Developing Goals, Objectives, and Performance Indicators for Community Health Improvement Plans (CHIPs)

May 9, 2012

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Community Indicators Consortium

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St. Clair County Health Department
Belleville, IL
Webinar Logistics

• The lines are muted. If you wish to mute/unmute your line to ask/answer a question, please do the following:
  • To **unmute** your own line, **press** *7
  • To **mute** your own line, **press** *6.

• Throughout the presentation and during the Q&A session, if you have a question, please use ReadyTalk’s ‘raise your hand’ feature or use the chat box to indicate you have a question. The facilitator will call your name and ask for your question.
PROJECT REQUIREMENTS & PHAB STANDARDS AND MEASURES: DEVELOPING A CHIP
Project Requirements: Developing a CHIP

Engage Community Members and LPHS Partners

“Community members must be engaged in a meaningful and substantive way throughout the CHA and CHIP processes, including indicator selection, data collection, data analysis, data presentation and distribution, issue prioritization, **CHIP creation**, implementation of CHIP, and monitoring of results.”

“Partners should be engaged in a strategic way **throughout the CHA and CHIP processes**, including gaining access to data, mobilizing community members, data collection, data review, issue prioritization, and CHIP implementation.”
Project Requirements: Developing a CHIP

Address the Social Determinants of Health

- “Consider multiple determinants of health, especially social determinants like social and economic conditions that are often the root causes of poor health and health inequities among sub-populations in their jurisdictions.”

- The project seeks to ensure that the CHAs conducted and the CHIPs developed have a particular focus on the following: Identifying populations within their jurisdictions with an inequitable share of poor health outcomes… **Including at least one of these issues as a priority for community health improvement efforts** in addition to other health priorities in the CHIP.
Project Requirements: Developing a CHIP

Required characteristics of the CHIP:

Background information that does the following:

• Describes the jurisdiction for which the CHIP pertains and a brief description of how this was determined.

• Briefly describes the way in which community members and LPHS partners were engaged in development of the CHIP, particularly their involvement in both the issue prioritization and strategy development.

• Includes a general description of LPHS partners and community members who have agreed to support CHIP action. Reference partners’ participation in the short term and long term as applicable.

Priority issues section that does the following:

• Describes the process by which the priorities were identified.

• Outlines the top priorities for action. The priorities need to include at least one priority aimed at addressing a social determinant of health that arose as a key determinant of a health inequity in the jurisdiction.

• Includes a brief justification for why each issue is a priority.
Required characteristics of the CHIP cont’d:

A CHIP implementation plan that does the following:

• Provides clear, specific, realistic, and action-oriented goals.

• Contains the following:
  • **Goals, objectives, strategies, and related performance measures for determined priorities in the short-term (one to two years) and intermediate term (two to four years),**
  • **Realistic timelines for achieving goals and objectives.**
  • Designation of lead roles in CHIP implementation for LPHS partners, including LHD role.
  • Formal presentation of the role of relevant LPHS partners in implementing the plan and a demonstration of the organization’s commitment to these roles via letters of support or accountability.
  • Emphasis on evidence-based strategies.
  • A general plan for sustaining action.
PHAB Requirements: Developing a CHIP

*Be sure to review the standards listed below to identify the measures and required documentation that PHAB seeks related to developing a CHIP.

Standard 5.2: Conduct a comprehensive planning process resulting in a tribal/state/community health improvement plan
PHAB Requirements: Developing a CHIP

For example...

**Measure 5.2.1 L: Conduct a process to develop community health improvement plan**

*Required documentation:* Completed community health improvement planning process that included 1a. Broad participation of community partners; 1b. Information from community health assessments; 1c. Issues and themes identified by stakeholders in the community; 1d. Identification of community assets and resources; and 1e. A process to set community health priorities.

**Measure 5.2.2 L: Produce a community health improvement plan as a result of the community health improvement process**

*Required documentation:* CHIP dated within the last five years that includes 1a: Community health priorities, measurable objectives, improvement strategies and performance measures with measurable and time-framed targets; 1b. Policy changes needed to accomplish health objectives; c. Individuals and organizations that have accepted responsibility for implementing strategies; 1d. Measurable health outcomes or indicators to monitor progress; and 1e. Alignment between the CHIP and the state and national priorities.
For example...

