STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
ALABAMA STATE HEALTH PLAN
2014-2017
ADMINISTRATIVE CODE

CHAPTER 410-2-2
HEALTH PRIORITIES

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410-2-2-.01 Introduction.

(1) This section of the Alabama State Health Plan underscores certain health issues which warrant focused attention. These few issues have been selected for a variety of reasons, including:

(a) Unusual Severity in Our State, e.g. Infant Mortality.

(b) Special Opportunities, e.g. The Medicaid Omnibus Budget Reconciliation Act (OBRA) option.

(c) Problems of Access to Health Care, e.g. The Issue of the Uninsured and the Vulnerability of Rural Hospitals.

(2) When resources are limited and needs great, focused attention on the most pressing problems will promote optimal use of any new or additional investments. What follows is a review of the health issues and health concerns, which require priority emphasis in Alabama.

Author: Statewide Health Coordinating Council (SHCC)
410-2-2-.02 Maternal And Child Health.

(1) The Problem

(a) Alabama’s infant mortality was 13.3 per 1,000 live births in 1988. In 2002 the provisional rate improved to 9.1 deaths per 1,000 live births, a significant drop from the 1988 rate and is the lowest rate recorded in history. Reasons for the improvements include a number of factors related primarily to improved Medicaid coverage.

1. Medicaid has been expanded to serve more children and pregnant women who do not receive cash assistance such as Aid to Families with Dependent Children. This trend started in 1988 with expansion of eligibility to pregnant women and children up to age one with incomes under 100 percent of the federal poverty level and now up to 133 percent of the federal poverty level.

2. Medicaid’s Maternity Care Program is statewide and Medicaid pays for approximately one-half of all deliveries. The Program continues to be successful in reducing the need for neonatal intensive care and hospital readmissions in the first year of life. The Program involves a primary provider that coordinates total care for the patient throughout pregnancy and until after the baby is born. Important components are case management, home visits and outreach.

3. As of September 1, 1991, Medicaid had workers out-stationed at hospitals, county health departments and other health facilities throughout the state to determine Medicaid eligibility for children and pregnant women who need help with payment for health care but who do not qualify for cash assistance.

4. Medicaid Targeted Case Management for Medically At-Risk Children was implemented through Alabama Department of Public Health (ADPH) in 1999. This program provides case management for Patient First recipients referred by private medical and dental providers in health department case managers.

5. The ADPH, in collaboration with the Alabama Department of Human Resources, implemented the Alabama Unwed
Pregnancy Prevention Program (AUPPP) in 2001 and the Family Planning Teen Care Coordination Program in 2002. The AUPPP addresses adolescent pregnancy and unwed pregnancy by providing funding support to community-based projects, a statewide teen pregnancy prevention campaign, and media outreach. The teen care coordination program provides medical social support to teen’s age 18 and under receiving family planning services in local health departments.

6. Other programs implemented by the ADPH that are affecting infant mortality include the Alabama Child Death Review Program legislated in 1997, a campaign addressing “back-to-sleep”, a “safety for sleeping babies” brochure, and folic acid outreach.

(b) Progress has been made in Maternal and Child Health in the state. In 2001, Alabama’s infant mortality rate was 9.5%, and in 2002 declined to 9.1%. In “real terms”, 538 of Alabama’s babies failed to reach their first birthday in 2002. Those at highest risk for infant mortality are infants born to blacks, single mothers, teenagers, and the socio-economically disadvantaged. Almost twenty-nine percent (29%) of Alabama’s population is black and other. Approximately one-third of the births in 2001 (34.4%) were to unmarried women, and 14.9 percent of infants resulted from teenage pregnancies.

(c) Infant death is not the only problem associated with high-risk birth. Research indicates that for every baby who dies, three more are born with handicapping conditions. In 2001, there were 9.6% of babies, which were low birth weight, putting them at greater risk for handicapping conditions.

(d) Alabama’s women and children must receive adequate health care—health care that is primarily preventive, appropriate for the need, and available. Barriers to care include the following:

1. Outreach Efforts. Outreach efforts at the local community level are varied and sometimes nonexistent. Some children do not receive the minimal recommended number of preventive health care visits as outlined by the American Academy of Pediatrics, thus immunization rates for these infants and young children are low, and conditions that could be identified through routine screening exams go untreated.

