Montcalm County Community Health Improvement Plan

2012-2015

Healthy Montcalm

BUILDING A HEALTHIER TOMORROW

"Montcalm County is an empowered community where people are engaged in living healthy active lives"

Revised May 6, 2013

Community Health Improvement Plan (CHIP) Summary

Healthy Montcalm is pleased to present the 2012-2015 Community Health Improvement Plan for Montcalm County. This CHIP was developed by over 40 member organizations and individuals who represent a broad spectrum of the community and subscribe to a broad definition of health.

The CHIP was developed by the members representing Healthy Montcalm using health status data, community input, and each member's professional expertise. The community's health status was obtained by conducting a community health needs assessment, which was then developed into the comprehensive *Community Health Profile Montcalm County 2011* report. This data along with community input gathered from over 450 Montcalm County Health Needs Assessment Survey's provided the necessary information for the Healthy Montcalm members to examine and identify priority health issues that will be addressed in the 2012-2015 Community Health Improvement Plan cycle.

The members identified five issues as health priorities. They are:

- *Improve Access to Care*
- *Increase Awareness of Existing Community Resources*
- *Address Mental Health*
- *Reduce the Prevalence of Obesity*
- *Reduce Substance Abuse*

Goals and objectives relating to these issues as well as intervention strategies, barriers and resources comprise the community health improvement plan.

These strategies which were determined to have the greatest likelihood of success will be implemented and monitored by individuals and groups committed to improving the health concerned with that particular health issue. These selected task forces will convene on a regular basis over this 3-year cycle to ensure that progress is being made on the identified issue.

The CHIP process is an ambitious and bold effort at community engagement for a common good. No single organization has the depth of resources needed to raise community health to an optimal level or to even maintain it at its current level. The CHIP process is based on the idea that through collaboration we as a community can accomplish more and have a greater impact on the health of our community members.

The CHIP was developed in alignment with State Priorities described in the Michigan's Health and Wellness 4 X 4 Plan and National Priorities included in Healthy People 2020.

Health Indicator – Access to Care

Goal: Recruitment and retention of qualified primary care professionals

Evidence for Effectiveness: Various resources exist offering guidance in the recruitment and retention of medical providers. Non-commercial resources include: Association of Staff Physician Recruiters, National Association of community Health Centers, American Hospital Association.

Target: Montcalm County primary care professionals and local healthcare systems

Baseline: Currently 34 Medicare and 31 Medicaid providers in Montcalm County
17.2% of Montcalm County adults report having no personal health care provider
16.7% of Montcalm County adults report not being able to see a doctor when needed in the past year
27.2% had a delay in seeing a doctor due to:
54% report they could not afford to see a doctor
18% had no transportation
9% could not get an appointment
3% had insurance that would not be accepted.

Baseline Data Source: Community Health Assessment – Montcalm County Profile 2011, CMS website, Medicaid website

Champions: Spectrum Health United/Kelsey, Carson City Hospital, Sheridan Community Hospital, Cherry Street Health Services

Objectives:

1) **Increase the number of service hours and/or the number of practicing primary care providers, especially accepting Medicare and Medicaid patients by 2015**

Barriers	Intervention Strategies	Expected Outcomes
- Baseline information for service hours - Reimbursement rates are low	**1.1)** Conduct primary care provider needs analysis **(2013)**	Evaluation
	1.2) Develop recruitment strategy for primary service area **(2012-2013)**	Recruitment strategy developed
	1.3) Implement recruitment strategy for specific disciplines and locations to increase providers **(2012-2014)**	Implement plan
	1.4) Evaluate current hours, location, accessibility and	Evaluation

	productivity **(2013-2014)** **1.5)** Based on evaluation and experience, implement expansion needs in terms of hours and location **(2013-2014)** **1.6)** With additional capacity, address access issues related to acceptance of Medicare, Medicaid and other insurers with new providers **(2013-2014)** **1.7)** Reevaluate primary care provider need and access issues **(2014-2015)**	Implement expansion plans in terms of hours/location Assess and implement plan to address access needs if necessary Evaluation

Health Indicator – Access to Care

Goal: Enhance Care Coordination and Health Outcomes of a At-Risk Population(s)

Evidence for Effectiveness: Agency for Healthcare Research and Quality

Target: At-Risk Population (To be determined by Planning Committee)

Baseline: Currently 34 Medicare and 31 Medicaid providers in Montcalm County
17.2% of Montcalm County adults report having no personal health care provider
16.7% of Montcalm County adults report not being able to see a doctor when needed in the past year
27.2% had a delay in seeing a doctor due to:
54% report they could not afford to see a doctor
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3% had insurance that would not be accepted.