Measure 5.2.3A: Implement elements and strategies of the health improvement plan, in partnership with others* Required documentation: 1. Reports of actions taken related to implementing strategies to improve health [Guidance: ...provide reports showing implementation of the plan. Documentation must specify the strategies being used, the partners involved, and the status or results of the actions taken...]; 2. Examples of how the plan was implemented [Guidance: ...provide two examples of how the plan was implemented by the health department and/or its partners].

Measure 5.2.4A: Monitor progress on implementation of strategies in the CHIP in collaboration with broad participation from stakeholders and partners* Required documentation: 1. Evaluation reports on progress made in implementing strategies in the CHIP including: 1a. Monitoring of performance measures and 1b. Progress related to health improvement indicators [Guidance: Description of progress made on health indicators as defined in the plan...]; and 2. Revised health improvement plan based on evaluation results [Guidance: ...must show that the health improvement plan has been revised based on the evaluation listed in 1 above...]

* Not required as part of the CHA/CHIP Project
Learning Objectives

At the completion of the session participants will be able to:

1. State the difference between a goal and objective.
2. Write a realistic, measurable and time-framed objective.
3. Discuss how national guidance, such as Healthy People 2020 can be used to guide goal and objective development.
4. Create performance indicators for at least two activities.
5. Identify processes for monitoring achievement of goals and objectives.
6. Re-state the project and PHAB documentation requirements for goals, objectives and performance monitoring in the CHIP.
What Is A Logic Model?

• A succinct series of statements linking goals, objectives and resources to strategies, tactics and their performance, and outcomes

• It shows the connections between what you do and what you are trying to accomplish

• A tool to help you identify and clarify what you’re trying to achieve, what you plan to do to get to there, and what you’ll need to do this

• An easy way to quickly show what the project/program entails, looks like, and seeks to change

• It allows stakeholders to improve and refine the project/program

• It reveals assumptions about the conditions needed for the project/program to be effective and what the program is intended to do

• It is a “road map”
Logic Models to Illustrate “Theories of Change”

**Situation**
Description of the problem.
Can be phrased as a **Goal** statement.

**Inputs**
- Resources
- Partners
- Assets

**Activities**
**Strategies and Tactics**
Logic model frameworks tend not to include “Strategies” explicitly, but feel free to add them.

**Outputs**
Performance Indicators documenting how much of or how well the Activities or **Tactics** were performed.

**Outcomes**
Objectives documented with **Outcome Indicators** reflecting the data.
Can be short-, intermediate- and/or long-term.
Two Useful Guides on Logic Models

United Way’s Measuring Program Outcomes: A Practical Approach:
http://www.unitedwaystore.com/product/measuring_program_outcomes_a_practical_approach/program_film

Community Anti-Drug Coalitions of America, Assessment Primer: Analyzing the Community, Identifying Problems and Setting Goals:
http://www.cadca.org/resources/detail/assessment-primer
Component of a Plan: Example Statements

Goal: Reduce the use of marijuana and alcohol use by youth.

Objectives: a) Decrease the percentage of youth using marijuana from 20% to 15% by 2014.  
b) Decrease the percentage of youth drinking alcohol from 50% to 30% by 2014.

Outcome Indicators: a) Percentage of middle and high school students indicating that they use marijuana. 
b) Percentage of middle and high school students indicating that they drink alcohol.

Strategies: a) Provide information to youth about the dangers and consequences of using marijuana and alcohol. 
b) Build the skills of parents and other adults to talk with their children about the dangers and consequences of using marijuana and alcohol. 
c) Reduce the access of marijuana and alcohol in the community.

Tactics: a) Provide marijuana and alcohol awareness programs to youth in middle and high schools. 
b) Provide workshops for parents and create parent chat groups 
c) Work with law enforcement to do local vendor compliance checks on alcohol sales to minors. 
d) Set up a tip line on marijuana sales.

