Community strategy and indicator toolkit: Chronic disease

This toolkit is part of Ohio's **2017-2019 state health improvement plan (SHIP)**, prepared by the Health Policy Institute of Ohio on behalf of the Ohio Department of Health and the Governor's Office of Health Transformation.

Contents

See the **master list of SHIP indicators** for a complete description of all of the indicators listed in this toolkit. (Numbers listed next to each indicator name refer to indicator numbers in the master list.)

Priority outcome indicators

Desired outcome	Indicator name	Indicator description	Data source (lead agency)
Reduce heart disease	**Coronary heart disease** (#8)	Percent of adults ever diagnosed with coronary heart disease	BRFSS (ODH)
	Heart attack (#9)	Percent of adults ever diagnosed with heart attack	BRFSS (ODH)
	Hypertension (#10)	Percent of adults ever diagnosed with hypertension	BRFSS (ODH)
Reduce diabetes	**Diabetes** (#11)	Percent of adults who have been told by a health professional that they have diabetes	BRFSS (ODH)
	Prediabetes (#12)	Percent of adults who have been told by a health professional that they have prediabetes	BRFSS (ODH)
Reduce child asthma morbidity	**Child asthma hospitalization** (#13)	Hospital admissions for pediatric asthma, per 100,000 children ages 2-17 (excludes patients with cystic fibrosis or abnormalities of the respiratory system, and transfers from other institutions)	Ohio Hospital Association, Clinical-Financial Dataset (ODH)

Cross-cutting strategies and outcome indicators

How were these strategies selected?

The strategies listed in this toolkit were prioritized by SHIP Work Team and Advisory Committee members after a careful review of available research. See Appendix A of the **2017-2019 SHIP** for a description of the strategy selection process. Most of the strategies listed here are evidence based; they were reviewed and found to be effective by the evidence registries and systematic review sources listed in Appendix B of the 2017-2019 SHIP. The **links in these tables** connect to external sources that provide a brief description of the strategy, and in most cases, an evidence review from one of the sources listed in Appendix B of the SHIP. Some types of strategies, such as infrastructure and systems changes, have not been reviewed by the sources listed in Appendix B, but were included based upon the subject matter expertise of Work Team members.

All of the strategies listed in this toolkit can be implemented at the community (local) level. See the SHIP for additional strategies that can be implemented at the state level.

Impact on disparities and inequities

Strategies with a ✓ in the orange "likely to decrease disparities" column have been rated by **What Works for Health** as "likely to decrease disparities" and/or recommended by the **Community Guide** as effective strategies for achieving health equity. These sources consider potential impacts on disparities and inequities by racial/ethnic, socioeconomic, geographic or other characteristics.

It is important to note that the evidence base on what works to decrease disparities is limited and evolving. Some strategies not identified as "likely to decrease disparities" may in fact be effective if culturally adapted well and tailored to meet the needs of priority populations. Local partners are encouraged to use the approaches to achieving health equity listed on page 12 to identify and implement strategies that meet the specific needs of their community.

Social determinants of health: Strategies and outcome indicators

Strategy	Diabetes/ heart disease	Child asthma	Likely to decrease disparities	Indicator to measure impact of strategy (source)
School-based health				
School-based health centers	✓	✓	✓	Chronic absenteeism (ODE) (#23)
				Third grade reading (ODE) (#21)
				High school graduation (ODE) (#22)
				Child asthma hospitalization (OHA) (#13)
Removal of asthma triggers in school buildings		✓		Child asthma hospitalization (OHA) (#13)
Early childhood supports				
Early childhood education (includes center-based early childhood education, preschool education programs and universal pre-kindergarten)	✓	✓	✓	Kindergarten readiness (KRA, ODE) (#20)
Early childhood home visiting programs See also: **Early childhood home visitation to prevent child maltreatment** and **specific evidence-based home visiting models supported by the Ohio Department of Health**	✓	✓	✓	Child abuse and neglect (JFS) (#87)
				Kindergarten readiness (KRA, ODE) (#20)

Social determinants of health: Strategies and outcome indicators (cont.)

