

**NOTE: THIS DOCUMENT IS DYNAMIC AND CHANGES AS NEW INFORMATION AND STUDIES ARE COMPLETED; IT WAS UPDATED DECEMBER, 2005.**

# **CREATING HEALTHY NEIGHBORHOODS: USING COMMUNITY VOICES AND EXISTING RESOURCES IN THE FIVE CORE COUNTIES OF METROPOLITAN ATLANTA**

A report developed by  
The Atlanta Regional Health Forum, Inc.  
and funded by  
The Community Foundation for Greater Atlanta, Inc.

<b><u>CONTENTS</u></b>	<b><u>PAGE</u></b>
Executive Summary.....	1
I. What do our residents say about perceptions of health in their neighborhoods and what do they identify as critical needs and useful assets?.....	2
A. Chart Summary Recent Regional Community Assessments.....	3
B. Chart Summary of ARHF Town Hall Meetings.....	4
C. Summary of Major Identified Issues .....	4
II. What do existing data, including measures of “social health,” say about our current health status? .....	6
III. Using this subjective (I.) and objective (II.) information, what are the prioritized opportunities for creating healthy neighborhoods that have been identified? .....	9
Regional Resources .....	11
<b>ADDENDA</b>	
A. Summary of Recent Community Assessments .....	13
B. ARHF Town Hall Meeting Process and Summary of ARHF Town Hall Meetings...	36
Footnotes .....	48

# CREATING HEALTHY NEIGHBORHOODS: USING COMMUNITY VOICES AND EXISTING RESOURCES IN THE FIVE CORE COUNTIES OF METROPOLITAN ATLANTA

## EXECUTIVE SUMMARY

There are solutions for the concerns and factors that affect the health of our neighborhoods:

- Increasing numbers of persons with no health insurance or inadequate health insurance,
- Expanding aging population,
- Increasing demand for affordable prescription drugs,
- Enlarging population living below the poverty level,
- Rising prevalence in chronic disease across all life stages,
- Increasing preventable morbidity and mortality from chronic diseases,
- Accelerating gap in health disparity among diverse populations,
- Persisting poor performance in high school graduation rates
- Escalating housing and healthcare costs
- Declining social capital in our neighborhoods

It is time to re-examine the way we plan and take action for the health of our community. Despite increased healthcare spending, many diseases are on the rise--obesity, asthma, diabetes, heart disease, mental health issues and Alzheimer's have reached all time highs--posing serious questions about the cost effectiveness of our current spending, although **health is more than healthcare**. The World Health Organization definition is "*Health is a state of complete physical, mental, social (and spiritual) well-being and not merely the absence of disease or infirmity.*" In the absence of health policy in the US that undergirds efforts to create the conditions that assure that persons across all life stages have the opportunity to achieve their health potential, the national debate on health and healthcare has been aborted and local and state efforts have been mobilized to seek solutions to this growing concern and priority for families and communities. This presents an opportunity to initiate discourse on the broad definition of health at the most effective level that can directly impact lives, **the local community**.

As the Atlanta region seeks to lure high tech industry and jobs to our region, it must recognize that the declining health status of our citizens and communities is a critical barrier to improving our economy and quality of life. Our region cannot sustain the rapidly rising costs and the deteriorating systems impacting our health. As our region continues to grow, new and existing residents will demand the high quality of life they came here seeking or have a right to expect. Significant decisions are being made now about housing, transportation, town and activity centers, and the nature of our region's expansion that will determine the type of communities we live in. Recently completed community assessments not only articulate the health problems facing local communities in the Atlanta region, but define the resources, tools and process for creating solutions. These include enhancing community infrastructure to support healthy lifestyles, increasing access to high quality healthcare services, disseminating critical information promoting health, addressing gaps in the region's transportation and housing, improving critical community supports, and encouraging increased social capital to maximize local health self-sufficiency. Working together across jurisdictional boundaries, the Atlanta region can foster cost-effective solutions to improve health and quality of living for all residents by creating:

- Communities that support healthy lifestyles, healthy families, and healthy individuals;
- Accessible and high quality health-related services
- Empowered consumers; and
- Policies that create the conditions that make it possible for individuals, families, and communities to achieve their highest health potential.

The goal of this report is to:

- Inspire the creation of healthy neighborhoods in metropolitan Atlanta through regional planning;
- Place and keep regional public health priorities in focus;
- Present community perceptions of health, their needs, current assets, and ideal solutions to opportunities identified for improvement;
- Document several recent profiles of local population groups, including teenagers, Hispanic/Latino, Pan-Asian, the elderly, and the homeless;
- Initiate the mapping of assets and capacities of regional agencies, associations, and services that address the broad context of health;
- Foster regional connections, communication, and collaboration among agencies and associations engaged in healthy community activities and stimulate sharing best practices;
- Introduce a new dynamic regional database of health status indicators, including “social health” measures;
- Provide a basis for informing the public, providers of services, businesses, community organizations, policy makers, and funders to assist in decision making; and
- Encourage facilitation of local community or neighborhood discussions around healthy community opportunities in their domain and build social capital by encouraging participation in local volunteer opportunities.

The Atlanta Regional Health Forum (ARHF) is an inclusive, multisectoral, results-oriented, nonpartisan coalition operating as a 501(c)(3) nonprofit corporation dedicated to creating healthy local communities which ensure the highest health potential for each person within the five core county region (Clayton, Cobb, DeKalb, Fulton, and Gwinnett) of metropolitan Atlanta.

Four core values frame the regional activities of ARHF:

- Justice should drive health decisions, focused especially on increasing access to quality healthcare and eliminating disparity in health status
- All segments of the community participate
- Investments in health use all community assets
- Coordination of health and human services is assured through relationships of trust and transparency

The strategy of ARHF is “Regional Planning for Local Action” in the following activities:

- Framing Issues
- Setting Agendas
- Developing Data
- Disseminating Information
- Shaping Views
- Convening Appropriate Stakeholders
- Brokering resources
- Catalyzing Change

As ARHF was being created, initial meetings of key regional stakeholders identified three interlocking questions to address continuously for the coalition successfully to pursue its “passion statement” of creating “*Healthy neighborhoods for everyone, especially for our children and grandchildren*”. These are:

- I. What do our residents say about perceptions of health in their neighborhoods and what do they identify as critical needs and useful assets?
- II. What do existing data, including measures of “social health,” say about our current health status?

III. Using this subjective and objective information, what are the prioritized opportunities for creating healthy neighborhoods that have been identified?

This report is presented to review our progress in using this process. ARHF is committed to re-asking these questions regularly in an ongoing continuous value improvement cycle to identify and prioritize opportunities, implement changes, and reassess outcomes.

The findings and outcomes of regional community health assessments done by others are reviewed, recent profiles of several population groups are presented, and the results of an initial series of neighborhood forums facilitated by ARHF are documented. Although the findings represent the concerns of participants only at one point in time, ARHF intends to continue these conversations to focus and strengthen future activities.

Some of the consistent issues that emerged from the initial ten town hall meetings conducted by ARHF include:

- No program or set of services directed to improving community or neighborhood health will be effective if the local residents have not been an integral part of the process from the very outset through each stage of planning and implementation
- There is a surprising willingness to volunteer personal time and resources among local residents if they are given reliable information that they can understand and are a part of the process of improving their neighborhood health.
- Monies appropriated to improve community health are not perceived by residents as actually reaching those in need.
- Faith and spirituality play a very important role in strengthening the personal lives of many of our regional residents.
- Cultural competence is lacking in regional healthcare providers, including, but not confined to, language barriers.

The report also introduces a new database of regional health information that can be used to obtain useful information about our current health status. The overall issues that have been identified by all the community assessments are summarized and existing regional resources available to facilitate the creation of healthy neighborhoods are presented.

Key opportunities to improve regional community health exist by simultaneously reducing poverty and injustice while improving transportation, disseminating information with key regional public health messages, expanding health promotion education and services, increasing access to healthcare services, creating cooperation and collaboration among healthcare providers, and increasing social capital in all regional programs and services. There is a surprising willingness among participants in the ARHF town hall forums to volunteer in community health programs.

**I. WHAT DO RESIDENTS SAY ABOUT PERCEPTIONS OF HEALTH IN THEIR NEIGHBORHOODS AND WHAT DO THEY IDENTIFY AS CRITICAL NEEDS AND USEFUL ASSETS?**

**A. SUMMARY OF RECENT REGIONAL COMMUNITY ASSESSMENTS**

Many regional organizations and agencies have conducted “listening sessions” recently and detailed summaries of their activities are included in Addendum A. The activities and issues raised are summarized table 1.

**TABLE 1.  
RECENT REGIONAL ASSESSMENTS**

<b>AGENCY</b>	<b>ISSUE</b>	Healthcare Access	Healthcare Cost	Healthcare Quality	Health Promotion/Disease Prevention	Disease Screening Services	Health Literacy	Cultural Competency	Needs of Children/Teens	Needs of Seniors	Transportation	Housing	Employment
Georgia Health Decisions		X	X	X	X								
Georgia Healthcare Coverage Project		X	X	X									X
Healthcare Georgia Foundation		X	X	X	X			X					
ARC Aging Atlanta		X	X	X	X	X				X	X	X	
Gwinnett Coalition		X	X	X	X	X	X	X	X	X	X	X	X
Healthy DeKalb		X	X	X	X	X	X	X	X	X	X	X	X
Legislative Task Force		X	X	X									X
Pathways Community Network		X	X	X	X	X		X	X	X	X	X	X
Clayton Collaborative		X	X	X	X	X	X	X	X	X	X	X	X
United Way		X	X	X	X	X	X	X	X	X	X	X	X
The Latino Health Survey/Dia de la Mujer Latina		X	X	X	X	X	X	X	X	X	X	X	X

**B. SUMMARY OF ARHF TOWN HALL MEETINGS**

Ten meetings have been held, with an average attendance of 50 participants in each, in diverse populations experiencing socioeconomic and/or racial or ethnic disparities. Particular attention has been given to the economically disadvantaged, uninsured, underinsured and medically underserved.

**DEMOGRAPHICS**

- 498 participants; 445 completed pre-meeting survey, including 274 women and 171 men
- 23% were employed
- 78% possessed some form of health insurance
- 66% knew where to go for preventive health information
- 63% knew where to go for screening health services

Participants receiving appropriate health screening services in the prior two years:

- Blood Pressure, 76%
- Blood sugar, 55%
- Colon cancer screening over age 50, 48%
- Women over age 20 receiving a Pap smear, 43%
- Women over age 40 receiving a mammogram, 72%
- Post-meeting survey: 85% increased their knowledge about where to receive health information and services for themselves and their family and 61% were willing to volunteer to help their family and friends with health activities in their community.

Detailed summaries of the findings are included in Addendum B. Population groups and major issues are summarized in Table 2.

**TABLE 2.  
ARHF TOWN HALL MEETINGS**

ISSUE	Healthcare Access	Healthcare Cost	Healthcare Quality	Health Promotion/Disease Prevention	Disease Screening Services	Health Literacy	Cultural Competency	Needs of Children/Teens	Needs of Seniors	Transportation	Housing	Employment
SELECTED POPULATION												
Hispanic/Latino	X	X	X	X	X	X	X	X	X	X	X	X
Inner City African-American	X	X	X	X	X	X		X	X	X	X	X
Middle Class African-American	X	X	X	X	X	X			X			
Elderly African American	X	X	X	X	X	X			X	X	X	
Homeless Men & Women	X	X	X	X	X	X		X	X	X	X	X
Homeless Women and Children	X	X	X	X	X	X		X		X	X	X
Mental Health/Substance Abuse	X	X	X	X	X	X		X	X	X	X	X
Korean	X	X	X	X	X	X	X		X	X	X	X
Vietnamese	X	X	X	X	X	X	X		X	X	X	X
Other Refugee/Immigrant	X	X	X	X	X	X	X	X	X	X	X	X

**C. SUMMARY OF MAJOR ISSUES IDENTIFIED BY COMMUNITY VOICES**

**Healthcare Service Delivery Issues**

- Most people are very willing to consider almost any solution to curb rising healthcare costs and the increasing numbers of uninsured and underinsured, especially the working uninsured and children and they are ready for their elected leaders to take action. No one should go without healthcare and everyone should have access to the same quality of care, even if there are differences in where and how they receive that care.
- People want to take responsibility for their healthcare and they want the system to share that responsibility by helping them make wiser healthcare decisions. They will “shop around” for healthcare, but first they want the system to give them information on the quality and prices of various healthcare providers so that they can make informed decisions.
- High costs of health insurance, medications, co-insurance, deductibles and co-payments for those who possess health insurance restrict access to care.
- Insufficient public transportation restricts access to care.
- Cultural competence is a primary concern for health service organizations that are seeing an increasingly diverse base of clients.
- Patients perceive disrespect by providers for minority and poor persons.
- Long waiting times in emergency rooms, in obtaining an appointment with a physician and being seen by a physicians restrict access to care
- Inadequate access to dental, mental health and substance abuse, vision care and pediatric services exists.
- Inability to provide follow up care after positive screening for illness results in costly missed opportunities for early intervention.
- There is inappropriate use of emergency rooms for primary care.
- Limited access to specialty or secondary care for the poor results in higher cost.
- Inability to explain complex healthcare needs due to short time allowed with providers results in costly missed opportunities for appropriate care.
- Common information and referral systems shared by providers are needed to eliminate inefficiency and duplication of effort by providers and needless complexity for patients.

### **Individual Issues**

- Teens in our communities are engaging in risky behaviors on a daily basis
- Delaying care because of expense, using of home remedies as substitute for medical care services and changing treatment plans or drug regimens to control cost of care are common practices.
- Cutting back on basic necessities to pay for medical care services is common as well as failing to buy prescription medications because of having to purchase basic necessities.
- Lack of trust in the healthcare system results in reduced use of services, especially by minorities or the poor.
- Inability to connect with existing healthcare services due to lack of information about sites and services available, or inadequate public transportation, results in decreased access to care.
- Lack of knowledge of benefits under Medicare, Medicaid and other insurance plans and lack of information about health promotion and preventive screening result in increased cost.
- People request more information about health promotion and disease prevention and desire more culturally competent health fairs accessible to their residential communities.

### **Support System Issues**

- Homeless shelters are perceived as dangerous and unsanitary with inadequate space and staff.
- Homeless shelters do not provide conditions for adequate rest or access to foods promoting health.
- Inability of family members to provide child or elder care to assist persons accessing healthcare services decreases timely intervention for illness resulting in increased cost.
- There is limited use of schools for preventive and treatment services.
- Family members learning how to prevent illness and to care for themselves and each other if they become ill would reduce cost to the healthcare system
- Inability of family members to be present to support and advocate for persons during hospital or nursing home confinement results in increased cost and morbidity.
- Insufficient transportation restricts many aspects of achieving healthy neighborhoods

### **Community Challenges**

- Increasingly pervasive poverty in our communities is the major impediment to healthy neighborhoods.
- Critically important for success in creating healthy neighborhoods are community based interventions by engaging key community constituents in the design, execution and evaluation of health-related programs for various underserved populations.
- Public health and disease prevention are judged as being under-funded and needing renewed attention. Persons lack knowledge of where to go to receive preventive health information and preventive health screening services.
- Homelessness and the sustained poverty of many persons and families, particularly the vulnerable elderly and homeless children, are major regional factors as barriers to healthy neighborhoods.
- The widespread practice by teens of high-risk behaviors that lead to addiction, pregnancy, disease transmission, violence and truancy is a major target for intervention.
- Inadequate public transportation limits success in accessing healthcare, job seeking and education completion.
- Increasing services for the vulnerable older adult would be long term cost effective.
- There is the perception of increased pollution in our neighborhoods.
- Racism and other cultural prejudices are a persistent influence among our communities.
- There are increasing percentages of uninsured or underinsured persons, as well as immigrants, in our community.
- Residents perceive that money designated for community improvement never reaches the community, but is consumed by organizations who are supposed to provide community service.
- Neighborhoods need more grocery stores with affordable foods that promote health.

## II. WHAT DO EXISTING DATA, INCLUDING MEASURES OF “SOCIAL HEALTH,” SAY ABOUT OUR CURRENT HEALTH STATUS?

To answer this question, a process that ensures credible and current information is crucial, not only to inform decisions about where to focus improvement efforts, but also to measure outcomes after interventions have been made. Stakeholders initially discussed building a regional health status report, recognizing that creating one is time consuming and the data frequently are outdated by the time it is complete. A report usually is underutilized and may not be consulted to inform day-by-day decisions, particularly if the information is not presented in an easily understood and engaging manner. A consensus of our conversations agreed that ideal health status data should allow reports to be:

- Designed and completed by any interested party, rather than having to request them from another person or agency;
- Revised easily to answer the “second and third questions” and to provide follow-up information after planned interventions are implemented;
- Made by using an easily accessible source;
- “Neighborhood specific,” as much as possible, (such as using census tract level aggregation around high schools, legislative districts, neighborhood planning units, etc) rather than the whole county level to inform, engage and energize the public using geographic information systems to present the data in an easily understood and compelling form; and
- Inclusive of multiple indicators, including “social health” measures (see Miringoff, et. al., “The Social Health of the Nation: How America is Really Doing”).

Therefore, to provide an ongoing picture of the health of the region, the **Atlanta Regional Health Forum** has collaborating with the **Kerr L. White Institute for Health Services Research, Kaiser Permanente**, the **Atlanta Regional Commission**, the **Federal Reserve Bank of Atlanta** and the **Division of Public Health of the Georgia Department of Human Resources** to construct a dynamic, searchable database created from multiple sources in the public domain. Data are included at the present time from census surveys, vital statistics and other sources that address criminal justice and education. Other sources will be added.

