information Data :

Developed to help website users visualize the Georgia County that was being described.

Source(s):

[Georgia Statistic System](#) which is a service of the Center for Agribusiness and Economic Development, the Department of Agricultural and Applied Economics, and the Cooperative Extension Service, University of Georgia. This web site's data source is from the Georgia County Guide and the Farmgate Value Report. The site's purpose is to facilitate economic development by improving the information base available to decision makers in local government, schools and businesses.

Parameters:

County Seat: US Census Bureau

Square Miles: US Census Bureau

ESTIMATES OF TOTAL POPULATION: 1999-2008 "Time Series of Georgia Intercensal Population Estimates by County: April 1, 1990 to April 1, 2000 (COEST2001- 12-13)" release date, 4/17/02; and "Annual Estimates of the Resident Population for Counties of Georgia: April 1, 2000 to July 1, 2008 (CO-EST2008-01-13)," release date, 3/19/09, **US Census Bureau <http://www.census.gov/popest/counties/> Census produce the estimate of each county's population, starting with the base population from either Census 2000 (for the July 1, 2000 estimates) or the revised population estimate for the prior year (for the July 1, 2001 and later estimates). Census then adds or subtracts the demographic components of population change calculated for that time period.

Basically, Census adds the estimated number of births and subtracts the estimated number of deaths for the time period. Next, the Census adds the estimates of net domestic migration, net international migration, and the net change in the group quarters population

Per Capita Income (1998-2007 REIS DVD 1969-2007, May 2009, Bureau of Economic Analysis, US Department of Commerce, Washington, DC. 202-606-5360. <http://www.bea.gov/regional/reis/>) is calculated as the personal income of the residents of a given area divided by the resident population of the area.

- In computing per capita personal income, BEA uses the Census Bureau's annual midyear population estimates.
- Per capita income is calculated as the total personal income of the residents of an area divided by the population of the area and is often used as an indicator of the quality of consumer markets and of the economic well-being of the residents of an area.
- In computing per capita personal income for States and counties, BEA uses the Census Bureau's annual midyear population estimates. Except for college students and other seasonal populations, which are measured on April 1, the population for all years is estimated on July 1.
- The local area estimates of per capita personal income should be used cautiously for several reasons.
 - In some instances, the change in the per capita personal income of an area may be the result of unusual conditions. For example, the income of an area may be raised for a year as the result of a bumper crop, or it may be reduced for a year as the result of a hurricane.
 - In other instances, the per capita personal income of an area may reflect the income levels of certain groups of the resident population, but it may not be indicative of the economic well-being of the residents of the area. For example, the per capita income of an area may be substantially raised for several years by a major construction project--such as a defense facility, power plant, or dam--that attracts highly paid workers whose wages and salaries are measured at the construction site. --
 - However, this high per capita income may not be indicative of the economic well-being of most of the residents of the area (or, in many cases, of the resident construction workers themselves, because they frequently send a substantial portion of their wages to dependents who live in other areas).
 - Conversely, the per capita income of an area may be reduced by the presence of a large institutional population--like that of a college or a prison--because little income is attributed to the residents of these institutions.
 - However, this low income may not be indicative of the economic well-being of most of the residents of the area (or, in many cases, of the institutional populations, because some of these populations, such as college students, typically receive support from their families who live in other areas).
 - Caution must also be used where the population changes rapidly. Per capita income of counties where farm proprietors' income is a large portion of personal income can also be misleading. Farm proprietors' income reflects current production, not current cash flows. Farm proprietors' income excludes sales out of inventories, which are included in current gross receipts, because these sales represent income from a previous year's production, not from current production. Furthermore, farm proprietors' income includes the value of additions to inventories. Therefore, the estimates of farm proprietors' income do not reflect the farmers' attempts to regulate their cash flow by adjusting inventories.
 - In addition, the per capita income of sparsely populated counties which are dependent on farming reacts more sharply to weather and world market demand and to changing government policies affecting agriculture than the per capita income of counties where the sources of income are more diversified.

Public Health Budget Information (development pending)

Social Determinants:

According to the World Health Organization's "Solid Facts Report", social determinants are defined as social causes of ill health.