Strategy	Diabetes/ heart disease	Child asthma	Likely to decrease disparities	Indicator to measure impact of strategy (source)
Healthy home environment assessments for asthma triggers (as part of early childhood home visiting)		✓	✓	Child asthma hospitalization (OHA) (#13) Asthma triggers in the home (children) (TBD)(#60)
Affordable, quality housing				
Healthy home environment assessments for asthma triggers		✓	✓	Child asthma hospitalization (OHA) (#13) Asthma triggers in the home (children) (TBD)(#60)
Home improvement loans and grants (including removal of asthma triggers) (see also: **housing rehabilitation loan and grant programs**)	✓	✓	✓	Child asthma hospitalization (OHA) (#13) Asthma triggers in the home (children) (TBD)(#60)
Additional local strategies to reduce asthma triggers in rental housing (such as advocacy, legal aid, rental registry, etc.)		✓		Child asthma hospitalization (OHA) (#13) Asthma triggers in the home (children) (TBD)(#60)
Service-enriched housing focusing on family health and tobacco cessation	✓	✓	✓	Severe housing problems (HUD via CHR) (#34)
Employment and income				
Earned income tax credits (local option: outreach to increase uptake)	✓	✓	✓	Child poverty (ACS via CHR) (#29) Adult poverty (ACS) (#30)
Employment programs, such as:				
Vocational training for adults	✓	✓	✓	Household income (ACS via CHR) (#26) Unemployment (BLS and CPS via CHR) (#27) Labor force participation (BLS and CPS)(#28)
Transitional jobs	✓	✓	✓	Household income (ACS via CHR) (#26) Unemployment (BLS and CPS via CHR)(#27) Labor force participation (BLS and CPS)(#28)
Local/regional built environment changes to support active living and social connectedness				
Community-scale urban design land use policies and **Streetscape design (Complete Streets)**	✓	✓		Physical inactivity (no leisure time physical activity (adult) (BRFSS via CHR) (#57) Insufficient physical activity (adult) (BRFSS) (#58) Physical inactivity (youth) (YRBSS) (#59)

Social determinants of health: Strategies and outcome indicators (cont.)

Strategy	Diabetes/ heart disease	Child asthma	Likely to decrease disparities	Indicator to measure impact of strategy (source)
Bike and pedestrian master plans	✓	✓		Physical inactivity (no leisure time physical activity (adult) (BRFSS via CHR)(#57)
				Insufficient physical activity (adult) (BRFSS)(#58)
				Physical inactivity (youth) (YRBSS) (#59)
				Alternative commute modes (ACS)(#40)
				Driving alone to work (ACS via CHR)(#39)
Green spaces and parks	✓	✓	✓	Physical inactivity (no leisure time physical activity) (adult) (BRFSS via CHR)(#57)
				Insufficient physical activity (adult) (BRFSS)(#58)
				Physical inactivity (youth) (YRBSS) (#59)
				Access to exercise opportunities (Census via CHR) (#38)
Public building siting considerations (such as location of schools)	✓	✓		Physical inactivity (no leisure time physical activity (adult) (BRFSS via CHR) (#57)
				Insufficient physical activity (adult) (BRFSS)(#58)
				Physical inactivity (youth) (YRBSS) (#59)
Smoke-free environments				
Smoke-free policies (including maintenance of smoke-free workplace law and increased policy adoption for multi-unit housing, schools and other settings) (see also: **Smoke-free policies for indoor areas**, **smoke-free policies for outdoor areas** and **smoke-free policies for multi-unit housing**)	✓	✓	✓	Children exposed to secondhand smoke at home (NSCH)(#43)
				Adolescents exposed to secondhand smoke (OYTS) (#44)
				Adults exposed to secondhand smoke — all environments (home, car, public spaces, etc.) (BRFSS) (#45)
				Adults exposed to secondhand smoke at home (BRFSS)(#46)
				Tobacco-free policies enacted (ODH, in development)(#47)
				Adult smoking (BRFSS via CHR) (#68)
				Youth all-tobacco use (OYTS) (#69)