Reports generated by users can include traditional measures of mortality and morbidity in addition to “social health” indicators, such as child abuse, child poverty, teenage drug use, high school completion, unemployment, wages, healthcare insurance coverage, violent crime and affordable housing. A goal is to have this database located on the Internet and, where possible, analyzable at the census tract level. The Atlanta Regional Commission and Georgia State University have collaborated to construct a web data base presenting the information from the U. S. Census survey aggregated at the census tract level allowing the user to construct a neighbourhood by selecting one census tract and selecting a radius around it to include other census tracts in the real time analysis. This site could be populated with easily health indicators and is located at <http://atlantacensus2000.gsu.edu>. More detailed analysis can include aggregation around subgroups by age, sex, race and ethnicity, socioeconomic status, housing, labor, violent crime statistics or other characteristics. Over 1,300 variables are included in the current data dictionary and information is available for 32 counties of the metropolitan Atlanta region.

A sample report of the health of our region at the county level for the 10 counties served by the Atlanta Regional Commission (ARC) follows. It includes six traditional indicators and six measures of social health. *It is presented to initiate discussion of how the quality and usability of available data can be improved.* Our purpose is to provide easy access to reliable data that can furnish useful information on which critical decisions regarding improvements in community or neighbourhood health can be made. *It is not, at this time, intended to be a basis for critical comparisons of county by county performance.* The Atlanta Regional Health Forum is conducting a series of both grassroots level town hall meetings and meetings of potential users to gather perceptions about local health status and to learn how these types of reports and the best ways to present them would be of practical benefit.

**Table 1. Population Health Indicators by ARC County**  
*(Data from Year 2000 unless otherwise noted)*

County	Premature mortality <sup>1</sup>	Tobacco related cancer mortality <sup>2</sup>	Breast cancer mortality <sup>3</sup>	Colorectal cancer mortality <sup>4</sup>	Suicide <sup>5</sup>	Fetal mortality <sup>6</sup>
Cherokee	195	61	58	68	13	6
Clayton	275	62	68	64	8	9
Cobb	183	53	57	53	8	6
DeKalb	244	57	47	62	7	9
Douglas	237	63	43	68	11	9
Fayette	159	41	31	48	9	4
Fulton	302	61	68	69	8	11
Gwinnett	162	41	35	44	10	6
Henry	249	69	48	94	11	8
Rockdale	245	87	39	91	9	5
<b>Average<sup>7</sup></b>	231	56	53	61	9	8

<sup>1</sup> Description: Number of deaths from all causes for persons less than 65 years of age per 100,000 population; Source: Georgia Vital Statistics Report 2000 and US Census 2000

<sup>2</sup> Description: Number of deaths from tobacco-related cancers as defined by American Cancer Society ([www.cancer.org](http://www.cancer.org)) per 100,000 population; Source: Georgia Vital Statistics Report 2000 and US Census 2000

<sup>3</sup> Description: Number of deaths from breast cancer per 100,000 population of women age 40 and older; Source: Georgia Vital Statistics Report 2000 and US Census 2000

<sup>4</sup> Description: Number of deaths from colorectal cancer per 100,000 population age 50 and older; Source: Georgia Vital Statistics Report 2000 and US Census 2000

<sup>5</sup> Description: Number of deaths from suicide per 100,000 population; Source: Georgia Vital Statistics Report 2000 and US Census 2000

<sup>6</sup> Description: Number of fetal deaths (at or greater than 20 weeks gestation) per 1000 fetal deaths (at or greater than 20 weeks gestation) and live births; Source: Georgia Vital Statistics Report 2000 and US Census 2000

<sup>7</sup> Ten-county average weighted by population

**Table 2 - Social Health Indicators by ARC County**  
*(Data from Year 2000 unless otherwise noted)*

County	Teenage fertility rate <sup>1</sup>	High school dropout <sup>2</sup>	Accidental mortality <sup>3</sup>	Homicide <sup>4</sup>	Family violence <sup>5</sup>	Property crime <sup>6</sup>
Cherokee	22	4	34	1	250	1752
Clayton	31	8	31	12	1230	5355
Cobb	19	3	31	5	175	3149
DeKalb	28	6	36	11	693	4613
Douglas	26	5	33	3	821	3620
Fayette	9	2	23	0	443	1470
Fulton	34	10	34	17	1019	6682
Gwinnett	18	1	24	5	104	2707
Henry	20	4	30	3	515	2440
Rockdale	24	4	50	3	131	2490
<b>Average<sup>7</sup></b>	25	4	32	9	576	4222

<sup>1</sup> Description: Total number of live births among females aged 10 to 19 years per 1,000 female population aged 10 to 19 years; Source: Georgia Vital Statistics Report 2000 and US Census 2000

<sup>2</sup> Description: Number of dropouts from grades 9-12 per 100 students enrolled grades 9-12 ; Source: Georgia Public Education Report Card 2000-2001

<sup>3</sup> Description: : Total number of accidental deaths per 1,000 population; Source: Georgia Vital Statistics Report 2000 and US Census 2000

<sup>4</sup> Description: Total number of homicide deaths per 100,000 population; Source: Georgia Vital Statistics Report 2000 and US Census 2000

<sup>5</sup> Description: Number of family violence incidences reported per 100,000 population; Source: Georgia Bureau of Investigations Uniform Crime Reporting Statistics (Family Violence Reports) and US Census 2000

<sup>6</sup> Description: Burglaries, larcenies, and vehicle thefts per 100,000 population; Source: Georgia Bureau of Investigations Uniform Crime Reporting Statistics (Family Violence Reports) and US Census 2000

<sup>7</sup> Ten-county average weighted by population

### **III. USING THIS SUBJECTIVE AND OBJECTIVE INFORMATION, WHAT ARE THE PRIORITIZED OPPORTUNITIES FOR CREATING HEALTHY NEIGHBORHOODS THAT HAVE BEEN IDENTIFIED?**

To target the prioritized opportunities to improve community health in our region that have been identified without simultaneously beginning to address the major root causes of suboptimal health, poverty and injustice, would fail to provide lasting and significant change. The highest priority opportunity is to assist all regional residents to reexamine the issues of poverty and injustice and to take a conscientious look at addressing them now. Five additional opportunities are identified.

#### **REDUCE POVERTY AND INJUSTICE**

- **Educate the public and advocate a shift in values and beliefs about poverty** from the current minimalist strategy to understanding poverty as an issue of fundamental concern to all Americans; each of us is directly and indirectly affected by America's high rate of poverty and reducing poverty now is in all of our best interests.
- **Encourage adequately paying jobs in areas where workers are located**
  - Supplement and raise the wages of existing jobs
  - Raise the minimum wage to the poverty level and index it to inflation
  - Adopt economic policies to stimulate job growth and appropriate distribution of jobs
  - Increase public service employment
- **Increase availability of and access to several key social and public goods, including:**
  - Quality education
  - Healthcare
  - Affordable housing
  - Child care
  - Transportation
- **Soften the economic consequences of disruptive family changes for children so no child will suffer from poverty, regardless of the type of family in which they are growing up**
  - Strengthen child support policies and their enforcement
  - Increase parenting class availability and participation
  - Increase teenage pregnancy prevention programs
- **Provide a sensible safety net for those truly in need**
  - Reverse the weakening of the social safety net that has occurred over the past 25 years by strengthening existing programs or by consolidating the vast number of U. S. social safety net programs into one overall program

#### **IMPROVE TRANSPORTATION SERVICES**

- Increase access to expanded modes of transportation to improve:
  - Participation in health promotion/disease prevention activities and obtaining healthcare services
  - Job seeking
  - Education, especially high school completion or GED and vocational training
- Address the growing perception among many agencies, churches, etc. that liability insurance coverage for vans or other vehicles may become impossible to obtain or come with prohibitive premiums

#### **DISSEMINATE INFORMATION WITH KEY REGIONAL PUBLIC HEALTH MESSAGES AND IMPLEMENT EDUCATIONAL PROGRAMS**

- Increase health promotion/disease prevention programs and health screening services
  - Increase the use of schools and churches for prevention education and treatment services
  - Focus on reducing risky teen behaviors
  - Institute coordinated health literacy programs
- Assist residents in learning how to navigate the current health care system

- Increase parenting classes and encourage participation
- Offer educational programs to increase senior care, self care and care for family members

**INCREASE ACCESS TO HEALTHCARE SERVICES AND TO HEALTH PROMOTION AND DISEASE PREVENTION SERVICES**

- Seek solutions to provide health insurance coverage for all
- Remove language barriers by improving translation/interpretation services
- Assure that healthcare providers offer culturally competent prevention programs and health services
- Increase access to transportation
- Provide more public toilets
- Improve sanitation in homeless shelters
- Serve more foods that promote health in homeless shelters

**INCREASE HEALTH SYSTEM PROVIDER COLLABORATION AND COORDINATION OF CARE**

- Create and employ common and/or compatible information systems for:
  - Coordinating health screening services
  - Improving efficiency of referral
  - Improving follow up after hospital discharge or other changes in the continuum of care
  - Preventing duplicate medical testing or misuse of existing resources

**INCREASE SOCIAL CAPITAL**

- Within all community health programs and services, capture and utilize the surprisingly robust willingness demonstrated among town hall meeting participants to volunteer in their neighborhoods

## **REGIONAL RESOURCES**

### **AGING ATLANTA AGEWISE CONNECTION**

(<http://www.agewiseconnection.com/>).

The Aging Services Division of the Atlanta Regional Commission has a new Web site with a searchable database that includes more than 2,000 service providers in the 10 core county region of metropolitan Atlanta.

### **ATLANTA CENSUS 2000 INTERACTIVE WEB DATABASE**

(<http://atlantacensus2000.gsu.edu>)

This resource was created by the collaborative work of the Atlanta Regional commission and Georgia State University. All of the data captured in the US Census surveys is available here and, in addition to prepared reports, users can configure custom reports to a “neighborhood” by selecting a single census tract and selecting the radius of the area they are studying.

### **CLAYTON COLLABORATIVE AUTHORITY**

(<http://www.claytoncollab.org/>)

The Clayton Collaborative Authority, created in 1997 by Senate Bill 355 as an instrumentality and political subdivision of the State of Georgia, is designed to achieve the following important goals for the benefit of children and families in the county: improved child health, improved child development, improved family functioning, improved school performance and improved family economic capacity.

### **COBB COMMUNITY COLLABORATIVE**

([www.cobbcollaborative.org](http://www.cobbcollaborative.org))

The Cobb Community Collaborative is a community organization focused on providing an arena for collaboration to improve the lives of all residents in Cobb County, Georgia. Our mission is accomplished through coordinating human services efforts and through this coordination, member organizations identify issues of concerns to the community, examine those issues and facilitate joint action to instigate needed change to benefit the citizens of Cobb County

### **DEKALB COUNTY DIRECTORY OF HEALTH AND WELLNESS AGENCIES**

(<http://www.dekalbhealth.net/index.asp>)

In 1998, the DeKalb County Board of Health created a Directory of Health and Wellness Agencies. This directory serves as a resource widely utilized by social service agencies throughout DeKalb County.

### **DIA DE LA MUJER LATINA, INC.**

([www.diadelamujerlatina.org](http://www.diadelamujerlatina.org))

Founded in 1997, this organization serves as a focal point for health promotion and prevention services for Latina and their families.

### **GEORGIA DEPARTMENT OF HUMAN RESOURCES COMMUNITY RESOURCE GUIDE**

([http://dhr.georgia.gov/vgn/images/portal/cit\\_1210/2638821DHR2003CommunityResourceGuideMar3.pdf](http://dhr.georgia.gov/vgn/images/portal/cit_1210/2638821DHR2003CommunityResourceGuideMar3.pdf))

This downloadable Resource Guide is a rich source of a wide variety of community service providers and programs including:

- Listing of community services agencies
- Listing of free and low cost medical clinics
- Community development social & economic services
- Media sources
- Listing of civic and cultural associations
- Faith communities and houses of worship

- Listing of interpreters and translators in Georgia
- Asian cultural and business organizations
- Latin American Consulates in Atlanta

### **GWINNETT COALITION HELP BOOK**

(<http://www.gwinnettcoalition.org/helpbook.html>)

The Gwinnett Coalition Help Book is an extensive listing of over 800 health and human service agencies including governmental, United Way-funded and other nonprofit organizations. This directory enables users to locate available human services in the greater Gwinnett County Area if they need help or want to help. Individuals in helping professions, schools, churches, civic organizations and the business community will find this directory an invaluable source of information.

### **HISPANIC HEALTH COALITION OF GEORGIA**

(<http://www.geocities.com/healthcoalition/>)

The Coalition has a downloadable directory, which is a rich source of organizations and individuals providing culturally competent services to the Hispanic/Latino population.

### **METROPOLITAN ATLANTA UNITED WAY 211**

(<http://211online.unitedwayatlanta.org/>)

Launched in June 1997, United Way 211 is the nation's first 3-digit telephone dedicated to community life. Today, nearly 300,000 people a year dial 2-1-1 or go online when they need help or want to help others. The service is free, confidential, bilingual (English and Spanish) and available 24 hours a day. 2-1-1 links callers to counseling, job training, substance or domestic abuse and more. 2-1-1 also enables callers to find volunteering opportunities and ways to donate household and office items.

### **PATHWAYS COMMUNITY NETWORK AND THE GEORGIA DEPARTMENT OF COMMUNITY AFFAIRS HOMELESS MANAGEMENT INFORMATION SYSTEMS (HMIS)**

(<http://www.pcni.org>)

Pathways Community Network is a nonprofit, collaborative effort of more than 180 human services organizations in metropolitan Atlanta providing a full range of data and training services that help community organizations work together securely and effectively, including:

- Collaborative Case Management and Referral Systems
- "Best Practices" Ethics, Confidentiality and Case Management Training
- Homeless Management Information Systems
- Internet Conferencing Systems
- Document Management Systems
- Wireless Data Collection Systems; Pathways and its corporate partners subsidize the cost of these systems and services. Pathways fees are based on ability to pay, because they believe that all organizations should benefit from this technology and training, even if they have limited financial resources.
- Pathways Community Network's Homeless Management Information System (HMIS) for the State of Georgia links 149 agencies providing shelter or other homeless related services throughout Georgia are linked through the Pathways Compass System.

## ADDENDUM A. SUMMARIES OF RECENT REGIONAL COMMUNITY ASSESSMENTS

**GEORGIA HEALTH DECISIONS**<sup>1</sup> was founded in 1991 by a group of individuals concerned about the rising cost of and lack of access to, affordable health services. Members pledged to come together as unbiased individuals, leaving professional, political and institutional affiliations aside, to form a non-profit, non-partisan organization designed strictly to reflect the voices of the people of Georgia regarding health related issues.

The goal of Georgia Health Decisions (GHD) is to understand Georgians' healthcare values through public discussion and scientifically valid research. Such values represent the criteria against which healthcare systems should be evaluated in terms of meeting the expectations and the expressed will of the people of Georgia. Since its institution, GHD has successfully sought to understand and report Georgians' beliefs on a variety of important healthcare issues. Using an innovative, integrated approach to public research, GHD engages individuals in constructive dialogue and positive deliberation through the use of focus groups, citizen panels, community forums, conferences, retreats and workshops, media campaigns and informational presentations. The work of the organization has included over 400 focus groups and citizen panels, 800 community forums and 55 conferences and workshops involving more than 35,000 citizens in all 159 Georgia counties.

Their initial report, "*Georgians Speak Out on Healthcare*", was released in September 1993 and was funded by fifteen major philanthropic foundations. It is the largest and most comprehensive assessment of Georgians' values on healthcare ever undertaken, resulted from 58 focus groups, 260 community forums and a random sample survey. Georgians were found to hold a deep mistrust of the healthcare system, which they described as wasteful, full of fraud and abuse and governed by red tape. It fails to give respect to patients who too often are "treated like cattle" and it provides world-class care to some people, while others go without any care at all.

A set of guiding principles emerged on which people want to base the Georgia healthcare system, termed *foundation values* of which there are six:

- **Honesty and trust** should be the cornerstone of all relationships in our healthcare system. People want to trust that the system will act in their best interest and that it will deal with them honestly. Georgians want "straight talk"—for instance, about their treatment, their bills and their healthcare options. What's more, they expect each other, as citizens, to use the healthcare system in honest ways—waste and abuse are intolerable;
- **Compassionate and humane care** should be provided to all Georgians;
- **Dignity and respect** should be the touchstone of how each person is treated when they come into contact with our healthcare system;
- **Concern for others** should guide the healthcare system;
- **High quality care** should be provided to all; and
- **Prevention** should be stressed as much as cure.

These foundation values guide Georgians' belief about healthcare—about what they want and what they expect. To ignore them is to invite failure. To fulfill them is to create a healthcare system based on a solid foundation.

In addition, when Georgians talk about healthcare, they point to four key *decisional values* on which decisions should be made if we are to create the healthcare system we want:

- **Fairness**—Georgians want a healthcare system that provides care to *all*, including people who find themselves unemployed, or those with "preexisting" conditions who find health insurance hard to obtain. They believe no one should go without care and everyone should have access to the same quality of care, even if there are differences in where and how they receive that care.
- **Power to Choose**—Making their own healthcare decisions is critical for Georgians. Yet they say they will accept *some* limits on their choices, if it will help to reduce costs. For instance, they will agree to see a nurse or a physician's assistant before deciding to see their doctor. They will go to a primary care physician before a specialist or even have some limitations placed on their choice of doctor, if they can choose from a wide enough list.
- **Reasonable Cost and Efficiency**—Georgians seek a system that is more reasonable than the existing one in cost and more accountable to the people it serves.
- **Shared Responsibility**—Georgians are ready—indeed want—to take responsibility for their healthcare. And they want the system to share that responsibility by helping people make wiser healthcare decisions. They will "shop around" for their healthcare, but first they need the system to give them information on the quality and prices of various healthcare providers so that they can make more informed decisions.