Baseline Data Source: Community Health Assessment – Montcalm County Profile 2011, CMS website, Medicaid website

Champions: Mid-Michigan District Health Department, Spectrum Health United/Kelsey, Carson City Hospital, Sheridan Community Hospital, Cherry Street Health Services

Objectives:

1) **Implement a Community Hub Model to serve the at-risk population(s)**

Barriers	Intervention Strategies	Expected Outcomes
	1.1) Form the Planning Committee **(2013)**	Committee Formed
	1.2) Determine Lead and Hub Agency **(2103)**	Agencies Chosen
	1.3) Conduct a Community Needs Assessment utilizing local and regional data to determine most critical health and social service issue) and chose a target population **(2103)**	Assessment completed and target population chosen

	1.4) Develop a plan to secure funding and determine Sustainability **(2103)** 1.5) Create Pathways to create accountability **(2103)** 1.6) Create supporting tools & documents for care Coordinators **(2103)** 1.7) Create incentives tied to desired outcomes **(2103)** 1.8) Develop systems to track and evaluate performance **(2103)** 1.9) Hire HUB Staff **(2103)** 2.0) Train staff at participating agencies **(2103)** 2.1) Conduct a Community Awareness Campaign **(2103)** 2.2) Launch HUB **(2103)**	Sustainability Plan developed Pathways Developed Tools Created Incentives for reimbursement created System developed Staff hired Staff trained Campaign developed and implemented HUB launched

Health Indicator – Awareness

Goal: Promote the importance of health prevention programs as it relates to health status/outcomes.

Evidence for Effectiveness: Coordinated School Health and Safety Programs (CSHSP). Initially proposed by Centers for Disease Control and Prevention, this program has been promoted by Michigan Department of Community Health and Michigan Department of Education.

Target: Montcalm County's public elementary, middle and senior high schools

Baseline: In 2006, 60.6% of U.S. public elementary, middle and senior high schools provided school health education regarding the importance of health screenings and checkups to promote personal health and wellness. In Montcalm county, 19% of public elementary, middle and senior high schools have current wellness committees. Total schools = 26 (CC-CAS= 4; CMPS=4; GPS=6*; LCS=3*; MCS=2; TCAS=5; VCS=2). *= schools with current wellness committees.

Baseline Data Source: Montcalm County schools

Champions: Spectrum Health United/Kelsey, Carson City Hospital, Sheridan Community Hospital

Objectives:

1) **Increase by 11 schools (80%) the proportion of the county's public elementary, middle and senior high schools that provide school health and wellness in the following area: education on the importance of health screenings and checkups, by July 1, 2015.**
2) **Develop, implement and support wellness committees within the county's public schools.**
3) **Work with existing wellness committees, staff/administration from targeted school districts, parent organizations, school nurses, healthcare providers, MAHC, MMDHD, MHSC, MCBH and interested community members to implement the strategies.**

Barriers	Intervention Strategies	Expected Outcomes
- Community receptivity - School budgets & resources - Lack of support at home - Need dedicated school nurse	**1.1)** Evaluate effectiveness of current wellness programs in targeted schools. **(2013)**	Evaluation
	1.2) Determine support for wellness committee at targeted schools. **(2013-2014)**	Identified community/school support
	1.3) Evaluate community resources and coordinate with community partners to provide education on	Evaluation

		screenings/checkups **(2013-2014)**	
	1.4)	Evaluate current screenings/checkups provided to schools. Recommended screenings include dental, depression, vision, hearing, skin, tobacco, substance use and physical. **(2013-2014)**	Evaluation
	2.1)	Establish wellness committees at targeted schools to include emphasis on education on the importance of health screenings/checkups. Committee representation includes members from the school, local health care providers and community members. Establish at least 3 district wellness teams. **(2014) (CSHSP)**	Establishment of 3 wellness committees at targeted schools
	3.1)	Establish a plan, including financial analysis, to provide education on the importance of screenings/checkups to at least 80% of targeted schools from a county-wide baseline of 19%.**(2014)**	Plan including financial analysis established
	3.2)	Implement the above plan with community partners. Implementation of the plan may vary slightly based on the school. **(2014)**	Implementation of plan
	3.3)	Evaluate effectiveness of wellness committees and education of health screenings/checkups. **(2015)**	Evaluation and report to community

Health Indicator – Awareness

Goal: Increase awareness and utilization of charitable care at hospitals

Evidence for Effectiveness: indeterminate at this time.