Public health system, prevention and health behaviors: Strategies and outcome indicators

Strategy	Diabetes/ heart disease	Child asthma	Likely to decrease disparities	Indicator to measure impact of strategy (source)
School-based prevention programs and policies				
School-based physical activity programs and policies:	✓			Physical inactivity (youth) (YRBSS)(#59)
Safe Routes to School	✓			Physical inactivity (youth) (YRBSS)(#59)
Active recess and policy adoption for minimum amounts of recess	✓			Physical inactivity (youth) (YRBSS)(#59)
Physically active classrooms	✓			Physical inactivity (youth) (YRBSS)(#59)
School-based physical education and Enhanced school-based physical education	✓			Physical inactivity (youth) (YRBSS)(#59)
Extracurricular activities for physical activity	✓			Physical inactivity (youth) (YRBSS)(#59)
School-based nutrition programs and policies:				
School breakfast programs	✓		✓	Chronic absenteeism (ODE)(#23)
				Third grade reading (ODE)(#21)
				Food insecurity (CPS/BLS/ACS via CHR) (#49)
				Fruit consumption (youth) (YRBSS)(#53)
				Vegetable consumption (youth) (YRBSS) (#54)
Competitive pricing for healthy food	✓			Fruit consumption (youth) (YRBSS)(#53)
				Vegetable consumption (youth) (YRBSS) (#54)
School-based nutrition education programs	✓			Fruit consumption (youth) (YRBSS) (#53)
				Vegetable consumption (youth) (YRBSS) (#54)
School fruit and vegetable gardens	✓			Fruit consumption (youth) (YRBSS)(#53)
				Vegetable consumption (youth) (YRBSS) (#54)
Farm to school programs	✓			Fruit consumption (youth) (YRBSS)(#53)
				Vegetable consumption (youth) (YRBSS) (#54)
Nutrition and physical activity interventions in preschool/child care	✓			Fruit and vegetable consumption among young children (TBD)(#55)
				Physical activity among young children (TBD) (#56)
Evidence-based asthma management services (including screening, education and medication administration) (linked to School-based health centers)		✓		Child asthma hospitalizations (OHA) (#13)
				Asthma triggers in the home (children) (TBD)(#60)

Public health system, prevention and health behaviors: Strategies and outcome indicators (cont.)

Strategy	Diabetes/ heart disease	Child asthma	Likely to decrease disparities	Indicator to measure impact of strategy (source)
Home visits to improve asthma self-management education and reduce home asthma triggers		✓		Child asthma hospitalizations (OHA) (#13)
				Asthma triggers in the home (children) (TBD)(#60)
Community-based active living and healthy eating support				
Community healthy food access				
Community gardens	✓			Vegetable consumption (adult) (BRFSS)(#52)
Healthy food initiatives in food banks	✓		✓	Food insecurity (CPS/BLS/ACS via CHR) (#49)
				Fruit consumption (adult) (BRFSS)(#51)
				Vegetable consumption (adult) (BRFSS)(#52)
				Fruit consumption (youth) (YRBSS)(#53)
				Vegetable consumption (youth) (YRBSS)(#54)
Farmers' markets/stands	✓			Fruit consumption (adult) (BRFSS)(#51)
				Vegetable consumption (adult) (BRFSS)(#52)
				Fruit consumption (youth) (YRBSS)(#53)
				Vegetable consumption (youth) (YRBSS)(#54)
Healthy food in convenience stores	✓		✓	Limited access to healthy foods (USDA via CHR)(#48)
				Fruit consumption (adult) (BRFSS)(#51)
				Vegetable consumption (adult) (BRFSS)(#52)
				Fruit consumption (youth) (YRBSS)(#53)
				Vegetable consumption (youth) (YRBSS)(#54)
Competitive pricing—fruit and vegetable incentive programs	✓			Fruit consumption (adult) (BRFSS)(#51)
				Vegetable consumption (adult) (BRFSS)(#52)
				Fruit consumption (youth) (YRBSS)(#53)
				Vegetable consumption (youth) (YRBSS)(#54)
WIC and senior farmers' market nutrition programs	✓		✓	Fruit consumption (adult) (BRFSS)(#51)
				Vegetable consumption (adult) (BRFSS)(#52)
				Fruit and vegetable consumption among young children (TBD)(#55)
SNAP infrastructure at farmers' markets/EBT payment at farmers' markets	✓		✓	Fruit consumption (adult) (BRFSS)(#51)
				Vegetable consumption (adult) (BRFSS)(#52)
				Fruit consumption (youth) (YRBSS)(#53)
				Vegetable consumption (youth) (YRBSS)(#54)