Another report, released in January 1996, was "*Georgians Views on Healthcare Services: Their Priorities, Concerns and Values*". This project involved more than 3,834 Georgians and was funded by the

Georgia Coalition for Health. It consisted of a six-month research process that identified citizens' priorities, concerns and values in making health decisions about healthcare services. Earlier research had discovered that Georgians believe a fair healthcare system is one in which all citizens have access to some basic level of care and this initiative sought to identify what specific health services Georgians believe are basic and should be considered standard in an insurance package. These include hospitalization, physician services, emergency care and generic prescription drugs. Although there was considerable discussion among participants over including preventive health services, like routine physical examinations and immunizations, when the cost of the plan was considered, most decided these services should be a part of the basic package. Dental care (routine and catastrophic) and vision care (exams and glasses), while highly valued and widely used, were considered too costly for the basic plan, although the cost of these health services was not perceived to be so great that most Georgians could not purchase them on their own. Two health services were considered borderline by participants: organ transplants and episodic mental health treatments, which stimulated debate focused on cost and demand; some participants questioned if there is great enough demand to justify their inclusion, while others argued that they are crucial and should be accessible to anyone who needs them, regardless of cost. Other health services required additional explanation before a decision could be made about inclusion in the basic plan since many participants were unfamiliar with them or confused them with another health service. These included hospice care, skilled home healthcare and durable medical equipment. A number of other health services were left out of the basic package because they were not thought to a necessity, although there was broad agreement to make them optionally available. These included chiropractic care, dental orthodontic care and mental health counseling. Other services participants did not want to include as standard benefits, but make available through tax funded programs, included chronic mental health treatment, family planning services, treatment for chemical dependency, long term care and preventive health education.

Other GHD studies within the State, and available at their office, include *"A Silent Anguish: Recognizing the Needs of Dying Patients and their Families"*, *"Georgians' Views on Medicaid"*, *Georgians' Views on Rural Health Services"*, *"Georgians' Views on Adolescent Pregnancy Prevention"*, *"How Providers, Consumers, Family Members and Advocates Address Mental Health Issues"*, *"Georgians' Attitudes Regarding Maternal and Child Health"* and *Georgians' Attitudes on Providing Coverage for the Uninsured"*.

**THE GEORGIA HEALTHCARE COVERAGE PROJECT** conducted 21 focus groups between September and December 2002 to assess Georgians' attitudes and opinions regarding the development of a plan for providing affordable insurance coverage for all Georgians. The focus groups were designed and facilitated by **GHD**<sup>1</sup> on behalf of the Governor's Office of the Consumer's Insurance Advocate under a grant funded by the U. S. Department of Health and Human Services. Key findings in their report include:

- Georgians are urgently alarmed about the escalating cost of healthcare and believe greed plays a major role.
- While most Georgians concur with the statement, "Everyone should get the healthcare they need," a small but vocal group of higher income Georgians is less likely to agree.
- Georgians are beginning to question whether the costs of having and using insurance coverage are worth the benefits of that coverage.
- Most Georgians are very willing to consider almost any solution to curb rising healthcare costs and increasing numbers of uninsured. Georgians are also more willing to consider a universal coverage plan than they were in the early 1990s.
- Georgians of all income levels feel a need for leadership and for immediate action to address escalating costs and increasing numbers of uninsured.

**THE GEORGIA HEALTHCARE ACCESS FORUM**, sponsored by the Georgia Health Policy Center brought together county commissioners, state legislators and community healthcare leaders in August 2003. It concluded that coverage for the working uninsured and for children should be in the top priorities for the state. An additional meeting, sponsored by The Atlanta Regional Health Forum, the Regional Business Coalition and the Georgia Health Policy Center, was held in December 2003 and brought together 25 persons representing small businesses, health systems, foundations, professional organizations, the diplomatic service and the state legislature with a threefold purpose to: 1) convey information from the Georgia Healthcare Coverage Project, 2) present a national best practice model and engender discussion about its relevance to Georgia, and 3) encourage participants to consider and comment on a set of options for expanding healthcare coverage. Conclusions were:

- 1.) Purchasing pools would be the first priority for small business employers in Georgia,
- 2.) Tax incentives, particularly as they relate to subsidies, are not a realistic scenario given the State's present budget crisis,
- 3.) Opinions were mixed regarding the feasibility of market reforms such as rate regulation, high risk pools and health savings accounts (HSAs), and

4.) Many saw areas of overlap and some suggested combining elements of the first three options to include the state health benefit plan functioning as a purchasing cooperative and a role for private, voluntary contributions.

**HEALTHCARE GEORGIA FOUNDATION**<sup>2</sup> released a report in 2002, “*Voices from the 2002 Listening Tour.*” The Foundation sought to hear directly from Georgians about the issues affecting their health and well-being and conducted 10 convenings in nine communities across the State. Group sizes ranged from 7 to 12 participants who were invited to represent the broad system of safety net providers, including public health, healthcare, social services, mental health, aging, legal services, community foundations, school systems, community health centers and other local nonprofit organizations. The broad themes and issues identified in the forum conducted in the metropolitan Atlanta region include: (1) *collaboration* of healthcare providers and services was cited as the best way to improve health outcomes, (2) *cultural competence* is a primary concern for health service organizations who are seeing an increasingly diverse base of clients, (3) *community based intervention* by engaging the key community constituents in the design, execution and evaluation of health-related programs for various underserved populations is very important for success, (4) *common information and referral* is a major need in elimination inefficiency and duplication of effort by providers and needless complexity for patients, and (5) *public health and prevention* are judged as being under-funded and need renewed attention.

**THE ATLANTA REGIONAL COMMISSION “AGING ATLANTA” PROJECT**<sup>3</sup>, funded by the Robert Wood Johnson Foundation, seeks to improve the long term care and supportive service systems (broadly defined) to meet the current and future needs of older adults by changing the way aging is addressed in the Atlanta region by moving from a reactive, isolated approach to a proactive, community approach. To aid in planning efforts and to establish a pre-intervention benchmark, a survey was conducted of roughly 400 elder adults in Fulton County using Mathematica Policy Research, Inc. The final report, “*The Community Partnerships for Older Adults Program: A Descriptive Analysis of Older Adults in Fulton County, Georgia*” was issued in February 2003. This survey was conducted by telephone, using a random-digit-dialing methodology to identify and interview adults age 50 and older. Half the sample consisted of “vulnerable” older adults whose characteristics make them more likely to need long-term care services for themselves or for a family member during the next few years. *Vulnerable older adults are defined as age 60 or over with at least one of the following criteria: (1) need help bathing; (2) use a cane, walker, or wheelchair; (3) rate their health as fair or poor; (4) are afraid to be alone for more than 2 hours; (5) have a chronic illness; or (6) are of advanced age (75 or older).* A rich source of data resulted, including a profile of the characteristics, health and functioning of older adults, their knowledge and awareness of long-term care issues and service availability, and their need for information and services. The broad themes and specific issues identified for these older adults in Fulton County include:

#### **POVERTY**

- 25% of older adults have annual incomes of less than \$10,000
- 30% of vulnerable older adults are unable to afford at least one item necessary for daily living (for example, rent, prescription drugs, or food)
- 40% of vulnerable adults believe they will not have enough money to take care of themselves for the rest of their lives

#### **HEALTHCARE**

- 67% of older adults are being treated for hypertension and 49% for arthritis
- 11% of older adults had been to the emergency room once or twice during the prior three months and 5% had been three times or more
- 4% of older adults had been admitted to the hospital overnight three or more times in the past year
- 30% of vulnerable older adults have no prescription drug coverage
- 8% of vulnerable older adults lack health insurance
- 50% of vulnerable older adults have difficulty doing daily chores and health reasons prevent 14% of them from doing daily chores at all.

#### **SOCIAL SITUATION**

- 9% of vulnerable older adults never leave their home for any reason
- 30% of vulnerable older adults have problems with, or need help with, at least one activity of daily living (for example, dressing or taking a bath)
- 50% of vulnerable adults leave their home on fewer than 4 days per week and over 1/3 of these are unable to do so due to health or transportation problems
- 40% of older adults say their community should do a lot more to address the needs of the vulnerable older adults, yet only 25% would be willing to pay additional taxes for this purpose

In addition, the Atlanta Regional Commission is the Area Agency on Aging for metropolitan Atlanta and has developed a robust Internet regional database of services available for senior citizens at <http://www.agewiseconnection.com/search.asp>.

**THE GWINNETT COALITION FOR HEALTH AND HUMAN SERVICES (GCHHS)**<sup>4</sup> has conducted three surveys in Gwinnett County. In 1996, a written questionnaire was given to 6,301 teens in middle and high school. Questions focused on several areas: physical activity and nutrition, sexual activity, delinquency, drug and alcohol abuse, mental and emotional health, home life, parental involvement and family support. “*The Comprehensive Youth Health Survey Results*” was issued in 1997 and the three broad themes the survey revealed were: (1) teens in all Gwinnett communities are engaging in risky behaviors on a daily basis, (2) during the transition between middle and high school years, there is an extremely vulnerable period in a young person’s life, and (3) parental involvement and community support has a direct influence on teens’ attitudes and actions. The second Comprehensive Youth Health Survey was conducted in November 2000 in Gwinnett County Public and private schools. The questionnaire was given to 3,833 youth in 5th grade, middle and high school to obtain a representative sample. Questions focused on several key areas: physical activity and nutrition, sexual activity, youth violence and delinquency, drug and alcohol abuse, mental and emotional health, home and community life, parental involvement and family support. The survey was based on national youth surveys to provide comparison data. Also several areas were added to the 2000 survey due to recent trends in youth behavior. The three main points the 2000 survey revealed are:

- Since the 1996 survey, there was improvement in many areas interpreted as resulting from the overwhelming community action and response to the 1996 survey.
- Youth across Gwinnett are still dealing with health risk issues and are participating in risky behaviors.
- There is a continuing need for education to inform Gwinnett parents on the behaviors their children are participating in and exposed to and how to counteract and prevent these behaviors.

#### CATEGORIES AND RESULTS FROM THE TWO GWINNETT COUNTY YOUTH HEALTH SURVEYS

##### **PHYSICAL ACTIVITY AND NUTRITION**

Healthy behaviors related to physical activity and nutrition are not just important for adults. Good habits established during childhood and adolescence are more likely to be continued as one grows older. Eating healthy foods and engaging in regular physical activities are important preventive measures against cancer and other chronic conditions that may occur later in life. The National Cancer Institute recommends that children and adults consume an average of 5 or more servings of fruits and vegetables each day. Given the findings presented below, it appears that many Gwinnett youth do not meet these recommendations. The goals of Healthy People 2010 for physical activity levels among adolescents and school age children are:

- Increase to 27% the number of adolescents who engage in moderate physical activity for at least 30 minutes on 5 or more of the previous 7 days.
- Increase to 65% the number of adolescents who engage in vigorous physical activities that promote cardio-respiratory fitness 3 or more days per week for 20 or more minutes per occasion.
- Increase to 57% the number of adolescents who view television 2 or fewer hours on a school day.

##### *Middle and High School Highlights*

<b>Survey Questions</b>	<b>HS 2000</b>	<b>HS 1996</b>	<b>MS 2000</b>	<b>MS 1996</b>
<b>In the past year have you:</b>				
Seen a doctor for a physical exam?	84.1%	67.0%	87.9%	72.1%
Seen a dentist for a cleaning?	86.0%	76.7%	87.1%	79.3%
<b>Did you 3 or more times in the past year do:</b>				
Activity that made you sweat?	47.2%	34.3%	61.3%	43.8%
Stretching exercises?	41.0%	25.2%	41.0%	n/a
Exercise to make muscle stronger?	36.2%	n/a	37.4%	n/a
Exercise for 30+ minutes?	42.6%	n/a	66.8%	n/a
<b>Did you at least one time a day in the past week:</b>				
Drink 100% fruit juice?	24.3%	n/a	12.8%	n/a
Eat fruit?	29.6%	n/a	38.4%	n/a
Eat vegetables?	37.9%	n/a	40.1%	n/a
Drink a glass of milk?	44.6%	n/a	53.3%	n/a
Do you feel slightly/very overweight?	29.0%	29.5%	26.0%	n/a
<b>Did you for 10+ hours in the past week:</b>				

<b>Survey Questions</b>	<b>HS 2000</b>	<b>HS 1996</b>	<b>MS 2000</b>	<b>MS 1996</b>
Watch TV?	18.0%	n/a	19.0%	n/a
Play video games?	2.3%	n/a	5.1%	n/a
Talk on the phone?	10.0%	n/a	9.6%	n/a
Play on internet/computer?	8.8%	n/a	9.3%	n/a
Hang out with friends?	27.0%	n/a	22.0%	n/a
<b>Are you:</b>				
Involved in 2+ school activities?	53.0%	n/a	38.0%	n/a
Involved in 2+ outside activities?	39.0%	n/a	54.0%	n/a
Not involved in any activities?	12.0%	n/a	9.0%	n/a

n/a = not asked

### *Middle and High School Findings*

- About 1 in 3 middle and high school youth reported eating fruit one or more times a day during the past week; fewer than 1 in 10 youth reported consuming no fruit during the past week.
- 36.8% of middle and high school youth reported eating vegetables one or more times a day during the past week; only 5.5% of youth reported no vegetable consumption during the past week.
- Over a quarter (27.7%) of all middle and high school youth reported feeling slightly or very overweight, but one-half (50%) of middle and high school youth reported that they agreed or strongly agreed with having a strong desire to be thinner..
- Almost 54% of middle and high school youth reported 3 or more days when they participated in an activity that made them sweat; in contrast, 12.2% reported no days of an activity that made them sweat.
- A similar percent (54.1%) of middle and high school youth reported exercising for 30 minutes or more on at least 3 days in the past week; 14.7% reported no days of exercise.
- 18.2% of middle and high school youth reported watching 10 or more hours of TV during the past week.

### *Fifth Grade Findings*

- Only 3.2% of 5th grade youth reported eating fruit one or more times a day during the past week; a much higher number (37.5%) reported no fruit consumption in the past week.
- 7.9% of 5th grade youth reported eating vegetables one or more times a day during the past week; only 32.0% of youth reported no vegetable consumption during the past week.
- Almost two-thirds (64.5%) of 5th grade youth reported 3 or more days when they participated in an activity that made them sweat; 4.9% reported no days of an activity that made them sweat.
- More than 2 in 3 (68.4%) of 5th grade youth reported exercising for 30 or more minutes on at least 3 days in the past week; 4.1% reported no days of exercise.

## **SEXUAL ACTIVITY**

Sexual activity among youth presents many serious threats to health and wellness, including emotional trauma, disease and pregnancy. While efforts to counteract adolescent sexual activity appear to have had dramatically positive results since the 1996 survey, the percentages of boys and girls reporting risky behaviors remains high. A major concern is that almost one-half of the sexually active youth reported having sex at the age of 14 or younger. The following facts illustrate both the improvements since the 1996 survey and the challenges that remain.

### *Middle and High School Highlights*

<b>Survey Questions</b>	<b>HS 2000</b>	<b>HS 1996</b>	<b>MS 2000</b>	<b>MS 1996</b>
<b>Have you:</b>				
Ever had sexual intercourse?	30.6%	40.3%	7.6%	8.3%
Had sex with three + partners?	12.1%	17.9%	2.4%	2.4%
<b>If sexually active, have you:</b>				
Always used birth control?	56.2%	n/a	58.9%	n/a
Always used a condom?	45.7%	n/a	62.6%	n/a
Ever been pregnant?	13.6%	12.6%	4.1%	9.2%
Ever had an abortion?	6.0%	12.1%	4.3%	n/a
Ever contracted a sexually transmitted disease?	5.8%	5.1%	4.5%	n/a
<b>The last time you had sexual intercourse, did you:</b>				
Use alcohol or other drugs?	27.1%	27.9%	18.1%	n/a

n/a = not asked

While the above results raise concern for our community, youth across the region and nation are reporting in staggering numbers that they are sexually active. In 2000, the Centers for Disease Control and Prevention (CDCP) reported that 55.3% of high school youth in the Southeast responded they had “ever had sex.” Nationally, the figure was 49.9%. The same study revealed that youth in both groups reporting they had sex with 3 or more partners was 16.2%.

*Middle and High School Findings*

- 49.8% of sexually active youth reported the onset of sexual intercourse at 14 years of age or younger.
- Sexually active middle school youth who reported using birth control at their last intercourse tended to obtain their birth control material from friends and relatives, whereas sexually active high school youth more often reported physicians, clinics, drugstores and convenience stores as their sources of contraceptives.
- Reports of “ever having had sex” and “having had sex with three or more partners” were significantly less common among households with two biological parents than among other households (16.0% and 5.5% respectively).
- The most common time sexually active middle and high school youth reported engaging in sexual intercourse was on weekend afternoons or evenings (54.3%).

**DELINQUENCY**

Juvenile delinquency and violence are a concern for all communities. Last year, 40 percent or 3,780 of the cases referred to the Gwinnett County Juvenile Court dealt with delinquency (offenses dealing with violence, sex, weapons, vandalism, drugs and alcohol) and unruly behavior. The 2000 Comprehensive Youth Health Survey results revealed reasons to be cautiously optimistic as well as areas of concern for parents and community members. For example:

- In every question regarding delinquency/violence, the percent of youth participating in delinquent behavior decreased from the 1996 survey.
- While the number of youth who reported threats from a gang are not extremely high (8.2% of middle schoolers and 11% of high schoolers) attention should be paid to the number of youth who reported being aware of gang activity in their school or neighborhood. More than half of all high schoolers and one in every four middle schoolers said they were aware of this activity.