Source(s):

[Georgia Statistic System](#) which is a service of the Center for Agribusiness and Economic Development, the Department of Agricultural and Applied Economics, and the Cooperative Extension Service, University of Georgia. This web site's data source is from the Georgia County Guide and the Farmgate Value Report. The site's purpose is to facilitate economic development by improving the information base available to decision makers in local government, schools and businesses.

Parameters:

Education: EDUCATIONAL ATTAINMENT BY RACE AND HISPANIC ORIGIN: 2000 Census 2000 Summary File 3, **US Census Bureau. <http://factfinder.census.gov/home/saff/main.html>

- The American Community Survey (ACS) is a nationwide survey designed to provide communities a fresh look at how they are changing. It is a critical element in the Census Bureau's reengineered decennial census program.
- The **American Community Survey (ACS)** is an ongoing statistical survey by the U.S. Census Bureau, sent to approximately 250,000 addresses monthly (or 3 million per year), It regularly gathers information previously contained only in the long form of the decennial census. It is the largest survey other than the decennial census that the Census Bureau administers.

Poverty: HOUSEHOLD INCOME, POVERTY CHARACTERISTICS BY AGE, RACE, HISPANIC ORIGIN: 1999 and 2007 US Census Bureau, "2008 Estimates for Georgia Counties," released 11/09 and "Estimated Population in Poverty Universe, July 2008," created 10/09. <http://www.census.gov/hhes/www/saiper/> (1999) Census 2000 Summary File 3, <http://factfinder.census.gov/home/saff/main.html>

- The American Community Survey (ACS) is a nationwide survey designed to provide communities a fresh look at how they are changing. It is a critical element in the Census Bureau's reengineered decennial census program.
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Crime: ARRESTS; INDEX CRIMES REPORTED: 2008 Index Crimes Reported, Crime Statistics Database, data accessed 7/08/08; and other unpublished data. GA Crime Information Center, Decatur, GA. 404-244-2880. <http://services.georgia.gov/gbi/crimestats/displayCrimeStatForm.do>

- To control for population differences, and thus make descriptions and comparisons between jurisdictions and over time more accurate and meaningful, index crimes are expressed as a rate. Rate is figured by dividing the number of crimes by the total population of a jurisdiction or group then multiplying by 100,000.
- Index crimes; include homicide and non-negligent manslaughter, robbery, forcible rape, aggravated assault, burglary, larceny/theft, motor vehicle theft, and arson.
- Data collection: Each month, law enforcement agencies report the number of known index crimes in their jurisdiction to the FBI. This mainly includes crimes reported to the police by the general public, but may also include crimes that police officers discover, and known through other sources.
- Criticism: may not accurately reflect crime rates in that they can only list crimes reported to law enforcement agencies. Also, should a number of crimes be connected, they only list the most serious one. For instance, if someone were murdered during a car theft, they would only list murder. Lastly, the list is biased in the reporting of rape. The UCR defines forcible rape as, "the carnal knowledge of a female forcibly and against her will." It does not list rapes against men, nor does it list same-sex rape.

Unemployment: CIVILIAN LABOR FORCE ANNUAL AVERAGES OF EMPLOYMENT AND UNEMPLOYMENT: 1999-2008 UNEMPLOYMENT INSURANCE CLAIMS: 2008 GA Dept. of Labor, Workforce Information and Analysis, Atlanta, GA. 404-656-3177.

http://www.dol.state.ga.us/em/workforce_info.htm US Dept. of Labor, Bureau of Labor Statistics (Southeast BLS Information Office in Atlanta, 404-331-3415). <http://www.bls.gov/lau/> <http://www.bls.gov/ro4/ro4con.htm>

Health Indicators:

According to the U.S. Department of Human Health Service's statement of national health statement, Healthy People 2020 Health Indicators reflect the major health concerns in the United States at the beginning of the 21st century.(11) This category can be considered a status report, "where are we now".