Public health system, prevention and health behaviors: Strategies and outcome indicators (cont.)

Strategy	Diabetes/ heart disease	Child asthma	Likely to decrease disparities	Indicator to measure impact of strategy (source)
Community physical activity programs:				
Shared use (joint use agreements)	✓		✓	Access to exercise opportunities (CHR) (#38)
				Physical inactivity (no leisure time physical activity)(adult) (BRFSS)(#57)
				Insufficient physical activity (adult) (BRFSS) (#58)
				Physical inactivity (youth) (YRBSS)(#59)
Activity programs for older adults	✓			Physical inactivity (no leisure time physical activity, adult) (BRFSS)(#57)
				Insufficient physical activity (adult) (BRFSS)(#58)
Community fitness programs	✓			Access to exercise opportunities (CHR) (#38)
				Physical inactivity (no leisure time physical activity)(adult) (BRFSS)(#57)
				Insufficient physical activity (adult) (BRFSS) (#58)
Individually-adapted health behavior change programs	✓			Physical inactivity (no leisure time physical activity, adult) (BRFSS)(#57)
				Insufficient physical activity (adult) (BRFSS) (#58)
Social support interventions for physical activity in community settings (see also: Community-based social support for physical activity)	✓			Physical inactivity (no leisure time physical activity, adult) (BRFSS)(#57)
				Insufficient physical activity (adult) (BRFSS) (#58)
Community-wide physical activity campaigns (see also: Community-wide physical activity campaigns)	✓			Physical inactivity (no leisure time physical activity, adult) (BRFSS)(#57)
				Insufficient physical activity (adult) (BRFSS) (#58)
Diabetes Prevention Program (DPP)	✓			Diabetes (BRFSS)(#11)
				Adult healthy weight (BRFSS)(#62)
				Adult obesity (BRFSS)(#63)
				Physical inactivity (no leisure time physical activity, adult) (BRFSS)(#57)
				Insufficient physical activity (adult) (BRFSS) (#58)
				Fruit consumption (adult)(BRFSS)(#51)
				Vegetable consumption (adult) (BRFSS)(#52)

Public health system, prevention and health behaviors: Strategies and outcome indicators (cont.)

Strategy	Diabetes/ heart disease	Child asthma	Likely to decrease disparities	Indicator to measure impact of strategy (source)
Tobacco prevention and cessation				
Increasing the price of tobacco products (cigarette and/or other tobacco products tax) (see also: **Tobacco pricing**)	✓	✓	✓	Adult smoking (BRFSS)(#68) Youth all-tobacco use (OYTS)(#69) Quit attempts (adults) (BRFSS)(#179)
Policies to decrease availability of tobacco products (see also: **Tobacco access restrictions for minors** and **Minimum tobacco age laws**)	✓	✓		Youth all-tobacco use (OYTS)(#69) Access to tobacco products (Countertools.org)(#74)
Mass-reach communications	✓	✓		Adult smoking (BRFSS)(#68) Youth all-tobacco use (OYTS)(#69) Quit attempts (adults) (BRFSS)(#179)
Links to cessation support, including focus on helping parents of children with asthma to quit (see Healthcare system and access for strategies)	✓	✓		See Healthcare system and access section for indicators