A critical finding of the 2000 survey, which was consistent with the 1996 survey findings, is how significantly parents influence teen behavior. Adolescents with more parental support viewed delinquency and gangs with a higher negative attitude and results showed they were less likely to be involved in delinquent behavior.

*Middle and High School Highlights*

<b>Survey Questions</b>	<b>HS 2000</b>	<b>HS 1996</b>	<b>MS 2000</b>	<b>MS 1996</b>
<b>Have you:</b>				
Stolen from a store?	20.0%	36.5%	11.0%	19.0%
Damaged property?	15.0%	23.0%	9.7%	15.8%
Taken part in a group fight?	11.0%	20.8%	13.0%	n/a
Hit/beat up someone?	24.0%	36.9%	26.0%	41.2%
Skipped school without parents knowledge?	25.0%	n/a	5.9%	n/a
Known of gang activity?	52.1%	n/a	27.0%	n/a
Been threatened by a gang?	11.0%	n/a	8.2%	n/a
Seen someone threatened by a gang?	34.0%	n/a	25.0%	n/a

n/a = not asked

*5th Grade Findings*

- 11.3% of 5th graders surveyed said they had hit/beat up someone.
- 7.6% said a gang had threatened them.
- 16.4% knew of gang activity in their school or neighborhood.

**SUBSTANCE ABUSE**

Regarding substance abuse, the survey results presented both good news and bad. The good news is that middle and high school youth reported a significant decrease in the use of most categories of drugs. The one exception is alcohol. Since 1982, previous drug use surveys administered in Gwinnett indicated that around 52% of high school youth reported that they had used alcohol. In the current survey, more high school youth reported they have used alcohol, but binge drinking decreased significantly. Even though Gwinnett’s teens reported less use of alcohol, tobacco and other drugs than other areas of the country, one third of our high school youth reported

that they have smoked cigarettes or marijuana, and more than half reported drinking alcohol. Another disturbing finding was the percentage of middle and elementary school youth who reported that they “rode with an impaired driver.” For children this young, the drivers would most likely have been parents, parents of their friends, older siblings or their siblings’ friends and other relatives.

- Elementary and middle school youth reported higher uses of inhalants, cigarettes and alcohol than other drugs. Research indicates that children are more likely to begin experimenting with substances like these that are available in their homes or the homes of friends.
- There was a significant increase in substance-using behaviors between middle school and the ninth grade.
- Youth who reported using alcohol, tobacco and/or other drugs are more likely to be involved in other high-risk behaviors, such as delinquent acts and sexual activity.

#### *Middle and High School Highlights*

<b>Survey Questions</b>	<b>HS 2000</b>	<b>HS 1996</b>	<b>MS 2000</b>	<b>MS 1996</b>
<b>Have you ever used:</b>				
Alcohol?	59.1%	52.8%	22.2%	n/a
Marijuana/	29.2%	37.8%	4.9%	7.1%
Inhalants?	9.3%	17.4%	11.2%	20.2%
Cigarettes?	31.7%	53.4%	9.7%	n/a
Cigars?	17.8%	n/a	4.8%	n/a
Cocaine?	6.3%	n/a	1.5%	n/a
Other illegal drugs?	13.1%	n/a	2.2%	n/a
<b>In the past 30 days, have you:</b>				
Drunk alcohol?	25.5%	31.9%	4.9%	n/a
Had 5+ drinks in a row?	15.8%	21.5%	2.0%	n/a
Ridden with impaired driver?	15.8%	19.8%	16.2%	12.2%
Driven under the influence of alcohol or other drugs?	4.9%	8.1%	n/a	n/a
Smoked cigarettes?	17.3%	28.5%	2.5%	n/a
Used marijuana?	14.4%	19.9%	2.3%	26.0%
Used inhalants?	2.0%	5.1%	4.2%	7.2%

n/a = not asked

#### *Fifth Grade Findings*

- 11.2% of 5th grade youth reported they had ridden with an impaired driver during the past 30 days.
- 2.1% reported they drank alcohol during the past 30 days.
- 1.1% reported they had used inhalants during the past 30 days.
- Less than 1% reported they had smoked cigarettes, chewed tobacco or used marijuana.

### **MENTAL AND EMOTIONAL HEALTH**

In the best of situations teens have a great deal of stress to deal with as they transition into adulthood. Sometimes their judgment and coping skills are inadequate for the pressures they face. Their behaviors are often beyond the understanding of adults who love them. It can be very difficult to discern whether certain acting-out behaviors are a cry for help or a display of symptoms of illness. It is important that adults do not measure the significance of life events by adult standards when faced with a child or teen that considers a life event as traumatic. **The Gwinnett Coalition found some of the most disturbing findings in the 2000 Comprehensive Youth Health Survey in the area of mental and emotional health.**

#### *Middle and High School Highlights*

<b>Survey Questions</b>	<b>HS 2000</b>	<b>HS 1996</b>	<b>MS 2000</b>	<b>MS 1996</b>
<b>Have you:</b>				
Been physically abused?	19.4%	20.2%	19.6%	n/a
Been sexually abused?	11.1%	7.1%	8.0%	n/a
Been forced into having sex?	9.9%	14.4%	6.9%	8.6%
Considered suicide in the last year?	16.7%	n/a	8.9%	n/a
Ever attempted suicide?	7.4%	5.9%	4.8%	n/a
Run away from home?	6.0%	n/a	6.5%	n/a
<b>Do you have:</b>				
Guns in your home?	43.2%	n/a	36.5%	n/a
Access to guns without permission?*	35.4%	n/a	15.2%	n/a

**Do you:**

Feel able to talk to your mother about serious problems?	69.0%	57.0%	83.0%	n/a
Feel able to talk to your father about serious problems?	54.0%	38.7%	69.0%	n/a

n/a = not asked

\*= of those with

*Middle and High School Findings*

- Almost 1 in 5 (19.5%) middle and high school youth reported being physically abused.
- 12% of middle school girls and 3.1% of middle school boys reported having been sexually abused.
- The percent of high school adolescents who reported sexual abuse has risen from
- 7.1% in 1996 to 11.1% in 2000.
- The percent of Gwinnett youth who reported forced sex was 9.9% compared to
- 9.6% in the region and 8.8% nationally.
- Reports of sexual abuse and being forced into having sex were significantly less common in households with two biological parents than among other households. (6.9% and 6.4% respectively).

*Fifth Grade Findings*

- 16.2% reported physical abuse.
- 3.4% reported sexual abuse.
- Between 84% and 90% reported being able to talk with their parents about girls/boys, alcohol/drugs and bullies/fighting.
- Using a 1(low) to 4(high) scale, fifth graders scored higher on the depression scale than middle or high school youths (2.05 and 1.72).

**Depression** is a common illness that can be treated successfully with counseling or medication, or a combination of the two. It is not a temporary adolescent disorder that children will grow out of or that can be overcome without proper medical attention.

- Using a 1 (low) to 4 (high) scale, middle and high school youth scored high on both the stress (2.38) and depression (1.72) scale, with girls scoring significantly higher than boys in both categories.
- Using the same 1 (low) to 4 (high) scale, our middle and high school youth scored high on self-esteem (3.34).

**Suicide** is the third most common cause of death for the 15-24 years age group (fifteen percent of all suicide deaths) in Georgia. According to the 2000 Georgia County Guide, the teen suicide rate (per 100,000) from 1990-98 was 7.6 in Gwinnett County.

- The percentage of suicide attempts among high school adolescents rose from 5.9% in 1996 to 7.4% in 2000.
- One in five (20%) high school girls has considered suicide and 9.2% reported having ever attempted suicide.
- Nearly 72% of all suicides in Gwinnett County involve firearms.
- The percentage of high school youth who reported having guns in their home was 43.2% and, of those with guns in the home, 35.4% reported having access to them without permission.

**POSITIVE ASSETS**

The more youth feel supported by and involved with their family, school and community, the more likely they are to be involved in positive behaviors. As national findings substantiate, the more assets youth have in their lives, the less likely they are to be involved in risky behavior. We as parents, teachers, coaches, pastors and caring adults **CAN** greatly influence the behavior of our youth by providing them positive support and influences. *The Search Institute has a list of "40 Developmental Assets". It has been proven that if children have these assets in their lives they have a greater chance to succeed. This list is available at [www.searchinstitute.org](http://www.searchinstitute.org) or [www.gaww.org](http://www.gaww.org).*

*Middle and High School Highlights*

<b>Survey Questions</b>	<b>HS 2000</b>	<b>HS 1996</b>	<b>MS 2000</b>	<b>MS 1996</b>
<b>During the school year, do you:</b>				
Volunteer 1 or more hours per week?	47.0%	n/a	44.0%	n/a
Volunteer more than 10 hours per week?	7.3%	n/a	44.0%	n/a
Like school?	60.0%	67.0%	71.0%	74.0%
Get a lot of encouragement at school?	63.0%	67.0%	71.0%	74.0%
Feel safe at school?	81.0%	n/a	88.0%	n/a

Feel able to talk with mother about serious problems?	69.0%	57.0%	83.0%	n/a
Feel able to talk with father about serious problems?	54.0%	38.7%	69.0%	n/a
Attend church at least once a week?	37.9%	n/a	40.1%	n/a
<b>Are you:</b>				
Involved in 2+ school activities?	53.0%	n/a	38.0%	n/a
Involved in 2+ activities outside of school?	39.0%	n/a	54.0%	n/a
<b>In the past 7 days, have you:</b>				
Had a good conversation with your mother?	78.0%	n/a	77.0%	n/a
Had a good conversation with your father?	61.0%	n/a	64.0%	n/a

n/a = not asked

Youth are much less likely to smoke cigarettes, drink alcohol, smoke marijuana or use other illegal drugs if they:

- Volunteer
- Read and/or study
- Are involved in activities, either in school or outside their schools
- Are involved in religious activities
- Are physically active
- Have a negative attitude toward substance use and delinquency
- Have consistent discipline by parents
- Have good communication with parents
- Feel attachment to their school

Conversely, youth are more likely to smoke cigarettes, drink alcohol, smoke marijuana or use other illegal drugs if they:

- Hold a job during the school year
- Are home alone
- Watch TV during the week
- Work during the week
- Have been physically or sexually abused
- "Hang" out with friends
- Are depressed
- Are stressed
- Are not involved in activities at school or outside of school

Many programs were developed in response to the results of the 1996 Gwinnett Coalition Comprehensive Youth Survey. Samples of these are:

- Volunteer services in 16 elementary, middle and high schools to promote community service among youth
- A tobacco prevention coalition in partnership with Public Health
- The Gwinnett Alliance With Youth, a collaboration to promote strategies for positive youth development
- Theatrical productions to promote awareness among youth and their families on topics such as teen pregnancy ("Baby Blues and "Project Magic"), teen parenting and AIDS
- "Let's Talk," a parent communication program designed to help parents develop the knowledge, skills and confidence needed to talk to their children about sensitive issues
- Prevention-oriented programs in high-risk communities in Buford and Norcross
- An adolescent substance abuse treatment program
- After-school tutoring and enrichment programs
- "Teen Time," an after-school program targeting high risk teens in Buford
- Abstinence and self-esteem building programs for juvenile offenders through the Juvenile Court System
- A Gwinnett County Commission Resolution to support the development of an infrastructure that fosters the collaboration and coordination of health and human services throughout the county
- The Youth Elements of Success (YES) Program, a structured program developed by a local church for youth who are suspended from school that allows them to keep up with their studies and to improve life skills
- "A Peaceable Place," a K-5 curriculum for violence prevention
- Peer mediation programs in elementary, middle and high schools
- Training for health teachers about inhalant abuse
- The 21st Century Grant programs that provide after-school academic support

- The ADVANCE program, a substance use and violence prevention program for fifth graders that focuses on understanding and avoiding drugs and violence, searching for positive alternatives, overcoming negative peer pressure and interpreting media influences
- A sexual harassment prevention program for middle and high school levels
- The Tobacco Intervention Program for students with three tobacco offenses
- The “Not My Kid” video for parents which focuses on marijuana and LSD use and the school and legal consequences of adolescent use or possession
- The “Families for Prevention” video-based training for parents
- The “Quest: Working It Out” intervention program for reducing student conflict with activities specific to grade level, subject area and type of conflict
- Project Adventure courses that enable students to practice problem solving, enhance appropriate decision-making skills and improve academic success

A third countywide written survey, “*The Gwinnett Coalition Community Assessment*” was conducted in 2002 to identify needs and resources, set priorities, establish accountability for results and educate and motivate the community to action. This \$136,900 effort was funded by The Community Foundation for Greater Atlanta, Gwinnett County government, Family Connections and the Kellogg Foundation, and was conducted in collaboration with the Wellsys Corporation. It was advertised through newspapers, flyers and email and was available at public sites such as hospitals and libraries, and could be completed on-line. In addition, it was administered directly by volunteers throughout the community and several versions with added questions were used for the mentally retarded, developmentally disabled, those who identified themselves as “caregivers” and those with young children who needed or were using child care. To enhance participation, persons with bilingual or multilingual skills were recruited and trained to administer the survey to Hispanic/Latino and Pan-Asian persons. Profiles of participants within the Hispanic/Latino and Pan-Asian populations highlight their most important issues and concerns.

**Hispanic/Latino Population – 1729 survey respondents**

Years of education completed:	0-7 years	34.6%
	8-12 years	46.1%
	13-16 years	14.2%
	16 or more	5.1%
Ability to read and write:	In native language	yes 88.4%, no 11.6%
	In English	yes 31.6%, no 68.4%
Employment:	Full time	56.8%
	Part time	15.0%
	Multiple jobs	4.1%
	Not employed	24.8%
Country of birth:	United States	7.9%
	Another country	92.1%

When needed, my Hispanic/Latino family is able to:	No/rarely	Sometimes	Most/all the time
See a dentist	<b>47.8%</b>	31.0%	21.3%
Get counseling & mental health treatment	<b>77.8%</b>	12.5%	9.7%
Get substance abuse treatment	<b>80.3%</b>	10.2%	9.4%
Get vision care	<b>50.0%</b>	30.5%	19.5%
Get prescriptions filled	<b>37.2%</b>	30.8%	32.0%
Easily get transportation to doctors, clinics, or hospitals	34.5%	26.6%	<b>38.9%</b>
Go to a doctor, clinic, or hospital where someone speaks the language you use	<b>42.0%</b>	30.2%	27.8%

Hispanic/Latino views of priorities for issues Gwinnett County needs to address:

Hispanic/Latino Priority Issues	1 <sup>st</sup> Choice	2 <sup>nd</sup> Choice	3 <sup>rd</sup> Choice
Meeting Basic Needs	<b>33.5%</b>	13.3%	10.9%
Accessible/Affordable Healthcare	24.2%	25.8%	<b>24.5%</b>
Economic Self-sufficiency	20.1%	<b>27.0%</b>	16.1%

Preparing Children to Succeed	14.3%	17.6%	20.9%
-------------------------------	-------	-------	-------

**Pan-Asian Population – 1153 survey respondents**

Years of education completed:	0-7 years	6.6%
	8-12 years	39.1%
	13-16 years	38.2%
	16 or more	16.2%
Ability to read and write:	In native language	yes 96.7%, no 3.3%
	In English	yes 71.2%, no 28.8%
Employment:	Full time	81.7%
	Part time	9.4%
	Multiple jobs	1.2%
	Not employed	9.4%
Country of birth:	United States	4.4%
	Another country	95.6%

When needed, my Pan-Asian family is able to:	No/rarely	Sometimes	Most/all the time
See a dentist	<b>47.8%</b>	31.0%	21.3%
Get counseling & mental health treatment	<b>77.8%</b>	12.5%	9.7%
Get substance abuse treatment	<b>80.3%</b>	10.2%	9.4%
Get vision care	<b>50.0%</b>	30.5%	19.5%
Get prescriptions filled	<b>37.2%</b>	30.8%	32.0%
Easily get transportation to doctors, clinics, or hospitals	34.5%	26.6%	<b>38.9%</b>
Go to a doctor, clinic, or hospital where someone speaks the language you use	<b>42.0%</b>	30.2%	27.8%

Pan-Asian views of priorities for issues Gwinnett County needs to address:

Pan-Asian Priority Issues	1 <sup>st</sup> Choice	2 <sup>nd</sup> Choice	3 <sup>rd</sup> Choice
Economic Self-sufficiency	<b>37.45%</b>	17.0%	
Accessible/Affordable Healthcare	17.2%	<b>24.8%</b>	<b>18.0%</b>
Meeting Basic Needs	23.6%	14.3%	
Preparing Children to Succeed	13.2%	21.3%	15.0%
Community Diversity & Relationships			17.7%
Community & Civic Involvement			12.9%

Overall, 3,727 surveys were received and the Wellsys Corporation has made the rich database available for additional analysis. Based on the results, GCHHS has developed a comprehensive strategic plan for 2004 – 2009 around which programs and services are being delivered with 12 specific goals and related strategies.

1. ***All Gwinnett Children And Youth Will Refrain From High-Risk Behaviors That Lead To Addiction, Pregnancy, Disease Transmission, Delinquency, Violence And Truancy.***
  - Tobacco, Alcohol and Drug Addiction Prevention Initiatives
  - Teenage Pregnancy and Disease Transmission Prevention
  - Delinquency and Violence Prevention and Truancy Intervention Initiatives
2. ***All Gwinnett Children And Youth Will Be Prepared For And Successful In School.***
  - S.P.A.R.K. or Supporting Partnerships to Assure Ready
3. ***All Gwinnett Children And Youth Will Develop Positive Character Skills And Become Involved In Their Communities.***
  - Leadership Training and Volunteerism Initiatives
4. ***The Gwinnett Community Will Provide Needed Resources For All Children And Youth That Are Inclusive And Accessible.***
  - After-School Childcare and Program Development (Brief description: To expand childcare and other alternative community programs to ensure youth engage in appropriate activities during periods of non-parental supervision).