Performance Indicators: a) Pre- and post test results of youth participating in awareness programs. 
b) Number of parents attending workshops. 
c) Number of parents participating in chat groups. 
d) Number of vendors who pass alcohol compliance checks. 
e) Number of calls to the tip line.
### Example of a Logic Model Using the Previous Statements

<table>
<thead>
<tr>
<th>Situation</th>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal:</td>
<td>Local School System</td>
<td>Provide information to youth about the dangers &amp; consequences of using marijuana &amp; alcohol</td>
<td>Pre-and post test results of youth participating in awareness programs</td>
<td>Decrease the % of youth using marijuana from 20% to 15% by 2014</td>
</tr>
<tr>
<td>Reduce the use of marijuana and alcohol use by youth</td>
<td>PTAs</td>
<td>-Provide marijuana and alcohol awareness programs to youth in middle &amp; high schools</td>
<td></td>
<td>-% of middle &amp; high school students indicating they use marijuana</td>
</tr>
<tr>
<td></td>
<td>Police Department</td>
<td>Build the skills of parents &amp; other adults to talk with their children about the dangers &amp; consequences of using marijuana and alcohol</td>
<td>Number of parents attending workshops</td>
<td>- % of middle &amp; high school students indicating they drink alcohol</td>
</tr>
<tr>
<td></td>
<td>Chamber of Commerce</td>
<td>-Provide workshops for parents and create parent chat groups</td>
<td>Number of parents participating in chat groups</td>
<td></td>
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<tr>
<td></td>
<td>Funding</td>
<td>Reduce the access of marijuana &amp; alcohol in the community</td>
<td>Number of vendors who pass alcohol compliance checks</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>- Work with law enforcement to do local vendor compliance checks of alcohol sales to minors</td>
<td>Number of calls to the tip line</td>
<td></td>
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</tbody>
</table>
Examples of Population Outcomes

**Outcomes:** Measurable changes in behaviors, attitudes or conditions.

**Goal:** Decrease the number of low birth weight births so more infants live after birth.

**Objective:** By 2013-2015, the three year rolling average for low birth weight births will decrease from 8.5% in 2009-2011 to 7.8%.

**Outcome Indicator:** Percentage of low birth weight births annually and the average percentage of low birth weight births over a three time period.

**Goal:** Reduce the rate of teenage pregnancies.

**Objective:** By 2015, reduce the rate of teen pregnancies from 30 per 1,000 teenagers (aged 12-19) to 27 per 1,000 teenagers.

**Outcome Indicator:** The number of teen pregnancies per 1,000 teenagers annually.

**Goal:** Decrease the number of families living in shelters.

**Objective:** By 2014, the number of homeless families living in shelters will decrease from 146 in 2012 to 130.

**Outcome Indicator:** The number of homeless families living in shelters annually.
Examples of Performance Indicators

**Performance Indicator:** A measure of the extent to which a tactic has been accomplished.

**Tactic:** Provide counseling to at-risk pregnant females about the impact of smoking on the birth weight of their baby.

**Performance Indicator:**
- a) The number of counseling sessions provided.
- b) The number of at-risk pregnant females who participated in counseling sessions and who stop smoking during pregnancy.

**Tactic:** Implement a text-line for youth to ask questions and receive answers about sex.

**Performance Indicator:**
- a) Number of questions submitted on a monthly basis.
- b) Amount of time to respond to questions.

**Tactic:** Create and deliver a financial literacy education program for homeless families.

**Performance Indicator:**
- a) Percentage of homeless families who participated in the financial literacy education program.
- b) Pre- and post-test of families who participated in the financial literacy education program.
An Example of a Monitoring Process

- Establish a team responsible for monitoring progress of (1) objectives and outcome indicators and (b) tactics and performance indicators.
- Report out progress information (objectives and outcome indicators and tactics and performance indicators) to steering committee or governing committee and all partners. This can be done monthly, every 3 months, every 6 months or annually depending on when outcome and performance data are available.
- Hold assessment sessions to discuss “How are we doing?”
  - What is going well? Why?
  - What is not going well? Why?
  - What changes or improvements are needed regarding the tactics? Develop a plan and implement changes or improvements

**The key is to develop a monitoring process to provide continuous feedback on how well things are going and to make changes/improvements when necessary.**
Collaborating for Health Improvement: A MAPP-based Approach
St. Clair County, Illinois

Wednesday, May 9, 2012

Mark Peters, MS
Director of Community Health
St. Clair County Health Department
SCC Health Care Commission

- **Coalition** of major health providers and community based organizations
- **Committed** to common cause of health improvement
- **Convened** by Public Health Board with support of County Board
Who Serves on the Commission?