Healthcare system and access: Strategies and outcome indicators

Strategy	Diabetes/ heart disease	Child asthma	Likely to decrease disparities	Indicator to measure impact of strategy (source)
Medicaid modernization and increase access to coverage				
Health insurance enrollment and outreach	✓	✓	✓	Uninsured adults (ACS and CHR) (#133)
				Uninsured children (ACS and CHR)(#134)
				Out-of-pocket spending (RWJF DataHub)(#135)
Paying for value				
Improve access to comprehensive primary care (**Patient Centered Medical Homes**)	✓	✓	✓	Medical home, children (NSCH) (#136)
				Unable to see doctor due to cost (BRFSS)(#137)
				Without usual source of care (BRFSS)(#138)
				Potentially avoidable emergency department visits for Medicare (CWF)(#152)
Care coordination				
Community health workers (including workers in community-based settings to address social determinants of health)	✓	✓	✓	Without usual source of care (BRFSS)(#138)
				Asthma triggers in home (children) (#60)
Pathways Community HUB model (including community-based settings to address social determinants of health)	✓	✓		Without usual source of care (BRFSS)(#138)
				Asthma triggers in home (children) (#60)
Standardized screening and evidence-based treatment services				
Prediabetes screening and referral (see also **USPSTF recommendation**)	✓			Prediabetes screening (in development)(#154)
Provider training and education to raise awareness of prediabetes screening, identification and referral through dissemination of the **Prediabetes Risk Assessment**, and **Prevent Diabetes STAT Toolkit**	✓			Prediabetes screening (in development)(#154)
Hypertension screening and follow up, including electronic health record utilization to identify undiagnosed hypertension	✓			Hypertension management (BRFSS)(#156)
Provider training and education to raise awareness among providers of **hypertension screening and management**	✓			Hypertension management (BRFSS)(#156)
Improved access and adherence to antihypertensive medications, including Medication Therapy Management by pharmacists	✓			Hypertension management (BRFSS)(#156)

Healthcare system and access: Strategies and outcome indicators (cont.)

Strategy	Diabetes/ heart disease	Child asthma	Likely to decrease disparities	Indicator to measure impact of strategy (source)
Team-based approach to controlling hypertension (may include **Community Health Workers**)	✓			Hypertension management (BRFSS)(#156)
Referral and follow up to increase patient use of community-based nutrition and physical activity resources:				
Nutrition prescriptions	✓			Fruit consumption (adult) (BRFSS) (#51)
				Vegetable consumption (adult) (BRFSS)(#52)
Prescriptions for physical activity	✓			Physical inactivity (no leisure time physical activity) (BRFSS)(#57)
				Insufficient physical activity (adult) (BRFSS)(#58)
Food insecurity screening and referral	✓			Food insecurity (Feeding America, via CHR)(#49)
Home visits to improve self-management education and reduce home asthma triggers		✓		Child asthma hospitalizations (OHA) (#13)
				Asthma triggers in the home (children) (TBD)(#60)
Healthcare workforce to increase access to services				
Higher education financial incentives for health professionals serving underserved areas (such as tuition reimbursement and loan repayment programs)	✓	✓	✓	Health professional shortage areas — primary care (HRSA) (#139)
				Provider availability — primary care physicians (AHRF/AMA) (#142)
				Provider availability — other primary care providers (AHRF/ AMA)(#143)
Cultural competence training for healthcare professionals	✓	✓	✓	Cultural understanding and skills (TBD)(#150)
Health career recruitment for minority students (can also include rural/Appalachian regions of the state and other underrepresented population groups)	✓	✓	✓	High school graduation for priority populations (ODE)(#148)
				Adult educational attainment for priority populations (ACS)(#149)
Infrastructure to collect accurate data about access, outcomes and disparities				
Integrate public health data and healthcare system clinical data	✓	✓		Data not currently available — to be defined at local level

Healthcare system and access: Strategies and outcome indicators (cont.)

