**Dashboard for Health**

**Introduction**

A community health improvement plan (CHIP) is a community-driven, long-term, systematic plan to address issues identified in a community health assessment (CHA). The purpose of the CHIP is to describe how hospitals, health departments, and other community stakeholders will work to improve the health of the county. A CHIP is designed to set priorities, direct the use of resources, and develop and implement projects, programs, and policies. The CHIP is more comprehensive than the roles and responsibilities of health organizations alone, and the plan’s development must include participation of a broad set of community stakeholders and partners. This CHIP reflects the results of a collaborative planning process that includes significant involvement by a variety of community sectors.

Portage County Community Health Partners has been conducting CHAs since 2015 to measure community health status. The most recent Portage County CHA was cross-sectional in nature and included a written survey of adults, adolescents, and children within Portage County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention (CDC) for the national and state Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), and National Survey of Children’s Health (NSCH). This has allowed Portage County to compare their CHA data to national, state and local health trends. Community stakeholders were actively engaged in the early phases of CHA planning and helped define the content, scope, and sequence of the project.

Portage County Community Health Partners contracted with the Hospital Council of Northwest Ohio (HCNO), a neutral, regional, nonprofit hospital association, to facilitate the CHA and CHIP. Portage County Community Health Partners then invited various community stakeholders to participate in community health improvement process. Data from the most recent CHA were carefully considered and categorized into community priorities with accompanying strategies. This was done using the National Association of County and City Health Officials’ (NACCHO) national framework, Mobilizing for Action through Planning and Partnerships (MAPP). Over the next three years, these priorities and strategies will be implemented at the county-level with the hope to improve population health and create lasting, sustainable change. It is the hope of Portage County Community Health Partners that each agency in the county will tie their internal strategic plan to at least one strategy in the CHIP.

**Public Health Accreditation Board (PHAB) Requirements**

National Public Health Accreditation status through the Public Health Accreditation Board (PHAB) is the measurement of health department performance against a set of nationally recognized, practice-focused and evidenced-based standards. The goal of the national accreditation program is to improve and protect the health of the public by advancing the quality and performance of Tribal, state, local, and territorial public health departments. PHAB requires that CHIPs be completed at least every five years, however, Ohio state law (ORC 3701.981) requires that health departments and hospitals collaborate to create a CHIP every 3 years. Additionally, PHAB is a voluntary national accreditation program, however the State of Ohio requires that all local health departments become accredited by 2020, making it imperative that all PHAB requirements are met.

PHAB standards also require that a community health improvement model is utilized when planning CHIPs. This CHIP was completed using NACCHO’s MAPP process. MAPP is a national, community-driven planning process for improving community health. This process was facilitated by HCNO in collaboration with various local agencies representing a variety of sectors.

**Mobilizing for Action through Planning & Partnerships (MAPP) Process Overview**

This 2020-2022 CHIP was developed using the Mobilizing Action through Partnerships and Planning (MAPP) process, which is a nationally adopted framework developed by the National Association of County and City Health Officials (NACCHO) (see Figure 1.1). MAPP is a community-driven planning process for improving community health and is flexible in its implementation, meaning that the process does not need to be completed in a specific order. This process was facilitated by HCNO in collaboration with a broad range of local agencies representing a variety of sectors of the community. This process involved the following six phases:

**1. Organizing for success and partnership development**

**Figure 1.1 The MAPP Framework**



During this first phase, community partners examined the structure of its planning process to build commitment and engage partners in the development of a plan that could be realistically implemented. With a steering committee already in place, members examined current membership to determine whether additional stakeholders and/or partners should be engaged, its meeting schedule (which occurs on a quarterly basis and more frequently as needed), and responsibilities of partnering organizations for driving change. The steering committee ensured that the process involved local public health, health care, faith-based communities, schools, local leadership, businesses, organizations serving minority populations, and other stakeholders in the community health improvement process.