- County Office on Aging
- Community Hospitals
- Community Health Center
- Medical Society
- SIUE School of Nursing
- Regional Office of Education
- Mental Health Board
- East Side Health District
- St. Clair County Health Dept
- Scott Air Force Base
- Programs/Services Older Persons
- Community Based Organizations
Our Goal

Partners for health improvement through prevention.
Our Principles

• Collaboration not competition
• Coordination not control
• Communication with confidentiality
• Common goals with consideration of individual mission
• Capitalize on community strengths
• Collective Commitment to community health improvement
Mobilizing for Action through Planning and Partnerships (MAPP)

A strategic approach to community health improvement. This tool helps communities improve health and quality of life through community-wide and community-driven strategic planning.

A **six-phase process** of community health assessment and planning.
MAPP Model

Community Themes & Strengths Assessment
- Organize for Success
- Partnership Development
- Visioning

Four MAPP Assessments
- Identify Strategic Issues
- Formulate Goals and Strategies

Evaluate Plan
- Action
- Implement

Forces of Change Assessment

Local Public Health System Assessment

Community Health Status Assessment
2006-11 MAPP Strategic Issues

How can the St. Clair County health care community:

- create a broader community connectedness
- strengthen the public health workforce
- address the needs of those who require behavioral health services
- improve health outcomes for cardiovascular diseases, maternal and child health and respiratory diseases
- improve health services to the aging community
- improve access to care
- reduce incidence of sexually transmitted disease*

* added in 2008
2011-16 MAPP Strategic Issues

• Risk Factor Prevention for Chronic Disease
  o Obesity (Active Living/Healthy Eating)
  o Tobacco Use

• Maternal and Child Health
  o Infant Mortality
  o Teen Pregnancy

• Behavioral Health
  o Suicide Prevention
  o Substance Abuse

• Violence Prevention & Safety
  o Homicide
  o Domestic Violence
  o Neighborhood Safety
2011-16 MAPP Strategic Issues

- **Risk Factor Prevention for Chronic Disease**
  - Obesity (Active Living/Healthy Eating)
  - Tobacco Use

- **Maternal and Child Health**
  - Infant Mortality
  - Teen Pregnancy

- **Behavioral Health**
  - Suicide Prevention
  - Substance Abuse

- **Violence Prevention & Safety**
  - Homicide
  - Domestic Violence
  - Neighborhood Safety
Formulating Goals and Strategies
Establish SMART Outcome & Impact Objectives:

- Simple
- Measureable
- Achievable
- Relevant
- Time-based

<table>
<thead>
<tr>
<th><strong>HEALTH PROBLEM:</strong> CHRONIC DISEASE</th>
<th><strong>OUTCOME OBJECTIVE:</strong></th>
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</thead>
<tbody>
<tr>
<td>Morbidity and Mortality due to select chronic diseases:</td>
<td>By the year 2016, reduce the premature mortality rates per 100,000 population for Lung Cancer, COPD, Heart Disease and Diabetes to 34.1, 19.5, 77.1 and 20.2, respectively (20 percent of their current rate).</td>
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<tr>
<td>• Diabetes</td>
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<tr>
<td>• Heart Disease</td>
<td></td>
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<tr>
<td>• Lung Cancer and COPDs.</td>
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<table>
<thead>
<tr>
<th><strong>RISK FACTOR(S):</strong></th>
<th><strong>IMPACT OBJECTIVE(S):</strong></th>
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<tbody>
<tr>
<td>• Tobacco Use</td>
<td>• By the year 2013, reduce the percent of adults (age 18 and older) who consumes less than 5 servings of fruits and vegetables per day from 79.8 percent (2007 BRFSS) to 60 percent.</td>
</tr>
<tr>
<td>• Inactive Lifestyle</td>
<td>• By the year 2013, reduce the percentage of adults who report doing no leisure time exercise or physical activity in the past 30 days from 24.3 percent (2009 SMART BRFSS) to 20 percent.</td>
</tr>
<tr>
<td>• Environmental Factors</td>
<td>• By the year 2013, improve attendance and participant compliance of local smoking cessation programs among community support and treatment organizations by 10 percent annually.</td>
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<tr>
<td>• Ambient Air Conditions</td>
<td></td>
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<tr>
<td>• Poor Eating Habits</td>
<td></td>
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<table>
<thead>
<tr>
<th><strong>CONTRIBUTING FACTORS (DIRECT/INDIRECT):</strong></th>
<th><strong>INTERVENTION STRATEGIES:</strong></th>
</tr>
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<tbody>
<tr>
<td>• Influence of peers, family and culture</td>
<td>• Increase promotion of QUITLINE and local Tobacco Cessation programs</td>
</tr>
<tr>
<td>• Lack of smoke-free policy and programs for smoking awareness and cessation</td>
<td>• Increase promotion of alternatives to leaf burning</td>
</tr>
<tr>
<td>• Access to Healthy Affordable Foods</td>
<td>• Increase the participation of communities and schools in the County’s Get Up &amp; Go Campaign</td>
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<tr>
<td>• Level of addiction</td>
<td>• Utilization of media and cessation products</td>
</tr>
<tr>
<td>• Stress/financial burden for employer/healthcare system</td>
<td>• Enhance screening, counseling and referral among healthcare providers</td>
</tr>
<tr>
<td>• Educational Attainment</td>
<td>• Expand advocacy participation among state level</td>
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<tr>
<td></td>
<td>• Strengthen workplace enforcement, screening, referral and hiring policies</td>
</tr>
</tbody>
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<tr>
<th><strong>COMMUNITY STAKEHOLDERS &amp; RESOURCES:</strong></th>
<th><strong>BARRIERS TO BE ADDRESSED:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• McKendree University</td>
<td>• Participant follow-up and monitoring of progress</td>
</tr>
<tr>
<td>• Get Up &amp; Go! Health and Wellness Campaign</td>
<td>• Funding shortages</td>
</tr>
<tr>
<td>• SIUE School of Nursing</td>
<td>• Effectively marketing to population 18-40 years of age</td>
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<tr>
<td>• Memorial Hospital</td>
<td>• Lack of inter-agency referral and policy enforcement</td>
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<tr>
<td>• St. Elizabeth’s Hospital</td>
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<tr>
<td>• St. Clair county Health Care Commission</td>
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</table>
Related Healthy People 2020 Objectives:

- **D–3**: Reduce the diabetes death rate. **Target**: 65.8 deaths per 100,000 population.
- **D–16.1** Increase the proportion of persons at high risk for diabetes with pre-diabetes who report increasing their levels of physical activity. **Target**: 49.1 percent.
- **HDS–2**: Reduce coronary heart disease deaths. **Target**: 100.8 deaths per 100,000 population.
- **C–2**: Reduce the lung cancer death rate. **Target**: 45.5 deaths per 100,000 population.
The IDEAS for Action Exist,

- Create Sustainable community gardens in all 22 townships of St. Clair County
- Monitor trends from BRFSS nutrition & physical activity responses.
- Create GIS maps for youth obesity, physical activity, & nutrition
- Collect & communicate hospital discharge data on obesity-related diagnosis, BMI, zip code
- By 2012 all hospitals in the county will work with St. Clair County Health Department to implement a surveillance system to track BMI and obesity-related diagnoses (Adult Data).
- Encourage parents exercising with kids - using PTA/PTC School wellness councils, etc
- Use Get Up & Go! to organize bulk purchase of items to improve fitness & corporate fitness program.
- Promoting events via Media (consolidate and spread the word on events)
- Increase Community Competitions for Family Friendly Fitness Events
- Target more programs for “At-Risk” populations.
- Help communities collaborate and share resources.
Including a Long Lists of Partners, but…

<table>
<thead>
<tr>
<th>St. Clair County Health Care Commission and Affiliate Members</th>
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<tbody>
<tr>
<td>• Allsup, Inc.</td>
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<td>• American Heart Association</td>
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<td>• American Lung Association</td>
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<td>• Area Agency on Aging</td>
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<td>• Asthma Coalition for the Greater St. Louis Metro East Area</td>
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<td>• East Side Health District</td>
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<tr>
<td>• Get Up &amp; Go! Health and Wellness Campaign</td>
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<td>• March of Dimes</td>
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<tr>
<td>• McKendree University</td>
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<tr>
<td>• Memorial Hospital</td>
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<td>• Pioneering Healthier Communities Initiative</td>
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<td>• Programs &amp; Services for Older Persons</td>
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<td>• St. Clair County Office on Aging</td>
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<td>• St. Clair County Youth Coalition</td>
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<td>• St. Elizabeth’s Hospital</td>
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<td>• St. Mary’s Hospital</td>
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<tr>
<td>• Southwestern Illinois Coalition Against Tobacco</td>
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<tr>
<td>• Southern IL Health Care Foundation</td>
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<tr>
<td>• Southern Illinois University, School of Nursing</td>
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<tr>
<td>• Southwest Illinois College</td>
</tr>
<tr>
<td>• Southwest Illinois HIV/AIDS Coalition</td>
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<tr>
<td>• Touchette Regional Hospital</td>
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<tr>
<td>• Willard C. Scrivner, MD Public Health Foundation</td>
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<tr>
<td>• YMCA of Southwest Illinois</td>
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</tbody>
</table>