Strategy	Diabetes/ heart disease	Child asthma	Likely to decrease disparities	Indicator to measure impact of strategy (source)
Tobacco cessation services				
Expand access to evidence-based tobacco cessation treatments including individual, group and phone counseling (including Quitline) and cessation medications	✓	✓	✓ (Quitline)	Adult smoking (BRFSS)(#68)
				Quit attempts (adult) (BRFSS) (#179)
				Tobacco use screening and tobacco cessation intervention (PCMH quality measure/HEDIS) (#180)
Remove barriers that impede access to covered cessation treatments, such as cost sharing and prior authorization	✓	✓		Adult smoking (BRFSS)(#68)
				Quit attempts (adult) (BRFSS) (#179)
				Tobacco use screening and tobacco cessation intervention (PCMH quality measure/HEDIS) (#180)
Promote increased utilization of covered treatment benefits by tobacco users, including parents of children with asthma	✓	✓		Adult smoking (BRFSS)(#68)
				Quit attempts (adult) (BRFSS) (#179)
				Tobacco use screening and tobacco cessation intervention (PCMH quality measure/HEDIS) (#180)

Approaches to achieve health equity

Local communities can reduce health disparities and inequities, and achieve health equity, by including the following steps in the community health improvement process:

- ☐ During the community health assessment process, identify priority populations or geographic areas that have higher rates of the selected priority outcome. For example, if reducing diabetes prevalence is selected, identify the groups with higher rates of diabetes, such as by race/ethnicity, age, income level, disability status, sexual orientation, immigration status, zip code, etc. Qualitative methods, such as key informant interviews or focus groups, can be a useful way to collect this information with groups that may not be well represented in secondary data.
- ☐ Prioritize the selection of strategies likely to decrease disparities.
- ☐ Prioritize the selection of social determinants of health strategies that address the underlying causes of health inequities, such as access barriers to employment, education and housing.
- ☐ Ensure that delivery of selected strategies is designed to reach your community's priority populations and high-need geographic areas.
- ☐ Ensure that programs and services are delivered by culturally-competent providers and are adapted to fit the cultural context of the priority populations.
- ☐ When data are available, set specific and measurable objectives for specific priority populations (such as an objective to reduce the black infant mortality rate, rather than only the overall infant mortality rate) and/or when data are not available, advocate for improvements to local and state-level data collection.
- ☐ Evaluate the impact of implemented strategies on health disparities.
- ☐ Use evaluation findings to improve reach and effectiveness of equity strategies.