2. Perinatal Services. Several components of the perinatal system are not available in all areas of the state. These components are obstetrical and neonatal outreach education, maternal-fetal and newborn transport systems, and high-risk infant-follow-up. Case management to include tracking and
follow-up for women and infants is not available in some areas. There is a need for additional social workers at the local level to provide these services.

(2) Recommendations

(a) Improve the accessibility of services to maternity and pediatric patients through expansion and improvement of services to women and children.

1. Outreach efforts should be strengthened and targeted to maternity and pediatric patients.

2. Evaluation of case management services should be designed and implemented and management data for the Alabama Department of Public Health should be refined.

(b) Strengthen the Alabama Perinatal Program to implement programs that address recommendations issued by the State Perinatal Advisory Council (SPAC) in 2002. Provide statewide follow-up of all infants identified as high-risk. Improve maternal-fetal and neonatal transport systems.

(c) Maintain and strengthen interagency efforts directed toward decreasing the amount and effects of substance abuse in women of childbearing age and their children.

(d) Encourage access in schools for perinatal testing, counseling, prenatal education, and care.

(e) The Statewide Health Coordinating Council (SHCC) is committed to maintaining and strengthening efforts to expand and improve quality pediatric health care throughout Alabama’s health care delivery system. This should be achieved through pediatric-trained personnel and systems whose expertise is to care for children--pediatric-trained physicians (family physicians, pediatricians, pediatric sub-specialists, etc.), nurses (including pediatric and family nurse practitioners), developmental specialists, mental health specialists, and other team members located in health care delivery sites and systems (physicians’ offices, multi-specialty ambulatory clinics, health maintenance organizations, children’s hospitals, and other service sites).

Author: Statewide Health Coordinating Council (SHCC)
410-2-2-.03 Care Of The Elderly And Chronically Ill.

(1) The Problem

(a) The elderly comprise one of the most rapidly growing age groups in the United States. The same is true in Alabama. Since 1900, the state’s total population (approximately 4.4 million people) has more than doubled and there are nearly ten times as many senior citizens. In 1900 persons 65 and older accounted for only 3% of the total population compared to 13% in 2002. This age group is expected to increase to over 22% by the year 2050.

(b) Improvements in life style, changes in diet, and development of medical technology for identification and treatment of diseases have resulted in increased life expectancy. Because of this increase, a new phenomenon is occurring, aging of the aged. More persons are living well into their 80s and even 90s. Within the ten-year period from 1990 to 2000, the 85 plus segment of the population increased by 40%. The special needs of these frail elderly will demand increased attention from service providers in the years ahead. The absolute number of people was 29,644 for females and 27,165 for males.

(c) The male population age 65 plus increased by 13.3% from 1990 to 2000 and the female population of the same age group increased by 9.3%, while one-third of the non-institutionalized elderly live alone, 80% of these are women.

(d) As age increases, the incidence of chronic disease and disability, particularly at the lower levels of severity, increases. Another factor affecting the increase of the chronically ill is the projection of an increase in the number of AIDS cases in the state.

(e) Many of our chronically ill live below the poverty level. The current census reflects, they do not always seek medical assistance because of out-of-pocket cost. Often they cannot afford required medications. Some live in substandard housing with inadequate plumbing and heating. They do not always practice proper nutrition because of economic concerns and the inability to shop.

(f) Depression, loneliness, alcohol and drug abuse, and suicide pose problems for many elderly and chronically-ill citizens.
Transportation is not available to all elderly and chronically ill persons. Many who have lived alone in the past will need to be placed in a facility where they can receive assistance. Families, with both husband and wife working, need assistance with parents during work hours and at other times for respite care.

Dental care and audiology are not available at affordable prices for all the elderly and chronically ill, although many more dentists are accepting Medicaid patients.

Recent statistics project an increase in the need for care of the elderly and chronically ill within the next few years. However, much of this care will be linked directly to functional limitations, and only indirectly to illness.

The social, economic, and cultural environment will have important bearing on how well our elderly maintain their overall health status. The support that was once provided by relatives is less feasible in today’s society because of scattered families, divorce, single parents, childless couples, and two-income families.