Target: healthcare providers, at risk populations

Baseline: Spectrum Health United/Kelsey combined for 1099 applications filed, 863 approved
Sheridan Community Hospital had 62 applications filed, 60 approved
Carson City Hospital had 159 applications filed , 129 approved

Baseline Data Source: hospital charitable care application records (FY 2011 data)

Champions: Sheridan Community Hospital, Carson City Hospital, Spectrum Health United/Kelsey

Objectives:

1) **Increase awareness and utilization of charitable care programs offered by local hospitals by 10% by 2015.**

Barriers	Intervention Strategies	Expected Outcomes
- Confidentiality - Pride	**1.1)** Review and identify current charity care programs **(2012-2013)**	Identify each hospitals charity care program by criteria and qualifications
	1.2) Share charity care information with other healthcare providers and at-risk populations via schools, WIC, food banks, CASA, 2-1-1, etc. **(2013-2014)**	Healthcare providers and at-risk populations will receive information on charity care programs
	1.3) Evaluate increase of utilization of charitable care given at local hospitals. **(2014-2015)**	Increased utilization of charity care

Health Indicator – Awareness

Goal: Increase awareness of community resources

Evidence for Effectiveness: Alliance of Information and Referral Systems (AIRS)

Target: Healthcare Providers, human service organizations, other healthcare organizations, food pantries, general population

Baseline: Number of Total Active Entities Currently Registered in 2-1-1 Montcalm-Ionia Database: Montcalm county – 72
Number of Calls to 2-1-1 Montcalm-Ionia Counties in the past year:
Jan 1, 2011 – December 31, 2011 = Montcalm = 312
Jan 1, 2012 – April 30, 2012 = Montcalm = 512

Baseline Data Source: 2-1-1 current database

Champions: 2-1-1 Montcalm-Ionia counties

Objectives:

1) **Increase 2-1-1 database content and referrals by 5% each year by July 1, 2015.**

Resources/Barriers	Intervention Strategies	Expected Outcomes
Resource: - Possible collaboration with 8-Cap **Barrier:** - Lack of funding/resources	**1.1)** Establish a baseline measurement for 2-1-1 data **(2012)**	Baseline data
	1.2) Enhance and expand 2-1-1 database to include all eligible healthcare resources **(2014)** - *evidence for effectiveness: Alliance of Information and Referral Systems (AIRS) is developing standards and investigating cost/benefit of I&R systems*	Increased number of healthcare resources/providers in the 2-1-1 database Increased utilization of 2-1-1
	1.3) Expand the 2-1-1 Marketing Committee infrastructure to increase capacity, and collaborate with the "awareness subcommittee" on all 2-1-1 related campaigns. **(2013-2015)**	Increased membership and participation in 2-1-1 Marketing Committee
	1.4) Increase the number of healthcare providers promoting 2-1-1 with their patients and peers **(2014)**	Increased knowledge and awareness of the available services

Health Indicator – Mental Health

Goal: Improve Coordination of Mental Health Care Services by Increasing Awareness of Available Resources

Evidence for Effectiveness: Objective #1) Develop Resource Directory – no specific information identified regarding evidence that resource directories improve access or health outcomes. Objective #2) Increase Awareness – Reduce Stigma: although not listed as a recommended evidence-based strategy by the 'Community Guide' or USPSTF, stigma-reduction campaigns do have some support in the scientific literature (Corrigan, P.W. and Shapiro, J.R., 2010). SAMHSA does offer a toolkit titled 'Developing a Stigma Reduction Initiative'.

Target: Health Care Providers, Service Agencies, Community

Baseline: TBD (addressed below in strategy 1.2)

Baseline Data Source: Consumer Care Committee, Deny & Refer statistics

Champions: Montcalm Center for Behavioral Health (MCBH), Montcalm County Suicide Prevention Coalition (MCSPC),

Objectives:

1) **Develop Montcalm County Mental Health Services Resource Database/Directory by 2014**
2) **Increase Awareness of Mental Health Resources/Services within the Community by 2015**

Barriers	Intervention Strategies	Expected Outcomes
- Social Attitudes (stigma) regarding mental illness - Limited information concerning available resources for seeking care - Lack of financial resources to pay for services	**1. Objective 1: Mental Health Services Resource Directory** **1.1.** Assemble community workgroup to address actions outlined in this Community Health Improvement Plan. (2012) **1.2.** Work with community partners to secure data necessary to determine mental health service assets/gaps/needs. 1.2.1. Review the Denial & Referral statistics collected by MCBH Consumer Care Committee to determine most frequent consumer requests for mental health services and the most frequent types of referrals. (2012)	Providers and service agencies are aware of available mental health services throughout Montcalm County

	1.2.2. Review 2-1-1 call data of mental health service requests and referrals. (2012) **1.3.** Compile database of available mental health services within Montcalm County and surrounding area. (2013) **1.4.** Share resource directory with health care providers and agencies to strengthen the referral system between providers and service organizations. (2014) **1.5.** Develop plan for housing database and regularly updating information. (2014) **2. Objective 2: Increase Awareness of Resources** **2.1.** Work with community partners to promote importance of recognizing and seeking assistance for mental health disorders. (2014) 2.1.1. Collaborate with MCBH to expand Anti-Stigma campaign within Montcalm County. (2013) **(SAMHSA)** 2.1.2. Collaborate with MCSPC to expand suicide prevention awareness objectives to broader mental health awareness and access to available resources. (2014) 2.1.3. Collaborate with service agencies to encourage referral to appropriate mental health services. (2015) 2.1.4. Collaborate with health care providers to encourage the sharing of 2-1-1 resources with patients. (2015)	Montcalm County residents are aware of available resources for mental health services.