Source(s):

[Georgia Department of Community Health](#) . The Georgia Department of Community Health (DCH) was created in 1999 to serve as the lead agency for health care planning and purchasing issues in Georgia. The General Assembly created DCH by consolidating four agencies involved in purchasing, planning and regulating health care. In 2009, the Division of Public Health and Emergency Preparedness transitioned to DCH. The department is also designated as the single state agency for Medicaid. Mission Statement: ACCESS to affordable, quality health care in our communities / RESPONSIBLE health planning and use of health care resources / HEALTHY behaviors and improved health outcomes

[Georgia Statistical System](#) which is a service of the Center for Agribusiness and Economic Development, the Department of Agricultural and Applied Economics, and the Cooperative Extension Service, University of Georgia. This web site's data source is from the Georgia County Guide and the Farmgate Value Report. The site's purpose is to facilitate economic development by improving the information base available to decision makers in local government, schools and businesses.

[OASIS](#) (Online Analytical Statistic Information System) OASIS is a suite of interactive tools used to access the Georgia Department of Community Health, Division of Public Health's standardized health data repository. OASIS and the Repository are designed, built and maintained by the Office of Health Information and Policy (OHIP). The Mapping Tool, designed by OHIP, is developed and maintained by the University of Georgia's Carl Vinson Institute of Government, ITOS Division. The standardized health data repository used by OASIS is currently populated with Vital Statistics (births, deaths, infant deaths, fetal deaths, induced terminations), Georgia Comprehensive Cancer Registry, Hospital Discharge, Emergency Room Visit, Arboviral Surveillance, Risk Behavior Surveys (Youth Risk Behavior Survey (YRBS), and Behavioral Risk Factor Surveillance Survey (BRFSS)), STD, and Population data.

Parameters:

Obesity: Fact Sheet, January 2010, Georgia Adult Obesity by County

-Obesity is defined as a body mass index (BMI) of 30 or greater. BMI is calculated from a person's weight and height and provides a reasonable indicator of body fatness and weight categories that may lead to health problems. Obesity is a major risk factor for cardiovascular disease, certain types of cancer, and type 2 diabetes.

-Data was calculated using a predictive modeling analysis using data from the Behavioral Risk Factor Surveillance System (BRFSS) produced county level obesity prevalence estimates for non-institutionalized civilian adults in 2007.

-The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of health surveys that collects information on health. The BRFSS is a cross-sectional telephone survey conducted by state health departments with technical and methodological assistance provided by the CDC. Every year, states conduct monthly telephone surveillance using a standardized questionnaire to determine the distribution of risk behaviors and health practices among non-institutionalized adults. The states forward the responses to the CDC, where the monthly data are aggregated for each state. The data are returned to the states, and then published on the BRFSS Web site.

STDs: SEXUALLY TRANSMITTED AND OTHER INFECTIOUS DISEASES: 1999-2008

Notifiable Disease Query; Online Analytical Statistical Information System (OASIS), data accessed 12/4/09; Epidemiology Section, GA DHR, Div. of Public Health.

<http://oasis.state.ga.us> <http://www.health.state.ga.us/healthdata/disease.asp>

- Formula = [Number of STDs / Population] * 100,000.
- STDs that are included: Chancroid, Chlamydiae, Gonococcal, Syphilis, Lymphogranuloma Venereum
- All Rates were per 100,000 population and calculated using Census 2005 estimated population for Georgia
- Data exported from GA Surveillance System (SendSS) All districts and counties with Internet access submitting notifiable disease reports (not including TB, STDs, or AIDS) through SENDSS
- All Georgia physicians, laboratories and other health care providers are required by law to report patients with notifiable conditions to their County Health Department or District Health Office. Cases may also be reported to the Acute Disease Section of the Epidemiology Branch. Both lab-confirmed and clinical diagnoses are reportable within the time interval required by law.