The kind of care and support needed to maintain the health of our elderly and chronically ill population cannot be sustained within the state’s current medical framework.

The availability of health care services has increased. Medicaid increased the payment to dentists and physicians in the last two years; the Medicaid drug formulary has been expanded and payments have been increased to nursing homes. Approximately 208 additional nursing home beds have been approved, as a result of the 10% Nursing Home Bill.

Recommendations

(a) The State should strengthen its existing support services for the elderly and chronically ill and, when appropriate, develop new services, beginning at the community level. These services should include, but are not limited to, the following:

1. Adult day care facilities to assist working families;

2. Assisted living homes to provide housing for elderly and chronically ill who can no longer live alone;
3. Counseling services that deal with depression, alcohol and drug abuse, suicidal tendencies, nutrition, appropriate life styles, and self care;

4. Geriatric training and education for caregivers;

5. Homemaker and chore services;

6. Home delivered meals;

7. Transportation services;

8. Emergency alert systems;

9. Dental care, including prosthodontics;

10. Audiology, including hearing aids;

11. Optometry services, including glasses;

12. Adaptive and assistive equipment;

13. Adequate housing for persons living below the poverty level.

(b) The success or the breakdown of these support services will determine to a considerable extent the demands made on health care services by the elderly and chronically ill. However, with the success of such support services, the need for more costly health care for our elderly and chronically ill will drastically diminish.

Author: Statewide Health Coordinating Council (SHCC)

410-2-2.04 Rural Health Care. Alabama has a Rural Health Plan developed with the assistance of the Alabama Department of Public Health’s Office of Primary Care and Rural Health and the State Health Planning and Development Agency. This plan is incorporated into this State Health Plan by reference hereto.

(1) The Problem. Trends in Alabama’s rural health care parallel those of the Nation. Both are related to changes
in environmental factors. A summary of the problems and possible alternatives follows.

(a) Reimbursement Factors. Reimbursement changes from the traditional cost-based system to either a prospective payment or per diem, depending on the third party payer, have had a dramatic effect on the solvency of rural hospitals. Generally speaking, hospitals in rural areas experience a higher mix of Medicare/Medicaid patients than do the facilities in urban areas; but rural hospitals receive a lower amount of reimbursement per patient from Medicare. The Centers for Medicare and Medicaid Services (CMS) implementation of the Prospective Payment System (PPS) assumes hospitals in rural areas will not experience the same labor costs for health personnel services, as do the urban hospitals. Therefore, the component parts of the prospective payment formula provides for a lower wage allowance for rural hospitals. Another factor that tends to limit reimbursement for rural hospitals is that the PPS system assigns weights related to patient attributes to each DRG. The higher the weight per DRG, the more reimbursement a hospital will receive if that hospital provides services to patients with the higher weighted/reimbursed DRGs than do the rural facilities. Therefore, the urban facilities may receive more reimbursement, in spite of the fact that the weight assignment per DRG has not been proven as accurate an indicator of the consumption of resources. The bottom line effect of Medicare reimbursement on rural hospitals is the payment rates are generally less for hospitals in rural areas, leading to a less than adequate payment system. Medicare cost reports in 2000 indicated that 34 percent of the hospitals in rural areas experienced a net loss from operations.

(b) Demographic Factors. A low population density, worsened by the emigration of the younger population in search of employment in larger communities, results in a high proportion of the elderly remaining in rural communities. Alabama’s overall population density in 2000 averaged 87.6 people per square mile, ranging from a low of 14.8 persons per square mile in Wilcox County to a high of 595 persons per square mile in Jefferson County. In this case a measurement of density may not be an accurate indicator as only 22 counties experienced a density factor equal to or above the average and 45 counties were below the average. Rural facilities thus have a smaller market from which to draw patients and fewer patients who pay adequately as compared to the costs of providing the care. Rural facilities are often under utilized as well. The elderly utilized more services than other groups. The average annual healthcare expenditure during 1985 – 2000 was more than six times greater for the elderly than for the younger groups. The population 65 and older comprises 13 percent of the state population as a whole and 14.5 percent for the 45 rural counties, further emphasizing
the need to develop and implement a rural health plan. Other
demographic factors affecting rural health care are the farm
economy, local tax base, and the number and percentage of rural
Americans who lack health insurance.