Health Indicator – Obesity

Goal: Reduce the prevalence of obesity in children

Evidence for Effectiveness: American Academy of Pediatrics (AAP), Centers for Disease Control & Prevention (CDC), World Health Organization (WHO)

Target: children 0- 5 years of age

Baseline: 14.3 % of Montcalm children age 0-5 with over 95% height/weight (WIC data only for 2,3,4 yr. olds for obesity)

Baseline Data Source: 2010 Pediatric Nutrition Surveillance (PNS), possibly MCIR in the future

Champions: MAISD, Great Start Collaborative, Head Start (8Cap), Mid-Michigan District Health Department, MSU Extension, K. Bassett, RD, Carson City Hospital, Sheridan Hospital, Spectrum Health Kelsey/United Hospital's , Western Region Resource Center

Objectives:

1) **Decrease the number of children to 13.3% who fall over 95% height/weight by September 30, 2015.**

Resources	Intervention Strategies	Expected Outcomes
- WIC data covers 40% of the kids in this age group - Head Start - Great Start Readiness Program - Early Childhood Investment Corp. - Family Future's database-ages & stages questionnaire per C. O'Connor - TBD - Michigan Quality Improvement Consortium guidelines www.mqic.org - BC/BS Toolkit for obesity prevention	**1.1)** Addressing physicians updates/collaboration using Ounce of Prevention strategy **(2012-2015) (AAP)** **1.2)** Educate parents and caregivers regarding nutrition and physical activity (utilize existing resources – WIC mothers, Let's Move, Great Start) **(2012-2015)** **1.3)** Support Breastfeeding opportunities throughout the community **(2012-2015)** - Great Start Collaborative - WIC Peer Counselors, Mid-Michigan District Health Department- **(CDC)** - Baby Friendly Hospitals, Spectrum Health **(WHO)**	Decrease the number of children who fall over 95% height/weight

Health Indicator – Obesity

Goal: Reduce the prevalence of obesity in seniors through health and wellness programs and education

Evidence for Effectiveness: National Council on Aging (NCoA), Centers for Disease Control & Prevention (CDC)

Target: seniors age 65+

Baseline: 34.8% of Montcalm seniors age 65+ with BMI at 30.0 or above (obese)
30.8% of Montcalm seniors age 65+ with inadequate physical activity (sedentary)

Baseline Data Source: local Behavioral Risk Factor Survey 2008-2010 data

Champions: Commission On Aging, MCC, MSU Extension, Physicians

Objectives:

1) **Decrease the number of seniors whose BMI is over 30 by 3% by 2015.**

Resources/Barriers	Intervention Strategies	Expected Outcomes
Resource: - Montcalm Senior Newsletter - MSUE website for nutrition information – www.msue.msu.edu - Include MSUE nutrition articles in senior newsletter - BCBS tool kits for physicians - Payers (Priority Health/BCBS) - CCH & SCH patient registry **Barrier:** - Tracking of physical activity opportunities for seniors	**1.1)** Support opportunities for seniors to be physically active **(2012-2015)** -Matter of Balance **(NCOA)**, Choga, Aquatics, T.O.P.S. programs; Healthy Moves for Aging Well **(NCOA)**, Walk with Ease **(CDC)** - Classes provided at local health clubs **1.2)** Support opportunities for seniors to cook and eat nutritiously **(2012-2015)** - Healthy Eating for Successful Living among Older Adults **(NCOA)**; Eat Better & Move More, Life Long Learners (MCC) - Senior Meals program, Project FRESH **1.3)** Educate local physicians on health and wellness resources available to seniors **(2012-2015)**	Decrease in BMI among seniors Increased awareness and access to resources for seniors

Health Indicator – Substance Abuse

Goal: Reduce youth substance abuse

Evidence for Effectiveness: Centers for Disease Control (CDC), Community Guide (CG), National Institute on Drug Abuse (NIDA), Office of National Drug Control Policy (ONDCP), Office of Juvenile Justice and Delinquency Prevention (OJJDP), Substance Abuse and Mental Health Services Administration (SAMHSA)

Target: youth under 21yrs of age, adults who influence this age population

Baseline: 13.6% tobacco vendors sales rates (2006-09 3-year average)
15.6% alcohol vendor sales rates (2011)
53.5% of Montcalm County youth who reported alcohol use by peers to be wrong or very wrong
64.3% of Montcalm County youth who reported tobacco use by peers to be wrong or very wrong
16.9% Among students who smoked recently, the percentage who usually purchased their own cigarettes from a person 18 years or older during the past 30 days.
29.0% Among students who drank recently, the percentage who usually got their own alcohol by giving someone else money to buy it during the past 30 days