But WHO is Doing WHAT?
MAPP Model

Community Themes & Strengths Assessment

Organize for Success

Partnership Development

Visioning

Four MAPP Assessments

Identify Strategic Issues

Formulate Goals and Strategies

Evaluate

Plan

Action

Implement

Forces of Change Assessment

Local Public Health System Assessment

Community Health Status Assessment
How can the St. Clair County health care community:

- create a broader community connectedness
- strengthen the public health workforce
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- improve health outcomes for cardiovascular diseases, maternal and child health and respiratory diseases
- improve health services to the aging community
- improve access to care
- reduce incidence of sexually transmitted disease*

* added in 2008
Create Community Connectedness

Launched “Get Up & Go” campaign

Mark Fenton, Host of the PBS series, America’s Walking, keynote speaker at Health Policy Summit.

Annual health conferences
We Needed to Improve Alignment & Execution

In 2009 the Health Care Commission was introduced to Community Balanced Scorecards
The Need to Collaborate around a Strategy

No Strategic Alignment

Execution Gap

Health Goals Progress

Can St. Clair County Use the Power of Strategic Alignment?

Mobilizing for Action through Planning & Partnership

Local & State Governments
Schools
Community Groups
Media
Faith Communities
Local Business Merchants
Nonprofits
Families and Individuals
Hospitals (Community Benefit)
Public Agencies

“2020 Vision”
Healthiest County
USA

41
Phase Six: the Action Cycle

Continuous Quality Improvement
Extracted Content from Existing Documents

From Nov 2009 Health Policy Summit

**Mascoutah, Scott ABF**
- **Project:** Create pedestrian and bike networks, including increased pathways and bike lanes, and specifically enhance safety by increasing placement of pedestrian signals at intersections.
- **Policies:** Schools policies to support physical activity. Specifically, schools must allow shared use facilities for evening, weekend, and holiday activity programs, and also begin instituting remote drop-off areas for walking to school (e.g., nearby church or park).
- **Big Goal:** Schools as centers of healthy education, both nutrition and physical activity. Specifically, increased community gardens, seniors involved in maintaining gardens, healthy cooking classes, as well as required daily physical activity in all schools, manipulation.

**McKendree University, Lebanon**
- **Project:** Get more involved in the school campuses around the county, get college students formally engaged in this work through classes & public service projects.
- **Big Goal:** Promote more physical activity and healthy eating in the school setting, and increase understanding among students of the importance of these two.

**O’Fallon**
- **Projects:** Community gardens are started, but have to grow and increase access to community in general.
- **Also:** Parks with facilities (such as skate parks) are pretty good, but need to make better connect better to surrounding areas.
- **Big Goal:** Once off 2005 bicycle plan, and make sure there are safe designated bicycle facilities throughout the area. Have to build implementation of bike plan into every routine, decision-making and city planning effort.

**Smithton & Freeburg**
- **Projects:** Develop a bike trail to connect Smithton, Freeburg & Millstadt.
- **Policies:** Adopt county wide development policies to include requirements for green space, walking and biking trails, and mixed use development (e.g., neighborhood parks, etc.) in all development throughout the county.
- **Big Goal:** Over time, connect this trail to the larger metropolitan trail system.