(c) Utilization Factors. Overall use of inpatient
services in rural areas continues to decline, while those same
services are increasingly used by the elderly who are covered by
decreasing Medicare reimbursement. Given that many of the rural
hospitals are sole community providers, the leading industry in
the community, and one of the major employers in the area, the
decreasing use has caused concerns both economically and
politically, and has affected the overall health status of the
community. Leaders are rightly concerned that the demise of the
rural hospital leaves a discontinuity of health care services for
citizens in their areas.

(d) Insufficient Health Professional Supply. Data
from the Bureau of Planning and Resource Development, Alabama
Department of Public Health, indicated that only six Alabama
counties did not have a health professional shortage area (HPSA)
designation for primary care physicians. Because of the problems
attracting specialized professionals and obtaining new
technologies, few rural hospitals can provide special services
that might increase their revenue. The migration of young people
to urban communities, lack of adequate reimbursement, and limited
patient resources are other problems hindering the recruitment of
professional personnel and fueling the state’s health
professional shortages. Government reports show that Alabama,
like many other parts of the South, is experiencing a physician
shortage. Utilization of nurse practitioners, physician
assistants, and nurse midwives meets a real need in addressing
the access problem faced by many rural Alabamians. Health
planners, providers, policy makers, and communities must approach
the recruitment and retention of non-physician health
professionals realistically. It is unrealistic to assume that
every rural community will be able to recruit and retain a
physician. In order to provide access to health care for the
citizens of many of the state’s most rural areas, the utilization
of non-physician health professionals must be seriously
encouraged. Also, payment for services provided by these
non-physician health professionals must be made by third party
payors and self-insured programs in order for their numbers to
increase.

(e) No one strategy will solve the state’s problems
with rural health care. Policy makers must realize that rural
facilities have fewer health care and political resources than do
their urban counterparts and that rural hospitals may be one
patient away from closing. The rural hospital of the future may,
therefore, have a limited number of acute care beds with the remainder of the facility given to swing beds, outpatient services, and specialty services. In short, rural hospitals need encouragement to take advantage of diversification. The essential issue remains, however, that without some emergency strategies and relief, the only alternative for the state’s rural hospitals may be closure. One new option for Alabama’s rural hospitals is the “Medicare Rural Hospital Flexibility Program” found in the Balanced Budget Act of 1997, which allows rural hospitals to convert to Critical Access Hospital status.

(2) Recommendations

(a) The State should continue to strongly support additional funding toward federal Medicaid match and should support the expansion of Medicaid program eligibility and benefits, especially for low-income pregnant women and infants.

(b) Encourage medical schools in Alabama to promote rural practice and retention.

(c) Encourage the secondary school systems to coordinate medical student recruiting efforts with the medical schools.

(d) Encourage the appropriate school of higher education to develop a physician assistant training program for utilization of such personnel in rural hospital emergency departments and/or rural health clinics. Encourage the continued support and recruitment of nurse practitioners and nurse midwives and expand the number of nurse practitioner programs in the state.

(e) Encourage the development of a capital access program giving rural hospitals and rural health clinics located in underserved areas easier access to capital through a capital pool with lower interest rates and less required collateral. Encourage the State Treasurer to consider adding rural hospitals to the Linked Deposit Program.

(f) Develop and implement programs to promote the utilization of nurse practitioners, physician assistants, and nurse midwives by:

1. Licensure and physician supervision requirements should be modified where access to care is hindered.

2. Promoting third party reimbursement by insurance companies and self funded programs.
(g) The state congressional delegation should continue to support the decisions made by the Medicare Geographic Reclassification Review Board process for reclassifying rural hospitals and correcting area wage index inequities in the basic DRG payments to hospitals. The delegation should also continue to be encouraged to support congressional action to revise reimbursement inequities for Alabama hospitals.

