

Education, Income, and Employment

Age, education, income, and employment are key demographic drivers of personal health status. In the previous section it was reported that the local service region is older than the state as a whole. In addition, the local service region is both less educated and less affluent than the state as a whole.

- In 2008, 24 percent of the service region population age 25 had not completed high school. This compares to 16 percent for the state as a whole.
- The 2008 estimated average household income within the service region was \$57,631, and the per capita income was \$23,717. Nearly 20,000 households – 24 percent of the total – had income below \$25,000. By comparison, Virginia as a whole is more affluent. Statewide, the average household income is above \$78,000, the per capita income is above \$30,000, and 19 percent of households with income below \$25,000.
- Among more than 163,000 service region residents age 16 or over in 2008, about 99,000 were employed in the civilian sector, about 3,800 were unemployed, and more than 60,000 were not in the labor force.

Births

Birth indicators are commonly used to measure community health status. A total of 2,354 births occurred to residents of the service region during 2007. Among these:

- A total of 165 births, or seven percent of the total, were low weight births. This compared to a statewide rate of 8.6 percent.
- A total of 620 births, or 26 percent of the total occurred to mothers who received late prenatal care (after the first trimester). This compares to a statewide rate of 16 percent.
- Within the service region, a total of 235 births were to teen mothers. Teen birth rate figures were not reliably available for the AHC Community Health Foundation service region as defined by zip codes. As a proxy, we compiled teen pregnancy rates for Health Planning District 6, which includes most of the AHC Community Health Foundation service region (see footnote 2). In 2007, the teen pregnancy rate per 1,000 females age 10-19 was 21.8 for Planning District 6, compared to a statewide rate of 27.2 per 1,000.

Infant Deaths

- Infant deaths are a commonly used measure of community health status. However, Infant death rate figures were not reliably available for the AHC Community Health Foundation service region as defined by zip codes. As a proxy, we compiled rates for Health Planning District 6, which includes most of the AHC Community Health Foundation service region (see footnote 2). In 2007 there were 22 infant deaths in Planning District 6. The average rate per 1,000 live births was 6.6, compared to a statewide rate of 7.7.

All Deaths

- A total of 1,895 deaths occurred to service region residents in 2007. The top ten leading causes of death were:
 - Major Cardiovascular Disease (n=592)
 - Malignant Neoplasm (n=452)
 - Unintentional Injury (n=101)
 - Alzheimer's Disease (n=84)
 - Chronic Lower Respiratory Disease (n=83)
 - Nephritis & Nephrosis (n=53)
 - Influenza & Pneumonia (n=53)
 - Diabetes (n=44)
 - Septicemia (n=30)
 - Suicide (n=25).
- When making comparisons it is customary to use age-adjusted death rates per 1,000 population rather than raw death rates. Age-adjusted death rates were not reliably available for the AHC Community Health Foundation service region as defined by zip codes. As a proxy, we compiled rates for Health Planning District 6, which includes most of the AHC Community Health Foundation service region (see footnote 2).
 - In 2007 the age-adjusted death rates in Planning District 6 were **higher** than the state rate for unintentional injury and Alzheimer's Disease, Nephritis & Nephrosis, Influenza and Pneumonia, and Suicide.
 - In 2007 the age adjusted death rates were **lower** than the state rate for Major Cardiovascular Disease (diseases of the heart and cerebrovascular disease), Cancer, Chronic Lower Respiratory Disease, Diabetes, and Septicemia.

Hospitalizations

Hospitalizations for ambulatory care sensitive conditions (ACSC hospitalizations) are defined as those “for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.”³ High rates of these hospitalizations may be an indication of ambulatory care access problems within the community.

According to data provided by Virginia Health Information, Inc, between July of 2007 and June of 2008 a total of 3,224 ACSC hospitalizations were recorded for residents of the service region).⁴ The primary diagnoses for these hospitalizations are shown below.

- Congestive Heart Failure (n=644)
- Bacterial Pneumonia (n=602)
- Chronic Obstructive Pulmonary Disease (n=458)
- Kidney & Urinary Tract Infection (n=342)
- Cellulitis (including Skin Graft with Cellulitis) (n=246)
- Diabetes (n=234)
- Dehydration (n=203)
- Asthma (n=191)
- Epileptic Events (n=72)
- Gastroenteritis (n=61)
- Hypertension (n=48)
- Convulsions (n=46)
- Severe Ear, Nose, or Throat Infection (n=19)
- Pelvic Inflammatory Disease (n=19)
- Dental Conditions (n=8)
- Hypoglycemia (n=7)
- Immunization-Related Conditions (n=3)

Within the service region, there were 16.2 ACSC hospitalizations per 1,000 population, compared to a statewide rate of 13.9 per 1,000. However, these figures are not age-adjusted. Given that the AHC Community Health Foundation service region has a higher prevalence of older Virginians than the state as a whole, and that ACSC hospitalizations are more common among older populations, the difference between local and state rates could be largely attributable to age.