Access to Physicians: PHYSICIANS BY SPECIALTY: 2006 Georgia Board for Physician Workforce, Atlanta, GA, 404-206-5420. http://gbpw.georgia.gov/00/channel_title/0.2094.49259818_54218987.00.html

- The Georgia Board for Physician Workforce (GBPW) is a state agency responsible for advising the Governor and the General Assembly on physician workforce and medical education policy and issues.
- The Board's responsibilities include monitoring and forecasting the supply and distribution of physicians in Georgia; assuring an adequate supply, specialty mix, and geographic distribution of physicians to meet the health care needs of Georgia; coordinating physician workforce planning with state funding for medical education; and the development and support of medical education programs required to meet physician workforce needs.
- Data Source: Composite State Board of Medical Examiners, Georgia Physician Survey, 2006.

Percentage Medically Uninsured: HEALTH INSURANCE COVERAGE: 2006 "2006 Health Insurance Coverage Status for Counties and States: Interactive Tables," last revised 7/15/09, data accessed 10/19/09. US Census Bureau. <http://www.census.gov/did/www/sahie/data/2006/index.html>

-The SAHIE program models health insurance coverage by combining survey data with population estimates and administrative records. Their estimates are based on data from the following sources:

- The Annual Social and Economic Supplement (ASEC) of the Current Population Survey (CPS);
- Demographic population estimates;
- Aggregated federal tax returns;
- Participation records for the Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp program;
- County Business Patterns;
- Medicaid and Children's Health Insurance Program (CHIP) participation records; and
- Census 2000.

-SAHIE estimate the number of people with health insurance coverage by county within demographic and income groups, and estimate the number without insurance as the difference between estimates of the number of people in a group and the number with insurance in that group. The number insured in a group is the product of the number in the group and the proportion in that group who are insured. Correspondingly, their model has two main parts: one for estimating the number of people in county demographic and income groups, and one for estimating the proportion with health insurance in these groups. Each part is a hierarchical two-level regression model. They use Bayesian methods to estimate the parameters in the model. Their estimates take into account that the estimates from the Annual Social and Economic Supplement (ASEC) of the Current Population Survey (CPS) for different counties have different reliabilities due to varying sample sizes in each county. Their estimates for counties with large sample sizes tend to be close to the CPS ASEC estimates. The demographic and income groups of the CPS ASEC estimates that are modeled are described in the *Model Details* section (refer to SAHIE link for more detail).

-Criticism: this model is an approximate, not exact, description of the distribution of the data. These models have been evaluated against the data and no major discrepancies have been found between the predictions from the model and the data. Research continues to improve the models so that they more accurately describe the distributions of the data. For example, modeling choices, including assumptions of independence, the choices of variance forms, and estimation of the sampling variances, have not been completely validated.

Because the models are determined using the same data used to produce the estimates, and because the model used is one of many possible models for the data, we may underestimate variances of the estimates.

Low Birth Weights: VITAL STATISTICS BIRTHS; LOW WEIGHT, SELECTED NATALITY STATISTICS: 1998-2007, DEATHS; SUICIDE AND HOMICIDE: 1998-2007 Georgia Vital Statistics Report, 2007, GA Dept. of Human Resources, Division of Public Health, Center for Health Information, Atlanta, GA. 404-657-6320. <http://health.state.ga.us/programs/ohip/birthdeath.asp> <http://oasis.state.ga.us/>

- Live births of a birth weight less than 2500 grams (5lbs. 8oz.) per 100 live births. Formula = [Number of live births under 2,500 grams / Number of live births] * 100.
- This report includes 2007 Georgia resident birth, death, fetal death and induced termination data received by the State Vital Records office.
- Geocoded birth, death, and fetal death records are used in the vital statistics report. Geocoding is a process that matches a street address to a map location, and can correct the reported county and state of residence.

Teen Pregnancies: VITAL STATISTICS BIRTHS; LOW WEIGHT, SELECTED NATALITY STATISTICS: 1998-2008, DEATHS; SUICIDE AND HOMICIDE: 1998-2007 Georgia Vital Statistics Report, 2007,, GA Dept. of Human Resources, Division of Public Health, Center for Health Information, Atlanta, GA. 404-657-6320. <http://health.state.ga.us/programs/ohip/birthdeath.asp> <http://oasis.state.ga.us/>

- The number of live births occurring to females between 15-19 years of age per 1,000 females in the same age group. Formula = [Number of Live Births in an age group / Female population in same age group] * 1,000. If a race, age, sex or ethnicity is chosen, both the numerator and denominator are filtered by that selection.
- This report includes 2008 Georgia resident birth, death, fetal death and induced termination data received by the State Vital Records office.
- Geocoded birth, death, and fetal death records are used in the vital statistics report. Geocoding is a process that matches a street address to a map location, and can correct the reported county and state of residence.