(h) Encourage providers, physicians, and other appropriate rural health care interest groups and community leaders to develop programs through the public and private sector which:

1. Ensure increased access to comprehensive health care with fewer financial barriers.

2. Access to health care services shall be provided in accordance with federal law.

3. Ensure that local community needs are met by encouraging planning efforts in rural and otherwise underserved areas.

4. Consider the impact on the infrastructure of local communities, jobs, schools, tax bases, and community leadership.

(i) Structure an agricultural safety program to:

1. Produce and accumulate a resource for instruction and analysis.

2. Establish a delivery system to disseminate the resource base to the agricultural community and local organizations, which will receive the educational resources and interact with the individual workers and farm families.

Author: Statewide Health Coordinating Council (SHCC)
(a) By December 2002, 859,000 cases of AIDS had been diagnosed in the United States. Of these, 849,780 have occurred in adults and adolescents and another 9,220 have been reported in children under age 13. Transmission of the AIDS virus occurs through sexual contact with an infected person, exposure to infected blood or blood products, and perinatally from mother to baby. To date, homosexual/bisexual men account for 45% of adult AIDS cases, with 6% occurring in homosexual/bisexual men who use intravenous drugs. Twenty-five percent of AIDS cases have been reported among heterosexual intravenous (IV) drug users; 1% among hemophiliacs; 1% blood transfusion recipients; and 12% among heterosexuals who have had sexual contact with infected partners. Approximately 10% fall into an “unknown” category.

(b) By October 2003, Alabama had reported 7,444 AIDS cases. Of these, 7,368 were in adults and adolescents and 76 were in children less than age 13. Alabama’s AIDS cases by reported risk behavior is as follows: 47.3% homosexual/bisexual male; 8.2% homosexual/bisexual with IV drug user; 16% heterosexual and IV drug abuse; 1.2% transfusion related; 1% hemophiliac; and 15.4% heterosexual contact with an infected person.

(c) There are at least one million Americans silently infected with HIV. Most of them will get sick during the next decade. Nationally, the cumulative deaths as of December 2000 were 501,669. Fifty-two percent of Alabama’s reported AIDS cases have died. Despite earlier diagnosis and the availability of treatment in Alabama, median survival for AIDS cases is estimated to be 18 - 20 months after diagnosis.

(d) In November 1987, the Alabama Department of Public Health designated HIV infection reportable by provider and patient name and identifiers. By October 2003, 6,180 persons who tested positive for HIV and 7,444 were reported with AIDS, had been reported to the Alabama Department of Public Health. Each one of these individuals is potentially capable of transmitting the virus to someone else and will ultimately have his/her life shortened due to virus infection.

(e) The lowest cost has been identified in areas, which have strong out-of-hospital support networks to provide services to AIDS and HIV positive patients. In addition to the obvious personal loss experienced by families and friends, the loss of productivity due to deaths of individuals with AIDS represents an economic cost to the state of more than $800 million.

(2) Recommendations
(a) The state needs to pursue three primary goals to deal with the problem of HIV/AIDS infection:

1. The elimination of HIV transmission from the infected population of Alabama to the uninfected population.

2. The provision of HIV services, both to prevent infection and to provide care in an environment free of discrimination and stigmatization.

3. The provision of appropriate and necessary health care to infected individuals.

(b) The State began participation in seroprevalence surveys with the Center for Disease Control (CDC) in 1987. Data from these surveys indicate that the State needs to continue to monitor the prevalence of infection in targeted at-risk individuals, such as homosexual/bisexual men, IV drug users, clients in Sexually Transmitted Diseases (STD) and Tuberculosis (TB) clinics, and women seeking prenatal and family planning services. Data collected in seroprevalence surveys should be used to target populations and geographic areas in need of HIV/AIDS prevention and educational efforts.

(c) The State needs to establish interventions to prevent the transmission of HIV from infected individuals to their sexual and/or needle sharing partners. This need can be addressed by HIV counseling/testing and partner notification services.

(d) Since AIDS is only the end of a spectrum of viral infection, the State needs to continue to monitor HIV infection through established reporting mechanisms. Physicians, laboratories, and others required by law to report should do so promptly to the Alabama Department of Public Health.