5. **All Gwinnett Residents Will Be Actively Involved Citizens And Live In Communities That Are Safe From Crime And Environmental Health Hazards.**
  - Crime Prevention and Citizen Involvement Initiatives
  - Environmental Health Initiatives
6. **All Gwinnett Residents Have Access To A Continuum Of Housing Options, From Emergency Housing To Home Ownership Opportunities.**
  - Continuum of housing services from emergency assistance to permanent housing GOAL
7. **All Gwinnett Households Will Have Opportunities To Maximize Their Economic Self-Sufficiency.**
  - Job Development and Family Support Service Initiatives
8. **Gwinnett County Will Be A Community Of Service Providers And Neighborhoods That Provide Equal Access To Resources And Services.**
  - Community-based programming to address growth and diversity
9. **All Gwinnett Residents Will Maximize Their Physical and Mental Health**
  - Vaccination Promotion and Support
  - Heart Disease and Cancer Prevention Initiatives
  - Physical fitness Initiatives
  - Community-Wide Suicide Prevention Initiatives
  - Community-Wide Mental Health and Substance Abuse Services
10. **Physical And Mental Health Services Will Be Available To All Gwinnett Residents.**
  - Expansion of health services to underserved residents
11. **All Gwinnett Seniors And Residents With Special Needs Will Maximize Their Level Of Independence And Have Access To Needed Support Services.**
  - Central clearinghouse of senior and disabilities service provider information (Brief description: To ensure timely and effective information and referral is provided to all Gwinnett residents in need).
  - Respite and Advocacy Services for Disabled populations (Brief description: Increase the capacity to serve persons with Mental Retardation/Developmental Disabilities).
12. **All Gwinnett Families Will Be Free From Neglect and Abuse.**
  - Family Violence Awareness Initiatives (Brief description: To increase awareness to the risks and resources available pertaining to family violence).
  - Family Violence Intervention Services (Brief description: To provide a comprehensive system of services for victims of family violence).

**HEALTHY DEKALB<sup>5</sup>** is an ongoing community-wide strategic planning process for health improvement which has a vision of “healthy people living in healthy communities” which has nine components:

- Informed people and engaged residents
- Good Jobs
- Strong health and safety services
- Access to quality healthcare for all
- Clean and healthy environment
- Lifelong learning opportunities
- Healthy lifestyles
- Positive media impact
- Improved health status for all

The process uses the “Mobilizing for Action through Planning and Partnerships” (MAPP) tool. Facilitated by public health leadership, this tool helps communities prioritize public health issues and identify resources for addressing them. Community ownership is the fundamental component of MAPP. Because the community’s strengths, needs and desires drive the process, MAPP provides the framework for creating a truly community-driven initiative. Community participation leads to collective thinking and ultimately results in effective, sustainable solutions to complex problems. Broad community participation is essential because a wide range of organizations and individuals contribute to public health. Public, private and voluntary organizations join community members and informal associations in the provision of local public health services. The MAPP process brings these diverse interests together to determine collaboratively the most effective way to conduct public health activities. There are two benefits of including community themes and strengths in the MAPP process. First, community members become vested in the process and have a sense of ownership in and responsibility for the outcomes. Second, the themes and issues identified here offer insight into the information uncovered during the other assessments. Avenues for accessing the community included meetings, dialogue sessions, focus groups, walking or windshield surveys and one-on-one discussions and interviews. Over 70 community groups have been involved with Healthy DeKalb. The “Values Statements” for the MAPP Steering Council are:

- “We believe in **humanity (the worth of each person)**; therefore we will listen to all voices, be sensitive to differences and include diverse groups.”

- “We believe that **education is a lifelong process**; therefore we will foster a learning environment.”
- “We believe in **quality public education**; therefore we will support teachers and school funding, encourage parental involvement and establish standards for success.”
- “We believe that all **communities must be part of the solution**; therefore we will invite the participation of every citizen.”
- “We believe in **openness and transparency**; therefore we will tell the truth, lead by example and make fact-based decisions.”
- “We believe **children and youth are all of our future**; therefore we will promote their care and nurture, mentor and educate and support families.”
- “We believe **change** is inevitable; therefore we will anticipate, accept and work for positive change.”
- “We believe in **results**; therefore we will establish benchmarks for success.”
- “We believe in **equal economic opportunity** for all, therefore we will advocate for economic justice.”
- “We believe in a **clean environment**; therefore we will advocate for new green space initiatives, stronger governmental environmental laws and environmental justice.”
- “We believe in a **safe environment**; therefore we will advocate for prevention of intentional and non-intentional injuries.”
- We believe **access to services** is a right; therefore we will promote accessibility to health and human services in a manner that embraces diversity and eliminates barriers.”
- “We believe in **universal access to quality healthcare**; therefore we will act to ensure that everyone has a medical home where prevention is the priority.”

Using four volunteer groups, information was gathered about the current status of DeKalb County using questions focused on these areas with their findings:

## 1. COMMUNITY THEMES AND STRENGTHS COMMITTEE (*What does the community think?*)

### **Childcare**

- Need after school childcare/ activities.
- In need of affordable childcare.
- 0.8% survey responses identify concerns on childcare access.

### **Community**

- Need more community involvement.
- Need concerned citizens.
- Only 4 responses address community involvement (0.1%).
- Some community coalitions.

### **Cultural Arts**

- More museums.
- Need a civic center.
- 2.8% of survey responses identify cultural arts need.
- Build on current assets: Fernbank, Carlos Museum, Callonwolde, Stone Mountain Museum, Emory Museum.

### **Cultural Diversity/ Race Relations**

- Improve race relations; North and South DeKalb.
- Improve assistance for immigrants, more services for Hispanics.
- 1.3% of survey responses address concerns with race relations/ diversity.
- Diverse population, refugee areas in Clarkston and Stone Mountain.

### **Economy/Jobs**

- Not enough jobs; better jobs, better benefits.
- More economic development.
- 5.1% of survey responses identify concerns with the economy in DeKalb; 3.3% address concerns with job availability.
- Strong economy within DeKalb (1/3 of households report an income > \$75,000, 1/3 with incomes **between \$40,000 and \$75,000**).

### **Education**

- Improve the school system.
- 7.6% of survey responses identify concerns related to education.
- Emory School of Medicine, 2 school systems supportive of youth health, public libraries-22, university systems, volunteers from university to support social service initiatives, magnet schools.

### **Entertainment**

- Community needs more: upscale restaurants, theaters and venues for concerts.
- 5.7% survey responses identify concern with entertainment availability.
- Starbucks, Restaurants with vegetarian options, 2/3 say there are places to go and have fun in DeKalb.

### **Environment/Cleanliness**

- Inadequate use of green space, too many apartments, too much new development.
- Limited county recycling efforts.
- Too many landfills.
- Participate in updating zoning plan (opportunity occurs every two years).
- Review garbage collection alternatives (once weekly instead of twice) and explore alternate ways to spend dollars (cleaning and maintaining parks, etc.).
- Good water system.

### **Health**

- Improve access to care.
- Better care for the uninsured and under insured.
- Better emergency assistance, improve EMS response time.
- Strong and model public health system.

### **Housing**

- More affordable housing, programs for first time home owners.
- Economically integrated neighborhoods.
- 2.9% survey responses cite housing availability concerns.
- Mature neighborhoods.

### **Political**

- Improve government: honest, visible, ethical, involved with the community.
- Simpler district voting lines.
- 3.1% of survey responses address political concerns.
- Electorate-General assembly and commissioners support community health initiatives.

### **Recreation**

- Availability and cost of acquiring and developing land for parks, recreation options (bike trails, walking trails, etc.)
- Schools have recreational facilities but money is needed to use these facilities.
- Current facilities need proper maintenance.
- There is a current policy in place which permits use of school property for recreation by the community.
- The community can participate in decision making for land acquisition and use under the current bond referendum.
- Stone Mountain park and paths, bike trails from Stone Mountain to downtown, malls for walking.

### **Safety**

- Communities are unsafe, too much crime, not enough police patrolling.
- 12.6 % survey responses identify concerns related to safety.
- Partner with local police department and become active in the safety watch program. Community involvement needed to continue the program. Police department will only be involved with the community's assistance.

### **Transportation**

- Extend the services of MARTA.
- General concerns about the travel needs of aging population for medical care and leisure travel.
- Need to beautify the county (roadways, medians, sidewalks, etc.).

- The community has the opportunity to participate in ongoing MARTA study that involves the design or transit options for Stonecrest and other areas.
- Look at bus availability (school and Marta) as transportation opportunity for aging.
- Corporations (Publix) do a great job of keeping up landscape and maintenance around its properties.
- Public Transportation is available.

## 2. LOCAL PUBLIC HEALTH SYSTEM COMMITTEE (*What does our public health system look like?*)

**Access to and use of Data:** Systematic collection, analysis and reporting of data within and for the Local Public Health System.

- Lack of knowledge about statistics and current technology.
- Need to be more resource intensive when gathering data and creative in disseminating the data.
- Organizations do not report information to a central location.
- Large gaps of information regarding behavioral health.

**Communication:** Communication among entities and organizations within the Local Public Health System and the community.

- The System does not communicate with the community on large endeavors and does not engage certain populations.
- Many community members are not aware of initiatives in DeKalb County such as the Clarkston Health Collaborative.
- Lab-to-lab communication is adequate when specimens are transferred from one lab to the other.
- The federal government provides websites with rankings of healthcare organizations; however, a lot of people cannot access the information.

**Coordination:** Effective coordination of entities and organizations within the Local Public Health System (all organizations and entities within the community that contribute to the public's health) and the community to assure maximum impact and reduce duplication.

- Lack of coordination of policy and epidemiological research among organizations and schools.
- Public health activities are not coordinated with all hospitals.
- The Metro Atlanta Surveillance Task Force lacks relationships with individual providers of care. However, the existence of the task force is a positive for the System.
- Emergency plans are not coordinated with the public. Those that could help in the case of an emergency do not know how and whom to contact.

**Dissemination:** Appropriate, timely dissemination of information throughout the community system.

- Educational information is out there for the community; however, they don't know where to find it.
- There is little media advocacy around health education.
- Evaluation results of organizations are not widely promoted or distributed.
- The System needs to identify more creative ways to distribute data and information to all involved.

**Evaluation:** Regular and systematic evaluation of standards, measurements and workforce capacity.

- Lack of standards and measurements to evaluate population-based and personal health services.
- The public is not given information on organizations that have been evaluated.
- The state does not enforce evaluation requirements.
- The Board of Health has done surveys to rate their activities, however there is no systematic evaluation.
- Lack of evaluation of communication between organizations.

**Public Health Emergencies:** Planning for, investigating and responding to problems, threats and hazards.

- Lack of communication with the public.
- Lack of preliminary plan for individual organizations and system wide.
- Need to connect private physicians with the emergency plan.
- There is no coordination across hospitals and private providers.

**Systems Development:** Defined roles and responsibilities of all of the entities within the Local Public Health System.

- Policies and strategic plans are not aligned with community health.
- Existing strategic plans do not allow the System to function and achieve its mission.
- Lack of communication, coordination and response according to the aim of the System.
- Collaboration among components is very informal; a high performing system would have a true, organized common aim.

**Workforce:** Skills and capacity of the workforce within the Local Public Health System agencies.

- Increase in number of retirees and a lack of students applying to public health fields.
- Lack of scholarships and incentives for students in public health.
- Lack of evaluation of recruitment and retention methods in order to improve the workforce.

- Lack of skills and know-how with people who work in nursing homes and personal care facilities.
- Need to create more performance measures.

### **3. COMMUNITY HEALTH STATUS COMMITTEE (What does our health status data say about us?)**

**Cancer:** Cancer is a devastating disease and treatment is costly for individuals, families and the community.

- DeKalb County's aging population contributes to higher cancer rates.
- Continue successful community education programs.
- Lobby state insurance industry to continue and/or expand screening as a reimbursable service.

**Cardiovascular Disease:** Cardiovascular disease is a leading cause of premature death in DeKalb County with disparities in premature death rates by race, ethnic group and gender.

- Healthcare reimbursement system designed so that economics of treatment are more profitable than economics of prevention.

- Poor nutritional habits, lack of physical activity, tobacco use and poor stress management behaviors contribute to development of cardiovascular risk factors such as high cholesterol and hypertension.

- Address preventable risk factors and promote regular checkups as cost-effective.

- Develop programs for populations at greatest risk: African-Americans, Hispanics and females over 40.

**Chlamydia Infection:** Teens in DeKalb County have a very high rate of chlamydia infection and this communicable disease may result in sterility if untreated.

- Lack of symptoms so an infection can go undetected and untreated.
- Continue and enhance prevention efforts targeted to teens and young adults.
- Encourage transformation of attitudes about teaching safe sexual practices.

**Diabetes:** The incidence of Type 2 diabetes is increasing in youth and adults resulting in significant complications such as cardiovascular disease, blindness, kidney disease and amputation.

- Ineffective training of healthcare professionals in early detection and ongoing monitoring to prevent disease progression results in development of complications.

- Type 2 diabetes linked with obesity epidemic and rate increases are expected for several years.

- Promote screening for early detection and include effective referral for early intervention, targeting at-risk populations with more education, screening and early intervention programs.

**Exercise:** DeKalb youth and adults are less physically active than national averages and physical inactivity is linked to obesity, cardiovascular disease and diabetes.

- Poor community design and reliance on vehicle transportation (especially autos) have resulted in lack of readily available and safe places for exercise.

- State education policy does not require physical education, especially in middle and high schools.

- Continue community programs and social marketing to encourage increasing physical activity and reducing screen time.

**HIV/AIDS:** Rates of new HIV infection are increasing again in DeKalb County, leading to the high treatment costs and premature death rates associated with AIDS.

- Current drug treatment for HIV infection is delaying conversion to active disease and resulting in more risky behaviors.

- Cultural taboos and superstitions in some community groups lead to unsafe sexual practices and delays in diagnosis.

- Increase programs to promote condom use and availability and have programs that are culturally and linguistically appropriate.

- Consider more options to prevent transmission (e.g., needle exchange program).

**Infant Mortality:** DeKalb County infant mortality rates are significantly higher for African-Americans than for whites and there is lack of knowledge regarding what is causing this disparity.

- Poor diet of and substance abuse by mother contribute to premature births and infant death.

- Continue programs to discourage teen pregnancy.

- Support and continue effective community programs, especially DeKalb County Board of Health teen clinics and WIC programs.

- Continue programs to reduce substance use and abuse, especially among children and youth.

**Motor Vehicle Crashes:** Motor vehicle crashes are leading causes of unintentional injury and death for children and leading causes of unintentional injury for adults.

- Drivers disregard rules of road, speed, drive recklessly and drive while intoxicated, especially teens and young adults.

- Non-English speaking residents not familiar with traffic laws.

- Lobby state to improve drivers' education and enforce stricter student driver laws.

- Provide car seat safety education for residents, including non-English speaking residents.

**Nutrition:** Over 80% of DeKalb youth and adults eat fewer than 5 servings of fruits and vegetables daily and poor nutritional habits are related to chronic diseases (cardiovascular disease, cancer, diabetes, obesity), osteoporosis and anemia.

- Lack of clear, effective nutrition education.
- Fast-paced lifestyles result in eating on the run due to availability of fast foods with over-consumption of high calorie, high fat foods.
- Continue public support of programs that improve nutritional status for target populations: WIC, food stamps, school breakfast and lunch and Status of Health in DeKalb small grants.
- Promote school policy changes to eliminate junk food in schools and lower prices of healthy foods in vending machines in schools.

**Tobacco Use (Substance Use & Abuse):** 17% of DeKalb youth smoke and smoking is linked to lung cancer, other cancers, chronic obstructive lung disease, cardiovascular disease and stroke.

- Teen peer pressure to smoke to “be cool” and to control weight.
- Addictive nature of nicotine makes quitting tobacco use difficult.
- Continue effective programs for prevention and cessation.
- Change state policy to create higher taxes on tobacco products.
- Eliminate cigarette displays and other point-of-sale marketing of tobacco products.
- Enhance clean indoor air ordinance.

#### **4. FORCES OF CHANGE COMMITTEE (Who is pushing us around?)**

**Demographics:** DeKalb County’s population is growing, aging and becoming more diverse and this will create pressures on the health delivery system.

- Lack of resources to meet current and increasing demand for health services (growth, economy, shifting providers, insurance).
- Need more personnel in geriatrics and healthcare and more nursing homes, retirement facilities and other services for seniors.
- Non-traditional family units, associated complexities: need for economic support for single parent households, need to promote family unity.

**Development:** There is currently no systematic connection between physical planning and health and environmental concerns.

- Lack of sidewalks and safety precautions for pedestrians – lack of coordination between physical development and health interests of stakeholders.
- Increase and highlight citizen input into healthcare and fiscal planning process (e.g., neighborhood association, hearing, etc.).
- Enhance building codes (e.g., firewalls).

**Diversity:** Because of its diversity, DeKalb County encounters disconnects due to differences in language, culture and lifestyles.

- Language and cultural barriers between caregivers and consumers.
- Opportunity to become a model diverse community.
- Utilization of foreign-born professionals brings technical and second-language skills.

**Economy:** Economic downturn, increasing healthcare costs and declining tax revenues are increasing demand for health services and competition for government resources.