³ Agency for Healthcare Research and Quality, 2004.

⁴ VHI requires the following statement to be included in this report: Virginia Health Information (VHI) has provided non-confidential patient level information used in this report which was compiled in accordance with Virginia law. VHI has no authority to independently verify this data. By accepting this report the requester agrees to assume all risks that may be associated with or arise from the use of inaccurately submitted data. VHI edits data received and is responsible for the accuracy of assembling this information, but does not represent that the subsequent use of this data was appropriate or endorse or support any conclusions or inferences that may be drawn from the use of this data.

Health Coverage Estimates

Community Health Solutions analyzed multiple sources of national and state data to develop estimates of the number of uninsured in the service region. These are 'synthetic estimates' in which national and state estimates for specific population estimates are applied to the particular demographic profile of the local region. These estimates are instructive for planning, but they may or may not be as statistically accurate as an actual survey.

- In 2008 an estimated 15 percent of the service region population, or more than 29,600 individuals, were uninsured at any given point in time. An estimated 14,500 uninsured lived in households with income below \$25,000 per year.
- The uninsured population is estimated to include about 25,000 adults and 4,600 children. Among households with uninsured members, it is likely that two thirds or more had someone working full time, and 75 percent or more had someone working full or part time.
- Given that synthetic estimates are not based on primary data collection, we do not make direct comparisons between the local and statewide rates.

Adult Health Estimates

Community Health Solutions analyzed national and state data from the U.S Behavioral Risk Factor Survey to develop estimates of the number of adults age 18 and over who have or are at risk for particular health issues. Like the health insurance estimates reported earlier in this report, these are 'synthetic estimates' which are useful for planning but not based on actual surveys of area residents. In this sense the results are instructive but not necessarily definitive. The findings for the service region:

- An estimated 76 percent of adults (n=121,027) are not eating enough fruits and vegetables
- An estimated 57 percent of adults (n=90,408) are overweight or obese
- An estimated 31 percent of adults (n=49,569) have high cholesterol
- An estimated 30 percent of adults (n=47,492) have arthritis
- An estimated 28 percent of adults (n=44,508) have high blood pressure
- An estimated 22 percent of adults (n=34,973) smoke
- An estimated 22 percent of adults (n=34,585) have not exercised in the past 30 days
- An estimated 20 percent of adults (n=31,220) have physical limitations due to health concerns
- An estimated 18 percent of adults (n=28,062) have not seen a dentist in two years.
- An estimated 15 percent of adults (n=24,172) are at risk for binge drinking

- An estimated 15 percent of adults (n=23,383) are in fair to poor overall health status
 - An estimated 13 percent of adults (n=19,978) have asthma
 - An estimated 8 percent of adults (n=12,464) have diabetes
- Given that these estimates are not derived from primary data, we do not make direct comparisons between the local and statewide rates.

Strategic Discussion Points

The study results are not surprising for a local service region of this size, geography, and demography. There is a substantial need to promote healthier lifestyles. There is also a substantial need to develop stronger and more integrated community services. All of this must be done against the backdrop of a serious economic recession and an aging population. The choices are not easy.

As discussion starters, we identify five strategic issues which the AHC Community Health Foundation may wish to consider as part of its continuing discussion in response to this study.

Population Health and Service Capacity

One strategic option is to focus primarily on improving health for one or more *populations* – for example, children, seniors, people with chronic disease, pregnant women, people with mental health or substance abuse problems, etc. Another strategic option is to focus primarily on improving community capacity in one or more discrete service areas such as primary care, mental health services, family services, etc. A third option is to merge elements of the first two. The AHC Community Health Foundation may wish to spend some time exploring the strategic pros and cons of these approaches.

Health Promotion, Prevention, and Treatment

Virtually every community health assessment raises questions about the proper balance between health promotion, preventive services, and treatment services. All are needed, but each may require a different investment strategy and development timeframe depending on the particular nature of community needs and potential community assets. The AHC Community Health Foundation may wish to spend some time exploring the strategic pros and cons of focusing on one or more of these emphases.

The Potential of Partnership

The issues facing communities today are too complex for any single organization or sector to address by itself. Community collaboration is expected to become more important than ever as communities struggle to do more with less. The AHC Community Health Foundation may wish to creatively consider a wide range of partnership strategies as it develops its strategic plans for the future.

The Question of Impact

Many foundations are struggling with the question of impact. On the one hand, any community investor would like to see demonstrable payback on their investment in terms of positive community impact. On the other hand, achieving and measuring impact requires an investment in evaluation research which not every foundation is willing to make. The AHC Community Health Foundation may wish to spend time clarifying the extent to which it values demonstrable community impact in return for its investments – and the implications for investment decisions.