(e) Even if a vaccine were available for HIV/AIDS, efforts to prevent transmission of the HIV virus must rely heavily on education. Educational efforts must be targeted at the general community, as well as, to designated at-risk individuals and populations. Targeted educational messages must be specific, culturally sensitive and stress how the virus is transmitted and ways to reduce or eliminate the risk of transmission. Information directed at the general populace should not only focus on how the virus is transmitted and ways to reduce individual risk, but also stress how the virus is not transmitted so that discrimination, stigmatization and ostracism of infected individuals are eliminated. The Alabama Department of Public Health should serve as the focal point for HIV/AIDS educational and informational activities.
(f) The Alabama Department of Public Health has established a multi-agency task force (Alabama AIDS Prevention Network) which should serve to evaluate the effect of HIV/AIDS infection on the health care needs of Alabama and its impact on the state’s health care resources. A system of community-based care for infected individuals must be established and maintained utilizing home health services, Medicaid waiver programs, long-term care facilities, hospice programs, and volunteer agencies.

(g) Legislation defining the right of access to HIV information for individuals who have a compelling need to know was passed in late 1991. The State needs to continue to monitor and refine this legislation in order to allow exchange of “needed” information, but in a manner, which will protect confidentiality and prevent discrimination against the HIV infected.

Author: Statewide Health Coordinating Council (SHCC)

410-2-2-.06 Health Care For The Medically Indigent.

(1) The Problem

(a) There have been a number of studies and estimates to determine the number of medically uninsured and underinsured, both in Alabama and nationally. Although the statistics may vary among the various studies, the conclusions are all consistent in that a large percentage of the population has either no health insurance coverage or the coverage is inadequate. For example, the Alabama Department of Public Health in 2002 estimated that 14.6% (652,766) of Alabamians were uninsured sometime during that year. Most of the uninsured were found in families where at least one person is employed, and most of the employed worked in small businesses.

(b) Lack of health insurance coverage including mental health coverage contributes significantly to uncompensated care provided by those who deliver needed health care. The uninsured and underinsured often fail to seek needed health care services early when treatment is generally less expensive and more effective. The financial impact of the uninsured in Alabama is
shown by 2001 data compiled by the Alabama Medicaid Agency. Total uncompensated care in Alabama was estimated to be $553 million.

(c) Providers should pursue collections based upon economic means based policies in order to recover part of the cost of uncompensated care, and according to generally accepted standards. Bad debt is an increasing problem for Alabama providers.

(d) Bad debt is the unpaid charges/rates for services rendered from a patient and/or third party payer, for which the provider reasonably expected payment.

(e) Charity care is defined as health services for which a provider’s policies determine a patient is unable to pay. Charity care could result from a provider’s policies to provide health care services free of charge to individuals who meet certain pre-established criteria. Charity care is measured as revenue forgone, at full-established rates or charges. Charity care would not include contractual write-offs, but could include partial write-offs for persons unable to pay the full amount of a particular patient’s bill.

(f) Uncompensated care is the combination of charity care and bad debt.

(g) Each county is responsible for indigent residents.

(2) Recommendations

(a) The SHPDA should work with other state agencies to develop a database to determine the nature and extent of uncompensated care in Alabama and to monitor changes in the level of uncompensated care over time.

(b) The State is examining ways to encourage provision of medical insurance through employers and ways to more effectively utilize public funding sources.

(c) The State is examining establishment of a risk pool for small employers and for individuals who lose employer provided insurance.

(d) The Statewide Health Coordinating Council believes that access to care, which is mandated as a part of the Certificate of Need (CON) Review process shall include the historical and projected charity care provided by each CON applicant and the impact each CON approval will have on access to health care for the medically indigent.
Counties are encouraged to provide adequate resources to fulfill obligations in accordance with the following state statutes:

1. Article 7 Title 21 Known as Hospital Service Program for Indigents (22-21-210), et seq

2. Article 10 Title 21 Financial Responsibility for Indigent Healthcare (22-21-290), et seq

Author: Statewide Health Coordinating Council (SHCC)

410-2-2-.07 Preventable Diseases.

(1) Obesity

(a) Discussion (Sources: www.cdc.gov & www.surgeongeneral.gov)

1. In 2000, the prevalence of obesity (BMI > or = 30) among U.S. adults was 19.8 percent, which reflects a 61 percent increase since 1991.