Baseline Data Source: 2010 Michigan Profile for Healthy Youth Survey (MiPHY), alcohol & tobacco vender compliance rates (DFM), adult community survey (still being developed)

Champions: Drug Free Montcalm, Cherry Street Health Services

Objectives:

1) **Assist 75% of alcohol vendors with sales compliance practices annually**
2) **Assist 75% of tobacco vendors with sales compliance practices annually**
3) **Support avenues to lower by 5% the youth perception of friends approval of using alcohol, tobacco, as reported on MiPHY surveys by September 30, 2015**
4) **Support avenues to lower by 5% the access youth have to tobacco, from adults, as reported on MiPHY surveys by September 30, 2015**

Barriers	Intervention Strategies	Expected Outcomes
- MiPHY data will not be available in 2015 (released in 2014 & 2016) - Law enforcement resources are limited	**1.1)** Support prevention initiatives that reduce access to alcohol by youth. **(2013-2015) (**ONDCP) -Implement alcohol compliance checks with 75% of the vendors (CG, OJJDP) -Implement alcohol vendor education with 75% of the vendors (OJJDP) Provide alcohol management classes to local alcohol vendors (OJJDP)	Decrease in youth access to alcohol & an increase vendor compliance/knowledge

	2.1) Support prevention initiatives that reduce access to tobacco by youth **(2013-2015)** (ONDCP, SAMHSA) -Implement tobacco compliance checks with 75% of the vendors (CDC, SAMHSA) -Implement tobacco vendor education with 75% of the vendors (CG, SAMHSA)	Decrease in youth access to tobacco & and increase vendor compliance/knowledge Decrease in tobacco usage
	3.1) Support collaboration and networking activities that promote Social Norming approaches with youth (CDC, ONDCP) -Collaborate with SADD chapters and network with other youth groups in the county to provide follow up activities from the Youth Summit of 2012 **(2013)** (CDC, ONDCP) -Advocate to youth for prevention messages on social networking sites **(2013-2015)** (CDC) -Community and youth surveys to be conducted by SADD chapters or other youth groups **(2013-2015)** (CDC)	Active participation from youth in alcohol, tobacco, and other drug prevention activities
	3.2) Support programs designed to empower youth with prevention messages **(2013-2015)** (ONDCP) -Support programs that deliver Protective Factor information to youth and adults (ONDCP) -Support high school leadership programs that provide mentorship with elementary students (CDC, OJJDP)	Increased sustainability of existing prevention programs
	4.1) Increase awareness and parenting skills with parents/guardians of youth. (CDC, ONDCP) -Create a plan to reach adults by partnering with existing organizations/coalitions to promote parenting skills **(2013)** (CDC, NIDA, ONDCP)	Increased involvement & knowledge with parents/guardians

Additional Information Supporting Evidenced-based Interventions

Health Indicator – Access to Care
Evidence-Based Support for Intervention Strategies

Goal 1: Recruitment/retention of primary care providers

The Association of Staff Physician Recruiters supported the Commonwealth Fund in its assessment of best practices in specialty provider recruitment and retention. These concepts can be helpful in strategizing a plan to recruit or retain primary care providers. The entire report can be accessed at: http://www.commonwealthfund.org/Publications/Fund-Reports/2005/Aug/Best-Practices-in-Specialty-Provider-Recruitment-and-Retention--Challenges-and-Solutions.aspx

The National Association of Community Health Centers supports a 2005 guide for best practices in physician recruitment and retention that was developed through a multi-state partnership. This guide is particularly useful for community health centers. The entire guide (Recruitment & Retention Best Practices Model, 2005) can be accessed at: http://www.nachc.com/client/documents/Recruitment%20%20Retention%20Best%20Practices%20Model.pdf

The Michigan Primary Care Association offers a recruitment and retention toolkit that can be used as a guide in training staff to be more prepared and involved in the recruitment and retention process. This toolkit is particularly useful for health centers. The toolkit and other resources can be accessed at: http://www.mpca.net/displaycommon.cfm?an=1&subarticlenbr=77

The American Hospital Association offers a document highlighting several cases as best practices in small or rural hospital recruitment and retention. This document can be accessed at: http://www.aha.org/content/00-10/08ruralrecruitment.pdf

Goal 2: Enhance care coordination of at-risk populations

Agency for Healthcare Innovations Exchange: *http://innovations.ahrq.gov/content.aspx?id=2933*

Not identifying at-risk populations and connecting them to the care they need has two consequences. First, health outcomes suffer. Secondly, overall health care costs are significantly higher because delays in preventive and primary care results in chronic health issues that result in emergency room visits and hospitalization. The process of identifying at-risk individuals and referring them to needed services is generally referred to as care coordination. While there are a number of organizations providing this type of service in our communities, there is little or no collaboration between the programs, resulting in individuals falling through the cracks or a duplication of efforts.