- Competition among providers for available funding.
- Poorer health status for the community.
- Creative approaches to preventive and emergency services.

**Education:** DeKalb residents suffer from an absence of literacy (including health literacy) at all age levels and backgrounds. There is a general lack of health education in DeKalb County.

- Illiteracy is the basic cause for unemployment and underemployment.
- Collaboration among health, government and community organizations to educate the public.
- Develop a model to promote health literacy.

**Environment:** Current state of DeKalb County’s air and water quality and the lack of green space are having a negative effect on health.

- Increased occurrence of asthma and other respiratory conditions.
- Past and current environmental planning causes inequities.
- Increased consciousness of environmental issues.

**Government:** Lack of consensus regarding government role in healthcare has made it a moving target in which the roles of regulation, lobbying, market forces, etc., are unclear.

- Immigration law and its impact on healthcare delivery.
- Cut in prevention funds for issues including teen pregnancy and women's health.
- Expansion of PeachCare (needs to be more affordable and accessible).
- Redistribution of funds due to bioterrorism threat.

**Healthcare:** There is more demand on the system and providers (number of patients, new models, paperwork, legal risk, etc.) and fewer resources and lack of flexibility to deploy resources that are there.

- Lack of coordination among DeKalb County healthcare providers wastes resources.
- Increase funding to providers to enhance access and improve financial stability of the provider network.
- Healthcare providers are expanding capacity as demand grows.

**Safety:** Population density and unplanned development have created unanticipated consequences that can erode personal safety and increase exposure to danger and disease (chronic, infectious and other).

- Areas without signs in other languages are unsafe.
- High rates of automobile and pedestrian collisions.
- Lack of sidewalks around schools and other areas frequented by pedestrians.

**Technology:** Pace of technology changes is having an impact on all aspects of life in DeKalb County.

- Lack of access, training and support to use the advanced technology.
- Expense of technology for healthcare providers increases the price of healthcare and the cost to the consumer.
- Allows for collaboration through sharing information (e.g., funding, research, medical records, etc.).

New jobs are developed with technological advances.

**Transportation:** Lack of adequate metro transportation alternatives is a barrier to access to healthcare services and clean air.

- Personal safety concerns about using public transportation.
- More metro counties adopting mass transit systems.
- Better state planning and funding of metro Atlanta mass transportation.

After these four groups completed their work, more community members attended a town hall meeting to review and prioritize the assessment results. The Healthy DeKalb Steering Committee used this input to identify the most important issues to address in the next few years and then conducted 41 focus groups with residents to hear their concerns and ideas about these areas. Three **Action Groups** were then formed to address each of the three health priorities:

- **Physical Activity and Nutrition Action Group (PANAG)**  
PANAG promotes healthier life styles. Their focus now is working with other local organizations to promote physical activity and good nutrition. Much of their work is done with schools and faith-based organizations.
- **Cultural Competency and Disparities Action Group (CCDAG)**  
CCDAG addresses health disparities (inequalities) among the populations in DeKalb County. They work with refugees and immigrants to increase access to healthcare. They also work with healthcare providers to increase culturally competency.
- **Partnerships Action Group (PAG)**  
PAG creates partnerships and coalitions with organizations and individuals throughout DeKalb County. They also recruit new partners for the other Healthy DeKalb Action Groups and the Steering Council

**THE GEORGIA LEGISLATIVE TASK FORCE ON HEALTH INSURANCE OPTIONS FOR SMALL BUSINESSES AND THE WORKING UNINSURED** summarized their work in a report in February 2004. The committee consisted of Representative Pat Gardner, Chair; Representative David Graves; Representative William Hembree; Representative Howard Mosby; Representative Don Parsons; and Representative Pam Stephenson and four hearings were held in 2003.

The task force was created because Georgia has the sixth highest number of uninsured in the nation, with over one million Georgians without any type of health insurance, two-thirds of whom are chronically uninsured. Of the one million uninsured in Georgia, over two-thirds work or are dependents of workers. Those working in small businesses comprise a disproportionate share of the working uninsured, while small employers offering health insurance benefits to their employees face higher costs and are able to offer fewer options than large private and public employers.

*The task force was charged with exploring options for expanding health insurance coverage among the working uninsured and employees in small businesses.* In order to fulfill that charge, the task force explored the results from **The Georgia Healthcare Coverage Project** to learn about the number and characteristics of workers without coverage, the distinctions between businesses offering and those not offering coverage and attitudes of employers about health

insurance. It heard from a wide variety of interested stakeholders including small business owners, providers, insurance industry experts and state agencies and reviewed the findings of **The Healthcare Access Forum**. Presenters to the legislative task force were asked to provide information about what state legislators might do to help our small businesses find affordable healthcare for their employees. The presentations and dialogue focused on what good public policy might be if we moved from “special” interests to “common” interests. Information presented to the group included:

- Over 90 percent of all privately insured Georgians obtain coverage through the employment-based market.
- Rural Georgians and those living in low to moderate income families are most likely to be uninsured.
- 80 percent of persons who are offered coverage will enroll in that coverage.
- 16 percent of employers currently not offering coverage previously offered a plan.
- 57 percent of the working uninsured and their dependents are employed by small employers (employers with less than 25 employees).
- For those employers not offering coverage, cost was the most prominent deterrent, followed by employee turnover and the hassle of administering insurance plans

The task force learned that there is a broad consensus supporting action to expand health insurance coverage in Georgia because of the burden on:

- Hospital emergency rooms, which have an unfunded mandate to provide emergency care resulting in high levels of uncompensated care
- Individuals, who are sicker because of poor access to medical care
- Providers, who are called on to care for uninsured individuals at later stages of illness, with the potential for worse outcomes at higher cost, and
- All participants in the system who bear the costs of caring for uninsured individuals because of cost shifting. Employers who provide health insurance for their employees pay more, in part, because other employers do not provide health insurance.

The Task force concluded that expansion of coverage could be achieved through one of two approaches:

1. *A complete transformation of the healthcare financing system in Georgia with a consolidated payer system that would cover all residents of the state.*

Develop a proposal for a consolidated-payer approach to achieving universal coverage by replacing the myriad of employer, private and public health plans with coverage for all Georgians regardless of age, employment, health status or other characteristics. Risk would be spread broadly, services would be comprehensive and the service delivery system would remain as it is, but without restrictions on choice of providers. Current public spending on healthcare programs would be consolidated and tax-based funding sources paid by all employers and residents would replace all premiums, deductibles and out-of-pocket payments. Aggregate health spending would be expected to decline and stabilize and administrative savings from directing all funding through one payer would be sufficient to cover all the uninsured and underinsured.

2. *An incremental approach which identifies cohorts of the uninsured in Georgia and targets coordinated policies to expand coverage to each cohort.*

In recognition of lack of public will to move to a consolidated payer at this time, the taskforce can support incremental change. Since, within the voluntary system as it now exists, there will always be some uninsured individuals, coverage expansions need to be designed based to identify the major cohorts of individuals who are uninsured and create programs and policies to “plug the holes” in the system. This strategy implies a process of reforming the healthcare system with multiple, but cohesive interventions implemented over time. It includes support for community efforts to provide comprehensive care for the residually uninsured in a comprehensive and cost effective manner. This approach requires an identification of short- and long-term steps that can be taken to move toward more comprehensive coverage in Georgia within the context of the current public/private partnerships.

**Short term proposals developed by this task force include:**

1. Facilitate the implementation of a high-risk pool in Georgia to provide coverage for medically uninsurable individuals who are unable to obtain health-care coverage due to pre-existing medical conditions.
2. Support communities with public resources that might be matched by private funds specifically designated for sharing information about existing Community Health System programs. Effective existing programs could be replicated to coordinate providers at the local level, increasing access to primary care for the uninsured and reducing the individual and institutional burden of the uninsured.

3. Engage researchers in formal modeling of specific proposals for insurance market reforms, purchasing cooperatives and subsidies to identify the best next steps and prepare the task force and the legislature for action in future sessions.
4. Provide operating support enabling counties seeking to provide healthcare to specific populations to contract directly with multiple providers.
5. Introduce legislation to improve patient understanding of the cost of care, particularly the cost of prescription drugs.
6. Explore ways to manage the cost and delivery of medications.
7. Expand the task force mandate to develop strategies to address all of the cohorts of uninsured Georgians in a coordinated manner that would move the state toward comprehensive health insurance.

**THE PATHWAYS COMMUNITY NETWORK<sup>6</sup> AND THE 2003 HOMELESS CENSUS ADVISORY COUNCIL** on behalf of **THE METRO ATLANTA TRI-JURISDICTIONAL COLLABORATIVE ON HOMELESSNESS** with the assistance of Applied Survey Research released “*The 2003 Metro Atlanta Tri-Jurisdictional Collaborative Homeless Census and Survey*” in November 2003. On the night of March 11 and the morning of March 12, 2003, a total of 6,956 homeless people were found to be on the streets, in shelters, transitional housing, or permanent supportive housing, or in institutions in the Tri-Jurisdictional Area covering the City of Atlanta, Fulton County and DeKalb County. The research team interviewed 1000 homeless persons and a representative profile emerged. The findings include:

- Based on survey results, it was estimated that 16,625 in the Tri-Jurisdictional area persons would be homeless at some time during 2003
- Roughly two-thirds occupied shelters or temporary housing and 33% said they usually spent nights on the street, in cars, abandoned buildings or in similar places that are not meant to be used for housing
- 14% of the homeless persons on the streets on census night were females
- The typical homeless person is single (84%), an adult male (74%), never married (64%), homeless for less than a year (67%) and a resident of the City of Atlanta, Fulton County or DeKalb County before becoming homeless (75%)
- Roughly 29% had children living with them and more than two-thirds of these children were under five years of age
- 17% had served in the military
- More than half had been homeless two or more times in the past three years
- One-third said they had been homeless for more than one year; 18% for two years or longer
- 64% said they had never been married (compared to only 27% for the general US population aged 15 or over)
- 41% had done some work for pay in the prior month and 9% had earned more than \$500 in that time. More than a third said they had received no income at all, from any source during the previous month
- The typical homeless person received no money from public assistance, disability, child support, panhandling, or blood donations
- 38% named alcohol or drug use as a primary cause of their homelessness. Other identified causes were unemployment (29%), inability to pay rent or mortgage (12%), illness or medical problem (12%), argument with family or friends (11%)
- The two top daily needs that respondents identified were (1) getting food, water and a place to cook (35%) and (2) public transportation (30%)
- Only two persons identified toilets as a daily need that was hard to access
- Most (59%) indicated that a job, job training, or employment assistance would be the greatest help in getting them out of homelessness, followed by housing and affordable housing, alcohol and drug treatment programs, money and better wages, transportation (including a bus ticket home) and a shelter or a safe place to stay
- Most (33%) received medical attention from a free clinic in a hospital or a hospital emergency room

Typical comments from survey respondents include:

- “If you are really trying to know about homelessness, you have to know the person.”
- “People think that you want to be out there. I don’t want to be here—helpless, hopeless...I am tired.”
- “I would like for society to stop stereotyping folks like myself, thinking just because we are homeless, we are nasty beggars looking for a handout. We are just lost.”
- “I really feel like a lot of people are homeless because people don’t give them a chance.”
- “It’s dangerous...the drugs, the hunger...”
- “More shelters that are properly manned will help.”
- “People take the wrong attitude in helping homeless people. They look down on us.”
- “Homeless people need someone they can trust.”
- “Homeless people are human; we have feelings too.”

- “When you’re homeless, you just live from day to day. You become more thankful for food, a place to sleep.”
- “Not all people are lazy or uneducated. Many of us are more than willing to work, but we need opportunities to make enough money to live on.”
- “Homelessness becomes a sickness...it becomes a way of life.”
- “I want to work. People don’t understand you aren’t lazy if you stay at a shelter.”

**THE CLAYTON COLLABORATIVE AUTHORITY**<sup>7</sup> listened to the citizens of Clayton County in 2003 and 2004 with numerous informal individual conversations, formalized focus groups and surveys to identify a number of issues and challenges with a variety of suggestions and solutions. One of the most consistent themes the Collaborative heard was concern about the community environment not being conducive to allow children and youth maximize their potential to achieve their hopes and dreams. Based on this finding, the Board of Directors adopted three goals as the basis for their strategic plan for the coming years with the theme of “How are the Children.” The theme reflects on the African tribal custom of addressing, every morning, its most important asset and is consistent with the Collaborative mission statement, “All Clayton County citizens, especially its children and families, shall have the fullest of opportunities to fully maximize their true potential, individually and collectively, in a community that reflects the finest of environments for their hopes and dreams to be realized.” The Board has adopted three goals:

#### 1. Community Development With Collaborative Partners

Community feedback made it clear that there are already collaborative partners, individuals, organizations and agencies whose activities and programs are positively impacting the environment needed for children to have the potential to achieve their hopes and dreams. *Collaborative development* will be achieved by maintaining and strengthening the already established collaborative and partnership efforts, while looking for additional opportunities and partners. Especially important will be a continuation of the development of the Clayton Collaborative Authority Youth Advisory Council and incorporating their ideas and suggestions into the overall working plan of action, especially in the areas of education and recreation.

#### 2. The Development of Social Capital

The strength of any democratic republic is best shown when like-minded neighboring citizens willingly and positively address issues of common concern to achieve the common good and share the responsibility for resolving local problems. To neglect these citizen duties and responsibilities erodes the ability to create a civic environment capable of promoting the hopes and dreams of its children, youth and families. There the Authority is committed to a goal which emphasizes *Community Systems Change-the development of the County’s social capital*. The Collaborative will attempt to make significant changes in expanding the county leadership base and enlarging its decision-making processes, especially at the grass-roots level, to positively impact the lives of its children, youth and families.

#### 3. Increase High School Graduation Rates

The twenty-first century world of work will reward the “knowledge worker.” Unlike previous centuries when a strong back and a good work ethic were sufficient building blocks to economic security, knowledge—the ability to obtain, process, analyze and apply information—will be the key to achieving one’s economic hopes and dreams in the future. Already, there are reports that over \$3.5 billion dollars of “knowledge” related jobs are being exported abroad because of the lack of skilled knowledge workers in America. Therefore, recognizing that a high school diploma is the first building block to producing that knowledge worker, the Authority is committed to a goal which improves the graduation rate of high school students.

**UNITED WAY OF METROPOLITAN ATLANTA**<sup>8</sup> in 2004 is developing a five year community impact plan that will help to move forward initiatives that will make a positive difference in the health in metropolitan Atlanta by conducting an extensive series of meetings of local community leaders in the 13 county region it serves. The United Way (UW) Board has defined *seven impact areas*, four of which are designated “Strategic Impact” and three of which are termed “Community Basics”. These are:

#### 4 Strategic Impact Areas

- Nurturing Children & Youth
- Strengthening Families
- Maximizing Economic Self-Sufficiency
- Promoting Community Leadership & Neighborhood Development

#### 3 Community Basics Areas

- Supporting Older Adults & Persons with Disabilities
- Meeting Basic Needs
- Optimizing Community Health & Individual Health

A county specific plan is being developed for *each of the seven impact areas* by engaging community stakeholders and leaders in day long conversations on these topics in each the 13 county service region. All of the county plans are then rolled together into a regional plan that identifies themes and specific action steps that could positively impact multiple communities. When completed, this massive activity of listening to community voices to inform decision making will be a rich source of information for improving health in the entire metropolitan Atlanta region. As an example, the regional plan being developed for the area of “Optimizing Community Health & Individual Health” has the vision of “We want individuals and communities who are healthy” to be achieved by two approaches: I.) Promoting Healthy Lifestyles and II.) Improving Access to Healthcare. Recommendations that will eventually form the action plan for each follows.

## I. PROMOTING HEALTHY LIFESTYLES

### **1. Advocacy/Public Policy**

- Advocate for [affordable] health insurance that includes comprehensive “well health” visits (physical and mental), preventative health programs and a reimbursed “wellness” benefit.
- Advocate for regional funding and policies for safe environments (e.g. sidewalks, recreation centers, lighted areas, green space, police officers) that support wellness programs and services (e.g. fitness, nutrition, health education, etc.) promoting a healthy lifestyle.

### **2. Maintain/Expand Existing Programs and Services**

- Encourage collaboration to maintain and expand existing programs and services (e.g. after-school, faith-based support groups, civic, social service, work site, etc.) to promote healthy lifestyle choices (e.g. physical activity, good nutrition, reduction of risky behaviors – e.g., tobacco use, sexual activity).
- Increase funding for programs that supports healthy lifestyles (e.g. physical activity, good nutrition and reduction of risky behaviors – i.e. tobacco use, sexual activity) and is school, faith and/or workplace-based or is delivered in other community-oriented settings.

### **3. Information Resources/Consumer Education**

- Enhance United Way 211’s database related to health and wellness providing accessibility to all providers (volunteers and professionals).

### **4. Service Innovation/New Initiatives**

- Develop and implement new models for integrating healthy life-style choices into the day-to-day environment (especially work place) to include: resource guide, physical activities, healthy eating choices, screenings/health fairs corporate incentives.

## II. IMPROVING ACCESS TO HEALTHCARE

### **1. Maintain/Expand Existing Programs**

- Expand programs and services to reduce physical (e.g. transportation, etc.) and socio-cultural (e.g. language, etc.) barriers to healthcare.
- Maintain and expand the availability of healthcare services (including vision and dental care), prescription drugs and healthcare providers through free and mobile health clinics, physician volunteers and other health-related programs.
- Provide health screenings (testing and counseling), appropriate referrals and follow-up to include hypertension, diabetes, cancer, HIV/AIDS, etc. in community-based settings including faith and work place.