From the CPPW Grant Application

**Appendix F**

**Community Action Plan**

<table>
<thead>
<tr>
<th>Project Goals with S.M.A.R.T. Objectives and Strategies (bulleted)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1:</strong> Develop the capacity of St. Clair County Schools to provide a healthy environment for children &amp; adolescents.</td>
</tr>
<tr>
<td>By 2011, 25% of public elementary schools in St. Clair County will adopt a standardized curriculum for media literacy specific to healthy eating and active lifestyles.</td>
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<tr>
<td><strong>Obj. 1:</strong> By 2012, produce and distribute to local media outlets 5 video and 4 audio public service announcements targeting youth that convey the importance of healthy eating and active lifestyles.</td>
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<tr>
<td>- Fall 2010 ROEC solicits interest from middle schools regarding media literacy curriculum.</td>
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<td>- Schools qualifying for media literacy component, must demonstrate health education curriculum that meets standards or a plan to upgrade curriculum.</td>
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<tr>
<td>- Center for Media Literacy provides professional development for middle school teachers &amp; administrators.</td>
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<tr>
<td>- Spring 2011 students participate in 5 interactive lessons delivered from Newsweek website creating their own media messages promoting healthy eating and active lifestyles.</td>
</tr>
<tr>
<td>- Schools utilize messages to promote healthy eating &amp; active lifestyles to parents, students, teachers, &amp; surrounding community for example, by the school website, billboards, or other mechanisms.</td>
</tr>
<tr>
<td>- Spring 2011, SC works with schools participating in Media Literacy initiative (in Obj. 1h) for students to enter competition for 4 best commercials.</td>
</tr>
<tr>
<td>- Summer 2011 panel of judges considers entries &amp; selects 4 best entries for video &amp; audio production.</td>
</tr>
<tr>
<td>- Summer 2011 youth go to SIUE Dept of Mass Communication for professional production.</td>
</tr>
<tr>
<td>- Fall 2011-end of project.</td>
</tr>
<tr>
<td>- Commercials aired on St. Louis &amp; local media as well as Get Up &amp; Go website and school websites.</td>
</tr>
</tbody>
</table>

And from other grant applications and planning documents
A Community Strategy in InsightVision

Get up and Go!®

Get up and Go Strategy Map

1. Increase Active Living & Healthy Eating
2. Minimize Obesity & Eliminate Disparities
3. Promote Nutrition & Fitness
4. Improve the Physical Environment
5. Enhance School & Community Nutrition+Fitness
6. Incentives & Support to Stimulate Change
7. Advocate for Better Policies, Plans & Programs
8. Encourage School-centered Health & Wellness
Zooming in to the Details of Execution

Get Up & Go!®

Strategy Map for Theme - Fitness

Increase Active Living & Healthy Eating

Promote Employee Fitness Programs

- Improve Fitness of Adults
- Encourage Biking Everywhere
- Develop Walking-Friendly Communities

- Improve Fitness of Youth
- Enhance Safety & Access of Fitness Venues
- Support Community Fitness Programs & Events

- Increase extra-curricular physical activity
- Prioritize PE & Recess in Schools

Help Firms Collaborate on Fitness Toolkits

- Develop Neighborhood Fitness Toolkits
- Use On-Line Tools
- Leverage Incentives to Encourage Group Participation in Fitness Events
- Engage Citizens to Enhance Fitness Venues
St. Clair County Health Care Commission Strategy Management System

This on-line system is designed to help organizations throughout the county collaborate to improve the overall quality of life of their communities and the health and well-being of our 262,000 citizens. For more information on how your organization can participate in this collaborative process, please contact Mark Peters, Director of Community Health, St. Clair County Health Department by phone at (518) 233-7703, ext 4423 or email at Mark.Peters@co.st-clair.ny.us.

For training videos and PDF's of exercises visit the Training Center.

Featured Measures

- MATCH: Diabetic screening
  - FY2011: 78%
  - FY2009: 28.6%
  - Description: Diabetic screening is calculated as the percent of diabetic Medicare patients whose blood sugar

- GUG T-Fitness: % of Adults who are obese
  - FY2011: N/A
  - FY2009: N/A
  - Description: From State BRFSS data

- GUG T-Fitness: # of Companies with Employee Fitness Programs
  - N/A
  - Description: # of Companies with Employee Fitness Programs
Easily Accessing Other Information

Theme - Fitness (GUG T-Fitness)

<table>
<thead>
<tr>
<th>Community Health Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>--------------------------------</td>
</tr>
<tr>
<td><strong>GUG: Increase Active Living &amp; Healthy Eating</strong></td>
</tr>
<tr>
<td>No Measures to display.</td>
</tr>
<tr>
<td><strong>GUG T-Fitness: Reduce Obesity in Adults</strong></td>
</tr>
<tr>
<td><strong>GUG T-Fitness: % of Adults who are overweight or obese</strong></td>
</tr>
<tr>
<td><strong>GUG: # Participants in &quot;Pointing the Way to Health&quot; Challenge</strong></td>
</tr>
<tr>
<td><strong>GUG T-Fitness: Reduce Obesity in Youth</strong></td>
</tr>
<tr>
<td><strong>GUG: # Participants in &quot;Pointing the Way to Health&quot; Challenge</strong></td>
</tr>
</tbody>
</table>

Community Implementation
One Click Drill-down to Health Assessment Data (e.g., BRFSS)
P-BRC: Encourage More People to Run More

The Belleville Running Club will play a lead role in promoting running as means of getting exercise (especially for new runners and especially in small groups that run together).