Community “HUB”, which is an evidenced-based model – promotes a system of collaboration, accountability and improved outcomes. The goal of this model to is improve the system by which at-risk individuals within a community are identified and connected to appropriate health care and social services. The HUB serves as a central clearinghouse that “registers” individuals and coordinates the care they receive making sure their physical, emotional and basic needs are met. The HUB does not support any single agency – it strengthens and supports all health and social service providers in the area. This model eliminates duplication and provides needed support services. There are three overarching principles included in the model: **Find:** Identify those at greatest risk. **Treat:** Ensure that they receive needed evidenced-based health and social services (eg. Prenatal care, immunizations, chronic disease management, parenting education, housing, food, clothing). **Measure**: Document and evaluate benchmarks and final outcomes.

These principles are consistent with the fundamentals of high-quality health care and within the principles of public health assessment, policy development, and service assurances outlined by the Institute of Medicine. The Pathways Community HUB provides the centralized processes, systems and resources that allow systematic tracking of those being served and that ties payments to milestones that improve the client’s health and well-being.

Health Indicator – Awareness of Resources
Evidence-Based Support for Intervention Strategies

Goal 1: Promote importance of health prevention programs in public schools

2.1 CDC: http://www.cdc.gov/healthyyouth/npao/wellness.htm
Congress recognizes the important role schools play in promoting the health of youth. In 2004, Congress passed the Child Nutrition and Women Infants and Children (WIC) Reauthorization Act (Sec. 204 of P.L. 108-205). This act required by law that all local education agencies participating in the National School Lunch Program or other child nutrition programs create local wellness policies. The legislation places the responsibility of developing a wellness policy at the local level so the individual needs of each local education agency can be addressed. Evidence of effectiveness: school wellness policies are only as effective as the implementation strategy outlined by its school health council/team. A Robert Wood Johnson Foundation evaluation of local school wellness policies can be accessed here:
http://www.bridgingthegapresearch.org/_asset/13s2jm/WP_2013_report.pdf

3.2 CDC: http://www.cdc.gov/chronicdisease/resources/publications/aag/dash.htm
Schools have a critical role to play in partnership with community agencies and organizations to improve the health and well-being of young people. One approach recommended by CDC is coordinated school health (CSH). CSH brings together school administrators, teachers, other staff, students, families, and community members to assess health needs; set priorities; and plan, implement, and evaluate school health activities.

Goal 2: Increase awareness/utilization of hospital charitable care

1.2 Indeterminate at this time. Definition of "charity care" varies among states, as well as policies/laws to regulate it. Citing Rosenbaum and Margulies in Public Health Reports, "...community benefit activities have, until the passage of the Affordable Care Act, remained largely a matter of individual hospital discretion, state law requirements, and informal IRS guidance." For a brief history of hospital charity care in the United States, access:
http://www.mffh.org/mm/files/hospitalchairtycareissuebrief.pdf

Goal 3: Increase awareness of community resources via 2-1-1

1.2 Alliance for Information and Referral Systems (AIRS): http://www.airs.org
Information & Referral organizations such as 2-1-1 create and maintain databases of programs and services, and then disseminate that information through a variety of channels to individuals and communities. The databases are maintained by trained Resource Specialists and may be published in directories and/or made available over the Internet. Systems that allow callers to talk directly to a Resource Specialist are more likely to be effective.

Health Indicator – Mental Health
Evidence-Based Support for Intervention Strategies

Objective 1: Mental Health Services Resource Directory

1.4 Unable to find evidence that providing resource directories improves outcomes such as increased access to services or providers.

Objective 2: Increase Awareness of Resources

2.1.1 SAMHSA - http://store.samhsa.gov/shin/content/SMA06-4176/SMA06-4176.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA) offers a toolkit designed to support the activities of those who plan to mount a statewide, regional, or local effort to address and counter mental health stigma and discrimination. It is intended for use by local mental health advocates, consumers of mental health services and their family members, community leaders, and other organizations that want to reduce the barriers of stigma and discrimination faced by people with mental illnesses. The toolkit is based on the social marketing approach to changing behaviors.

Additional Information regarding evidence of effectiveness of mental health interventions:

The Guide to Community Preventive Services ('Community Guide') recommends the following interventions (sufficient evidence that intervention is effective):

1. Collaborative Care for the Management of Depressive Disorders: a multicomponent, healthcare system-level intervention that uses case managers to link primary care providers, patients, and mental health specialists. This collaboration is designed to: a) Improve the routine screening and diagnosis of depressive disorders, b)Increase provider use of evidence-based protocols for the proactive management of diagnosed depressive disorders, and c) Improve clinical and community support for active patient engagement in treatment goal setting and self-management. http://www.thecommunityguide.org/mentalhealth/collab-care.html