2. An estimated 300,000 deaths per year in the United States may be attributable to obesity.

3. In 2001, Alabama had the seventh highest prevalence rate of obesity in the United States. This is an increase of over 10% since 1991.

4. Even moderate weight excess (10 to 20 pounds for a person of average height) increases the risk of death, particularly among adults aged 30 to 64 years.

5. Overweight and obesity are associated with heart disease, certain types of cancer, type 2 diabetes, stroke, arthritis, breathing problems, and psychological disorders, such as depression.

(2) Diabetes

(a) Discussion (Sources: www.adph.org & www.cdc.gov)
1. Almost 1 in 10 people in Alabama has been diagnosed with diabetes. Thousands are unaware that they have the disease.

2. Diabetes is the sixth leading cause of death for the year 2000 in Alabama. The diabetes-related death rate for Alabama and the United States has steadily increased since 1980. For 2000, the death rate in Alabama was 29.6 per 100,000 population, up from 28.0 in 1995. The Alabama rate has remained consistently above the national rate at 25.2 per 100,000 population for 1999.

3. More than 60 percent of lower limb amputations in the United States occur among people with diabetes. In 2000-2001, about 82,000 nontraumatic lower-limb amputations were performed among people with diabetes.

4. Diabetes is the leading cause of new cases of blindness among adults aged 20-74 years.

5. About 73% of adults with diabetes have blood pressure greater than or equal to 130/80 mm Hg or use prescription medications for hypertension.

(3) Hypertension (High Blood Pressure)

(a) Discussion (Sources: www.cdc.gov & www.encarta.msn.com)

1. Hypertension is a condition where the blood circulates through the arteries with too much force. Hypertension tires the heart, harms the arteries, and increases the risk of heart attack, stroke, and kidney problems.

2. Often called the “silent killer,” hypertension usually causes no symptoms until it reaches a life-threatening stage.

3. Hypertension affects 20 percent of people living in the United States. Of these, almost a third are unaware of their condition.

(4) Stroke

(a) Discussion (Sources: www.cdc.gov & www.adph.org)

1. Stroke is a type of cardiovascular disease. It affects the arteries leading to and within the brain. A stroke occurs when a blood vessel that carries oxygen and nutrients to
the brain is either blocked by a clot or bursts. When that happens, part of the brain cannot get the blood (and oxygen) it needs, so it starts to die.

2. Stroke is the third leading cause of death after heart disease and cancer and a leading cause of serious, long-term disability.

3. In 2000, stroke killed 167,661 people (61% of them women), accounting for about 1 out of every 14 deaths. The death rate was 61 per 100,000 population.

4. Each year about 700,000 people suffer a stroke (about 500,000 first attacks and 200,000 recurrent attacks).

5. After many years of steady decline, the stroke mortality rate among Alabamians has begun to increase. Since 1994, the rate has increased on average by more than 1 percent per year. Currently, stroke is the third leading cause of death in the state, accounting for more than 3,100 deaths in the year 2000.

(5) Summary

(a) Discussion (Source: Alabama Center for Health Statistics)

1. The Alabama age-adjusted death rate rankings for obesity related diseases are among the highest in the nation: 5th for heart disease, 7th for stroke, and 10th for diabetes. Left unabated, overweight and obesity will cause as much preventable disease and deaths as cigarette smoking. The estimated direct and indirect costs of obesity and being overweight in the US are $117 billion and rising rapidly. This figure exceeds even the annual costs of tobacco-related illnesses.

2. Because obesity is a chronic disease, it requires long-term management. Treatment focuses on losing weight to improve or eliminate related health problems or the risk for health problems, not to attain an ideal weight. Treatment consists of modifying your eating behaviors, physical activity, and monitoring your behavior, such as tracking what triggers you to eat, medication and surgery may be used if this treatment is not effective.

Treatment also covers the psychological and social components of obesity. Stress management and counseling may be helpful. Getting family support and creating community contacts help you deal with the stereotypes and other social issues that are associated with obesity.
3. Bariatric surgery such as stomach bypass and stomach stapling increased five fold in the 1990’s from about 4,900 operations in 1990 to 23,000 operations in 1999. The American Society of Bariatric Surgeons estimates 80,000 severely obese patients will get the operations in 2004. The International Bariatric Surgery Registry estimates one in 1,000 patients will die within four weeks of the surgery and three in 1,000 will die within three months. Some surgeons in the field put the fatality rate as high as one in 100 who have the surgery.