### **2. Advocacy/Public Policy**

- Advocate for increased funding for healthcare professionals (including government, non-profit agencies and private, for-profit providers) so they can lower malpractice insurance cost and provide subsidized/low cost/free services, supplies and medication to underinsured/uninsured people (including older adults and people with disabilities).
- Advocate for affordable insurance for individuals of all ages at various income levels.

### **3. Public Awareness**

- Develop multi-media and multi-language campaign promoting healthcare resources targeting specific areas (i.e. pediatrics, the importance of general primary care, etc.)
- Promote community health events including fairs and seminars.

### **4. Service Innovation/New Initiatives**

- Implement the “Benefits Bank Model” regionally and locally.

In addition, responding to the Mayor of Atlanta Shirley Franklin’s desire to tackle homelessness head on and her request for a comprehensive approach to the issue, United Way of Metropolitan Atlanta convened a commission charged with developing a workable action plan to alleviate problems associated with homelessness. With the input,

support and guidance of multiple and diverse sources, the Commission on Homelessness led the development of the **Blueprint to End Homelessness in Atlanta in Ten Years**. The Blueprint was unveiled March 26, 2003 and contains recommended strategies and related projects to help the City make significant progress toward fulfilling its obligation, as expressed by the Mayor, “to make sure that services are available to assist the homeless in making the transition to self-reliance.” The Blueprint is currently being implemented. Mayor Franklin chose seven of the Blueprint projects as an immediate action plan. The implementation of the projects in this **Seven Point Plan** will make rapid progress in the effort to prevent and end homelessness in Atlanta. The Blueprint can be downloaded from the Internet at <http://www.unitedwayatl.org/docs/homeless/AtlantaHomeless.pdf>. The initial Commission has been expanded to include jurisdictional representation from the following counties: Clayton, Cobb, DeKalb, Douglas and Fulton.

**THE HEALTH TASK FORCE FOR THE GOVERNOR’S LATINO COMMISSION FOR A NEW GEORGIA** performed a Latino Health Survey in 2004 by using a written instrument sent to 120 health centers treating Hispanic/Latinos and 61 responded. The major findings include:

- The three top health risks for Hispanic/Latinos are lack of education, 31%; diabetes, 16%; and lack of employment, 12%
- The three most prevalent health problems in Hispanic/Latinos are diabetes, 51%; Pregnancy, 44%; and Hypertension, 33%
- The three most prevalent methods of payment for healthcare by Hispanic/Latinos are sliding scale, 35%; Medicaid, 33%; and self-pay, 23%
- **Dia de la Mujer Latina** has conducted health festivals for 8 years to assess the needs of the Hispanic/Latino families as well as provide health screening and arrange follow-up care for participants. Their registrants have increased from 286 in 1997 to 1444 in 2003 and needs identified include increased access to lower cost high quality, healthcare, dental and mental health services and health promotion/prevention information and screening services as well as transportation, housing and employment.

## **ADDENDUM B. ARHF TOWN HALL MEETING PROCESS AND SUMMARIES OF RECENT ARHF TOWN HALL MEETINGS**

### **ARHF TOWN HALL MEETING PROCESS**

Grassroots level dialogues are being conducted in local town hall meetings to define the most critical health issues existing in local neighborhoods and to initiate discovery of the regional capacity and assets of our communities. We are gathering information about health in the broad context, including wellness and prevention services, especially as they relate to our most vulnerable citizens. Participants include adults children, youth, women, families, seniors, refugees and immigrants and those experiencing racial/ethnic disparities with particular attention to the economically disadvantaged, uninsured, underinsured and medically underserved. The dialogues serve as the foundation for defining the opportunities or gaps in services and for creating a regional capacity inventory and asset map of existing health activities. Communities or neighborhoods can use the resulting data to build integrated and coordinated healthy community services, including wellness and prevention programs. This asset-based approach serves to foster the development of social capital by inspiring individuals to participate in volunteer activities and by encouraging grassroots organizations, associations and other institutional services within the community and neighborhoods to connect, communicate, collaborate and share best practices. The strong internal focus stresses the importance of local residents providing definition, investment, creativity and hope.

#### **Selection of Meeting Locations and Participants**

ARHF uses a strategic and opportunistic approach to select meeting participants and locations. Collaboration is sought with partner organizations whose members represent target populations to take advantage of using established meeting schedules in venues that are familiar, comfortable and located where people normally congregate. For example, to obtain true grassroots representation from the Hispanic/Latino population, community leaders recommended meetings conducted entirely in Spanish on Sunday to capture the participation of male family members who work six days each week. They suggested using mission churches, beginning the forum immediately after the last Sunday morning service, closing the discussions with a simple meal prepared by church members, and using members of the congregation as translators to ensure an environment perceived as “safe” by the participants. The Hispanic Health Coalition, the Medical Interpreters Network of Georgia and representatives from the church community served as volunteer facilitators/translators at this meeting. A forum focused on the homeless population was held in mid-town at the Crossroads Community Ministries soup kitchen after a regularly scheduled meal and a group of homeless women and children participated in a group at Genesis Shelter. To capture input from the African-American community, an inner city neighborhood forum was held at the Georgia/Hill Community Center, a middle class neighborhood forum was held at the Hillside Chapel and Truth Center and a senior forum took place at the Quality Living Services Center. Additional refugee/immigrant forums included Korean, Vietnamese, Afghan, Iraqi, Burmese, Ethiopian, Bhutanese, Lebanese and Somali representatives.

#### **Pre-Meeting and Post-Meeting Surveys**

To facilitate analysis of the objective data collected during this project, pre- and post-meeting surveys, in both English and Spanish, have been designed using Teleform technology, which permits scanning of forms into an electronic format. This allowed preparation of individual forum results and also facilitated collective analysis of all the forums. The pre-meeting survey requested unbiased subjective information prior to the ensuing discussion. For the Hispanic/Latino forums only, an *optional* question was included on the pre-meeting survey, “Are you undocumented?” This was answered with a “yes” or “no.” The post-meeting survey asked only two questions: “Have you increased your knowledge about where to get health information and services for yourself and/or your family?” and “Would you be willing to be a volunteer to help with health activities in your neighborhood or community?” The pre- and post-meeting survey forms did not require any personal identifier information, so the answers cannot be traced to the participant. Only if the attendee wishes to receive follow up information concerning the outcomes of the forum or wishes to volunteer to help in the community did they complete a third “contact information” questionnaire. A full report of each meeting was given to any participant desiring it after each forum and contact information for those participants who volunteered to help in the community was given to appropriate local agencies for follow up.

#### **Selection of Meeting Format and Discussion Questions**

Depending on the number of participants, a single group (up to 25) has been facilitated together. Groups larger than 25 participants had “break out” discussions with 8-10 members each to ensure full participation by everyone in attendance. Questions were posed by a central facilitator who used personal examples to illustrate the issue and the smaller groups were led by a group facilitator assisted by another person, ideally from within that particular community,

to record the stories and comments from each person participating in the discussion. Questions were formulated using the “ORID” process that uses four kinds of questions (Objective, Reflective, Interpretive and Decisional) to generate a sense of collective unity and focus. Examples of these are:

**Objective:**

- Age, Gender, Employment (yes/no)
- “In the past two years, have you received any information on how to stay healthy?”
- “Have you had any of the following health services in the past two years:
- Blood pressure taken?
- Blood sugar (diabetes) test?
- Cancer check: a test for blood in feces and/or sigmoidoscopy?
- Females only: Mammogram? Pap smear?”
- “Do you know where you can go to receive any of the health services above?”
- “Do you know where you can go to get information on how to stay healthy?”
- “Do you have health insurance coverage?” and “If you do not have health insurance, please list the problems this causes you.”
- (For Hispanic/Latino population only: “Are you undocumented?” and “if you are undocumented, please list the problems this causes you.”)
- “Please list the most important health issues you have now.
- “Where do you go now for help with your health needs?
- Are you helping any persons in your community improve their health or stay healthy?”

**Reflective:**

- “Tell us about a good health experience you have had that surprised you”
- “Tell us about a bad health experience that you have had.”

**Interpretive:**

- “What are the most important health issues that challenge or confront you, your family, or your friends?”
- “What is happening now in your neighborhood related to the most important health issues you have listed?”
- “What is most helpful to you, your family and friends when you seek health now?”

**Decisional:**

- “What would you identify as one ideal solution to your health concerns?”

## **SUMMARIES OF ARHF FORUMS**

### **Summary of Meetings to Date:**

Ten meetings involving 498 persons with an average attendance of 50 have been held with diverse populations experiencing socioeconomic and/or racial/ethnic disparities with particular attention to the economically disadvantaged, uninsured, underinsured and medically underserved.

### **OVERALL DEMOGRAPHICS**

- 23% were employed
- 78% possessed some form of health insurance
- 63% knew where to go for preventive health information
- 66% knew where to go for screening health services

Participants receiving appropriate health screening services in the prior two years:

- Blood Pressure, 76%
- Blood sugar, 55%
- Colon cancer screening over age 50, 48%
- Women over age 20 receiving a Pap smear, 43%
- Women over age 40 receiving a mammogram, 72%
- Post-meeting survey: 85% increased their knowledge about where to receive health information and services for themselves and their family and 61% were willing to volunteer to help their family and friends with health activities in their neighborhood or community.

**HISPANIC/LATINO NEIGHBORHOOD  
AT THE SAN FELIPE MISSION IN FOREST PARK  
(CLAYTON COUNTY)**

**DEMOGRAPHICS**

- 114 attendees; 84 completed pre-meeting survey, including 43 men and 41 women
- 55% were employed
- 62% possessed some form of health insurance
- 25% knew where to go for preventive health information
- 25% knew where to go for screening health services

Participants receiving appropriate health screening services in the prior two years:

- Blood Pressure, 39%
- Blood sugar, 23%
- Colon cancer screening over age 50, 13%
- Women over age 20 receiving a Pap smear, 59%
- Women over age 40 receiving a mammogram, 58%
- Post-meeting survey: 90% increased their knowledge about where to receive health information and services for themselves and their family and 66% were willing to volunteer to help their family and friends with health activities in their neighborhood or community.

**TYPICAL COMMENTS FROM PARTICIPANTS**

- “Health Fairs conducted in Spanish for education and screening would be very well attended.”
- “I do not know where to go for healthcare.”
- “Vision and dental services are very expensive and even insurance doesn’t pay for much of it.”
- “Our highest priority is for preventive health services, especially for children, including more available pediatricians, dentists, etc.”
- “We don’t have health fairs around here like they do in other communities, so we don’t have a lot of health information.”
- “It’s hard to pay for prenatal care so sometimes I skip my appointments; I couldn’t pay for an ultrasound, so I did not have one.”
- “Many people get their medicines from other countries because it’s much cheaper. Often, family or friends back home will send the medicines. The practice of prescribing for ourselves is very common since we cannot afford to see the doctor.”

**KEY FINDINGS**

Health in this community could be improved significantly by addressing:

- Language and cultural barriers to receiving health services
- Participants were unanimous in expressing great need for “I Speak” translation cards created by the Medical Interpreter Network of Georgia (MING) for use in their activities of daily living.
- Lack of health insurance
- High cost healthcare, including prescription medicine
- Lack of efficient public transportation
- Inaccessibility of vision and dental services
- Lack of knowledge about health promotion and prevention practices
- Lack of sufficient health promotion and screening preventive health services with very low rates of receiving blood pressure, diabetes and colon cancer screening
- There is a surprising 66% willingness to volunteer within the community

**OUTCOMES**

- Copies of this town hall meeting summary were furnished to the San Felipe Mission, the Office of Multicultural Affairs, Grady Health System and the Southside Community Health Center to assist in the provision of more culturally competent health services.
- The contact information of volunteers was furnished to the San Felipe Mission and the Southside Community Health Center.

- Following a request from the Atlanta Regional Health Forum to the Georgia Department of Human Resources for printing of “I Speak” card, 10,000 cards were printed and furnished to MING to distribute throughout the metropolitan Atlanta community.
- As a result of the forum, a regular health fair has been established at the Mission for distribution of health promotion and preventive care education and services using many of the volunteers from the forum.

**INNER CITY AFRICAN AMERICAN NEIGHBORHOOD  
AT THE GEORGIA/HILL COMMUNITY CENTER IN PEOPLETOWN/SUMMERHILL  
(FULTON COUNTY)**

**DEMOGRAPHICS**

- 28 attendees with 26 completed the pre-meeting survey, including 20 women and 6 men
- 68% were employed
- 60% possessed some form of health insurance
- 92% knew where to go for preventive health information
- 73% knew where to go for screening health services

Participants receiving appropriate health screening services in the prior two years:

- Blood Pressure, 78%
- Blood sugar, 56%
- Colon cancer screening over age 50, 43%
- Women over age 20 receiving a Pap smear, 75%
- Women over age 40 receiving a mammogram, 64%
- Post-meeting survey: 91% increased their knowledge about where to receive health information and services for themselves and their family and 87% were willing to volunteer to help their family and friends with health activities in their neighborhood or community.

**TYPICAL COMMENTS FROM PARTICIPANTS**

- “Funding that was designed to help low-income communities is not actually being provided to the community. Specifically, the Empowerment Zone monies never reached those who needed it.”
- “There is a lack of information targeted towards senior citizens and the resources specifically available for them.”
- “Funding designated for low-income communities should be sent directly to the community and not given to other organizations who supposedly act on the behalf of the community.”
- “There is a large percent of uneducated teen parents in the community who are not equipped mentally to handle family responsibilities.”
- “More grassroots groups needed to breakdown the communication barriers within the community and with others.”
- “We need more established community-based organizations that are run by individuals in the community.”
- “Require individuals that receive Section 8 to attend community forums so they can be educated on various issues.”

**KEY FINDINGS**

Health in this community could be improved significantly by addressing:

- The need for more community forums on health promotion, including parenting classes and information for seniors
- The need for more preventive health screening services, especially for colon cancer screening

**OUTCOMES**

- Copies of this town hall meeting summary were furnished to all participants and to the Georgia/Hill Community Center, Southside Community Health Center, Emmaus House Mission and Chapel and The Fulton County REACH (Racial and Ethnic Approached to Community Health Program).
- REACH has established regular health promotion educational programs and services at the Emmaus House Mission.
- Participants were guided to the resources available at the Atlanta Regional Commission Area Agency on Aging.

**HOMELESS NEIGHBORHOOD  
AT THE CROSSROADS COMMUNITY MINISTRIES IN MIDTOWN  
(FULTON COUNTY)**

Crossroads Community Ministries, affiliated with St. Luke's Episcopal Church in downtown Atlanta, served over 90,000 meals to the homeless in 2003. Crossroads has noted a significant trend of increasing numbers of homeless women and children served: 480 in 2001, 814 in 2002 and, 1475 in 2003.

**DEMOGRAPHICS**

- 80 attendees; 68 completed pre-meeting survey, including 3 women, 65 men
- 9% were employed
- 21% possessed some form of health insurance
- 55% knew where to go for preventive health information
- 58% knew where to go for screening health services

Participants receiving appropriate health screening services in the prior two years:

- Blood Pressure, 64%
- Blood sugar, 39%
- Colon cancer screening over age 50, 33%
- Women over age 20 receiving a Pap smear, 33%
- Women over age 40 receiving a mammogram, 50%
- 8% had received dental care in the prior two years
- 21% had received vision care in the prior two years
- Post-meeting survey: 70% increased their knowledge about where to receive health information and services for themselves and their family and 68% were willing to volunteer to help their family and friends with health activities in their community.

**TYPICAL COMMENTS FROM PARTICIPANTS**

- "Shelters are a place to get sick, because of poor hygiene, etc and general stress and lack of sleep that is associated with staying there."
- "The homeless are 'lumped together': some have addiction issues, some have mental illness and some are just temporarily down on their luck and really want to improve their situation."
- "Homeless people who want to help themselves are hindered by being put through the same wringer as those that are not willing or able to improve their situation, regardless of how much help they receive."
- "I cannot walk the 10 blocks from where I sleep to where I get food without being threatened with physical violence if I do not purchase drugs from multiple drug dealers in the area."
- "I need to make a choice each day because of the long waiting times to get medical care: decide if I want to eat, or get medical attention, or to try to find work. I can't do them all, so I need to pick which one is more important to use my time."
- "We have lack of access to doctors unless there is an 'emergency' situation,"
- "Transportation issues for all aspects of health service is my main obstacle - this includes seeking employment, as well as going for medical care."
- "The state could set up some kind of payment plan tracking homeless individuals who need medical care, perhaps via social security numbers. A running tab could be kept of the individual's medical expenses through the state and then, when the individual was able to find and sustain work, the state could begin taking money out of his/her paycheck to pay off the medical bills."
- "We could really benefit from public bathrooms where we at least can go to clean up before a job interview, not to mention the general sanitation improvement that would occur."

**KEY FINDINGS**

Health in this community could be improved significantly by addressing:

- Improved access to public transportation
- Improved access to healthcare services, especially dental and vision care
- Improved shelter hygiene and public bathrooms
- Establishing a "triage" system to separate the population into sub-groups ranked on ability to benefit from a little help to those unable to benefit from any intervention.

## OUTCOMES

- Copies of this town hall meeting summary were furnished to Crossroads Community Ministries, Mobile Mercy Care of St. Joseph's Hospital, the Metro Atlanta Task Force for the Homeless, United Way of Metropolitan Atlanta, The Metro Atlanta Tri-Jurisdictional Collaborative on Homelessness, All Saints' Episcopal Church Public Policy Network, Atlanta Medical Center and the Grady Health System to assist in planning and in the provision of services.