The community can rally around the Bellville Running Club as a great resource for people who want to start running or run more consistently, and the BRC will expand their efforts to support runners who need a little extra encouragement.

Wiki Link: Belleville Running Club
Visibility to their Objective & Measure

Belleville Running Club

**Community Implementation**

<table>
<thead>
<tr>
<th>Name</th>
<th>Prior Period</th>
<th>Current Value</th>
<th>Change</th>
<th>Target Value</th>
<th>Most Recent Period</th>
<th>Comments/Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>P-BRC: Encourage More People to Run More</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>P-BRC: Number of active participants in the Beginner Program</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
Additional Partnership Projects Underway

Community Benefit Steering Committee
The Patient Protection and Affordable Care Act Section 9007 requires non-profit hospitals to:

1. conduct a community health needs assessment at least every three years and
2. adopt an implementation strategy to meet the community health needs identified by the assessment.

The community health needs assessment must include input from persons who represent the broad interests of the community served by the hospital facility...
Community Benefit Needs Assessment Process -- 2012

Leede Survey
Health Issues:
- High blood pressure: 62.6%
- High Cholesterol: 54.4%
- Heart Disease: 24.1%
- Diabetes: 22.9%
- Mental Health issues: 13.1%
- Asthma: 11.4%
- Stroke: 7.6%
- Substance Abuse: 5.8%
- Cancer: 5.5%
- STD: 2.0%

Personal Health Rating:
- 18.4% said poor to fair

Lack Insurance Coverage:
- 12%
- Did not receive needed care
- 6.5% due to cost or no insurance

St. Clair Co IPLAN
Health Issues:
1. Chronic Diseases:
   - Diabetes
   - Heart Disease
   - Lung Cancer & COPD
2. Maternal & Child Health
   - Infant Mortality
   - Teen Pregnancy
   - STD/HIV
3. Behavioral Health
   - Suicide
   - Substance Abuse
4. Violence
   - Homicide
   - Domestic Violence
   - Neighborhood Safety

Other Data Sources
Mo. Hospital Ass. For St. Clair Co:
- Preventable hospitalizations:
  - CHF
  - Bacterial pneumonia
  - Diabetes
  - COPD
- County Health Rankings of 102 counties:
  - Mortality: 96
  - Morbidity: 93
  - Health Factors: 100
  - Healthy Behaviors: 101
  - Clinical Care: 25
  - Social & Economic: 99
  - Physical Environment: 64

Catholic Healthcare West:
- Community Need Index

Community Engagement Groups
- ID gaps in services
- ID opportunities to improve health of community
- Recommend priorities

St. Elizabeth’s Board
- Reviews & finalizes Strategic Goals for FY 13

HSHS Community Benefit Committee
- Reviews plans

Admin Team
- Reviews priorities

Community Benefit Comm.
- Finalizes priorities
- Sets goals for three new/expanded programs for FY 13

Community Engagement Priorities
1. Access to Health Care
   - Clinics for uninsured
   - Lack of PCPs
   - Insurance costs
2. Education
   - Healthy living
   - Healthcare resources
   - End of Life
3. Mental Health/Addictions
4. Chronic Issues
   - Cardiac/Pulmonary
   - Obesity
   - Mother/Child
5. Services
   - Geriatric
   - Special needs
Thank You

Contact Information for Mark Peters

Telephone: (618) 233-7703 ext. 4423
Email: mark.peters@co.st-clair.il.us
Discussion and Questions
Last Word

The next CHA/CHIP training webinar will be on:

‘Choosing Strategies and Tactics for Health Improvement’

*Presenter:* Marni Mason

Wednesday, 6/13/12 at 2:30 PM ET

Please complete the evaluation before logging off the webinar.