2. Mental Health Benefits Legislation: involves changing regulations for mental health insurance coverage to improve financial protection (i.e., decrease financial burden) and to increase access to, and use of, mental health services. Such legislation can be enacted at the federal or state level. Moving toward parity for mental health coverage is a key element of most mental health benefits legislation (defined as having no greater restrictions for mental health coverage than physical health coverage). http://www.thecommunityguide.org/mentalhealth/benefitslegis.html

3. Home-Based Depression Care Management (Intervention to Reduce Depression Among Older Adults): Home-based depression care management involves: a) Active screening for depression, b) Measurement-based outcomes, c) Trained depression care managers, d) Case

management, e) Patient education, and f) a supervising psychiatrist. Can be applied to diverse home settings (public housing, residential facilities, home care clients). http://www.thecommunityguide.org/mentalhealth/depression-home.html

4. Clinic-Based Depression Care Management (Intervention to Reduce Depression Among Older Adults): Clinic-based depression care management involves: a) Active screening for depression, b) Measurement-based outcomes, c) Trained depression care managers providing case management, and d) Primary care provider and patient education, antidepressant treatment and/or psychotherapy, and a supervising psychiatrist. Can be applied broadly to primary care clinics. http://www.thecommunityguide.org/mentalhealth/depression-clinic.html

5. Reducing Psychological Harm from Traumatic Events Among Children and Adolescents: Cognitive-Behavioral Therapy (Individual & Group): Therapists administer CBT individually or in a group, and treatment may be accompanied by therapy sessions for or with parents. [A traumatic event is one in which a person experiences or witnesses actual or threatened death or serious injury, or a threat to the physical integrity of self or others]. http://www.thecommunityguide.org/violence/traumaticevents/behaviortherapy.html

The Guide to Community Preventive Services ('Community Guide') reviewed but did not recommend the following interventions, as there was insufficient evidence that intervention is effective:

1. Community-Based Exercise Interventions (Interventions to Reduce Depression among Older Adults): the community-based exercise interventions assessed in this review provided individual or group exercise classes for older adults. These classes may focus on: a) Strengthening, b) Endurance, or c) Functional training. An older adult is defined as 60 years of age or older. The clinical significance of the interventions could not be determined for depressed individuals. http://www.thecommunityguide.org/mentalhealth/depression-oa.html

The following clinical recommendations come from the U.S. Preventive Services Task Force (USPSTF), which evaluates clinical research in order to assess the merits of preventive measures:

1. Screening for Depression in Adults: recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. http://www.uspreventiveservicestaskforce.org/uspstf/uspsaddepr.htm

2. Major Depressive Disorder in Children and Adolescents: recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up. http://www.uspreventiveservicestaskforce.org/uspstf/uspschdepr.htm

The U.S. Preventive Services Task Force (USPSTF) reviewed but did not recommend the following interventions, as there was insufficient evidence that intervention is effective:

1. Screening for Suicide Risk: concludes that the evidence is insufficient to recommend for or against routine screening by primary care clinicians to detect suicide risk in the general population. http://www.uspreventiveservicestaskforce.org/uspstf/uspssuic.htm

Health Indicator – Obesity
Evidence-Based Support for Intervention Strategies

Goal 1: Children Focus:

1.1 **AAP – https://www2.aap.org/obesity/links.html**
American Academy of Pediatrics Recommends – "Ounce of Prevention" program is designed for infancy through 18 years of age and provides parent handouts, a physician guide and posters to help prevent obesity. Addressing the growing epidemic of obesity is top priority for many health-care providers. Physicians who regularly monitor growth and provide anticipatory guidance related to parenting, eating, and physical activity can perform an important intervention in a child's life.

1.3 **CDC -** http://www.cdc.gov/breastfeeding/pdf/BF_guide_3.pdf
Centers for Disease Control Recommends- Peer Counselors. Because women's social networks are highly influential in their decision-making processes, they can be either barriers or points of encouragement for breastfeeding. New mothers' preferred resource for concerns about child rearing is other mothers. For example, advice from friends is commonly cited as a reason for decisions about infant feeding. Perceived social support has also been found to predict success in breastfeeding.

WHO - http://www.unicef.org/programme/breastfeeding/baby.htm
The World Health Organization Recommends- Hospitals and maternity units set a powerful example for new mothers. The Baby-Friendly Hospital Initiative (BFHI), launched in 1991, is an effort by UNICEF and the World Health Organization to ensure that all maternities, whether free standing or in a hospital, become centers of breastfeeding support.