Health Outcomes:

National Institute of Health defines Health Outcomes as data that looks beyond the physiological measures of success to examine the effects of the health care process on patients and populations. These parameters measure how long people live and how healthy people feel while alive.

Source(s):

[Community Health Status Indicator \(CHSI\)](#): The goal of CHSI is to provide an overview of key health indicators for local communities and to encourage dialogue about actions that can be taken to improve a community's health. The CHSI report was designed not only for Public Health professionals but also for members of the community who are interested in the health of their community. The CHSI report is compiled by the Department of Health and Human Services

[Centers for Disease Control and Prevention: Diabetes Data & Trends](#): is a United States federal agency under the Department of Health and Human Services. It works to protect Public Health and safety by providing information to enhance health decisions, and it promotes health through partnerships with state health departments and other organizations. The CDC focuses national attention on developing and applying disease prevention and control (especially infectious diseases), environmental health, occupational safety and health, health promotion, prevention and education activities designed to improve the health of the people of the United States. The Data and Trends section, which includes the National Diabetes Fact Sheet and the National Diabetes Surveillance System, provides resources documenting the Public Health burden of diabetes and its complications in the United States.

[Georgia Department of Community Health](#) . The Georgia Department of Community Health (DCH) was created in 1999 to serve as the lead agency for health care planning and purchasing issues in Georgia. The General Assembly created DCH by consolidating four agencies involved in purchasing, planning and regulating health care. In 2009, the

Division of Public Health and Emergency Preparedness transitioned to DCH. The department is also designated as the single state agency for Medicaid. Mission Statement: ACCESS to affordable, quality health care in our communities / RESPONSIBLE health planning and use of health care resources / HEALTHY behaviors and improved health outcomes

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Parameters:

Life Expectancy: Average Life Expectancy — the average number of years to be lived by a group of people born in the same year, if mortality at each age remains constant in the future.

- Life expectancy at birth is also a measure of overall quality of life in a country and summarizes the mortality at all ages. It can also be thought of as indicating the potential return on investment in human capital and is necessary for the calculation of various actuarial measures.
- How long a given person is expected to live. Average life expectancy is calculated for categories of people, such as all females, or all citizens of a certain country. To calculate average life expectancy, a wide variety of characteristics can be looked at, including gender, country of residence, family medical history, and many lifestyle habits including smoking, drinking, eating, exercise, and sleep patterns.
- Calculations were made by Chris Murray and colleagues at the Harvard School of Public Health. Methodology and data source information is described in: Murray CJL, Kulkarni SC, Michaud C, Tomijima N, Bulzacchelli MT, et al., Eight Americas: Investigating Mortality Disparities across Races, Counties, and Race-Counties in the United States. PLoS Medicine Vol. 3, No. 9, e260 doi:10.1371/journal.pmed.0030260”.

Diabetes: 2007 Age-Adjusted Estimates of the Percentage of Adults with Diagnosed Diabetes

- The prevalence of diagnosed diabetes by county was estimated using data from CDC's Behavioral Risk Factor Surveillance System (BRFSS) and data from the U.S. Census Bureau's Population Estimates Program.
- The BRFSS is an ongoing, monthly, state-based telephone survey of the adult population. The survey provides state-specific information on behavioral risk factors and preventive health practices.
- Respondents were considered to have diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes. Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes.