Resources for collaboration and community engagement

Resource	Description	Link
American Hospital Association (Health Research and Educational Trust and Association for Community Health Improvement): Engaging patients and communities in the community health needs assessment process	Step-by-step guide to community health improvement that describes different types of stakeholder engagement and provides guidance on defining community.	http://www.healthissuescentre.org.au/images/uploads/resources/Engaging-patients-communities-health-needs-assmt.pdf
Association of Ohio Health Commissioners: Ohio's CHA/CHNA Toolkit	List of resources, including "benefits of collaboration" and "barriers to collaboration."	http://aohc.net/aws/AOHC/pt/sp/members_10
Bank of Ideas: Tips for Maintaining Community Interest and Involvement	This tool provides suggestions for keeping members and active participants involved and the community informed and supportive. Participants can use it as a checklist for how to keep momentum going.	http://www.countyhealthrankings.org/resources/tips-maintaining-community-interest-and-involvement
CDC: A Practitioner's Guide for Advancing Health Equity	This resource offers ideas on how to maximize the effects of policy, systems, and environmental improvement strategies with a goal to reduce health inequities. Meaningful community engagement is addressed on pages 20-23.	http://www.countyhealthrankings.org/resources/practitioner%E2%80%99s-guide-advancing-health-equity
CDC: Community Health Improvement Navigator—Tools for success community health improvement efforts	Designed for use by hospitals and local health departments, this website includes tools for working together and engaging the community.	https://www.cdc.gov/chinav/tools/index.html
Center for Health Affairs: Boosting Community Health Impact: The Vital Role of Collaboration	Description of IRS CHNA requirements for hospitals, examples of highly effective health partnerships and recommendations for effective collaboration.	http://chanet.org/TheCenterForHealthAffairs/MediaCenter/Publications/IssueBriefs/11-15_Health-Impact.aspx
Center for Sharing Public Health Services: Accreditation and Essential Services resource library	Tools, example documents and reports to assist local health departments with sharing accreditation resources, including accreditation preparation.	http://phsharing.org/category/resources/accreditation-and-essential-services/
Community Health Rankings and Roadmaps: Building a Contact List	Building a contact list can help you target your outreach across sectors to people who have an investment in seeing improved health.	http://www.countyhealthrankings.org/resources/building-contact-list
EdChange: Awareness Activities	These activities address diversity, social identity, and cultural competence and include facilitation guidelines.	http://www.countyhealthrankings.org/resources/awareness-activities
EdChange: Knowing the Community (Sharing Activity)	This tool is an example of an icebreaker that introduces exploration of members' background to surface the diversity and similarities within the group.	http://www.countyhealthrankings.org/resources/knowing-community-sharing-activity
FSG: Collective Impact	Video and overview materials that describe the collective impact approach to collaboration across sectors.	http://www.fsg.org/ideas-in-action/collective-impact

Resources for collaboration and community engagement (cont.)

Resource	Description	Link
Health Policy Institute of Ohio: Making the most of community health planning in Ohio: The role of hospitals and local health departments	This policy brief describes community health planning requirements for local health departments and hospitals and identifies opportunities for increasing collaboration among various partners. The appendix includes a list of additional community health planning resources.	http://www.healthpolicyohio.org/wp-content/uploads/2016/03/PolicyBrief_CHAS_CHNAS_FINAL.pdf http://www.healthpolicyohio.org/making-the-most-of-community-health-planning/
Hospital Council of Northwest Ohio (HCNO): HCNO approach to local collaboration in CHA and CHIP processes	This brief document describes the approach HCNO has used in conducting collaborative assessments and plans with local health departments and hospitals in over 40 Ohio counties.	http://www.hcno.org/pdf/HCNO_Approach_to_Local_Collaboration_in_CHA_Improvement_Final_wLogo.pdf
Local Initiatives Support Corporation (LISC): Resources for comprehensive community development	Practitioner resources for engaging community members to drive neighborhood change.	http://www.instituteccd.org/resources/category/513
M + R: Coalition Mapping Worksheet	This tool (from M + R) can help identify new sources of support, resources, and perspectives.	http://www.countyhealthrankings.org/sites/default/files/CoalitionMappingWorksheet.pdf
M + R: Effective Recruitment of Coalition Members	This tool (from M + R) helps you analyze "what's in it for them?" when recruiting a new organization.	http://www.countyhealthrankings.org/resources/effective-recruitment-coalition-members
Missouri Foundation for Health's Social Innovation for Missouri Project: Coalition Core Competencies Checklist	This tool helps your team identify where your strengths are in the improvement process and where additional skills, knowledge, and/or resources may be needed.	http://www.countyhealthrankings.org/resources/coalition-core-competencies-checklist
NAACHO Resource Center: Engaging Partners, Stakeholders and Community Members	This tool demonstrates how to engage community stakeholders from a variety of local sectors.	http://www.naccho.org/programs/public-health-infrastructure/community-health-assessment/resources
Northwestern University: Asset-based Community Development	This organizations provides capacity-building training, worksheets and publications on community engagement, including a series of facilitation tools such as "Creating space for resident action and engagement" and "Tips for working with neighborhoods."	http://www.abcdinstitute.org/toolkit/index.html
National Quality Forum - Improving Population Health by Working with Communities – Action Guide	The Action Guide is a framework to help multisector groups work together to improve population health by addressing 10 interrelated elements for success and using the related resources as needed. Like a "how-to" manual, the Action Guide is organized by these 10 elements and contains definitions, recommendations, practical examples, and a range of resources to help communities achieve their shared goals and make lasting improvements in population health.	http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=83002