**2. Visioning**

Next, steering committee members re-examined its vision and mission. Vision and values statements provide focus, purpose, and direction to the CHA/CHIP so that participants collectively achieve a shared vision for the future. A shared community vision provides an overarching goal for the community—a statement of what the ideal future looks like. Values are the fundamental principles and beliefs that guide a community-driven planning process.

**3. The four assessments**

While each assessment yields valuable information, the value of the four MAPP assessments is multiplied considering results as a whole. The four assessments include: The Community Health Status Assessment (CHSA), the Local Public Health System Assessment (LPHSA), the Forces of Change (FOC) Assessment, and the Community Themes and Strengths Assessment (CTSA).

**4. Identifying strategic issues**

The process to formulate strategic issues occurs during the prioritization process of the CHA/CHIP. The committee considers the results of the assessments, including data collected from community members (primary data) and existing statistics (secondary data) to identify key health issues. Upon identifying the key health issues, an objective ranking process is used to prioritize health needs for the CHIP.

In order to identify strategic issues, the steering community considers findings from the visioning process and the MAPP assessments in order to understand why certain issues remain constant across the assessments. The steering committee uses a strategic approach to prioritize issues that would have the greatest overall impact to drive population health improvement and would be feasible, given the resources available in the community and/or needed, to accomplish. The steering committee also arranged issues that were related to one another, for example, chronic disease related conditions, which could be addressed through increased or improved coordination of preventative services. Finally, the steering committee members considered the urgency of issues and the consequences of not addressing certain items.

**5. Formulate goals and strategies**

Following the prioritization process, a gap analysis is completed in which committee members identify gaps within each priority area, identify existing resources and assets, and potential strategies to address the priority health needs. Following this analysis, the committee to formulate various goals, objectives, and strategies to meet the prioritized health needs.

**6. Action cycle**

The steering committee begins implementation of strategies as part of the next community health improvement cycle. Both progress data to track actions taken as part of the CHIP’s implementation and health outcome data (key population health statistics from the CHA) are continually tracked through ongoing meetings. As the end of the CHIP cycle, partners review progress to select new and/or updated strategic priorities based on progress and the latest health statistics.

**Strategies**

To work toward **improving mental health, substance use and addiction outcomes** the following action steps are recommended:

Mental Health Strategies

1. Assess, develop, and provide mental health resources to youth and adults in Portage County

2. Screening for Adverse Childhood Experiences (ACEs) using a standardized tool

3. Screening for suicide for patients 12 or older using a standardized tool

4. Youth alcohol/other drug prevention and mental health programs

5. Community-based comprehensive plan to reduce alcohol and drug abuse

6. Increase awareness and accessibility of treatment options for those with substance use disorder

Substance Use and Addiction Strategies

7. Safe Communities campaign

8. Tobacco-free policies

9. Links to cessation support

10. Data sharing

To work toward **improving chronic disease outcomes**, the following actions steps are recommended:

1. Food insecurity screening and referral

2. Nutrition prescriptions

3. Healthy eating practices through fostering self-efficacy

4. Prediabetes screening and referral

5. Hypertension screening and follow up

6. Increase awareness of nutrition/physical activity resources

7. Prescriptions for health

8. Community gardens

9. Shared use (joint use agreements)

10. Community fitness programs

To work toward **improving maternal, child and infant health outcomes,** the following actions steps are recommended:

1. Reproductive health interventions

2. Home visiting programs that begin prenatally

3. Increase enrollment of WIC program

4. Provide referrals/resources to all patients on health insurance access to ensure reproductive health care

5. Create and implement a Safe Kids Coalition plan

To develop **cross-cutting strategies that address multiple priorities**, the following action steps are recommended:

Social Determinants of Health

1. Home improvement loans and grants

2. Service-enriched housing

3. Outreach to increase uptake for earned income tax credits

4. Financial literacy

5. Increase transportation through a county transportation plan

Healthcare System and Access

1. School-based health centers

2. Health transportation outreach

3. Health insurance enrollment and outreach

4. Expand SOAR Student-Run Free Clinic

Health Equity

1. Implicit bias training