4. Americans collective weight gain leveled off in 2003 after half a decade of getting fatter, according to a new national survey of eating habits. Consumers appear to be focusing on healthier foods and more worried about the fats and additives. While fewer households were interested in dieting, 35 percent of Americans say they carefully plan to eat nutritious meals, which is a slight increase. More people are checking their food labels. 53 percent of Americans say they check food labels, up from 51 percent last year. And two-thirds of Americans say they exercise at least once a week.

Author: Statewide Health Coordinating Council (SHCC)  
### LEADING HEALTH INDICATORS FOR HEALTHY PEOPLE IN 2010

<table>
<thead>
<tr>
<th>HEALTH INDICATOR</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Activity</td>
<td>Regular physical activity throughout life is important for maintaining a healthy body, enhancing psychological well being, and preventing premature death.</td>
</tr>
<tr>
<td>Overweight and Obesity</td>
<td>Overweight and obesity are major contributions to many preventable causes of death. On average, higher body weights are associated with higher death rates.</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>Cigarette smoking is the single most preventable cause of disease and death in the United States. Smoking results in more deaths each year in the US than AIDS, cocaine, heroin, homicide, suicide, motor-vehicle crashes, and fires - - combined.</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Alcohol and illicit drug use are associated with many of this country’s most serious problems, including violence, injury, and HIV infection.</td>
</tr>
<tr>
<td>Responsible Sexual Behavior</td>
<td>Unintended pregnancies and sexually transmitted diseases (STDs), including infection with the human immunodeficiency virus that causes AIDS, can result from unprotected sexual behaviors.</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Approximately 20 percent of the U.S. population is affected by mental illness during a given year; no one is immune. Of all mental illnesses, depression is the most common disorder.</td>
</tr>
<tr>
<td>Injury and Violence</td>
<td>More than 400 Americans die each day from injuries due primarily to motor vehicle crashes, firearms, poisonings, suffocation, falls, fires and drowning. The risk of injury is so great that most persons sustain a significant injury at some time during their lives.</td>
</tr>
<tr>
<td>Environmental Quality</td>
<td>An estimated 25 percent of preventable illnesses worldwide can be attributed to poor environmental quality. In the U.S., air pollution alone is estimated to be associated with 50,000 premature deaths and an estimated $40 billion to $50 billion in health-related costs annually.</td>
</tr>
<tr>
<td>Immunization</td>
<td>Vaccines are among the greatest public health achievements of the 20th Century. Immunizations can prevent disability and death from infectious disease for individuals and can help control the spread of infections within communities.</td>
</tr>
<tr>
<td>Access to Health Care</td>
<td>Strong predictors of quality health care included in having health insurance, a higher income level, and a regular primary care provider or other source of ongoing health care. Use of clinical preventative services, such as early prenatal care, can serve as indicators of access to quality health care.</td>
</tr>
</tbody>
</table>

Source: www.healthypeople.gov
410-2-2-.08 Influenza.

(1) Problem

(a) Seasonal epidemics of influenza occur every year in the United States, beginning in the fall. Typically, the epidemics cause thousands to tens of thousands of deaths and about 200,000 hospitalizations.

(b) Since the 1940’s, a vaccine has been available to prevent influenza; unfortunately, the vaccine is not used as much as it should be. To prevent the hospitalizations and deaths caused every year by influenza virus, the Center for Disease Control and Prevention has recommended that all U.S. citizens more than 6 months of age receive the influenza vaccine.

(c) The rate of vaccination is low (25-45%).

(d) The cost of vaccination is minimal ($10-$18) depending on type (injections vs. nasal).

(e) Side effects are minimal.

(f) Influenza causes children to miss school, usually up to a week, which in some cases causes parents to miss work.

(2) Recommendations

(a) The State should consider adding the influenza vaccine to the required immunization schedule 420-6-1-.03 of the Code of Ala. 1975.

(b) Vaccinating school aged children would keep more kids in school and probably save the state millions of dollars.

Author: Statewide Health Coordinating Council (SHCC).