### **MIDDLE CLASS AFRICAN-AMERICAN NEIGHBORHOOD AT THE HILLSIDE CHAPEL AND TRUTH CENTER, CASCADE ROAD (FULTON COUNTY)**

## DEMOGRAPHICS

- 17 attendees, including 15 women and 2 men
- 35% were employed
- 94% possessed some form of health insurance
- 94% knew where to go for preventive health information
- 88% knew where to go for screening health services

Participants receiving appropriate health screening services in the prior two years:

- Blood Pressure, 94%
- Blood sugar, 71%
- Colon cancer screening over age 50, 33%
- Women over age 20 receiving a Pap smear, 66%
- Women over age 40 receiving a mammogram, 67%
- Post-meeting survey: 87% increased their knowledge about where to receive health information and services for themselves and their family and 33% were willing to volunteer to help their family and friends with health activities in their neighborhood or community.

## TYPICAL COMMENTS FROM PARTICIPANTS

- "There are too many cracks in the system and they are getting larger; I make too much for public assistance, but I do not have enough to pay for the healthcare I need."
- "I was given medication that was wrong for the diagnosis. I don't always want to take medication. I feel that too much medication is being given. I've been to a holistic doctor. I think holistic and general medicine should be combined."
- "We should take more responsibility for our own health, get more exercise, improve our nutrition and have regular check ups."
- "The 'Hallelujah for Health' fair sponsored by the church was wonderful, especially the exercise program which encourages walking 10,000 steps/day."

## KEY FINDINGS

Health in this community could be improved by:

- Increasing educational programs about the availability of and the necessity for colon cancer screening
- Increasing colon cancer screening which was inadequate in this community
- Increasing nutrition education and physical activity programs in the community

## OUTCOMES

- Copies of this town hall meeting summary were furnished to all participants, the Hillside Chapel and Truth Center, the Fulton County REACH program and Southwest Hospital and Health Center.

### **ELDERLY AFRICAN-AMERICAN COMMUNITY AT THE QUALITY LIVING SERVICES SENIOR CENTER, DANFORTH ROAD (FULTON COUNTY)**

## DEMOGRAPHICS

- 165 attendees, including 146 women and 19 men
- 8% were employed
- 98% possessed some form of health insurance
- 79% knew where to go for preventive health information

- 91% knew where to go for screening health services
- Participants receiving appropriate health screening services in the prior two years:
- Blood Pressure, 96%
  - Blood sugar, 77%
  - Colon cancer screening over age 50, 60%
  - Women over age 20 receiving a Pap smear, 75%
  - Women over age 40 receiving a mammogram, 86%
  - Post-meeting survey: 82% increased their knowledge about where to receive health information and services for themselves and their family and 52% were willing to volunteer to help their family and friends with health activities in their neighborhood or community.

#### TYPICAL COMMENTS FROM PARTICIPANTS

- “If I am sound spiritually, I am sound otherwise; everything will follow when the spiritual life is intact.”
- “I would like healthcare in my neighborhood to be closer; transportation is a major problem.”
- “More information is needed about diet and exercise and about different therapies for my diseases.”
- “Transportation is my biggest need. We have a car but can't drive it anymore.”
- “You are what you eat; we need more information about healthier living.”
- “We need more diabetes and cancer support groups.”

#### KEY FINDINGS

Health in this community could be improved by:

- Increasing educational programs about nutrition and preventive health measures and offering exercise classes
- Increasing transportation opportunities to access health services
- Increasing health literacy by furnishing more health information and education programs and support groups

#### OUTCOMES

- Copies of this report were furnished to all participants, the Quality Living Services staff, the Fulton County REACH program and Southwest Hospital and Health Center to assist in providing more effective services. Southwest Hospital has committed to exploring opening a regular clinic for general care and screening services

### **HOMELESS WOMEN & CHILDREN AT THE GENESIS SHELTER, DOWNTOWN ATLANTA (FULTON COUNTY)**

#### DEMOGRAPHICS

- 6 women, representing 14 children. One mother was one week post delivery of her third child and one 36 year old mother of three was pregnant with twins.
- 17% were employed
- 17% possessed some form of health insurance
- 100% knew where to go for preventive health information
- None knew where to go for screening health services

Participants receiving appropriate health screening services in the prior two years:

- Blood Pressure, 67%
- Blood sugar, 67%
- Women over age 20 receiving a Pap smear, 83%
- Women over age 40 receiving a mammogram, 32%
- Post-meeting survey: 83% increased their knowledge about where to receive health information and services for themselves and their family and 67% were willing to volunteer to help their family and friends with health activities in their neighborhood or community.

#### TYPICAL COMMENTS FROM PARTICIPANTS

- “Free child care is my most important need; we couldn't do it without child care; this allows us to find a job or to finish high school.”
- “Child care and transportation are the best help to us in our situation.”
- “Regular shelters aren't like this one (Genesis Shelter); Genesis provides classes and programs to help us. Not all shelters are alike; some shelters only provide night services. At Genesis, we feel more relaxed, but there is stress in

all shelters; they “mess up your head”. At Genesis we have to do our part; take responsibility for ourselves and our children.”

- “Many people are one pay check away from being homeless.”
- “The public has the wrong image of women in shelters or who are homeless – not all homeless are down-trodden.”

#### KEY FINDINGS

Health in this community could be improved significantly by addressing:

- Child care and transportation needs to allow mothers seek employment and/or high school completion
- Parenting education for young mothers which was requested by participants

#### OUTCOMES

- Copies of this town hall meeting summary were furnished to all participants, the Genesis Shelter staff, the All Saints’ Episcopal Church Public Policy Network, Fulton County REACH program and the Grady Health System to assist in providing more effective services.

### **MENTAL HEALTH, DEVELOPMENTAL DISORDERS AND ADDICTIVE DISEASES POPULATION AT THE JOHN C. BURDINE NEIGHBORHOOD FACILITY, LAKEWOOD (FULTON COUNTY)**

The participants were members of a psychosocial rehabilitation group (PSR) of the Fulton County Department of Mental Health, Developmental Disorders and Addictive Disease and the forum was held at the time of one of their regular meetings.

#### DEMOGRAPHICS

- 13 attendees, 8 women and 5 men
- 15% were employed
- 93% possessed some form of health insurance
- 93% knew where to go for preventive health information
- 100% knew where to go for screening health services

Participants receiving appropriate health screening services in the prior two years:

- Blood Pressure, 100%
- Blood sugar, 38%
- Colon cancer screening over age 50, 50%
- Women over age 20 receiving a Pap smear, 86%
- Women over age 40 receiving a mammogram, 100%
- Post-meeting survey: 100% increased their knowledge about where to receive health information and services for themselves and their family and 38% were willing to volunteer to help their family and friends with health activities in their neighborhood or community.

#### TYPICAL COMMENTS FROM PARTICIPANTS

- “Difficult to know where to go for mental health services as the services are so far away. There is a need for transportation and to have mental health services closer to our neighborhoods.”
- “We can get coverage for mental health medications, but not other medications. It is very difficult to get medication for high blood pressure; I’ve been without it for over a month. I have Medicare, but I need Medicaid to get my B/P medication and it is very difficult to complete all the forms.”
- “Need transportation directly related to this program. There were transportation services at one time, but these were cut when the budget needed to be reduced.”
- “I live at Phoenix House and they provide transportation for medical appointments, but not for other things like this program.”
- “Getting a job is my biggest need. If I work, I loose my SSI, or it will be decreased. The problem is getting re-training for things that I can do in the work place. In the past, Goodwill services provided job training, but now you have to pay for it and there is a long wait and there is also a long wait for vocational rehab training services. Funds have been cut back for such programs.”

#### KEY FINDINGS

Health in this community could be improved significantly by addressing:

- Public transportation inadequacy to allow job seeking and/or accessing health services
- Inadequate eye and dental care
- High cost of prescription drugs, especially for conditions other than mental illness
- Lack of affordable housing
- Inadequate blood sugar and colon cancer screening

### OUTCOMES

- Copies of this town hall meeting summary were furnished to all participants, the Psychosocial Rehabilitation staff, the Fulton County Department of Mental Health, Developmental Disorders and Addictive Diseases, and the Grady Health System to assist in providing more effective services.

### **REFUGEE/IMMIGRANT POPULATION (KOREAN) AT THE SALVATION ARMY INTERNATIONAL WORSHIP CENTER, DORAVILLE (DEKALB COUNTY)**

A teacher at the Korean Senior School facilitated this meeting in Korean and explained that the participants would not fill out individual survey forms because, as is traditional in the Korean culture, decisions and information are discussed and submitted in community.

### DEMOGRAPHICS

- 34 women, 3 men with an average age of 82
- None of the attendees were employed
- 62% possessed some form of health insurance
- 100% knew where to go for preventive health information
- None knew where to go for screening health services

Participants receiving appropriate health screening services in the prior two years:

- Blood Pressure, 89%
- Blood sugar, 55%
- Colon cancer screening over age 59, 16%
- Women over age 20 old receiving a Pap smear, 29%
- Women over age 40 receiving a mammogram, 32%
- Post-meeting survey: 96% increased their knowledge about where to receive health information and services for themselves and their family and 91% were willing to volunteer to help their family and friends with health activities in their neighborhood or community

### TYPICAL COMMENTS FROM PARTICIPANTS

- “We hate emergency rooms because there is no one to translate for us.”
- “American doctors never allow the patient to talk with the physician. A patient can wait as long as three hours for a 3-minute visit and doctors are not kind or friendly; who will punish these doctors for their behavior?”
- “Not being able to have a routine check up is a problem because we do not have a regular doctor in the clinic, a family doctor, who follows our health and illnesses. We might see a different doctor each time we go to the clinic. Doctors just ask what’s wrong with you, then prescribe and don’t communicate with the patient.”
- “Different doctors prescribe different medicines and sometimes these medications are not compatible and therefore the patient can become ill from the medication.”
- “We often get prescription drugs which we did not know how to use and have to go to a Korean pharmacy for instructions.”

### KEY FINDINGS

Health in this community could be improved significantly by addressing:

- Language barriers
- Transportation
- Poor communication between healthcare providers and patients
- High cost of specialty services and lack of health insurance
- Lack of information regarding location of available preventive health services
- Poor participation in obtaining recommended health screening services, especially for colon cancer after age 50 and mammograms after age 40 and Pap smears after age 20 in female members

## OUTCOMES

Assist the Korean Senior School and the Center for Pan-Asian Community Services to:

- Increase educational programs on health promotion and prevention
- Assist constituents in locating and accessing health services
- Explore transportation solutions to existing barriers preventing receiving health promotion and healthcare services
- Encourage regular health screening, especially for colon cancer for all over 50 and mammography and cervical cancer screening in the female population

### **REFUGEE/IMMIGRANT POPULATION (VIETNAMESE) AT THE PAN-ASIAN CENTER FOR COMMUNITY SERVICES (DEKALB COUNTY)**

A translator and coordinator from the Center for Pan-Asian Community Services helped facilitate this meeting in Vietnamese at the Center.

## DEMOGRAPHICS

- 25 attendees; 19 completed the pre-meeting survey, including 3 women and 16 men
- 26% were employed
- 89% possessed some form of health insurance
- 26% knew where to go for preventive health information
- 42% knew where to go for screening health services

Participants receiving appropriate health screening services in the prior two years:

- Blood Pressure, 74%
- Blood sugar, 37%
- Colon cancer screening over age 50, 38%
- Women over age 20 receiving a Pap smear, 0%
- Women over age 40 receiving a mammogram, 33%
- Post-meeting survey: 96% increased their knowledge about where to receive health information and services for themselves and their family and 91% were willing to volunteer to help their family and friends with health activities in their neighborhood or community.

## TYPICAL COMMENTS FROM PARTICIPANTS

- “I am old and poor and I don’t have money when I am sick.”
- “I do not know English and, when I am sick, I do not know how to tell my doctor what is wrong.”
- “I am poor and need your help with everything.”
- “We have a problem with language and ask for people for help translating, but they don’t come until we are almost dead.”
- “I need a permanent job. If I get a temporary job, it doesn’t have benefits. I am disadvantaged and cannot get a permanent position.”

## KEY FINDINGS

Health in this community could be improved significantly by addressing:

- Unemployment
- Lack of health insurance
- Language barriers
- Poverty
- Lack of knowledge about health promotion and prevention practices
- Lack of information regarding location of preventive health services, as well as acute and chronic healthcare services
- Poor participation in obtaining all recommended health screening services
- Lack of utilization of uniform willingness of participants to volunteer with health promotion and prevention programs within the community

## OUTCOMES

Assist the Center for Pan-Asian Community Services to:

- Increase education programs on health promotion and prevention
- Assist their constituents in locating and accessing health services
- Encourage regular health screening, particularly mammography and cervical cancer screening in the female population
- Create health prevention and promotion programs to utilize widespread willingness among participants to volunteer in the community

**REFUGEE/IMMIGRANT POPULATION  
(AFGHAN, BURMESE, BHUTANESE, ETHIOPIAN, IRAQI, LEBANESE, SOMALI)  
AT THE CLARKSTON COMMUNITY CENTER  
(DEKALB COUNTY)**

Thirteen Community Health Promoters participated in one of their regularly scheduled educational meetings with a format modified from the other forums. The pre-meeting survey was completed with personal information, but the participants were asked to represent their respective communities in answering the discussion questions rather than answering from a personal viewpoint.

**DEMOGRAPHICS**

- 13 attendees, all women
- 46% were employed
- 61% possessed some form of health insurance
- 77% knew where to go for preventive health information
- 85% knew where to go for screening health services

Participants receiving appropriate health screening services in the prior two years:

- Blood Pressure, 77%
- Blood sugar, 54%
- Colon cancer screening over age 50, 50%
- Women over age 20 receiving a Pap smear, 46%
- Women over age 40 receiving a mammogram, 33%
- Post-meeting survey was not completed because all the participants were already volunteering and the meeting was an educational meeting

**TYPICAL COMMENTS FROM PARTICIPANTS**

- “Mental health issues, particularly depression, suicide and fear, are primary concerns in our communities. There is fear of getting sick and not being able to pay the bills because of lack of insurance and fear after 9/11 that the American people do not understand the true nature of Islam and will persecute us.”
- “Suicide is a big issue in the Bosnian and Ethiopian communities.”
- “There are free services for refugees, but immigrants have many restrictions to receiving help and constantly fear deportation if their lack of citizenship is discovered.”
- “We need help in preparing our people to enter into the American way of life and customs.”
- “Our men are not engaged in any healthy community activities because they are completely engaged in ‘survival’ for their family and we have learned that it will take ten years for them to get out of the survival mode of existence.”
- “Language and cultural barriers restrict us in our activities of daily living and receiving healthcare services.”
- “There is a great need for transportation services.”
- “Nutrition education, education regarding the dangers of tobacco use and exercise promotion are areas in which we need help.
- “At the mosque, we discuss weight control and exercise, but there is no place where women can exercise in private.”
- “The ideal solution for many of our problems would be the creation of an International Cross-Cultural Women’s Center. We have cultural customs restricting our participation in exercise and other health promotion programs that could be addressed here.”

**KEY FINDINGS**

Health in this community could be improved significantly by addressing:

- Health promotion, disease prevention and basic screening services, particularly for males who are not engaged in any health neighborhood activities at this time
- Increasing mental health and stress services, especially addressing a pervasive climate of fear in this community

- Language and cultural barriers are a major impediment to healthy neighborhoods

#### OUTCOMES

Assist the Clarkston Community Center to:

- Increase education programs on health promotion and prevention
- Assist their constituents in locating and accessing health services
- Encourage regular health screening, particularly mammography and cervical cancer screening in the female population and all health promotion and screening in the males.
- Explore the feasibility of an International Women's Center accessible to the community

## FOOTNOTES

<sup>1</sup>*Georgia Health Decisions*, 1720 Peachtree Street, Suite 1029, Atlanta, GA 30309  
(404) 874-9327, Beverly A. Tyler, Executive Director  
Web site: <http://www.critical-conditions.org/>

<sup>2</sup>*Healthcare Georgia Foundation*, 50 Hurt Plaza, Suite 550, Atlanta, GA 30303  
(404) 653-0990, Gary D. Nelson, PhD, President  
Web site: <http://www.healthcaregeorgia.org/>

<sup>3</sup>*The Atlanta Regional Commission*, 40 Courtland Street, NE  
Atlanta, GA 30303, (404) 463-3100, Charles Krautler, Director  
Web site: <http://www.atlantaregional.com/agingatlanta>. The regional database of services available for senior citizens is located at <http://www.agewiseconnection.com/search.asp>.

<sup>4</sup>*The Gwinnett Coalition for Health and Human Services*, 750 S. Perry St., Suite 312, Lawrenceville, GA 30045, (770) 995-3339, Ellen Gerstein, Executive Director  
Web site: <http://www.gwinnettcoalition.org/>

<sup>5</sup>*Healthy DeKalb Project*, DeKalb County Board of Health (Richardson Building), 445 Winn Way, Decatur, GA 30030, (404) 294-3700, Paul Wiesner, MD, Director  
Web Site: <http://www.dekalbhealth.net/community-collaborations/healthy-dekalb.asp>

<sup>6</sup>*The Pathways Community Network Inc.*, 1908 Cliff Valley Way, Suite 250  
Atlanta, GA 30329-2479, (404) 584-6591, William Matson, Executive Director  
Web site: <http://www.pcni.org>

<sup>7</sup>*The Clayton Collaborative Authority*, 696 Mount Zion Road, Suite 8-A, Jonesboro, GA 30236, (770) 472-8070 Robert Bolander, Executive Director  
Web site: <http://www.claytoncollab.org>

<sup>8</sup>*United Way of Metropolitan Atlanta*, 100 Edgewood Avenue, NE, Atlanta, GA 30303,  
(404) 527-7200 Mark O'Connell, President and CPO  
Web site: <http://www.unitedwayatl.org>