Asthma: Asthma in Georgia 2007 Report from the Department of Community Health

- Georgia Hospital Inpatient Discharge Data, Office of Health Information and Policy (OHIP), 2005
- The Georgia Hospital Association provides the Georgia Department of Public Health (GDPH) with an abridged data set of hospital discharge records for the State of Georgia. This data set is provided on an annual basis. This data is available to GDPH employees and partners in the Georgia Department of Community Health.
- Emergency room (ER) visit data in this report are based on ER visit data by Georgia residents who were seen in the ER with asthma as the primary diagnosis. The ICD-9 codes used to select hospitalizations were 493.0-493.9. ER visit data included only information reported by non-federal acute care hospitals in Georgia. Rates were age-adjusted to the 2000 US standard population via the direct method.

Cancer: Age Adjusted Death Rate for all Cancers 2007. VITAL STATISTICS BIRTHS; LOW WEIGHT, SELECTED NATALITY STATISTICS: 1998-2007, DEATHS; SUICIDE AND HOMICIDE: 1998-2007

Georgia Vital Statistics Report, 2007,, GA Dept. of Human Resources, Division of Public Health, Center for Health Information, Atlanta, GA. 404-657-6320. <http://health.state.ga.us/programs/ohip/birthdeath.asp>
<http://oasis.state.ga.us/>

- Age-Adjusted Rates are a weighted average of the age-specific mortality rates, where the weights are the proportions of persons in the corresponding age groups of a standard population. The calculation of an Age-Adjusted Rate uses the year 2000 U.S. standard million.
- Benefit: Controls for differences in age structure so that observed differences in rates across areas such as counties are not due solely to differences in the proportion of people in different age groups in different areas
- Death Rate Formula = [Number of Deaths / Population] * 100,000. Rates that use Census Population
- Cancers included: Oral, Throat, Stomach, Colon, Liver, Pancreatic, Lung, Skin, Breast, Cervical, uterine, Ovarian, Prostate, Testicular, Bladder, Kidney, Brain, Lymph and Leukemia
- This report includes 2007 Georgia resident birth, death, fetal death and induced termination data received by the State Vital Records office.
- Geocoded birth, death, and fetal death records are used in the vital statistics report. Geocoding is a process that matches a street address to a map location, and can correct the reported county and state of residence.

Heart Disease Age Adjusted Death Rate for all Major Cardio Vascular Diseases. VITAL STATISTICS BIRTHS; LOW WEIGHT, SELECTED NATALITY STATISTICS: 1998-2007, DEATHS; SUICIDE AND HOMICIDE: 1998-2007 Georgia Vital Statistics Report, 2007,, GA Dept. of Human Resources, Division of Public Health, Center for Health Information, Atlanta, GA. 404-657-6320.
<http://health.state.ga.us/programs/ohip/birthdeath.asp> <http://oasis.state.ga.us/>

- Age-Adjusted Rates are a weighted average of the age-specific mortality rates, where the weights are the proportions of persons in the corresponding age groups of a standard population. The calculation of an Age-Adjusted Rate uses the year 2000 U.S. standard million.
- Benefit: Controls for differences in age structure so that observed differences in rates across areas such as counties are not due solely to differences in the proportion of people in different age groups in different areas
- Death Rate Formula = [Number of Deaths / Population] * 100,000. Rates that use Census Population
- Major Cardio Vascular diseases included: High Blood Pressure (Hypertension), Rheumatic Fever & Heart Diseases, Hypertensive Heart Disease, Obstructive Heart Diseases (Ischemic Heart Diseases, includes Heart Attack), Stroke, Hardening of the Arteries, and Aortic Aneurysm & Dissection
- This report includes 2007 Georgia resident birth, death, fetal death and induced termination data received by the State Vital Records office.
- Geocoded birth, death, and fetal death records are used in the vital statistics report. Geocoding is a process that matches a street address to a map location, and can correct the reported county and state of residence.

Attachment C: Partner Up for Public Health – Example Full County Report

APPLING COUNTY SNAPSHOT

Average overall GA Ranking 87 [1 Best - 159 Worst]

Better than GA Average in **11** of 15 measures **Worse** than GA Average in **4** of 15 measures

Better than US Average in **11** of 14 measures **Worse** than US Average in **3** of 14 measures

Strengths: Ranks in top 25% of Georgia counties for **4** of 15 measures. **Challenges:** Ranks in bottom 25% of Georgia counties for **4** of 15 measures.