Goal 2: Senior Focus:

1.1 **NCOA -** http://www.ncoa.org/improve-health/center-for-healthy-aging/a-matter-of-balance.html
National Council on Aging Recommends– "A Matter of Balance" emphasizes practical strategies to reduce fear of falling and increase activity levels. Participants learn to view falls and fear of falling as controllable, set realistic goals to increase activity, change their environment to reduce fall risk factors, and exercise to increase strength and balance. This program has been adapted from the original intervention to be more suitable for community-dwelling older adults by allowing small group sessions to be led by a trained facilitator.
NCOA Recommends – http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/program-summary-healthy-2.html
"Healthy Moves for Aging Well" (Healthy Moves) is a simple and safe evidence-based physical activity program designed to enhance health outcomes for frail, high-risk, and diverse older adults receiving services in the home. The program utilizes

care managers from community-based care management agencies to teach the program's exercises to their older clients in their home. At their regularly scheduled visits, care managers enroll clients into the program by assessing their ability and readiness to participate safely and by using motivational interviewing techniques to engage each client in setting a goal.
CDC Recommends- http://www.cdc.gov/arthritis/interventions/physical_activity.htm
"Walk with Ease" (WEE) is a community-based, group walking program offered by the Arthritis Foundation. The WEE arthritis self-management program was developed by the Arthritis Foundation to be used in a community setting with individuals who may be either self or medically diagnosed with arthritis. Participants met three times a week at regional sites in groups of up to 30 participants under the direct supervision of a walking leader trained according to guidelines of the Arthritis Foundation.

1.2 **NCOA** Recommends -http://www.ncoa.org/improve-health/center-for-healthy-aging/healthy-eating-for-successful.html
"Healthy Eating for Successful Living in Older Adults" is program for diverse community-dwelling adults age 60 and older. The overall goal of Healthy Eating is to increase self-efficacy and general well being by improving participants' knowledge of nutritional choices that focus on heart and bone healthy foods as well as supportive physical activities. Goal setting, problem solving and self-monitoring are used to optimize individual behavior change.

Indicator – Substance Abuse
Evidence-Based Support for Intervention Strategies

Intervention Strategy 1.1

a) ONDCP - www.ncjrs.ondcppubs/publications/prevent/evidence_based_eng.html
Successful approach: Reduce availability of alcohol for the under-aged.

b) OJJDP - www.udetc.org/documents/accesslaws.pdf
Best practice: Restrict commercial availability of alcohol to youth, with a focus on the practices of alcohol retailers. Carry out compliance check programs. Give vendors advance notice of compliance check program. Provide opportunities for retailers to participate in responsible sales and service programs prior to the start of the compliance check.

c) CG - www.thecommunityguide.org
Recommended strategy: Enhanced enforcement of laws prohibiting sales to minors, including sting operations.

Intervention Strategy 2.1

a) ONDCP – www.ncjrs.ondcppubs/publications/prevent/evidence_based_eng.html
Successful approach: Reduce availability of tobacco for the under-aged.

b)SAMHSA- www.samhsa.gov/prevention/2011-Annual-Synar-Report.pdf
The federal Synar Amendment requires annual, random compliance checks and strongly recommends the provision of merchant education to all retailers in a variety of formats.

b) CDC – www.cdc.gov/tobacco/stateandcommunity/bp_userguide_youth/index.htm
Best Practice: Mobilize the community to restrict minors' access to tobacco products when combines with additional interventions, including sting operations.

c) CG - www.thecommunityguide.org
What works/tobacco use: Restrict minors' access to tobacco products, including enforcement of laws for retailers and retailer education.

Intervention Strategy 3.1

a) CDC- www.cdc.gov/tobacco/stateandcommunity/bp_userguide_youth/index.htm
Form community linkages. Support environmental changes, through policy, that have the most impact on social norms around tobacco use. Recruit and engage youth through social networking sites. Conduct community engagement activities, including community assessments. Focus on environmental change, rather than individual change.

b) ONDCP – www.ncjrs.gov/ondcppubs/publications/prevent/evidence_based_eng.html
Successful approach: Strengthen anti-drug-abuse attitudes and norms.

c) OJJDP – www.udetc.org/documents/accesslaws.pdf
Implementation Principle: Foster youth participation and activism.

Intervention Strategy 3.2

a) ONDCP – www.ncjrs.gov/ondcppubs/publications/prevent/evidence_based_eng.html

Successful approach: Strengthen social bonding, including use of mentoring programs and structured recreational activities.

b) CDC – www.cdc.gov/tobacco/stateandcommunity/bp_userguide_youth/index.htm

What works: Coordinate efforts with local organizations. Use a community and school approach, involving everyone with influence on youth.

c)OJJDP - www.udetc.org/documents/accesslaws.pdf

Implementation Principle: Foster youth participation and activism, including leadership.

Intervention Strategy 4.1

a) CDC – www.cdc.gov/tobacco/stateandcommunity/bp_userguide_youth/index.htm

Community Engagement: Coordinate efforts with local organizations, including parent-teacher organizations.

b) ONDCP – www.ncjrs.gov/ondcppbus/publications/prevent/evidence_based_eng.html

Successful approach: Reduce risk and enhance protection in families.

c) NIDA – www.drugabuse.gov/sites/default/files/preventingdruguse.pdf

Guiding principles: Prevention programs should enhance protective factors and reverse or reduce risk factors. Family-based prevention programs should enhance family bonding and relationships.