Resources for collaboration and community engagement (cont.)

Resource	Description	Link
PhotoVoice	PhotoVoice utilizes innovative participatory photography and digital storytelling methods. These skills enable individuals to represent themselves and create tools for advocacy and communication.	https://photovoice.org/vision-and-mission/
Prevention and Equity Institute: Collaboration Multiplier	This is an interactive framework and tool for analyzing collaborative efforts across fields. It is designed to help an organization better understand the partners it needs, how to engage them, and how to lay the foundation for shared understanding among partners.	https://www.preventioninstitute.org/tools/collaboration-multiplier
Stanford Social Innovation Review: Collective Impact	Collective Impact (from the Stanford Social Innovation Review) discusses the five conditions for communities' collective success.	http://www.countyhealthrankings.org/resources/collective-impact

Glossary

Evidence-based strategy — A policy, program or service that has been evaluated and demonstrated to be effective based on the best-available research evidence, rather than personal belief or anecdotal evidence.

Health disparities — Differences in health status among distinct segments of the population, including differences that occur by gender, race, ethnicity, education, income, disability or living in various geographic localities.

Health equity — Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

Health inequity — A subset of health disparities that are a result of systemic, avoidable and unjust social and economic policies and practices that create barriers to opportunity.

Indicator — A specific metric or measure used to quantify an outcome, typically expressed as a number, percent or rate. Example: Number of deaths due to suicide per 100,000 population.

Objective — A statement describing the specific outcome to be achieved. SMART objectives are specific, measurable, achievable, realistic and time-bound. Example: Reduce the number of deaths due to suicide per 100,000 population in Ohio from 13.9 in 2015 to 12.51 in 2019.

Outcome — A desired result. Example: Reduced suicide deaths.

Priority population — A population subgroup that has worse outcomes than the overall Ohio population and should therefore be prioritized in SHIP strategy implementation. Examples include racial/ethnic, age or income groups; people with disabilities; and residents of Appalachian counties.

Acronyms

ACS — American Community Survey
AHRF — Area Health Resources Files
AMA — American Medical Association
BLS — U.S. Bureau of Labor Statistics
BRFSS — Behavioral Risk Factor Surveillance System
CDC — Centers for Disease Control and Prevention
CHR — County Health Rankings
CMS — Centers for Medicare & Medicaid Services
CPS — Current Population Survey
CWF — Commonwealth Fund
HEDIS — Healthcare Effectiveness Data and Information Set
HRSA — Health Resources and Services Administration
HUD — U.S. Department of Housing and Urban Development
JFS — Ohio Department of Job and Family Services
KRA — Ohio's Kindergarten Readiness Assessment
NSCH — National Survey of Children's Health
ODE — Ohio Department of Education
ODH — Ohio Department of Health
OHA — Ohio Hospital Association
OYTS — Ohio Youth Tobacco Survey
PCMH — Patient-Centered Medical Home
RWJF — Robert Wood Johnson Foundation
SOBP — State of Ohio Board of Pharmacy
TBD — To be determined
USDA — United States Department of Agriculture
VS — Vital Statistics
WIC — Supplemental Nutrition Program for Women, Infants, and Children
YRBSS — Youth Risk Behavior Surveillance System

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