Link to full Appling County report

County Seat: Baxley

Population Census Estimate July 1, 2008: 18,038

Area Total Square Miles: 512.1

Per Capita Income 2007: 22,485

Budget 2007: 695,848

Budget Trend: coming soon

SOCIAL DETERMINANTS

Appling County	County Value	Rank (Of 159 GA Counties)	Best GA County	GA Average	Better or Worse than GA	US Average	Better or worse than US
Educational Attainment: % of High School Graduates or Higher 2007	67.3	98	Fayette County (92.4)	78.6	Worse	84.5	Worse
Below Poverty, Percentage of Persons, 2008 Model Based Estimate	20.3	90	Fayette County (4.7)	14.7	Worse	13.2	Worse
Total Index Crime Rate per 100,000, 2008	1,114.30	18	Baker County (78.8)	4,315.90	Better	4,982.00	Better
Unemployment Rate, 2008	7.1	98	Oconee County (4)	6.2	Worse	5.8	Worse

(Continued)

HEALTH INDICATORS

Appling County	County Value	Rank (Of 159 GA Counties)	Best GA County	GA Average	Better or Worse than GA	US Average	Better or worse than US
Percentage of Obese Adults	30.20	85	Fulton County (23.20)	29.62	Worse	26.3	Worse
All STDs, Total Rate per 100,000, 2008	471.2	70	Forsyth County (59.5)	633.4	Better	436.2	Worse
Low Weight Births, Total Rate per 100 Live Births, 2007	11.9	129	Webster County (0)	9.5	Worse	7.5	Worse
Percentage Uninsured <65 Years of Age, All Income Levels, 2006	21.30	116	Clinch County (14)	19.7	Worse	15.8	Worse
Number of Persons per Physician, 2006	554	27	Richmond County (153)	494	Worse	394	Worse
Teen Birth Rate per 1000, 2008	89.3	130	Talbot County (11.6)	51.7	Worse	42	Worse

(Continued)

HEALTH OUTCOMES

Appling County	County Value	Rank (Of 159 GA Counties)	Best GA County	GA Average	Better or Worse than GA	US Average	Better or worse than US
Average Life Expectancy	72.9	130	Fayette County (78.9)	74.3	Worse	76.5	Worse
Age Adjusted Percent Estimate of Diagnosed Diabetes	10.3	33	Cherokee County (8.1)	11.2	Better	9.1	Worse
Asthma Hospitalization Age Adjusted Rates, 2007	169	106	Baker, Clay, Glascock, Quitman, Taliaferro, Webster (<5)	133.0	Worse	NDA	NDA
Age Adjusted Death rate, Major Cardio Vascular Disease Total 2007	400.3	144	Evans County (139.9)	269	Worse	249.1	Worse
Age Adjusted Death Rate, Cancer, Total 2007	150.8	12	Jeff Davis County (280.6)	179.4	Better	180.7	Better

Attachment D: Partner Up for Public Health – draft parameter comparison page
Overall Georgia County Rank

County	GA County Ranking	County	GA County Ranking
Appling County	87	Jeff Davis County	126
Atkinson County	117	Jefferson County	158
Bacon County	118	Jenkins County	140
Baker County	124	Johnson County	150
Baldwin County	100	Jones County	42
Banks County	56	Lamar County	82
Barrow County	39	Lanier County	98
Bartow County	23	Laurens County	118
Ben Hill County	133	Lee County	20
Berrin County	121	Liberty County	95
Bibb County	76	Lincoln County	93
Bleckley County	115	Long County	101
Brantley County	40	Lowndes County	72
Brooks County	137	Lumpkin County	7
Bryan County	34	Macon County	149
Bulloch County	60	Madison County	67
Burke County	138	Marion County	110
Butts County	109	McDuffie County	69
Calhoun County	128	McIntosh County	104
Camden County	16	Meriwether County	135
Candler County	143	Miller County	77
Carroll County	79	Mitchell County	166
Catoosa County	14	Monroe County	27
Charlton County	41	Montgomery County	97
Chatham County	48	Morgan County	17