The Economy, the Age Wave, and Community Roles

Community leaders across the country are in the process of trying to understand the implications of the economic recession for community health. It seems clear that in the short run there is and will continue to be increasing demand for community services. Most analysts admit that the long run scenario remains a question mark.

Compounding the economic recession and its ripple effects is the coming age wave. The aging of the baby boomers is a major concern at the federal, state, and local level as policy makers and community stakeholders ponder what will happen to federal entitlements, local tax bases, and local service demands, etc.

Given the economic crisis and the age wave, how will the roles of federal, state, and local government change – and how will this affect community infrastructure and the role of local foundations? This is an important strategic question for every foundation engaged in strategic planning.

A Checklist for United Ways that are Planning for, Implementing, Sustaining, Using and Seeking to Benefit from Program Outcome Measurement

Indicators below are indicators that United Ways have identified as important in planning for, implementing, sustaining, using and benefiting from program outcome measurement. The numbers in parentheses show the percentage of respondents saying the indicator was "True here and essential" / "Not true here but wish it were." Using the checklist will help your United Way take advantage of the experience of others on this journey. Review each section of this report and the data in Appendix A to add indicators of special concern in your United Way.

IS OUR UNITED WAY. . .

	We haven't thought about this	We're making progress	We've taken care of this
PREPARED TO PLAN FOR PROGRAM OUTCOME MEASUREMENT?			
The president/executive director is interested in developing program outcome measurement. (100/0)			
Some staff are interested in developing program outcome measurement. (95/2)			
Staff are aware of United Way of America support and resources. (90/2)			
There has been preliminary discussion with some agencies regarding program outcome measurement. (89/6)			
Some board members are interested in developing program outcome measurement. (86/8)			
PREPARED TO IMPLEMENT PROGRAM OUTCOME MEASUREMENT?			
Some (staff, volunteers, agencies) are committed to a focus on outcomes. (97/3)			
United Way can dedicate some time to outcome measurement. (97/3)			
We have identified key staff and volunteer leadership for the effort. (95/5)			
We have identified available resources. (92/6)			
There are plans for building agency outcome measurement capacity that include:			
• Agency training. (89/9)			
• Availability of technical assistance. (82/15)			
• United Way feedback and support for improvements. (80/17)			
Key stakeholders know WHY we are doing this. (84/13)			
There is a strategy and timeline for training staff. (78/19)			
There is a strategy and timeline for training volunteers. (77/22)			
Key stakeholders know this takes time. (77/21)			
Key stakeholders have realistic expectations. (74/25)			

IS OUR UNITED WAY. . .

	We haven't thought about this	We're making progress	We've taken c of thi
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PREPARED TO SUSTAIN PROGRAM OUTCOME MEASUREMENT?

The organization has demonstrated a commitment to stay the course. (98/2)			
Some agencies can articulate the benefits of outcome measurement. (97/2)			
We ask for outcome information from agencies. (95/5)			
We provide technical assistance. (83/16)			
We provide ongoing training. (83/14)			
The understanding of outcome measurement extends beyond a single outcome "champion." (82/17)			
Volunteer and staff structures support the outcome focus. (81/19)			
We have strategies in place to improve outcome measurement practice. (70/27)			
We have a system in place for accepting outcome measurement data. (64/32)			
Multiple staff and volunteers are aware of and use available resources. (63/32)			
Staff and volunteers know which data is useful. (62/37)			
Staff are trained in the use of outcome data. (60/37)			
Public and donors are aware of the commitment and the process of program outcome measurement. (45/45)			
Staff and volunteers use data consistently. (44/52)			

PREPARED TO USE PROGRAM OUTCOME MEASUREMENT?

We have someone who is prepared to judge the quality of programs' outcome measurement effort. (86/11)			
Funding criteria include consideration of programs' learning and improvement. (75/20)			
The organization sees the benefit of an outcome focus in its own work (66/29)			
We have a strategy to continue to support training and technical assistance. (63/31)			

IS OUR UNITED WAY. . .

	We haven't thought about this	We're making progress	We've taken care of this
ACTUALLY USING PROGRAM OUTCOME MEASUREMENT?			
Marketing and communications staff use outcome messages in materials. (73/23)			
Resource development and campaign refer to outcome measurement in appeals. (72/22)			
We can give examples of significant program changes associated with outcome measurement. (63/34)			
BENEFITING FROM PROGRAM OUTCOME MEASUREMENT?			
The organization uses program outcome data to enhance marketing and fundraising messages. (73/27)			
The organization uses program outcome data to increase accountability to donors. (73/23)			
The organization uses its focus on program outcome measurement to improve its image and become more visible. (70/26)			
The organization uses its focus on program outcomes to retain, maintain or increase dollars. (68/29)			
The organization uses outcome data to identify where improvement is needed. (60/38)			
The organization uses its focus on program outcomes to create a problem-solving environment and a learning organization. (51/44)			